Intermediate Billing Training

Health First Colorado
(Colorado's Medicaid Program)

Training Overview

- Claims Processing
- Payment Timelines
- Timely Filing
- Suspended Claims
- Adjustments & Voids
- Resubmissions, Reconsiderations & Appeals
- Resources
- Claim Submission Reminders

Claims Processing
Common Terms

- Paid - Claim could be paid on all line items or only partially for some line items
- Denied – Provider can resubmit as a new claim
- Suspend - Claim must be manually reviewed by fiscal agent before final decision
- Adjustment - Corrects a paid claim; can be initiated by the Department or the provider.
- Void - Cancels a paid claim which may result in a balance due
- Resubmit – Rebills a previously denied claim
- Internal Control Number (ICN) - Unique identification number assigned to each claim to track and process payment for services provided to members

Claims Processing
via Provider Web Portal

- Claim submission through the Provider Web Portal is a real-time exchange of information between the provider and Health First Colorado
  - Submit one claim at a time
  - Immediately receive response about that single transaction indicating whether the claim is denied, suspended or paid
    - Reminder: Suspended claims require manual review by the fiscal agent
- The Provider Web Portal reviews claim information for compliance with Health First Colorado billing policy and passes the claim to the Colorado interChange (iC) system for adjudication and reporting on the Health First Colorado Provider Remittance Advice (RA)

Claims Processing
via Batch

- Batch billing refers to the electronic creation and transmission of several claims or eligibility inquiries in a group
- All batch claim submission software must be tested and approved by the Department's fiscal agent. Any submitter, such as a clearinghouse, sending electronic transactions through the Health First Colorado Secure File Transfer Protocol (SFTP) for processing must complete Electronic Data Interchange (EDI) Trading Partner enrollment. This provides EDI the information necessary to assign a Logon Name, Logon ID and Trading Partner ID, which are required to submit electronic transactions, including claims.

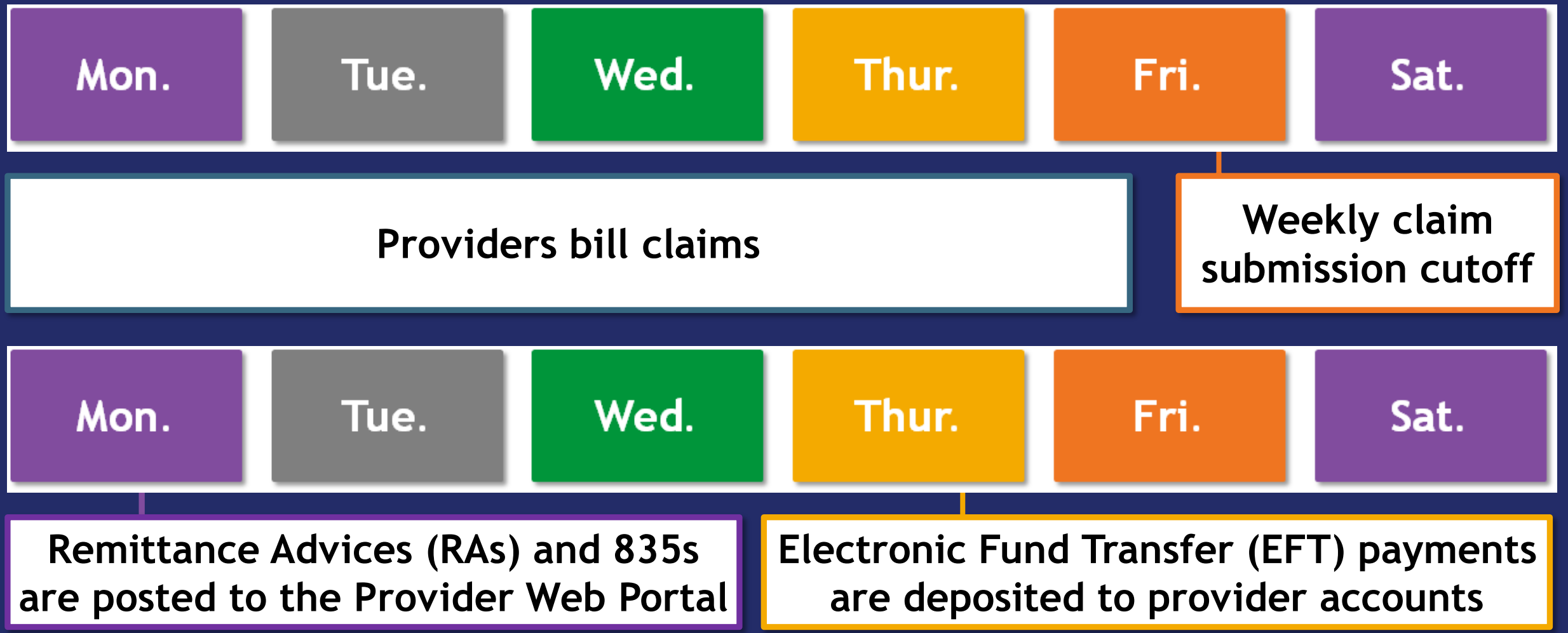
Claims Processing
via Batch

- Claim submission through batch processing occurs via providers' in-house software or through a separate company that does batch billing and is enrolled as a submitter through Health First Colorado
  - Batch processing uses the national X12 format which has a specific coding protocol
  - Guides are published by Washington Publishing Company
  - Health First Colorado does not provide batch creation instruction but does provide companion guides

Claims Processing
Remittance Advice

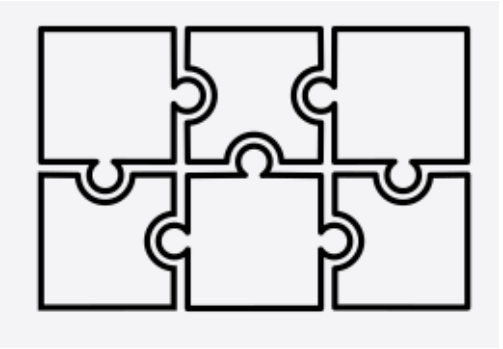
- The Provider Web Portal provides access to reports, as well as the Secure File Transfer Protocol (SFTP) which clearinghouses may use
- One Remittance Advice (RA) or X12N 835 ERA will contain all claims regardless of submission type (e.g., paper, batch or Provider Web Portal)
- Remittance Advice (RA) reports are posted each Monday
- Providers can also check the status of claims prior to the RA being posted by doing a claim status inquiry on the Provider Web Portal

Payment Timelines



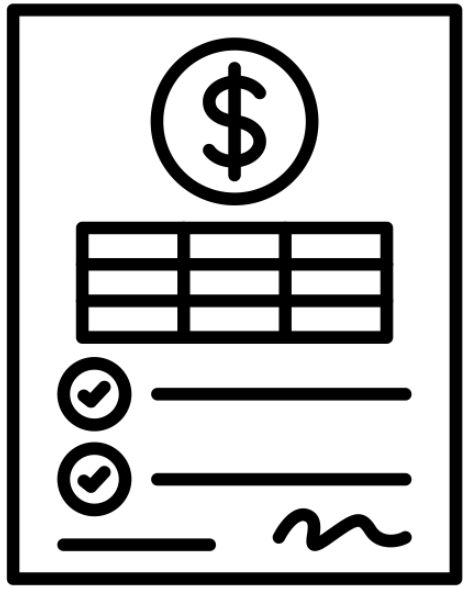
Claims Processing
Secondary Billing

- Providers must accept all forms of a member's insurance prior to rendering services
- If a provider does not accept the primary insurance or is not enrolled with the primary insurance, such as Medicare, they may not bill Health First Colorado as secondary
- Providers may not charge the member for any co-pays, deductibles and difference in payments from the primary insurance



Claims Processing
Secondary Billing

- Refer to the Third-Party Liability and Medicare Reference Guide
- Includes detailed instructions for entering required data fields to complete the CMS1500 and UB-04 claim forms
  - Third Party Liability
    - CMS1500 fields: 6, 9, 9a, 9d, 11d and 29
    - UB-04 fields: 39, 40, 41, 50, 51, 54, 55, 58, 60, 61 and 62
  - Medicare
    - CMS1500 fields: 4, 11, 11a and 29
    - UB-04 fields: 30, 40, 41, 50, 51, 54, 55, 58 and 60

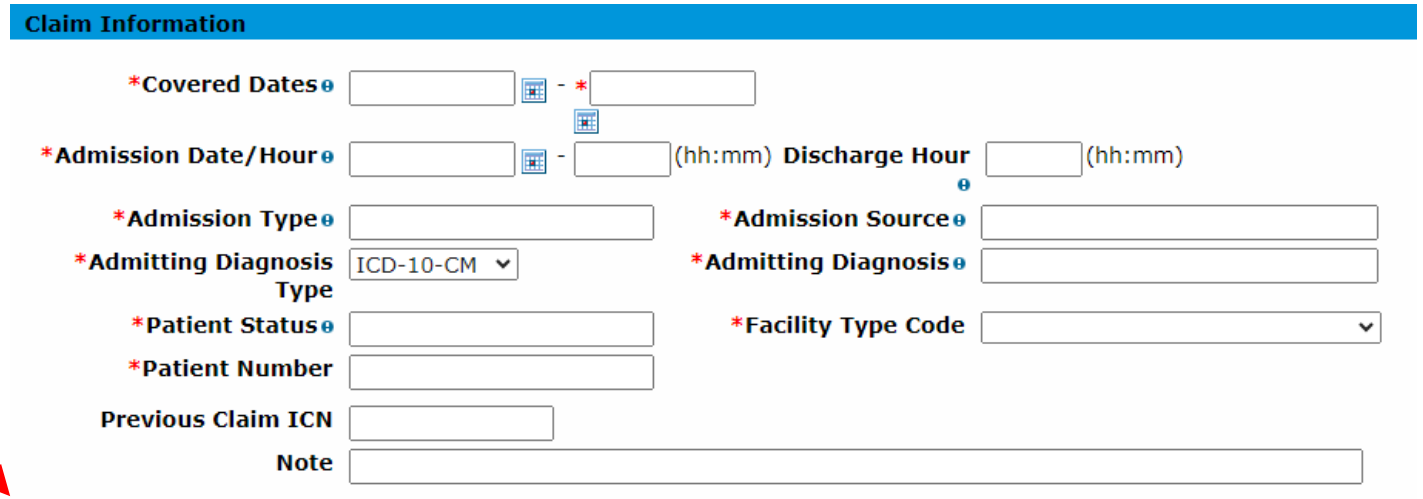


Claims Processing
Medicare Crossover

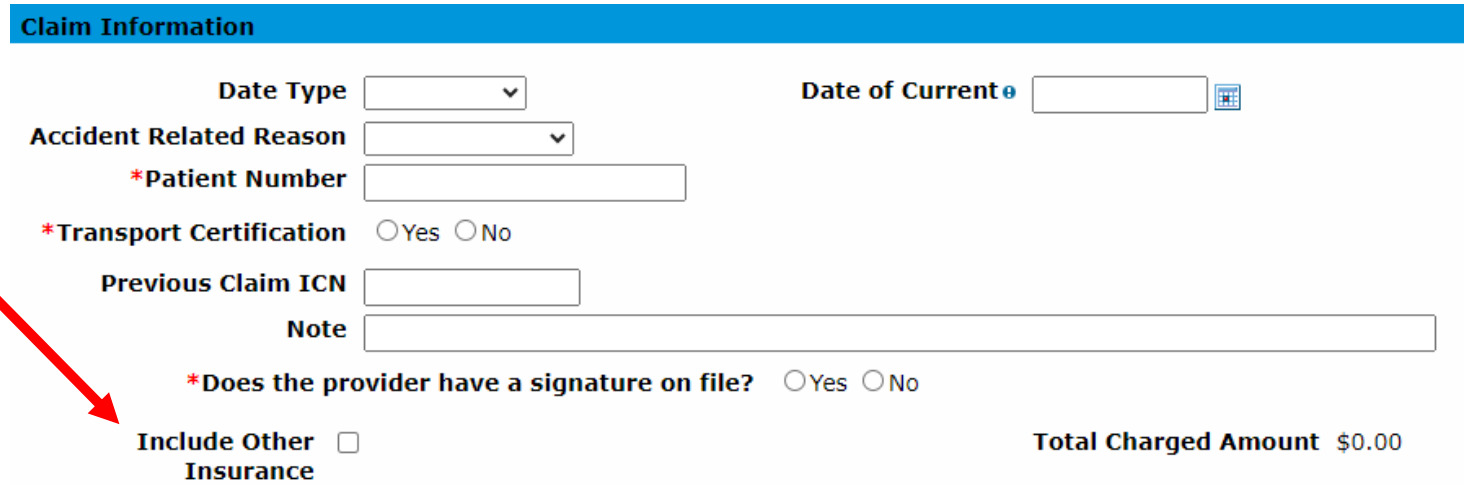
- Note that Medicare Advantage Plans or Medicare HMO plans should be entered as Medicare, not TPL or other insurance
- Refer to the Provider Web Portal Quick Guide:
  - Submitting a Claim with Other Insurance or Medicare Crossover Information
- Includes detailed instructions for entering required data fields to complete the CMS1500 and UB-04 claim forms
  - Professional Claim with Medicare (Crossover)
  - Institutional Inpatient Claim with Medicare (Crossover)
  - Institutional Inpatient Claim with Medicare (Part B Only Crossover)
  - Institutional Outpatient Claim with Medicare (Crossover)

Claims Processing
Medicare Crossover Claim Details

INSTITUTIONAL CLAIM
Do not check the "Include Other Insurance" box.



PROFESSIONAL CLAIM
Do not check the "Include Other Insurance" box.



COLORADO
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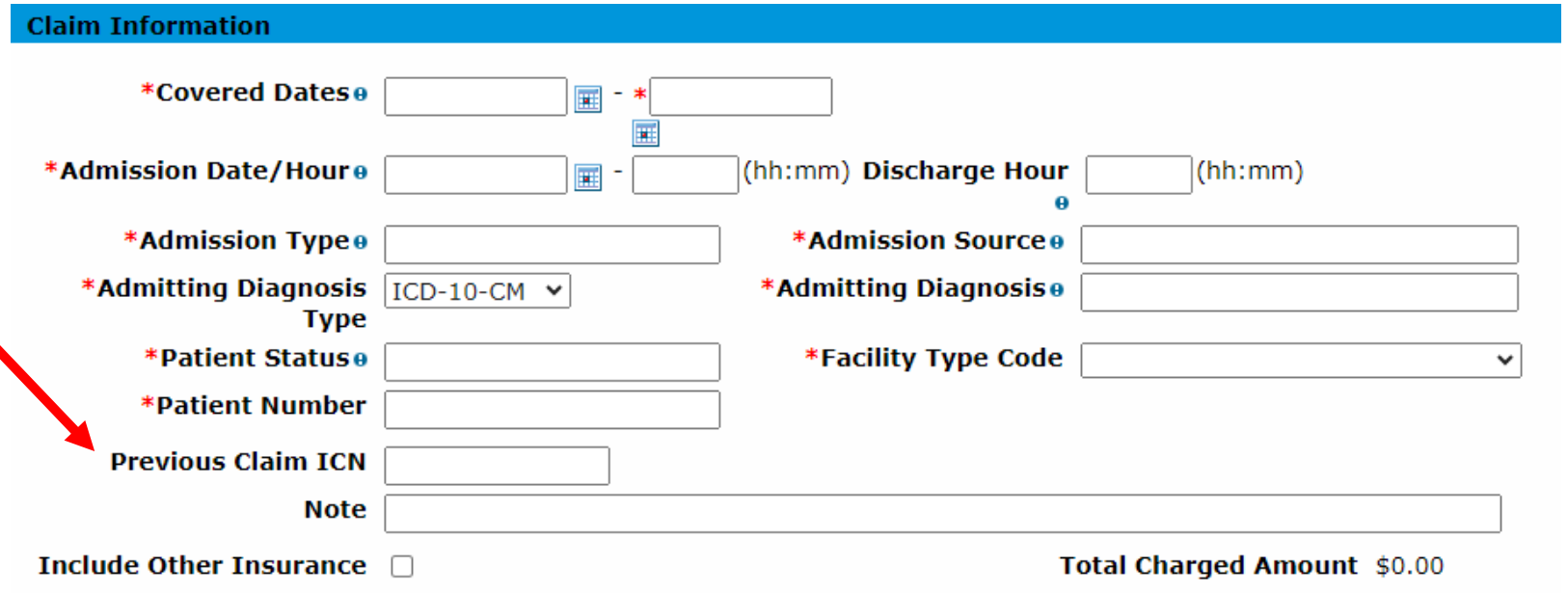
Timely Filing
Summary Table

Scenario	Within 365 Days from Date of Service	Past 365 Days from Date of Service
Original claim (first submission)	Yes	No
Resubmitted claim (after denial[s])	Yes	Yes, within 60 days of remittance advice or returned paper claim and with reference to original ICN/Claim ID
Commercial insurance as primary payer	Yes, after receiving commercial insurance Explanation of Benefits (EOB)	No
Medicare as primary payer	Yes, after receiving Medicare Explanation of Benefits (EOB)	Yes, within 120 days of Medicare Explanation of Benefits (EOB)
Provider verifies that member has Health First Colorado benefits after date of service	Yes	No
Member receives retroactive (backdated) eligibility for Health First Colorado benefits	Yes	Yes, within 60 days of load letter from county (attached to claim)
Provider receives approval for retroactive (backdated) enrollment in Health First Colorado	Yes	Yes, within 60 days of enrollment letter (attached to claim)

Timely Filing
Referencing the Previous ICN on Institutional Claim

- If the date of service (DOS) is past 365 days, enter the previous Internal Control Number (ICN) in the field “Previous Claim ICN”
- The previous ICN should be from the most recent claim submitted within the previous 60 days
  - Provider Web Portal Quick Guide: Submitting an Institutional Claim
    - See step #16

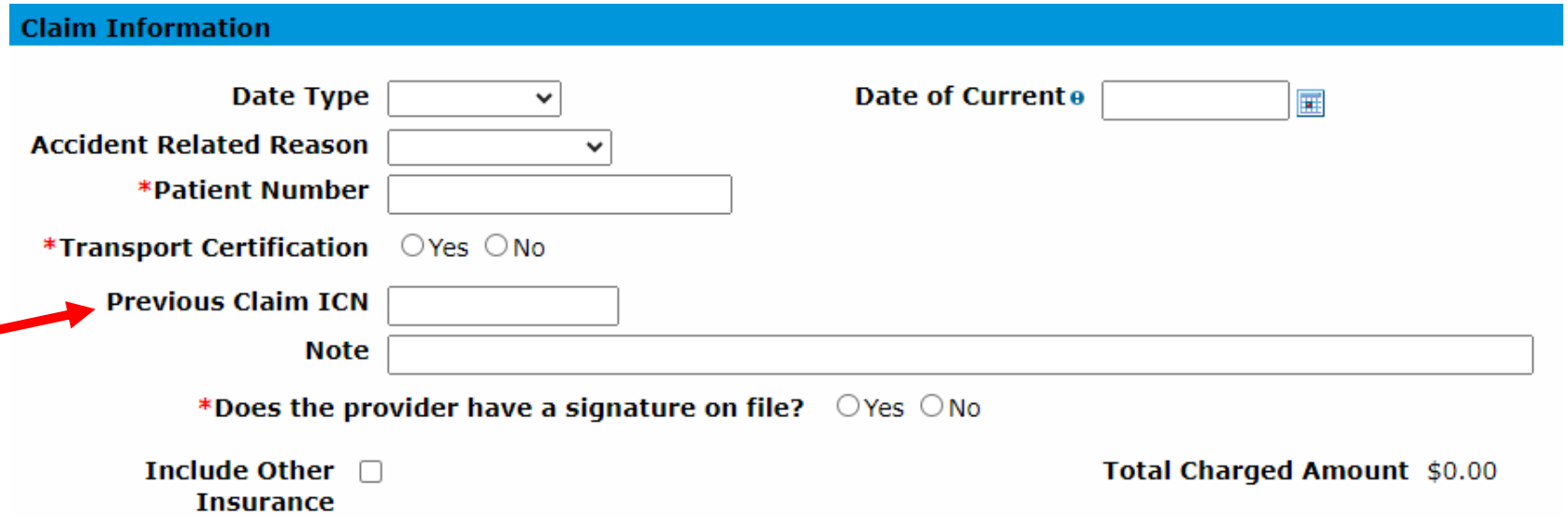
Reference the original Internal Control Number (ICN) if you are resubmitting a claim after it has been denied.



Timely Filing
Referencing the Previous ICN on Professional Claim

- If the date of service (DOS) is past 365 days, enter the previous ICN in the field “Previous Claim ICN”
- The previous ICN should be from the most recent claim submitted within the previous 60 days
  - Provider Web Portal Quick Guide: Submitting a Professional Claim
    - See step #9

Reference the original Internal Control Number (ICN) if you are resubmitting a claim after it has been denied.



Timely Filing
Frequently Asked Questions

- See the following FAQ web page:
  - Frequently Asked Questions (FAQs) and Billing Resources

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Timely Filing
Attachments Required For Backdated Eligibility

- If the timely filing period expires because the member’s determination is delayed or backdated, the fiscal agent is authorized to consider the claim to be filed timely if it is received within 60 days of the date that the member's eligibility is approved
  - A load letter must be attached to the claim

Timely Filing
Attachments Required for Specific Services

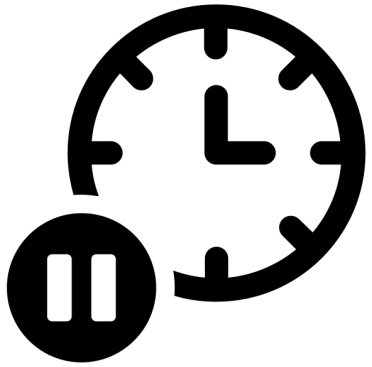
- **Physician Administered Drug or DME/Supply**
  - Manually-priced codes require an invoice for the drug or supply so claims agents can calculate the correct reimbursement (EOB 0653)
- **Surgical/Medical**
  - Med 178 Form – Sterilization consent form signed by the member (EOB 6700)
- **Surgical/Medical**
  - Unlisted Procedure Code form along with Operative report to indicate a comparable listed code and description of procedure that was performed (EOB 0653)
- **Non-Emergent Medical Transportation (NEMT)**
  - Attached documentation containing details of a trip that is more than 52 miles per day (EOB 5537)

Suspended Claims

- A suspended claim must be manually reviewed by the fiscal agent before a final decision is made
- Suspended claims only show up once on the Remittance Advice (RA)
  - Not reported on the 835
- The claim will not appear again on the RA until the claim either pays or denies
- Once the claim is finalized, it will be reported on the RA and the 835
- *Note*: If any suspended claim is pending for more than 14 days from the date of receipt by the fiscal agent, contact the Provider Services Call Center so it can be escalated for processing

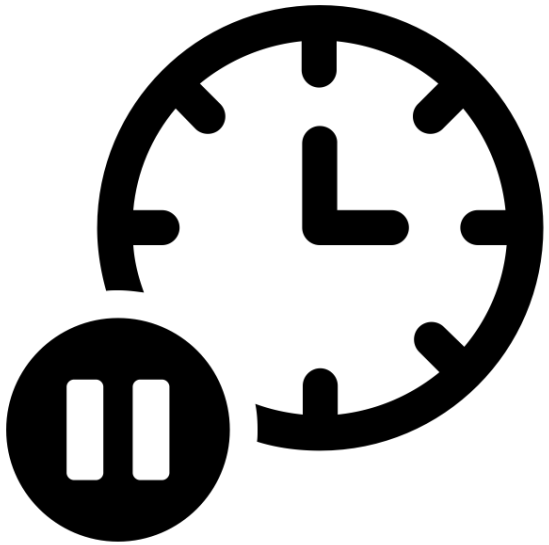
Suspended Claims
Reason #1

- **EOB 0000** - This claim/service is pending for program review
  - Explanation: The Colorado interChange is updated with billing codes based on the Centers for Medicare & Medicaid Services (CMS) release of deletions, changes and additions. Claims will be released from suspense once the update is complete.
  - Estimated Time for Processing: May be under review for 30 - 60 days. Physician Administered Drugs (PADs) require a National Drug Code (NDC) assignment and may take up to 90 days before implementation.



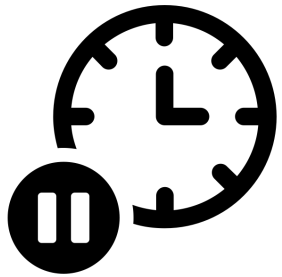
Suspended Claims
Reason #2

- **EOB 0101** - This is a duplicate service
  - Explanation: This may be a duplicate claim, but not all parameters for an exact duplicate are met, so the claim must be reviewed by the fiscal agent to determine if it is a duplicate
  - Estimated Time for Processing: 7 days



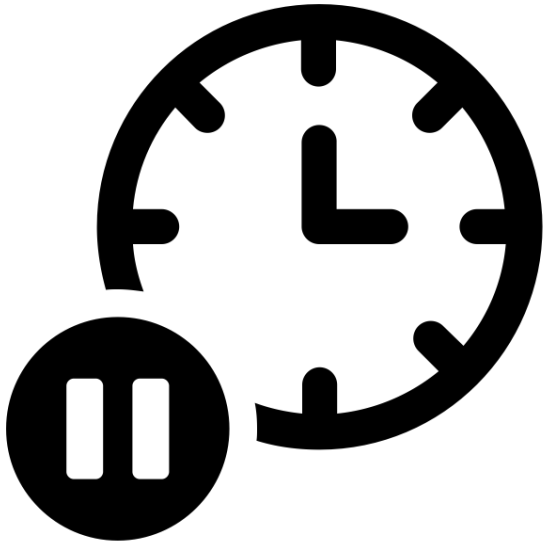
Suspended Claims
Reason #4

- **EOB 1786** - The date of service date is out of timely filing. Refer to the billing manual.
  - Explanation: The claim is outside of the initial timely filing period of 365 days. Claims with a timely filing attachment must be reviewed by the fiscal agent.
  - Additional Details: If the provider has submitted an appropriate timely filing waiver within 60 days, the fiscal agent can review for payment
  - Note that medical records and other explanations are not reviewed. Contact the Provider Services Call Center to discuss the scenario further.
  - Estimated Time for Processing: 7 days



Suspended Claims
Reason #5

- **EOB 2960** - Claim processed with closest eligibility span
  - Explanation: The member currently is not eligible for the date of service
  - Estimated Time for Processing: This claim will be recycled after 15 calendar days. If after the 15 days the member is still not eligible for the date of service, the claim will deny.



Adjustments & Voids
Provider-Initiated and Health First Colorado-Initiated

- **Adjustments** are replacements of original paid claims
  - Providers may adjust claims within timely filing if a correction is needed
  - Providers should include all of the original information along with any additions. Anything that is removed will be deducted.
- **Voids** will retract the entire original claims
  - Voids are only suggested if the original claims had the wrong member, wrong provider ID or was billed in error and needs to be completely cancelled

Adjustments & Voids
Lower of Pricing Logic for Rate Adjustments

- Usual and Customary Charges vs. Fee Schedule Rates
  - If the Department implements rate increases, claims that were already billed with and paid at a rate lower than the new rate cannot be adjusted by the fiscal agent for the higher rate. The Department will always use the “lower of” pricing logic.
  - Providers are advised to bill their usual and customary charges
    - Example of lower of pricing logic:
      - If a provider bills $5 per the fee schedule and the rate goes up to $6, Health First Colorado cannot pay the $6 if the provider only billed $5 when claims are reprocessed
      - If a provider bills less, Health First Colorado always pays less

Adjustments & Voids
Rate Adjustment Guidelines

- Usual and Customary Charges vs. Fee Schedule Rates
  - Key Takeaway
    - Providers are encouraged to bill the actual cost, which may be more, but be prepared to accept the listed fee schedule rate
    - Any future changes to claim reimbursement rates are reprocessed automatically which always works to the provider's benefit
  - See a recent example from the November 2023 Provider Bulletin
    - The July 1, 2023, Pediatric Personal Care rates were not appropriately allocated the Across-the-Board increase. The rates for Pediatric Personal Care have been adjusted to reflect the increase received. Rates have been corrected in the Colorado interChange and on the Home Health and Private Duty Nursing (PDN) Rate Schedule located on the Provider Rates and Fee Schedule web page. **Providers billing the fee schedule rate instead of their usual and customary charges must manually adjust claims to the increased rate. Providers billing usual and customary charges will see claims adjustments via claims reprocessing.**

Adjustments & Voids
How to Indicate Adjustments

If the original timely filing period (365 days from date of service) has expired, the next submission must be received within 60 days of the last action (i.e., Remittance Advice, load letter, returned paper claim)

Provider Web Portal	Batch	Paper
• Search for original claim and click “Adjust” at the bottom	• Qualify claim loop with F8 and use the previous Internal Control Number (ICN) as the Payer Claim Control Number along with the 7 code in the 2300/CLM segment	• Indicate adjustment by using code 7 in box 22 and the original Internal Control Number (ICN) in the adjacent 22 box

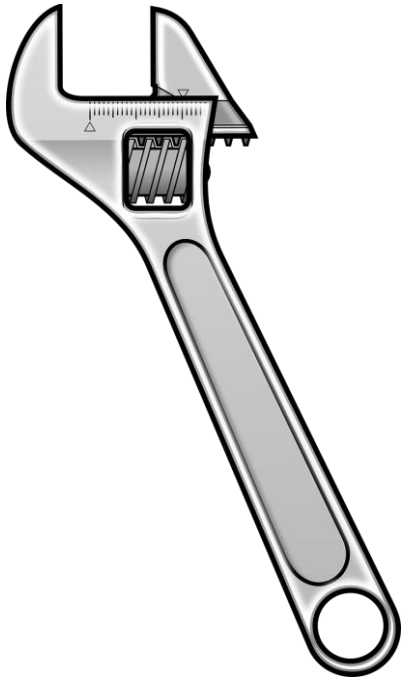
Adjustments & Voids
How to Indicate Voids

- Providers should void claims only if there is an incorrect Member ID or Provider ID or if accidentally submitted
- Refund recoupment will appear on Remittance Advice

Provider Web Portal	Batch	Paper
• Search for original claim and click “Void” at the bottom	• Qualify claim loop with F8 and use the previous Internal Control Number (ICN) as the Payer Claim Control Number along with the 8 code in the 2300/CLM segment	• Indicate void by using code 8 in box 22 and the original Internal Control Number (ICN) in the adjacent 22 box

Adjustments & Voids

- For more information on how to process adjustments and voids via the Provider Web Portal, visit the Provider Web Portal Quick Guide - Copy, Adjust, or Void a Claim

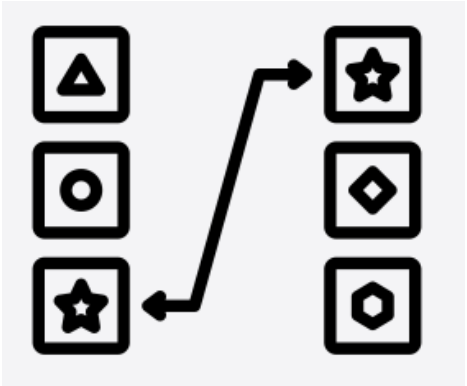


Claim Denials
Approved Prior Authorization Request on File

- For all providers, when a claim requires a Prior Authorization Request (PAR), the Colorado interChange will use a series of criteria to find the matching authorization
  - Providers do not need to indicate the PAR number on the claim
  - System automatically populates the PAR number on the claim if it finds a match
  - If a claim denies for a PAR despite an approved PAR being on file, it means the PAR on file does not match all the criteria that is on the claim
- **For Home and Community-Based Service (type 36) providers:**
  - Case managers submit PAR to the Bridge system
  - Bridge system links an approved PAR to the Colorado interChange
  - Allow at least one day for the approved PAR to be available for claims processing

Claim Denials
Approved PAR on File - Explanation of Benefits

- If the claim has denied for either of the following EOBs despite having an approved PAR on file:
  - **E0B 0192 -** Prior Authorization (PA) is required for this service. An approved PA was not found matching the provider, member, and service information on the claim.
  - **EOB 5110 -** The prior authorization does not match the services billed on your claim. Please correct services or submit a new prior authorization for the services billed.



Claim Denials
Approved PAR on File - Related Issues

- One of the following issues may apply:
  - The prior authorization was never fully approved. Check the Provider Web Portal for prior authorization. If there is no approved PAR for the dates of service on the claim, contact the case manager or the Colorado PAR program to confirm status.
  - The service dates may not match the PAR. Check the date spans on the claim to ensure the dates of service are within the date range of the PAR.
  - The PAR units are exhausted. If all units have been billed, the claim will deny. If additional units are needed, a PAR revision must be requested.
  - The modifiers do not match. Check the authorization to ensure the claim line item has the same modifiers as the PAR line item.

Resubmissions
Denied Claims: Date of Service Within 365 Days

Provider Web Portal or Batch

- Copy original claim and make corrections
- Do not reference original Internal Control Number (ICN)

Paper

- Submit new claim with corrections
- Do not reference original Internal Control Number (ICN)

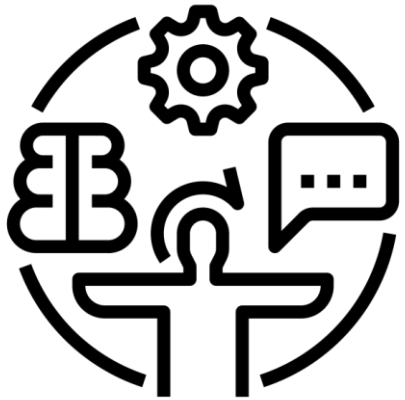
Resubmissions
Denied Claims: Date of Service Past 365 Days

If the original timely filing period (365 days from date of service) has expired, the next submission must be received within 60 days of the last action (i.e., Remittance Advice, load letter, returned paper claim)

Provider Web Portal	Batch	Paper
• Copy original claim and make corrections • Reference original Internal Control Number (ICN) in the "Previous Claim ICN" field in the Claim Information section	• Qualify claim loop with F8 and use the previous Internal Control Number (ICN) as the Payer Claim Control Number along with the 1 code in the 2300/CLM segment	• Indicate resubmission by using code 1 in box 22 and the original Internal Control Number (ICN) in the adjacent 22 box

Reconsiderations
Denied Claims

- Request for Reconsideration form or a reconsideration claim type is **not** necessary for denied claims
- A denied claim should be resubmitted electronically as a new claim once corrections have been made. If no corrections are made, the system will automatically deny the claim again. All claims are not manually reviewed even if notes are attached.

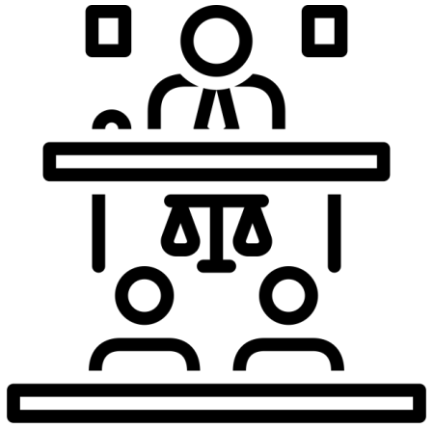


Reconsiderations
Reasons

- If a provider would like a denial reconsidered for a policy reason, they must call the Provider Services Call Center and explain the situation in detail
- The Provider Services Call Center will refer the policy change to the Department for further review
  - System changes may be necessary before the claim can be processed
- If the claim is outside of timely filing for extenuating circumstances and no timely filing waiver can be attached, providers may contact the Provider Services Call Center and submit an explanation in writing through secure correspondence via the Provider Web Portal
  - The Provider Services Call Center will refer the timely filing request to the Department for further review

Appeals
Reasons

- If all means of achieving satisfactory claim resolution through the fiscal agent and the Claims Processing unit have been exhausted, providers may file a written appeal with the Office of Administrative Courts at the address listed in Appendix A on the Billing Manuals web page under Appendices
- Appeals submitted to the Office of Administrative Courts must be received within 30 days from the mailing date of the last notice of action



Claims Submission Reminders

- Rates and Fee Schedules
  - Review all relevant fee schedules to ensure services are covered prior to rendering them
  - Bill usual and customary charges
- Medicare Advantage and Medicare HMO Plans
  - Medicare Advantage plans or Medicare HMO plans should be entered as Medicare crossover claims, not as Third-Party Liability or "Other Insurance"
- Attachments for Medicare and Third-Party Liability
  - Explanation of Benefits (EOBs) from primary insurance do not need to be attached to claims
- Suspended Claims Do Not Need to be Resubmitted
  - Processing time can take up to 60 days
- Do Not Send Reconsiderations for Denied Claims
  - Correct any errors from a denied claim and simply resubmit it
- Provider Web Portal Void Claim Option Appears Only on Eligible Claims
  - Only paid claims can be voided

Resources

Billing Manuals web page

- General Provider Billing Manual
- Appendix R (for a detailed list of Explanation of Benefits (EOB) codes)

Provider Web Portal Quick Guides

Provider Training web page

Provider Contacts web page

Provider Services Call Center
1-844-235-2387

Regional Provider Support web page

hcpf.colorado.gov/our-providers

Where can I find…?

For Our Providers

- Why should you become a provider?
- Provider enrollment
- Provider services: Forms, rates, & billing manuals
- What's new: Bulletins, updates & emails
- CBMS: CO Benefits Management System
- Care and Case Management
- Web portal
- Revalidation
- Provider contacts: Who to call for help
- Provider resources: Quick guides, known issues, EDI, & training

- Enrollment forms
- Revalidation dates spreadsheet
- National Provider Identifier (NPI) information
- Provider types

- Fee schedules
- General Provider Information manual
- Billing manuals & appendices
- Forms
  - Prior Authorization Requests (PARs)
  - Load letters
  - Request to use paper claims form

- Newsletters
- What's New?

- Check member eligibility
- Submit claims
- Review Prior Authorization Requests (PARs)
- Receive Remittance Advices (RAs)
- Complete provider maintenance requests

- Quick Guides for Web Portal
- Known issues
- EDI Support
- Training registration
- Information about
  - Accountable Care Collaborative & RAEs
  - Co-Pays
  - EVV

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COVID-19 Provider Information | Resources for HCBS Providers | SAVE System | ColoradoPAR | DDDWeb | Value Based Payments

Thank you!