Practitioner Specialty 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.

Agenda

- Early Intervention
- EPSDT
- Laboratory Services
- Obstetrical Care
- Outpatient Imaging and Radiology
- SBIRT
- Surgery
- Telemedicine
- Vaccines and Immunizations

Universal Procedure and Diagnosis Coding

- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires providers to use universal Current Procedural Terminology (CPT) coding guidelines
  - Providers should consult CPT manual definitions for each code submitted for reimbursement
  - Health First Colorado payment policies are based on CPT descriptions

- Providers must also use International Classifications of Diseases 10th Revision, Clinical Modification diagnosis codes (ICD-10)

- Refer to provider-specific billing manuals located on the Department website for more detailed benefit and billing information
  - For Our Providers → Provider Services → Billing Manuals → Professional (CMS 1500)

Early Intervention

Early Intervention

- Early Intervention services are provided to children birth to age three (3) who have or are at risk for developmental disabilities or special needs
  - Some children remain in early intervention until preschool special education services begin
- All codes billed for children who are receiving services as part of an approved Individualized Family Service Plan (IFSP) should include the TL modifier
  - Assistive Technology
  - Audiology services
  - Nurse visit
  - Nutrition services
  - Sick care
  - Therapies
- For Our Providers → Provider Services → Billing Manuals → Professional (CMS 1500) → Early Intervention

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program

EPSDT
Overview

- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program
- Federally mandated health care benefits package for all Health First Colorado members ages birth to 20 years
- Emphasizes preventive care
  - Focuses on early identification and treatment of medical, dental, vision, hearing and developmental concerns
  - Establishes a regular pattern of health care through routine health screenings, diagnostic and treatment services
    - See the AAP Bright Futures periodicity for recommended well child visits
    - https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

EPSDT
Screening

- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program well child screenings must include testing for lead poisoning
  - At 12 and 24 months of age or between 36 and 72 months of age if not previously tested
  - Will continue to be a Centers for Medicare & Medicaid Services (CMS) requirement for all Health First Colorado eligible children until Colorado can provide enough data to show it is not a concern in this region

EPSDT
Diagnostic

- When a screening indicates the need for further evaluation, diagnostic services must be provided
  - Referrals should be made without delay
  - Providers should follow up to make sure that the child receives a complete diagnostic evaluation

EPSDT
Treatment

- Diagnostic evaluations should lead to treatment or other measures to correct or improve illness or conditions discovered by screenings
- All services must be provided if:
  - Covered by Health First Colorado
  - Medically necessary, even if not covered by Health First Colorado for members over the age of 20
- Health First Colorado is not an insurance plan with an exclusions list
  - Providers should ask for services and items if members need it

EPSDT
Medical Necessity

- Additional services beyond what is covered by Health First Colorado must be allowed for any member ages 20 and under when medically necessary
  - Services must be covered as listed in 1905(a)(c) of the Social Security Act
- Health First Colorado may determine which treatment it will cover among equally effective and available treatments
  - As long as the determination is specific to the individual members
  - No arbitrary limitations on series allowed (e.g., 1 pair of eyeglasses or 10 physical therapy visits per year)

EPSDT
Limitations

- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) does NOT include:
  - Experimental or investigational treatments
  - Services or items not in accordance with professionally recognized standards for health care in the United States
  - Services or items when an equally effective but less expensive option is available
  - Services primarily for provider or caregiver convenience

EPSDT
Prior Authorization Requests

- Providers should submit Prior Authorization Requests (PARs) for non-covered services or items to be reviewed under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines
- Requests must include a letter of medical necessity
- All requests will be reviewed by the appropriate entity for medical necessity
- Determination will be returned to the requesting provider

EPSDT
Letter of Medical Necessity

- Prior Authorization Requests (PARs) must include a letter of medical necessity which states:
  - Appropriate Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes, units and other related details
    - Services or items not listed on the Health First Colorado fee schedule can still be requested (e.g., glucose monitoring equipment)
  - Detailed information about how the service or item will improve or maintain the member's health, prevent it from worsening or prevent the development of additional health problems
  - Duration and treatment goals for the request, as well as any previous treatments and responses

EPSDT
Letter of Medical Necessity, cont.

- Letters of medical necessity must also include:
  - answers to the questions: “Is the service or item safe?” and “How does the provider believe the item to be effective?”
- Include relevant documents and manufacturer information with the request

Laboratory Services

Laboratory Services

- Providers who perform laboratory tests are the only ones eligible to bill and receive payment
  - Providers may only bill for tests performed in their office or clinic
  - Testing performed by independent laboratories or hospital outpatient laboratories must be billed by the laboratories
- In order to receive payment, all laboratory service providers must be:
  - Enrolled in Health First Colorado
  - Clinical Laboratory Improvement Act (CLIA) certified
- All claims with services rendered by **any type of provider** must contain the National Provider Identifier (NPI) of the Ordering, Prescribing and Referring (OPR) provider who ordered the services
  - OPR providers must be actively enrolled with Health First Colorado

Laboratory Services

- Claims with unlisted codes must include operating report and Unlisted Procedure Code Form
- Clinical Laboratory Improvement Act (CLIA) Claims
  - Pass-through billing is not allowed
  - Only one (1) CLIA number can be included on the claim
- Collection, Handling and Conveyance Charges
  - Specimen collection, handling and conveyance is generally not reimbursable as a separate charge
    - Exception: Member is homebound, bedfast or otherwise non-ambulatory and specimen cannot be conveyed by mail
  - Transfer of specimen is a benefit only if the first laboratory's equipment is not functioning or certified to perform ordered tests (Use modifier KX with procedure code 99001)

Laboratory Services

- Papanicolaou (Pap) Smears
  - Health First Colorado covers one (1) screening and examination per 12-month period for women under 40 years of age
  - More than one (1) screening and examination is allowed for women ages 40 and over and those with medical necessity determined by physician
- Breast Cancer (BRCA) Screening and Testing
  - Screening must be conducted prior to genetic testing
  - Screening, genetic counseling and testing only covered for members over the age of 18
- Newborn Metabolic Screening
  - Code S3620 may only be billed by providers not reimbursed for delivery who submit a second specimen screen that cannot be linked to an initial specimen

Laboratory Services

- Drug Testing
  - Codes 80305, 80306 and 80307 have unit limit of four (4) per month per member

- For Our Providers → Provider Services → Billing Manuals → Professional (CMS 1500) → Laboratory Services

Obstetrical Care

Obstetrical Care
Global Codes

Global Care

- Affiliated providers should bill medical care provided during pregnancy, antepartum, labor and delivery and postpartum period using global obstetrical codes
- Global codes should be billed once all services are provided
- Utilize the delivery date as “date of service” for global/bundled service code billing

Non-Global Care

- Unusual circumstances
- Conditions which are unrelated to the pregnancy or delivery
- Complications of pregnancy
- Certain adjunctive services
- Medical/Surgical services unrelated to the pregnancy
- Depression screens for pregnant and postpartum women

For Our Providers → Provider Services → Billing Manuals → Professional (CMS 1500) → Obstetrical Care

Obstetrical Care
Additional Charges

- These services should be billed in addition to global obstetrical care charges:
  - Prenatal testing
  - Testing, including ultrasound
  - Clinical laboratory testing
  - Adjunctive services
  - Initial antepartum visit
  - Conditions requiring additional treatment
  - Case management
  - Medical or surgical complications
  - Anesthesia (including epidural)
  - Assistant surgeon at cesarean delivery
  - Family planning
  - Surgical sterilization
  - Newborn care in hospital
  - Examination and evaluation of healthy newborn
  - Newborn resuscitation or care of high-risk newborn

Obstetrical Care
Sterilizations

- All claims associated with a sterilization procedure must include the MED-178 Sterilization Consent form
- Member must:
  - Be at least 21 years of age
  - Be mentally competent
  - Give informed consent
- At least 30 days, but not more than 180 days, must pass between date MED-178 is signed by member and date of the sterilization procedure (except in specific circumstances of preterm delivery or emergency abdominal surgery)

- For Our Providers → Provider Services → Forms → Claim Forms and Attachments → Consent to Sterilization – MED 178 (also available in Spanish)

Obstetrical Care
Sterilizations

- Claims must be submitted electronically through the Provider Web Portal
- Claims need to include the family planning diagnostic code and/or the family planning modifier ‘FP’
- Common errors:
  - Using an old version of the MED-178 (2004) form
  - Missing member’s signature
  - Type of operation entered on MED-178 form differs from that in the Physician’s Statement
  - Incomplete facility address (must include zip code)
  - Operation performed less than 30 days or more than 180 days from signature date

Outpatient Imaging and Radiology

Outpatient Imaging and Radiology
Prior Authorization

- Outpatient settings need to obtain prior authorization for:
  - Non-emergent Computerized Tomography (CT)
  - Non-emergent Magnetic Resonance Imaging (MRI)
  - All Positron Emission Tomography (PET) and Single Photon Emission Computed Tomography (SPECT) scans
- CT and MRI tests are exempt from prior authorization if the emergency indicator box is checked on the professional claim form
- Prior Authorization Request (PAR) revisions due to a change of test need to be submitted within 48 hours

Outpatient Imaging and Radiology
Billing Guidelines

- All claims with services rendered by **any type of provider** must contain the National Provider Identifier (NPI) of the Ordering, Prescribing and Referring (OPR) provider who ordered the services
  - OPR providers must be actively enrolled with Health First Colorado
- National Correct Coding Initiative (NCCI) billing edits affect this benefit
- Claims with unlisted codes must include operating report and Unlisted Procedure Code Form

Outpatient Imaging and Radiology
Modifiers

- Component modifiers must be indicated on the claim if reimbursement is split between the professional and technical components
  - Professional component – modifier 26
  - Technical component – modifier TC bilateral radiology procedures should be reported using modifiers RT and LT
  - Claims using modifier 50 for bilateral radiology will be denied

Outpatient Imaging and Radiology
Limitations

- The following procedures are NOT covered by Health First Colorado:
  - Not ordered by the member's rendering physician
  - For the purposes of cosmetic treatment
  - For the purposes of infertility treatment
  - Considered experimental or not approved by the Food and Drug Administration (FDA)
  - Part of a clinical study

- For Our Providers → Provider Services → Billing Manuals → Professional (CMS 1500) → Outpatient Imaging and Radiology

Screening, Brief Intervention and Referral to Treatment (SBIRT)

SBIRT

- Screening, Brief Intervention and Referral to Treatment
  - Used to identify and treat drug and alcohol abuse for members ages 12 and above
  - Requires special certification and training that can be completed online or in person
  - The following providers are eligible to provide SBIRT:
    - Physician
    - Psychiatrist
    - Psychologist (PsyD and PhD)
    - Nurse Practitioner
    - Physician Assistant
    - Master's level clinicians: Licensed clinical social worker (LSCW), Licensed marriage and family therapist (LMFT), Licensed professional counselor (LPC)

- For Our Providers → Provider Services → Billing Manuals → Professional (CMS 1500) → Screening, Brief Intervention and Referral to Treatment (SBIRT)

Surgery

Surgery

- Surgical reimbursement includes:
  - Payment for the operation
  - Local infiltration
  - Digital block or topical anesthesia
  - Normal, uncomplicated follow-up care

- Claims will deny if surgery has 30, 60 or 90 post-operation days and providers bill an office visit within those time periods as office visits are included in surgical reimbursement

Surgery
Multiple Surgeries and Procedures

- Multiple surgery should be billed with one (1) unit of service on (1) line using the 50 modifier for additional reimbursement
- Modifier 59: Distinct Procedural Service is used to identify procedures and services that are normally reported together, but should be reported only if:
  - A more descriptive modifier is unavailable
  - Clinical documentation can justify the use of modifier 59 to explain the circumstances

- For Our Providers → Provider Services → Billing Manuals → Professional (CMS 1500) → Medical-Surgical

Telemedicine

Telemedicine

- Providers who can bill for telemedicine service include:
  - Clinic
  - Physician and Osteopath
  - Physician Assistant
  - Nurse Practitioner
  - Psychologist
  - Federally Qualified Health Centers
  - Rural Health Clinics

- Provider types not listed may facilitate telemedicine services but may not bill procedure code Q3014 or use the GT modifier

Telemedicine

- Bill all telemedicine services on the professional claim form or electronically as an 837P
  - Bill only procedure codes for which providers are eligible to bill
- Bill the Regional Accountable Entity (RAE) when appropriate
- Prior Authorization Request (PAR) requirements remain the same

- For Our Providers → Provider Services → Billing Manuals → Professional (CMS 1500) → Telemedicine

Vaccines and Immunizations

Vaccines and Immunizations

Immunizations for children:

- A benefit when recommended by Advisory Committee on Immunization Practices (ACIP)
  - For members aged 18 and under
  - Only administration fee reimbursed
- Available from federal Vaccines for Children Program (VFC)

Immunizations for adults:

- A benefit when recommended by ACIP (subject to Health First Colorado rules)
  - Administration fee and vaccine reimbursed

- For Our Providers → Provider Services → Billing Manuals → Professional (CMS 1500) → Immunization

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

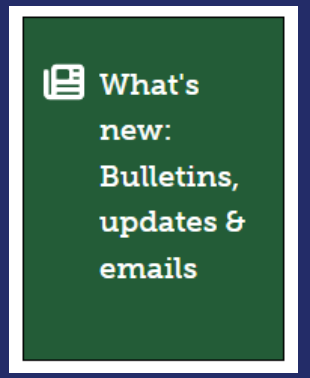
Provider Contacts web page

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

Reminders

- Remember to sign up for Department of Health Care Policy & Financing communications by visiting the website and clicking “For Our Providers” and then “What’s new: Bulletins, updates & emails.” Be sure to sign up for Provider Type 00.

- Interested in more training? Sign up or view training materials by visiting the website and clicking “Provider Resources” and then “Provider Training.” Presentations are listed under the calendar in the “Billing Training – Resources” section.



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!