Intermediate Billing Training

Health First Colorado
(Colorado's Medicaid Program)

Navigating This Presentation

- Underlined words or phrases often will link viewers to more information, such as web pages. If you are viewing this presentation in normal mode (not slideshow mode), you may need to press the Ctrl key while you click on the link in order to open it.
- Use color-coded table of contents slides to navigate to specific areas of interest in the presentation.
  - Use back arrows provided in the bottom right corner of some slides to return to table of contents slides.

Training Overview

Claims Processing

Billing and Payment

Timely Filing

Suspended Claims

Paid Claims: Adjustments and Voids

Claim Denials

Resources

Reminders

Claims Processing

Claims Processing
Common Terms

- Paid - Claim could be paid on all line items or only partially for some line items
  - Adjustment - Corrects a paid claim; can be initiated by the Department or the provider
  - Void - Cancels a paid claim; can be initiated by the Department or the provider
    - Adjustments and voids may result in a balance due
- Denied – Provider can resubmit as a new claim
  - Resubmit – Rebills a previously denied claim
- Suspended - Claim must be manually reviewed by fiscal agent before final decision
  - Suspended claims do not need to be resubmitted

There are 3 ways to submit claims to Health First Colorado.

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.
  - The Provider Web Portal can only accept one claim at a time.
  - The Provider Web Portal reviews the claim information for compliance with Health First Colorado billing policy and then passes it to the Colorado interChange claims processing system for adjudication.
  - An immediate response about that single transaction is given, indicating whether the claim is paid, denied or suspended.

Claims Processing
via Batch

- Batch billing refers to the electronic creation and transmission of several claims or eligibility inquiries in a group.
- 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
via Batch

- All batch claim submission software must be tested and approved by the Department's fiscal agent Gainwell Technologies.
  - Any submitter, such as a clearinghouse, that sends 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.

Attachments are not required in most cases.

Claims Processing
Attachments

- Attachments are not necessary for most claims.
- Attachments are required ONLY for:
  - Specific services listed on the next two (2) slides
  - Backdated member eligibility
  - Institutional Certification on all institutional claims submitted on the **paper** UB-04
- Attachments that are NOT required:
  - Third-party liability Explanation of Benefits (EOBs) (i.e., Medicare, commercial insurance)
  - Medical or session notes
  - Explanations for denied claims

Claims Processing
Attachments Required for Specific Services

- **Non-Emergent Medical Transportation (NEMT)**
  - Standardized Trip Logs must be attached to all claims
  - 25+ Mile Verification Form for trips more than 25 miles one way (EOB 5537)
- **Physician Administered Drug or Durable Medical Equipment (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**
  - Unlisted Procedure Code Form along with Operative report to indicate a comparable listed code and description of procedure that was performed (EOB 0653)
  - Med 178 Form – Sterilization consent form signed by the member (EOB 6700)

Claims Processing
Attachments Required for Specific Services

- **Women's Health**
  - Acknowledgement/Certification Statement for a Hysterectomy
  - Certification Statement for Abortion to Save the Life of the Mother
  - Certification Statement for Abortion for Sexual Assault (Rape) or Incest
  - Certification Statement Form for Non-Viable Pregnancies
    - Complete when billing for Mifeprex if used with an early pregnancy loss, miscarriage or anembryonic service

Successful provider enrollment and revalidation is a prerequisite for submitting claims.

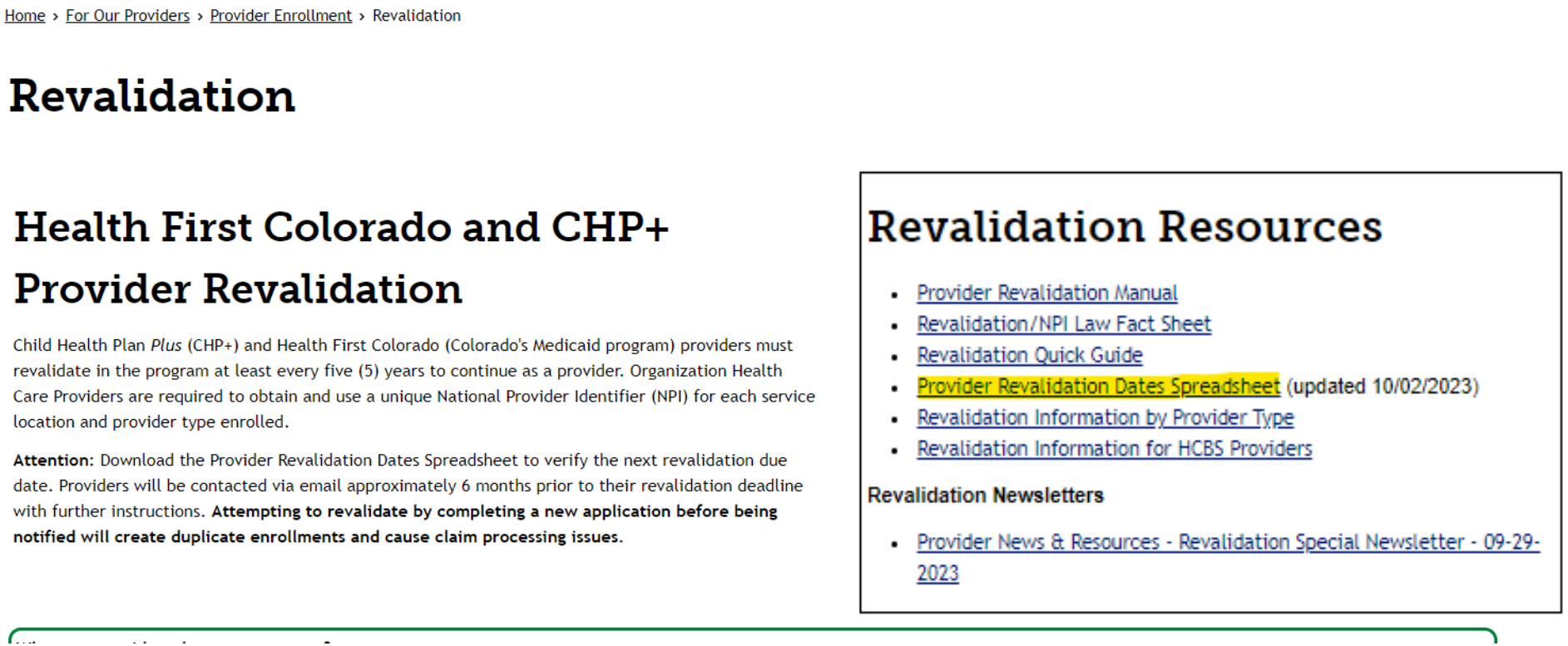
Claims Processing
Revalidation

- Every provider listed on a claim must be enrolled with Health First Colorado
  - All providers, including those who do not bill (i.e., Ordering, Prescribing and Referring) must complete the process of **revalidation** at least once every five (5) years per rule 42 CFR § 455.410(b))

- Providers are notified in a variety of ways about upcoming revalidation deadlines:
  - Several email reminders are sent beginning six (6) months in advance of due date
  - Revalidation link appears on the Provider Web Portal six (6) months in advance
  - Explanation of Benefits (EOBs) codes for notification will appear on Remittance Advices (RAs) within six (6) months
    - Claims will still pay prior to revalidation

Claims Processing
Revalidation

- A spreadsheet with providers' revalidation dates can be found on the Department's Revalidation web page.



Home › For Our Providers › Provider Enrollment › Revalidation

Revalidation

Health First Colorado and CHP+ Provider Revalidation

Child Health Plan *Plus* (CHP+) and Health First Colorado (Colorado's Medicaid program) providers must revalidate in the program at least every five (5) years to continue as a provider. Organization Health Care Providers are required to obtain and use a unique National Provider Identifier (NPI) for each service location and provider type enrolled.

Attention: Download the Provider Revalidation Dates Spreadsheet to verify the next revalidation due date. Providers will be contacted via email approximately 6 months prior to their revalidation deadline with further instructions. **Attempting to revalidate by completing a new application before being notified will create duplicate enrollments and cause claim processing issues.**

Revalidation Resources

- Provider Revalidation Manual
- Revalidation/NPI Law Fact Sheet
- Revalidation Quick Guide
- Provider Revalidation Dates Spreadsheet (updated 10/02/2023)
- Revalidation Information by Provider Type
- Revalidation Information for HCBS Providers

Revalidation Newsletters

- Provider News & Resources - Revalidation Special Newsletter - 09-29-2023

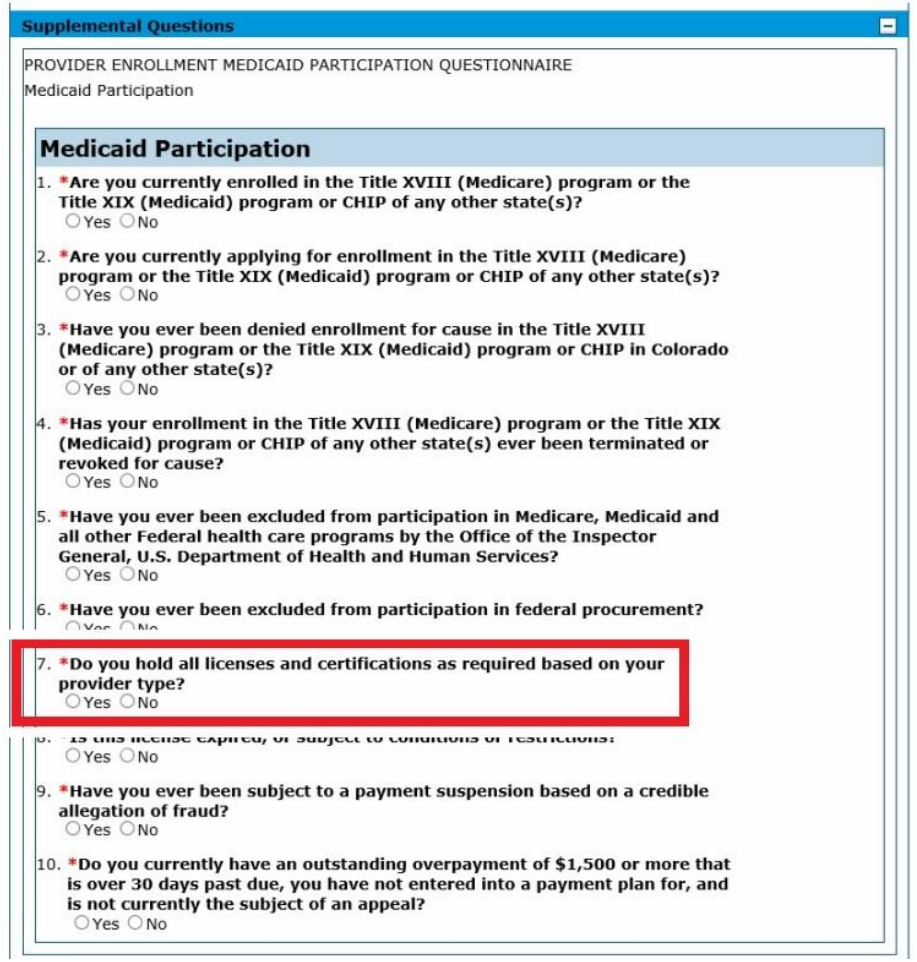
Claims Processing
Revalidation

- Once the revalidation due date has passed:
  - Explanation of Benefits (EOBs) codes will appear on Remittance Advices (RAs) for six (6) months past the due date.
  - Providers will be disenrolled.
    - The revalidation application will remain available in the Provider Web Portal for six (6) months past the due date. After that time, providers will need to complete new enrollment applications.
  - Claims will deny.
    - Providers will need to resubmit claims after revalidation or re-enrollment is completed.

Claims Processing
Revalidation

Expected timeline for approval is five (5) business days. Approval may take longer if an application is returned to the provider due to incorrect or incomplete information.

One of the most common reasons for applications to be returned is on the Supplemental Questions panel. Providers should check “yes” on question seven (7) if the provider holds an appropriate license and certification.


Supplemental Questions

PROVIDER ENROLLMENT MEDICAID PARTICIPATION QUESTIONNAIRE

Medicaid Participation

Medicaid Participation

1. *Are you currently enrolled in the Title XVIII (Medicare) program or the Title XIX (Medicaid) program or CHIP of any other state(s)?
   ○ Yes ○ No
2. *Are you currently applying for enrollment in the Title XVIII (Medicare) program or the Title XIX (Medicaid) program or CHIP of any other state(s)?
   ○ Yes ○ No
3. *Have you ever been denied enrollment for cause in the Title XVIII (Medicare) program or the Title XIX (Medicaid) program or CHIP in Colorado or of any other state(s)?
   ○ Yes ○ No
4. *Has your enrollment in the Title XVIII (Medicare) program or the Title XIX (Medicaid) program or CHIP of any other state(s) ever been terminated or revoked for cause?
   ○ Yes ○ No
5. *Have you ever been excluded from participation in Medicare, Medicaid and all other Federal health care programs by the Office of the Inspector General, U.S. Department of Health and Human Services?
   ○ Yes ○ No
6. *Have you ever been excluded from participation in federal procurement?
7. *Do you hold all licenses and certifications as required based on your provider type?
   ○ Yes ○ No
8. ○ Yes ○ No
9. *Have you ever been subject to a payment suspension based on a credible allegation of fraud?
   ○ Yes ○ No
10. *Do you currently have an outstanding overpayment of $1,500 or more that is over 30 days past due, you have not entered into a payment plan for, and is not currently the subject of an appeal?
    ○ Yes ○ No

Billing and Payment

Billing and Payment
Timeline

Mon.	Tue.	Wed.	Thur.	Fri.	Sat.

Providers bill claims

Weekly claim submission cutoff

Mon.	Tue.	Wed.	Thur.	Fri.	Sat.

Remittance Advices (RAs) and 835s are posted to the Provider Web Portal

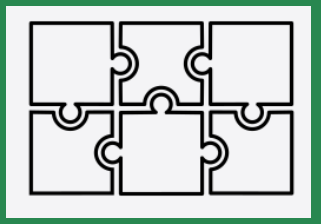
Electronic Fund Transfer (EFT) payments are deposited to provider accounts

Billing and Payment
Remittance Advice

- Remittance Advice (RA) reports are posted each Monday.
- 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 Electronic Remittance Advice (ERA) will contain all claims regardless of submission type (e.g., paper, batch or Provider Web Portal).
- Providers can check the status of claims prior to the Remittance Advice (RA) being posted by doing a claim status inquiry on the Provider Web Portal.

Health First Colorado is always the payer of last resort.

Billing and Payment
Secondary Billing



- Third-Party Liability (TPL) is the term used when a member has health insurance in addition to Health First Colorado.
- Health First Colorado is always the payer of last resort.
  - Third-party liability resources are always considered the primary payers.
- 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 or differences in payments from Third-Party Liability.

Billing and Payment
Secondary Billing - Prior Authorizations

If a member has insurance in addition to Health First Colorado:

- Prior authorization is not required if the primary insurance pays the claim.
  - If the primary pays at zero due to applying everything to deductible, attach Explanation of Benefits (EOB) so payment can be verified since dollar amount will show zero. Attach the EOB ONLY in this situation.

- Prior authorization **is required** if the primary insurance denies the claim.

Note: This policy does not apply to Physician-Administered Drugs.

Billing and Payment
Commercial Insurance as Primary Payer

- Submitting Third-Party Liability Information on the **Professional Claim Form (CMS 1500)**

Field Number	Instructions
Field 6	Place an "X" in the box that identifies the member's relationship to the policyholder.
Field 9	Enter the full last name, first name and middle initial of the insured. If the insured used a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name.
Field 9	Enter the policy or group number.
Field 9	Enter the insurance plan or program name.
Field 11d	Place an "X" in the YES box.
Field 29	Enter the total amount paid by the commercial health insurance on the billed services. • Do not use commas when reporting dollar amounts. • Enter 00 in the cents area if the amount is a whole number.

Billing and Payment
Commercial Insurance as Primary Payer

- Submitting Third-Party Liability Information on the **Institutional Claim Form (UB-04)**

Field Number	Instructions

Fields 39-41	Enter appropriate codes and related dollar amounts to identify monetary data or number of days using whole numbers, necessary for the processing of this claim.
	• Enter the deductible amount applied by the indicated payer:
	  ○ A1 Deductible Payer A
	  ○ B1 Deductible Payer B
	  ○ C1 Deductible Payer C
	• Enter the amount applied to the member's coinsurance by the indicated payer:
	  ○ A2 Coinsurance Payer A
	  ○ B2 Coinsurance Payer B
	  ○ C2 Coinsurance Payer C
	• Enter the amount paid by the indicated payer:
	  ○ A3 Estimated Responsibility Payer A
	  ○ B3 Estimated Responsibility Payer B
	  ○ C3 Estimated Responsibility Payer C

Field 50	Enter the payment source code followed by the name of each payer organization from which the provider might expect payment. • At least one line must indicate Health First Colorado. • Example: F (Insurance Company)

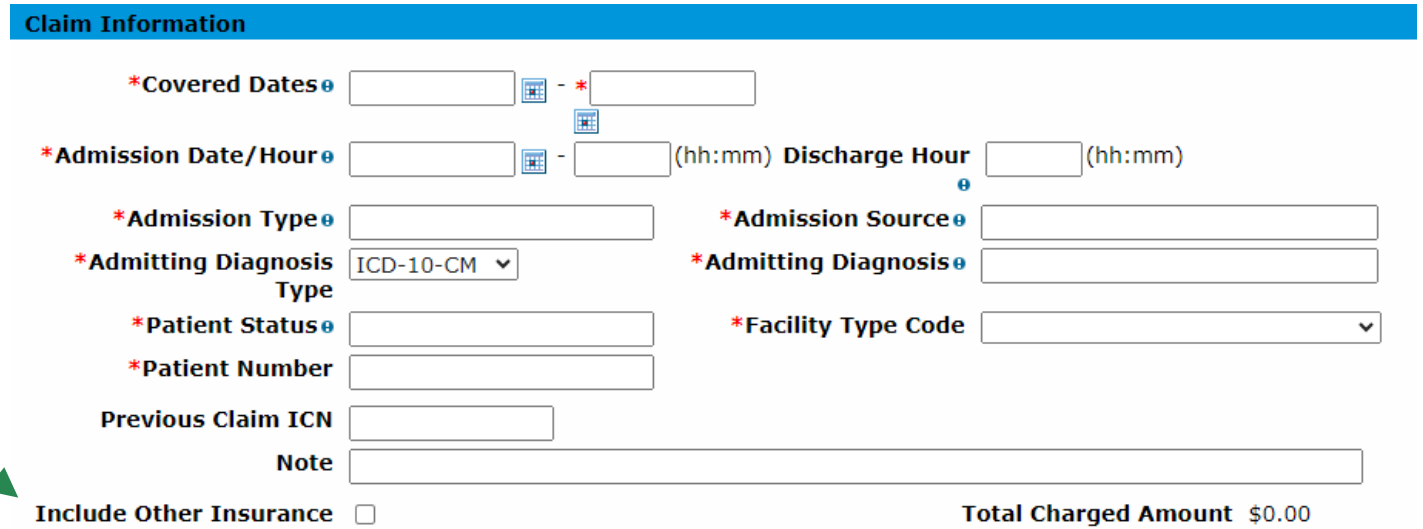
Billing and Payment
Commercial Insurance as Primary Payer

- Submitting Third-Party Liability Information on the **Institutional Claim Form (UB-04)**

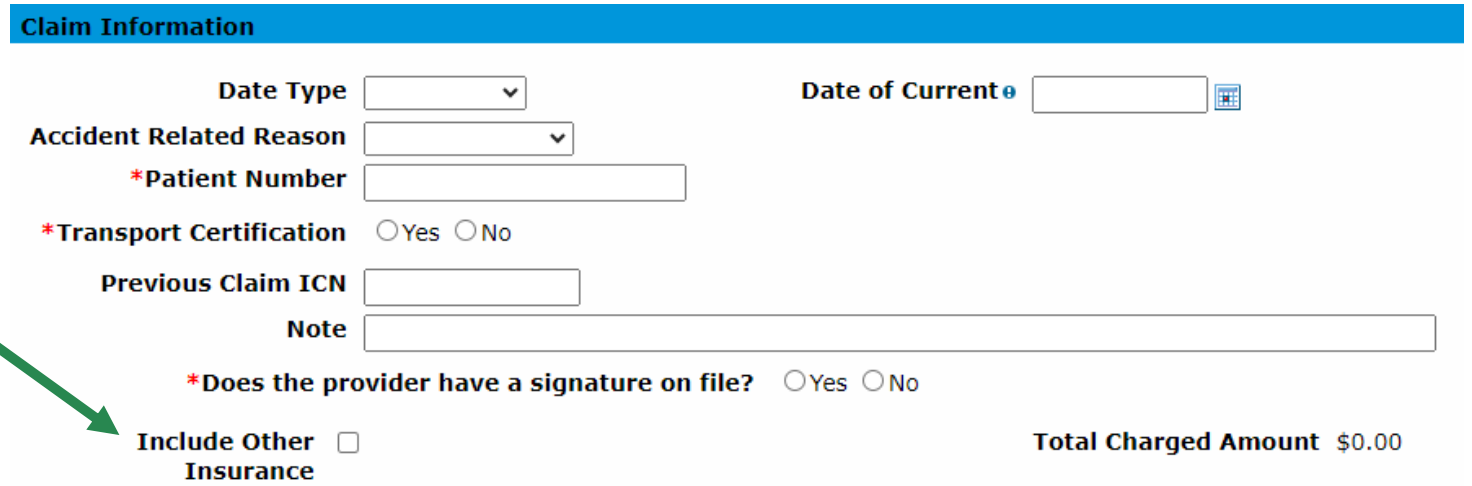
Field 51	Enter the provider's Health Plan ID for each payer name.
Field 54	Enter third-party payments.
Field 55	Enter the net amount due from Health First Colorado after the provider has received payment from third-party coverage.
Field 58	After entering the member's name on the first line for Health First Colorado coverage: • Complete additional lines when there is third-party coverage. • Enter the policyholder's last name, first name and middle initial.
Field 60	After entering the member ID on the first line for Health First Colorado coverage: • Complete additional lines when there is third-party coverage. • Enter the insured's unique identification number assigned by the payer organization exactly as it appears on the health insurance card. ○ Include letter prefixes or suffixes shown on the card.
Field 61	Enter the name of the group or plan providing the insurance to the insured exactly as it appears on the health insurance card.
Field 62	Enter the identification number, control number or code assigned by the carrier or fund administrator identifying the group under which the individual is carried.

Billing and Payment
Commercial Insurance as Primary Payer

INSTITUTIONAL CLAIM
Check the "Include Other Insurance" box if submitting claim on the Provider Web Portal.



PROFESSIONAL CLAIM
Check the "Include Other Insurance" box if submitting claim on the Provider Web Portal.

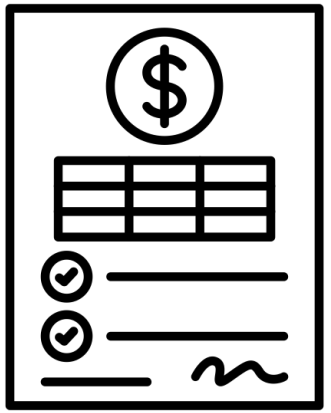


COLORADO
Department of Health Care Policy & Financing

A “crossover” claim is any claim that includes Medicare information.

Billing and Payment
Medicare as Primary Payer

- Note: Medicare Advantage Plans and Medicare HMO plans should be entered as Medicare, not Third-Party Liability or other insurance.
- Automatic crossover of claims to Health First Colorado is a service by Medicare, but it is not guaranteed.
    - If providers wish to adjust those claims, a crossover claim can be resubmitted manually.



Billing and Payment
Medicare as Primary Payer

- Submitting Medicare Information on the **Professional Claim Form (CMS 1500)**

Field Number	Instructions
Field 4	Enter the full last name, first name and middle initial of the insured. • If the insured used a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name.
Field 11	Enter the policy number of the insured as it appears on the ID card. • Only complete if Field 4 is completed.
Field 11a	Enter the birth date of the insured using two (2) digits for the month, two digits for the date and two digits for the year. • Example: 070114 for July 1, 2014. Place an "X" in the appropriate box to indicate the sex of the insured.
Field 29	Enter the total amount paid by Medicare on the billed services. • Do not use commas when reporting dollar amounts. • Enter 00 in the cents area if the amount is a whole number.

Billing and Payment
Medicare as Primary Payer

- Submitting Medicare Information on the **Institutional Claim Form (UB-04)**

Field Number	Instructions

Fields 39-41	Enter the appropriate codes and related dollar amounts to identify the monetary data or number of days using whole numbers, necessary for the processing of this claim.
	• Enter the deductible amount applied by the indicated payer:
	  ○ A1 Deductible Payer A
	  ○ B1 Deductible Payer B
	  ○ C1 Deductible Payer C
	• Enter the amount applied to the member's coinsurance by the indicated payer:
	  ○ A2 Coinsurance Payer A
	  ○ B2 Coinsurance Payer B
	  ○ C2 Coinsurance Payer C
	• Enter the amount paid by the indicated payer:
	  ○ A3 Estimated Responsibility Payer A
	  ○ B3 Estimated Responsibility Payer B
	  ○ C3 Estimated Responsibility Payer C

Field 50	Enter the payment source code followed by the name of each payer organization from which the provider might expect payment. • At least one line must indicate Health First Colorado. ○ Example: C (Medicare)

Billing and Payment
Medicare as Primary Payer

- Submitting Medicare Information on the **Institutional Claim Form (UB-04)**

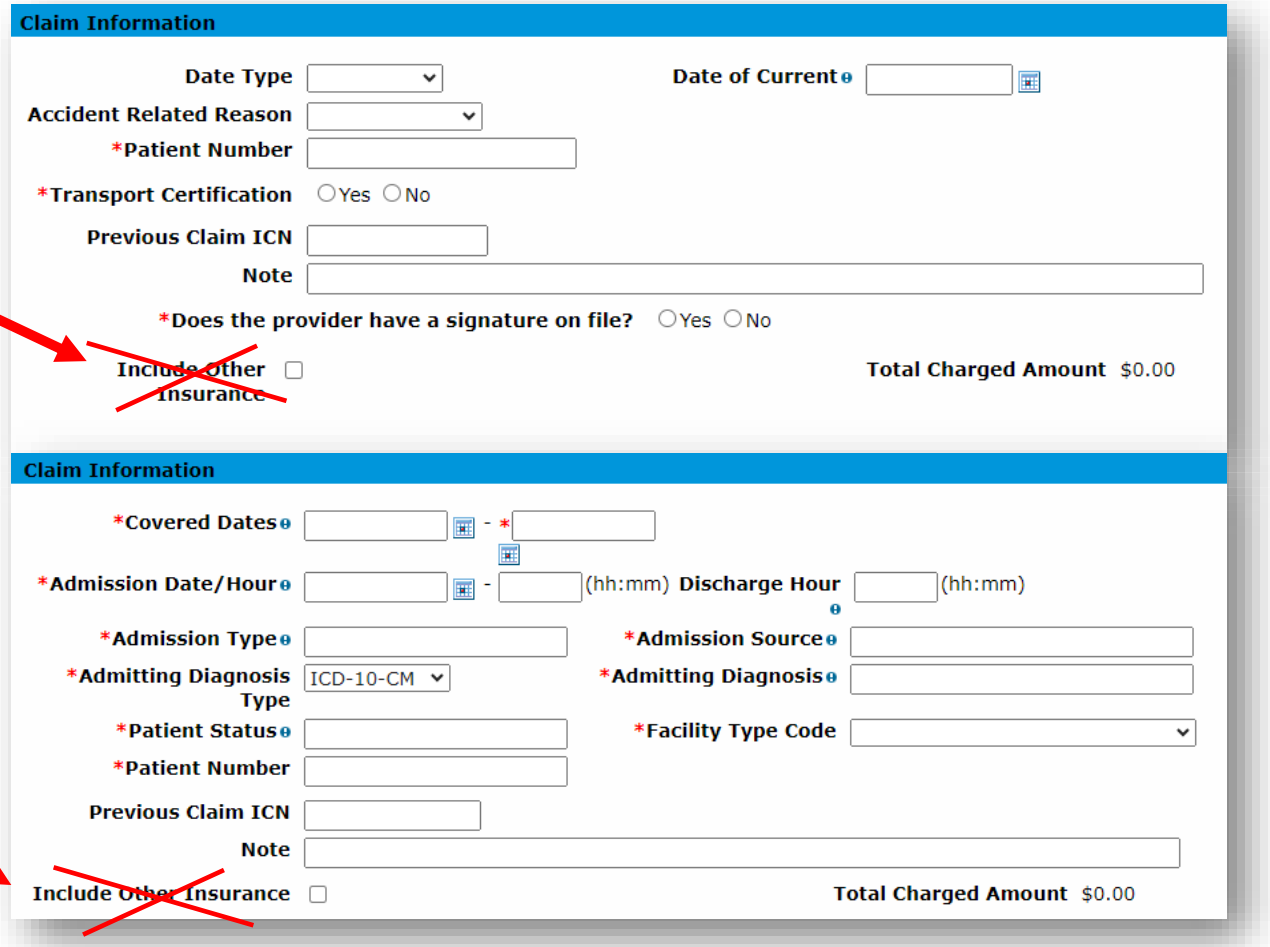
Field 51	Enter the provider's Health Plan ID for each payer name.
Field 54	Enter Medicare payments.
Field 55	Enter the sum of the Medicare coinsurance plus Medicare deductible less third-party payments and member payments.
Field 58	After entering the member's name on the first line for Health First Colorado coverage: • Complete additional lines when there is Medicare coverage. • Enter the policyholder's last name, first name and middle initial.
Field 60	After entering the member ID on the first line for Health First Colorado coverage: • Complete additional lines when there is Medicare coverage. • Enter the unique identification number of the insured assigned by the payer organization exactly as it appears on the health insurance card. ○ Include letter prefixes or suffixes shown on the card.

Billing and Payment
Medicare as Primary Payer

- When submitting claims on the Provider Web Portal, select one of the "crossover" claim types.

PROFESSIONAL CLAIM
Do not check the "Include Other Insurance" box if Medicare is the primary payer.

INSTITUTIONAL CLAIM
Do not check the "Include Other Insurance" box if Medicare is the primary payer.



Managed Care Organizations (MCOs) are different from primary payers like third-party liability and Medicare.

Billing and Payment
Other Payers

- Regional Accountable Entities (RAEs)
  - Manage members' behavioral health and coordinate care
  - Most behavioral health claims are submitted directly to the Regional Accountable Entities (RAEs)
- Managed Care Organizations (MCOs)
  - Rocky Mountain Health Plans and Denver Health Medical Plan (Denver county only)
    - Most claims are billed directly to the Managed Care Organization (MCO)
    - Distinct fee schedules, policies and procedures that may be different from Health First Colorado
    - Also operate as Regional Accountable Entities (RAEs) for some members
      - When listed as a member's RAE, medical claims are billed directly to the Fiscal Agent Gainwell Technologies

Providers may only bill members for services not covered by Health First Colorado.

Billing and Payment
Member Billing

- ✕ Billing members for covered services is prohibited regardless of whether Health First Colorado has reimbursed the provider. Balance billing is not permitted.
- ✕ If a Prior Authorization Request (PAR) is partially approved, it is considered covered. Members may not be billed for the denied portion of the request or services rendered beyond what is prior authorized.
- ✕ PAR Technical/Lack of Information (LOI) denial does not mean those services are not covered. Members may not be billed for services rendered but not prior authorized due to lack of information on the PAR.
- ✓ The provider may only bill members for services not covered by Health First Colorado.
  - Services totally denied for not meeting medical necessity criteria are considered non-covered services.

Timely Filing

Timely Filing

Is this within the timely filing guidelines?

- **Scenario: Original claim (first submission)**
  - Within 365 days from the date of service? YES
  - Past 365 days from date of service? NO

- **Scenario: Resubmitted claim (after denial[s])**
  - Within 365 days from the date of service? YES
  - Past 365 days from date of service? YES, within 60 days of Remittance Advice or returned paper claim and with reference to original Internal Control Number (ICN)

Timely Filing

Is this within the timely filing guidelines?

- **Scenario: Commercial insurance as primary payer**
  - Within 365 days from the date of service? YES, after receiving commercial insurance Explanation of Benefits (EOB)
  - Past 365 days from date of service? NO

- **Scenario: Medicare as primary payer**
  - Within 365 days from the date of service? YES, after receiving Medicare Explanation of Benefits (EOB)
  - Past 365 days from date of service? YES, within 120 days of receiving Medicare Explanation of Benefits (EOB)

Timely Filing

Is this within the timely filing guidelines?

- **Scenario: Member does not notify provider that they have Health First Colorado benefits**
  - Within 365 days from the date of service? YES
  - Past 365 days from date of service? NO

- **Scenario: Member receives retroactive (backdated) eligibility for Health First Colorado benefits**
  - Within 365 days from the date of service? YES
  - Past 365 days from date of service? YES, within 60 days of load letter from the Department (attached to claim)

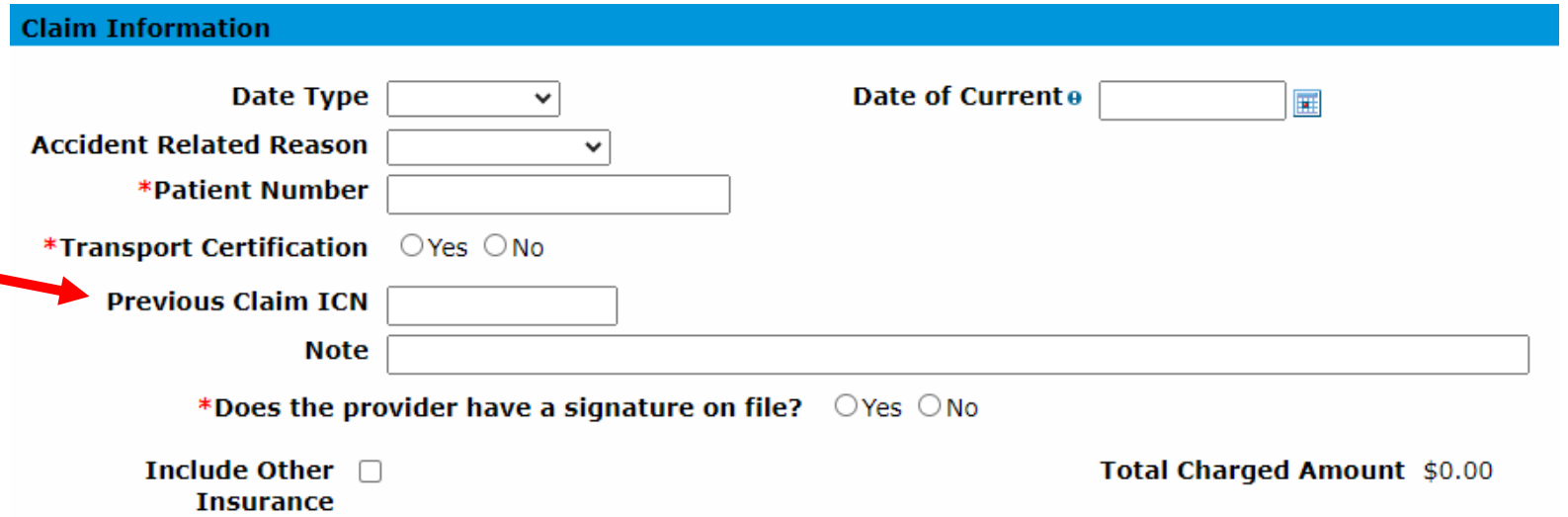
Timely Filing
Attachments Required For Backdated Eligibility

- 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 requested from the Department and attached to the claim.

Timely Filing
Referencing the Previous Internal Control Number (ICN)

- If the date of service 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).
- Referencing the ICN on the **Professional Claim on the Provider Web Portal:**

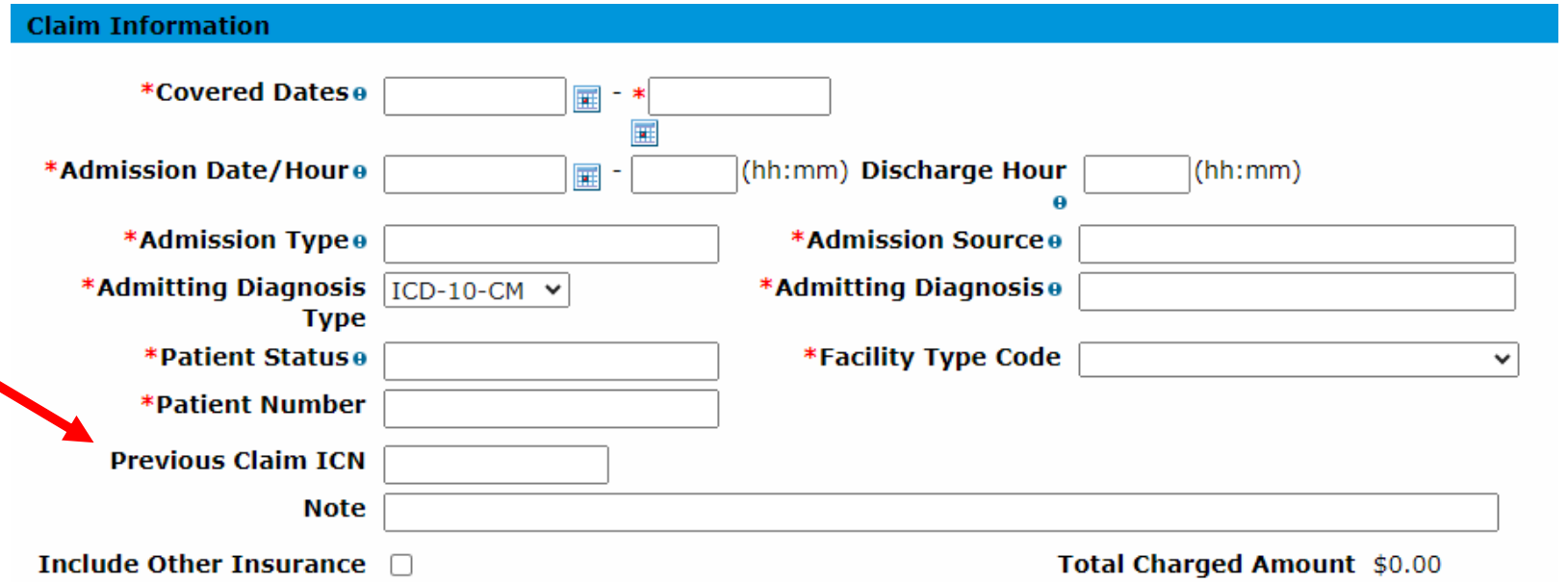
Reference the original Internal Control Number (ICN) if you are resubmitting a claim after it has been denied.



Timely Filing
Referencing the Previous Internal Control Number (ICN)

- Referencing the ICN on the **Institutional Claim on the Provider Web Portal:**

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



Suspended Claims

Suspended Claims

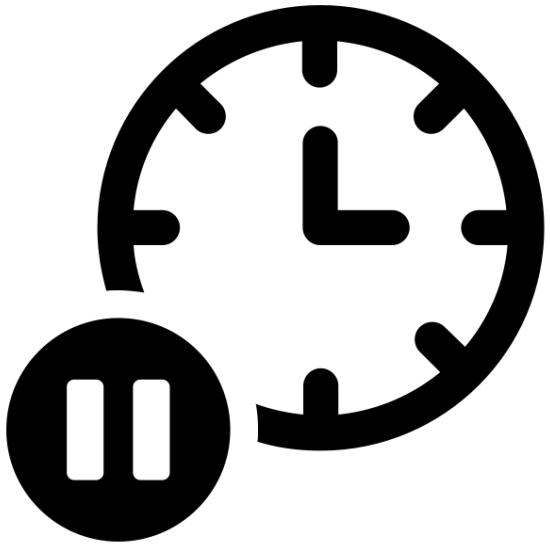
- A suspended claim must be manually reviewed by the fiscal agent before a final decision is made.
  - Processing time can take up to 60 days
- Suspended claims only show up once on the Remittance Advice (RA).
  - Not reported on the 835
- The claim will not appear again on the Remittance Advice (RA) until the claim either pays or denies.
- Once the claim is finalized, it will be reported on the Remittance Advice (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. This does not apply to physician administered drugs.

Suspended Claims
Reason #1

- **EOB 0000** - This claim/service is pending for program review.
  - Explanation: The Colorado interChange claims processing system is updated with billing codes based on the Centers for Medicare and 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

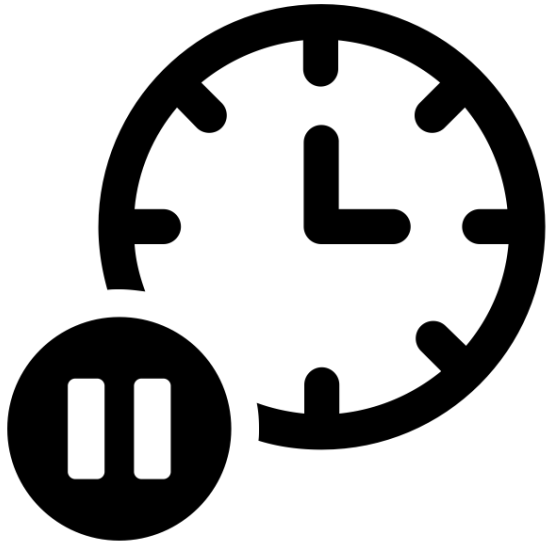


Suspended Claims
Reason #3

- **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 override 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 #4

- **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 and Voids

Adjustments and Voids

- **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 claim.
  - Voids are only suggested if the original claim had the wrong member ID, wrong provider ID or was billed in error and needs to be completely cancelled.
- Adjustments and voids may result in a negative balance.

Providers are encouraged to bill usual and customary charges but be prepared to accept the listed fee schedule rates.

Adjustments and Voids
Lower of Pricing Logic for Rate Adjustments

- Usual and Customary Charges vs. Fee Schedule Rates
  - Providers are advised to bill their usual and customary charges.
  - If the Department implements rate increases, the Department will always use the “lower of” pricing logic.
    - Providers billing usual and customary charges will see claims adjustments via claims reprocessing.
    - Providers billing the fee schedule rate instead of their usual and customary charges will need to manually adjust claims to an increased rate.

      Example: 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.

Adjustments and 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.
    - If a provider bills less, Health First Colorado pays less.

Adjustments and voids can only be made to paid claims.

Adjustments and 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

Provider Web Portal	Batch	Paper
• Search for original claim and click “Adjust” at the bottom • *Note: “Adjust” option appears only on eligible claims*	• 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 and Voids
How to Indicate Voids

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

Provider Web Portal	Batch	Paper
• Search for original claim and click “Void” at the bottom • *Note: “Void” option appears only on eligible claims*	• 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

Claim Denials

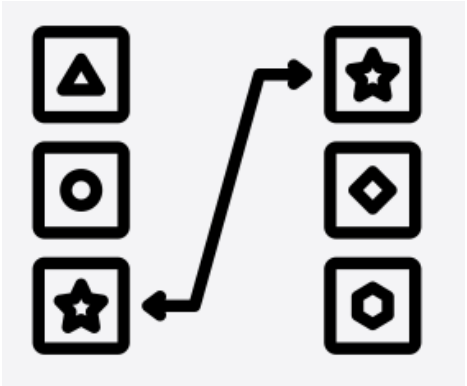
Claim Denials
Prior Authorization Requests (PARs)

- For all providers, when a claim requires a Prior Authorization Request (PAR), the Colorado interChange claims processing system 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 providers:**
  - Case managers submit PAR to the Bridge system.
  - Allow at least one day for the approved PAR to be available for claims processing.

Claim Denials

Prior Authorization Requests - Explanation of Benefits (EOBs)

- If the claim has denied for either of the following Explanation of Benefits (EOBs) despite having an approved Prior Authorization Request (PAR) on file:
  - **EOB 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
Prior Authorization Requests - 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 Prior Authorization Request (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 Prior Authorization Request (PAR). Check the date spans on the claim to ensure the dates of service are within the date range of the PAR.
  - The Prior Authorization Request (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 Prior Authorization Request (PAR) line item.

Claim Denials
Electronic Visit Verification (EVV)

Electronic Visit Verification (EVV) electronically verifies that home and community-based service visits occur by documenting the following data:

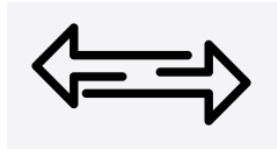
- Date, location and type of service performed
- Time the service begins and ends
- Individual receiving the service
- Individual providing the service

Providers that require EVV include:

- Home and Community-Based Services (HCBS)
  - Consumer Directed Attendant Support Services (CDASS)
  - Homemaker
  - Independent Living Skills Training (ILST) and Life Skills Training (LST)
  - In-Home Support Services (IHSS)
  - Personal Care
  - Respite and Youth Day
- Home Health
- Pediatric Behavioral Therapies
- Pediatric Personal Care
- Physical, Occupational and Speech Therapies
- Private Duty Nursing

Claim Denials
Electronic Visit Verification (EVV)

- Providers must enroll with the Electronic Visit Verification (EVV) program vendor for each unique Health First Colorado ID.
- Electronic Visit Verification (EVV) records collected by the vendor or provider-choice system are transmitted nightly.
- Electronic Visit Verification (EVV) records on file match automatically to claim lines submitted.
  - Visits are available for matching the day after a visit has been recorded and verified.
  - Claims must be billed after service has been completed and a visit has been recorded to ensure proper matching.
  - Adjust paid claims if an Electronic Visit Verification (EVV) record is modified by the provider after payment is made by Health First Colorado. This must be done to ensure that the correct EVV record matches the claim.



Claim Denials
Electronic Visit Verification - Explanation of Benefits

If a claim is denied for the following Explanation of Benefit (EOB) despite being enrolled with the Electronic Visit Verification system:

- **E0B 3054 - EVV Required and Not Found**

One of the following issues may apply:

- Claim was submitted prior to having a visit available for matching. Resubmit the claim once the visit is available.
- One of the points of data being captured was incorrectly entered. Log into the Sandata Provider Portal or the Sandata Aggregator (for provider-choice systems) and find the visit(s) that was logged for those claim lines.

Claim Denials
Electronic Visit Verification - Related Issues

To find your Visit ID, navigate to the Reports section and choose “Date Range Reports” and then select “Detail Visit Status.” The first column of the report is the Visit ID.

When checking the Sandata Provider Portal or the Sandata Aggregator, check the following things:

- Does the Location ID for the Electronic Visit Verification (EVV) account match the Billing Provider ID on the claim?
- Does the Member ID match what is on the claim?
- Do the visit’s first and last dates of service match what is on the claim?
- Does the claim procedure or revenue code match the correct grouped code on the visit?
  - EVV Service Code List
  - EVV Crosswalk of Codes

Only denied claims can be resubmitted.

Claim Denials

Resubmissions: 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)

Claim Denials

Resubmissions: Date of Service Past 365 Days

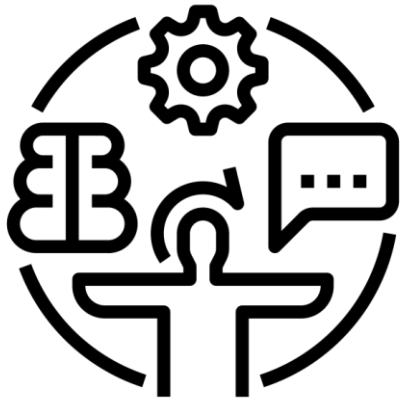
If the original timely filing period (365 days from date of service) has expired, the next submission must be received within 60 days of the last action

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

Submitting a reconsideration claim is not necessary.

Claim Denials
Reconsiderations

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

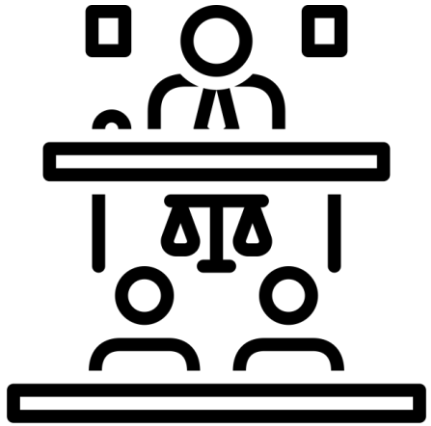


Claim Denials
Reconsiderations - Reasons

- 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 consideration.
  - 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 override 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 consideration.

Claim Denials
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.



Reminders

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
- Provider-Specific Billing Manuals
- Appendix R (for a detailed list of Explanation of Benefits [EOB] codes)

Provider Web Portal Quick Guides

- Technical help for the Provider Web Portal

Provider Training web page

- Training schedule and sign-up
- Training presentations and materials

Provider Contacts web page

- Contact information for Fiscal Agent (Gainwell Technologies) and Health First Colorado vendors
- Contact information for Regional Accountable Entities (RAEs)
- Virtual Agent Fact Sheet

hcpf.colorado.gov/our-providers

Where can I find…?

For Our Providers

- 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 claim form

- Newsletters
- What's New?

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	Long-Term Services and Supports	Web portal	
Revalidation	Provider contacts: Who to call for help	Provider resources: Quick guides, known issues, EDI, & training	

Where can I…?

- 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

COLORADO
Department of Health Care Policy & Financing

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

Thank you!