Beginner Billing Workshop: Institutional Claims (UB-04)

Health First Colorado

(Colorado's Medicaid Program)

Institutional Claim - Who completes it?

- Inpatient/ Outpatient Hospital
- Nursing Facility
- Home Health
- Hospice
- Dialysis Centers
- Residential Treatment Centers
- Rural Health Clinics
- Outpatient Lab
- FQHC
- Indian Health Services

Training Overview

Program Overview

Department Website

Provider Enrollment

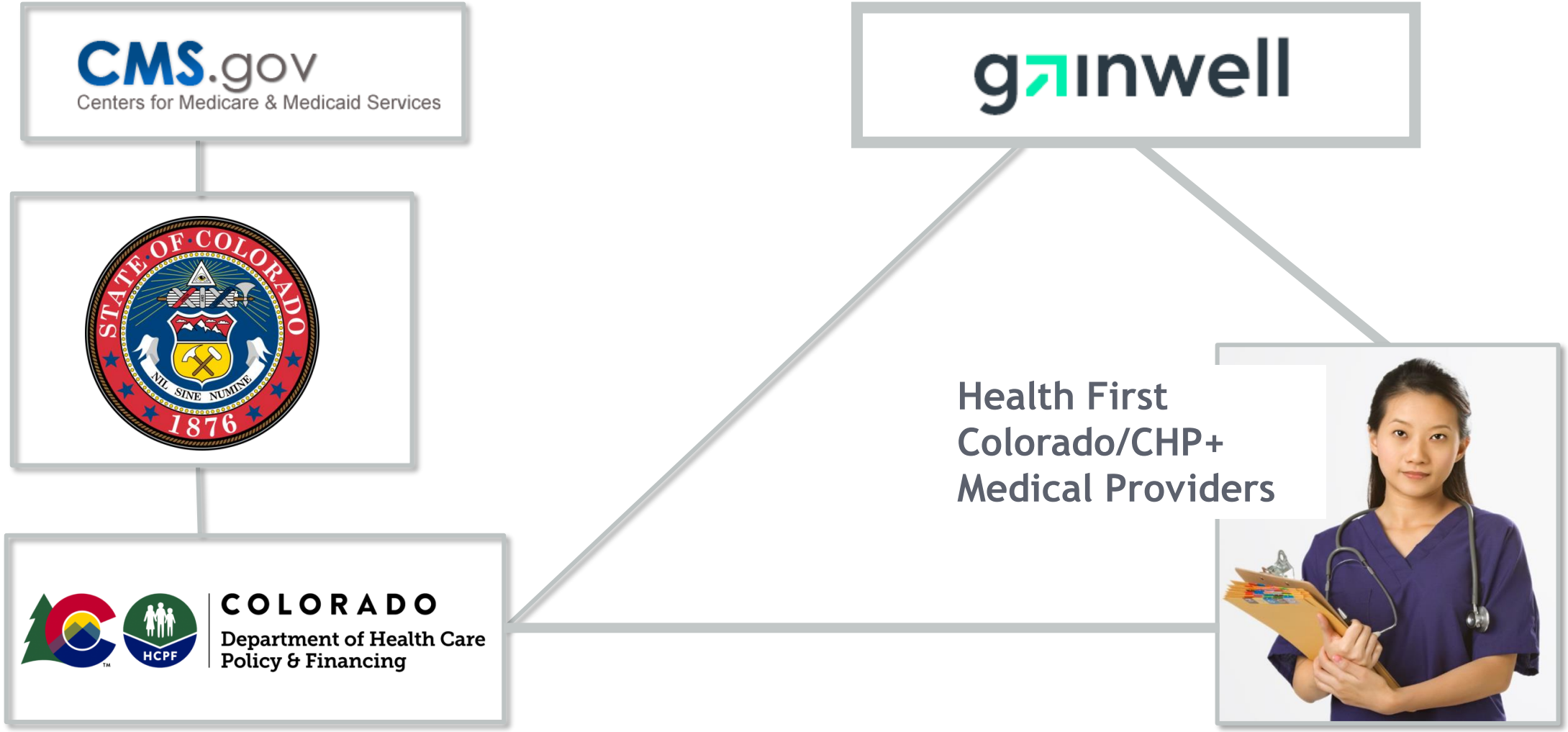
Eligibility Verification

Prior Authorizations

Billing and Payment

Claim Submission

Program Overview



Department Website

1

hcpf.colorado.gov

2

For Our Providers

https://hcpf.colorado.gov/

HCPF | Department of Health Care Policy & Financing
https://hcpf.colorado.gov/

Visit "Where can I get vaccinated" or call 1-877-COVAXCO (1-877-268-2926) for vaccine information.

COLORADO
Department of Health Care Policy & Financing

Search

Home | For Our Members | For Our Providers | For Our Stakeholders

We administer Health First Colorado (Colorado's Medicaid program), Child Health Plan *Plus*, and other programs.

Apply Now | Explore Programs | Find a Doctor | Get Help

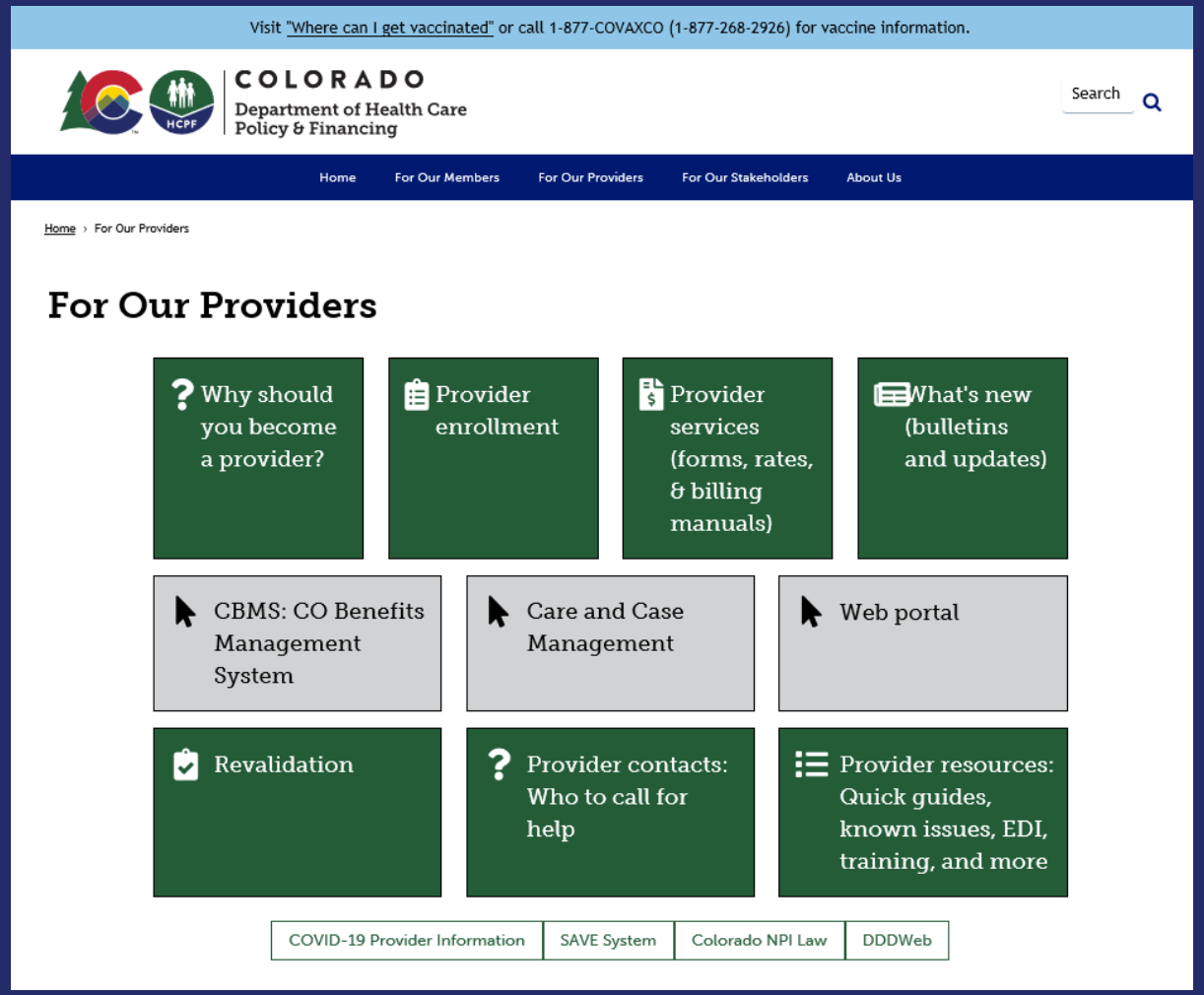
Health First COLORADO
Colorado's Medicaid Program

COVID-19 Information For Members, Providers and Stakeholders

Provider Home Page

Access to fee schedules, billing manuals, revalidation, enrollment, the provider web portal, contacts and resources

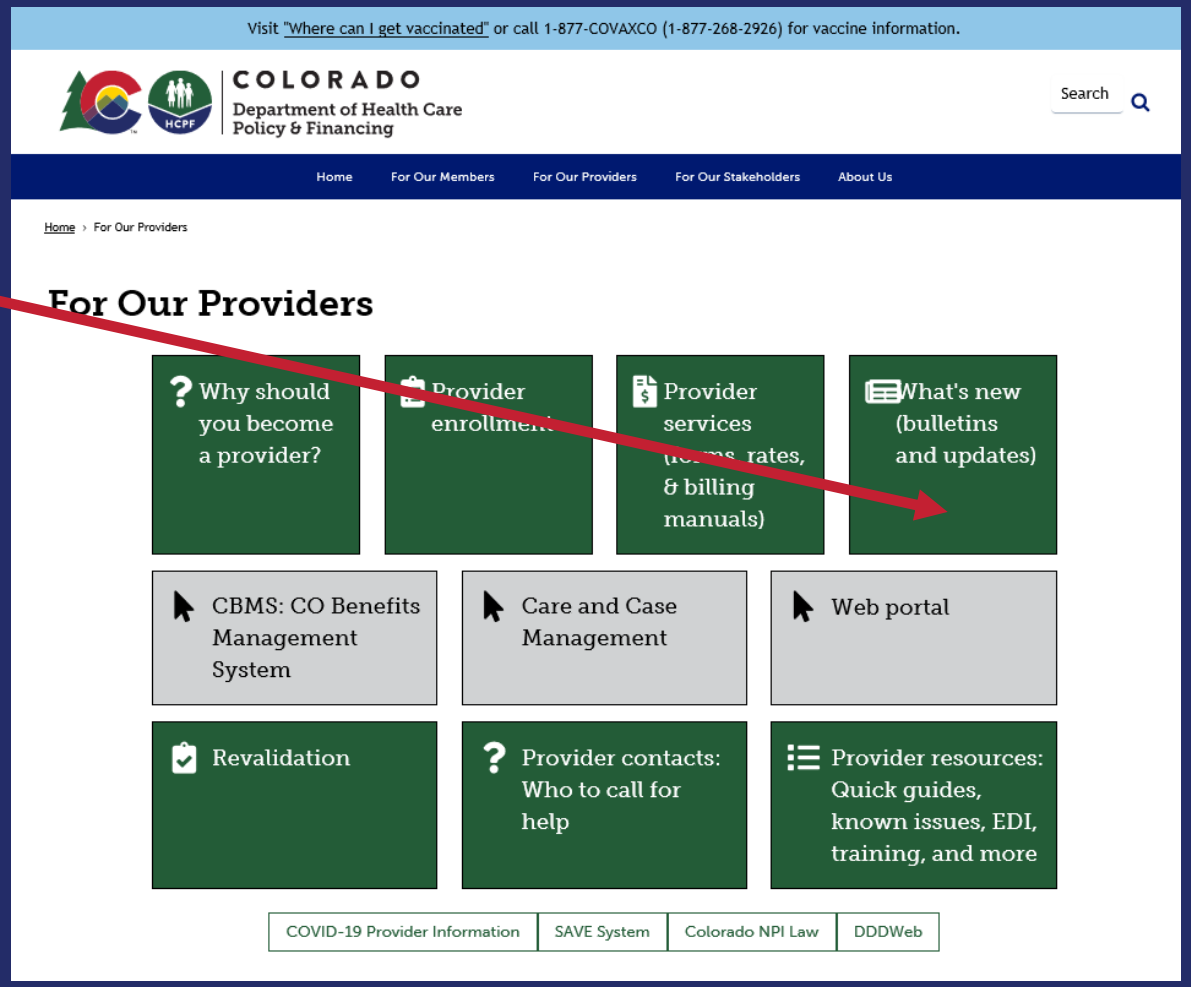
Contains important information regarding Health First Colorado (Colorado's Medicaid Program) & other topics of interest to providers and billing professionals



What's New, Bulletins, Newsletters

Sign up for publications

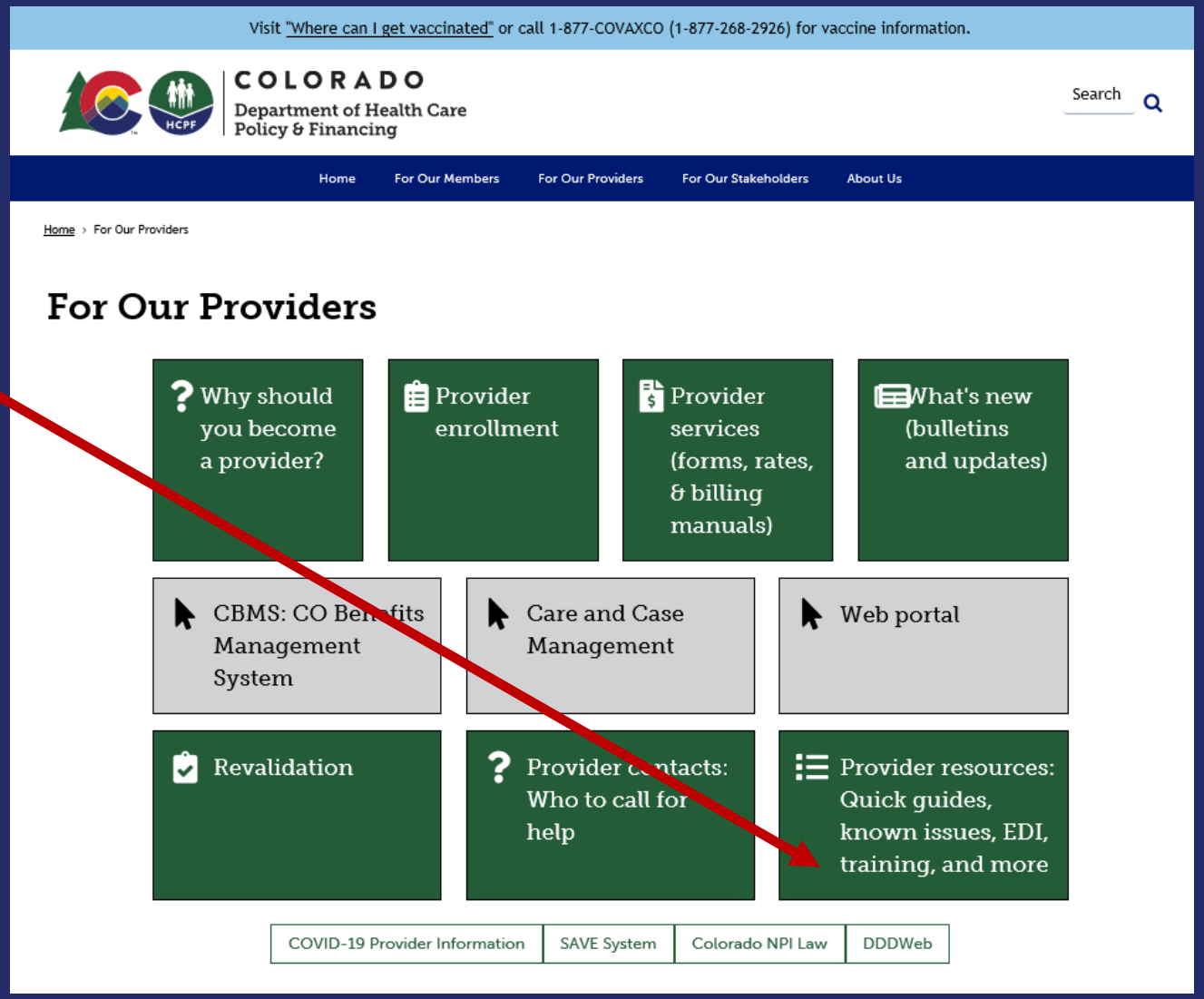
Weekly newsletters and bulletins



Provider Resources

Provider Resources

Web Portal Quick Guides, Electronic Data Information (EDI) for batch billing info, training presentations, field representatives and more



Provider Resources

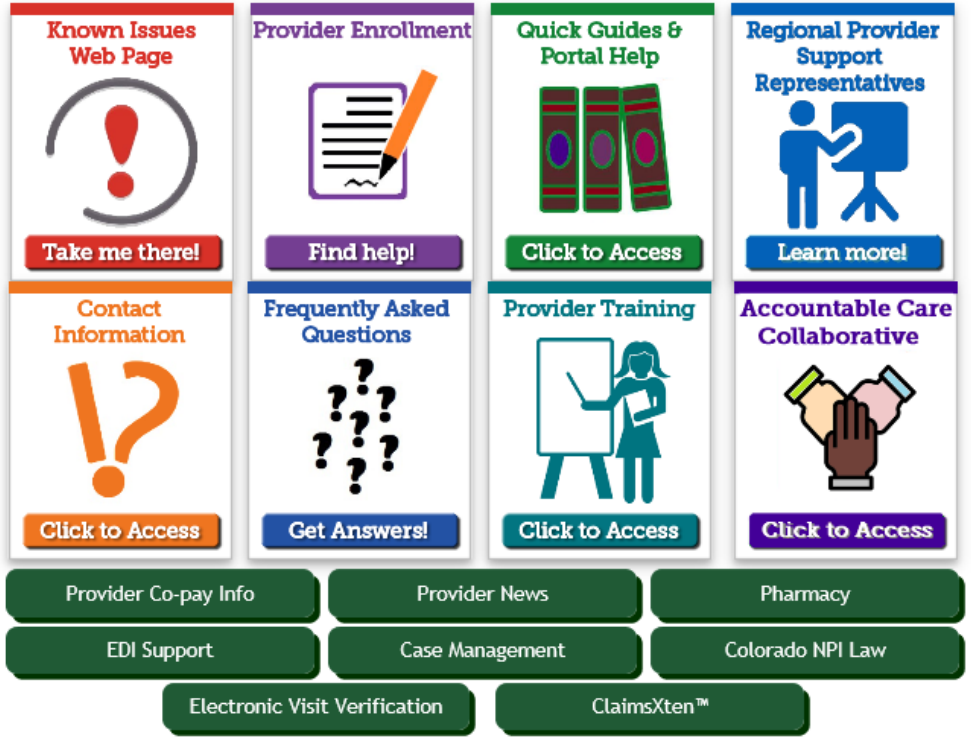
Provider Resources

Provider Services Call Center New Friday Hours: Effective February 5, 2021, the current fiscal agent (now referenced as Gainwell Technologies) extended the Friday hours of the Provider Services Call Center, with hours of operation Monday - Friday from 7:00 a.m. - 5:00 p.m. MT.

Upcoming Holidays

Memorial Day- Monday, May 31- State Offices, the ColoradoPAR Program, DentaQuest and Gainwell Technologies will be closed.

The receipt of warrants and EFTs may potentially be delayed due to the processing at the United State Postal Service or providers' individual banks.



National Provider Identifier

- A National Provider Identifier (NPI) is a unique 10-digit identification number issued to U.S. health care providers by CMS
- Non-medical providers such as some home and community based services (HCBS) do not require an NPI
- All HIPAA covered health care providers/organizations must use NPI in all billing transactions
- The Colorado interChange claims system will use the NPI to find the unique Health First Colorado Provider ID
- NPIs are permanent for individual providers regardless of rendering provider location or affiliation. Individuals should only have one NPI and one Health First Colorado ID

National Provider Identifier

- How to Obtain & Learn Additional Information:
  - Centers for Medicare and Medicaid Services (CMS) web page
    - (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/NPI-What-You-Need-To-Know.pdf)
  - National Plan and Provider Enumeration System (NPPES)
    - NPPES website (https://nppes.cms.hhs.gov)
    - 1-800-456-3203
    - 1-800-692-2326 TTY

NPI Law

- HB 18-1282 requires newly enrolling and currently enrolled organization health care providers (not individuals) to obtain and use a unique National Provider Identifier (NPI) for each service location and provider type enrolled in the Colorado interChange.

- Who Is Impacted by the Colorado NPI Law?
  Newly Enrolling Providers
  Organizational Health Care Providers (Facilities or Groups)
- Who Is **Not** Impacted by the Colorado NPI Law? Individual Practitioners
  Individual practitioners (Individuals Within a Group, Billing Individuals or Ordering/Prescribing/Referring), as individuals are limited to one enrollment and one NPI per person.
  Atypical (Non-Medical) Providers

- Providers who bill Medicare need to ensure each National Provider Identifier (NPI) for Health First Colorado is also enrolled with Medicare.

Provider Enrollment

Question:

What does Provider Enrollment do?

Answer:

Enrolls **providers** into Health First Colorado, *not* members

Question:

Who needs to enroll?

Answer:

Everyone who provides services for Health First Colorado members

Provider Enrollment

Provider Enrollment

ATTENTION: Some providers can now temporarily enroll in Health First Colorado (Colorado's Medicaid program) to provide services during the COVID-19 public health emergency. New applicants will be required to indicate whether they are enrolling temporarily due to the public health emergency or enrolling for the long-term. Refer to the drop-down section further down on this page, titled New Provider Specialties for COVID-19 Long-Term and Temporary Enrollment, for further details.

Revalidation Information | NPI Law Web Page

Enrollment Instructions & Application

Enrollment Resources

- Enrollment Best Practices
- Trading Partner Enrollment Information
- Enrollment and Web Portal Quick Guides
- Information for Ordering, Prescribing, Referring (OPR) Providers

Need to speak to a live agent for help with your enrollment? Please call the Provider Services Call Center at 1-844-235-2387, then select option 2 and then option 5.

Completed your application? Click here for next steps

- To prepare for enrollment as a new provider, go to the Provider Enrollment web page and click the Enrollment Instructions & Application button.
- There is a list of resources as well as forms for enrolling providers

Enrollment Forms

- Application Fee Refund Form
- Behavioral Therapy Provider Attestation Form
- Disclosure Instructions EIN
- Disclosure Instructions SSN
- EFT Exemption Instructions
- Enrollment Backdate Form
- Network Participation Verification Form
- Provider Participation Agreement
- SUD Clinic Supervisor Attestation Form

Revalidation

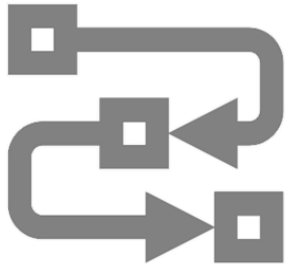
- Child Health Plan Plus (CHP+) and Health First Colorado (Colorado's Medicaid Program) providers must revalidate in the program at least every five (5) years to continue as a provider.
- Organization Health Care Providers are required to obtain and use a unique National Provider Identifier (NPI) for each service location and provider type enrolled.
- A spreadsheet with providers' revalidation dates can be found on the Department's Revalidation web page.

Verifying Member Eligibility

- Always save copies of eligibility verifications
- Keep member's eligibility information in member's file for auditing purposes
- Member's eligibility must be checked on each date of service
- Ways to verify eligibility:

Provider Web Portal

IVR
1-844-235-2387



Batch 270

Eligibility Information

- Web Portal
- Member ID Cards
- Eligibility Types
- Managed Care
- Medicare
- Third Party Liability
- Co-Pay

Viewing Member Information

Provider Web Portal

COLORADO
Department of Health Care Policy & Financing

Health First COLORADO
Colorado's Medicaid Program

Contact Us | Logout

Home | Eligibility | Claims | Care Management | Resources

Home — Monday 05/04/2020 01:32 PM MST

Provider Name	Provider ID	Location
	Taxonomy	

User Details

Welcome RevailProv1

- My Profile
- Manage Accounts

Provider

Name

Provider ID

Location ID

Revalidation Date

- Provider Maintenance
- EFT/ERA (835) Enrollment
- Disenroll

Revalidation

Provider Services

- Member Focused Viewing
- Search Payment History
- Search Accounts Receivable
- BIDM

Welcome Health Care Professional!

We are committed to make it easier for physicians and other providers to perform their business. In addition to providing the ability to verify member eligibility and submit claims, our secure site provides access to benefits, answers to frequently asked questions, and the ability to search for providers.

Provider Portal News

You are connected to the Model Office System

- Contact Us
- Notify Me
- Alerts
- Secure Correspondence

Verification called “CAPTCHA” to ensure provider is not a robot will be required first. On the Search tab, enter the Member ID or Last Name, First Name and Birthdate.

Member in Focus: FRIEDA FRANK Change ID: S700001 Close Member Focus

Member Details

Member ID S700001
Name Ima Member
Birth Date 07/15/1961
City NORTH
State Connecticut
Gender Female
Primary Language English

Coverage Details

Coverage	Effective Date	End Date
Medicaid State Plan	01/01/2014	12/31/2299
Behavioral Health Benefits	01/01/2014	12/31/2299

View eligibility verification information

Other Details

Secure Correspondence
Review previously sent messages or send new secure messages.

Your Member Claims

Medical/Dental

Submit a Professional Claim
Submit a Dental Claim
Submit an Institutional Claim

Claim ID	Service Date	Claim Type	Claim Status
2216152001011	01/01/2016 - 02/01/2016	LongTermCare	Denied
2216109001026	03/15/2015 - 03/15/2015	Inpatient	Suspended

Your Member Authorizations

Submit an Authorization

There are no authorizations for this member.

Search tab -

Member Focus Search

Last Members Viewed | Search

* Indicates a required field.

Enter the Member ID or Last Name, First Name and Birth Date.

Member ID S700001
Last Name
First Name
Birth Date
City
Zip Code

Search Reset

Search Results

Click on the member name below to access the Member Focus View.

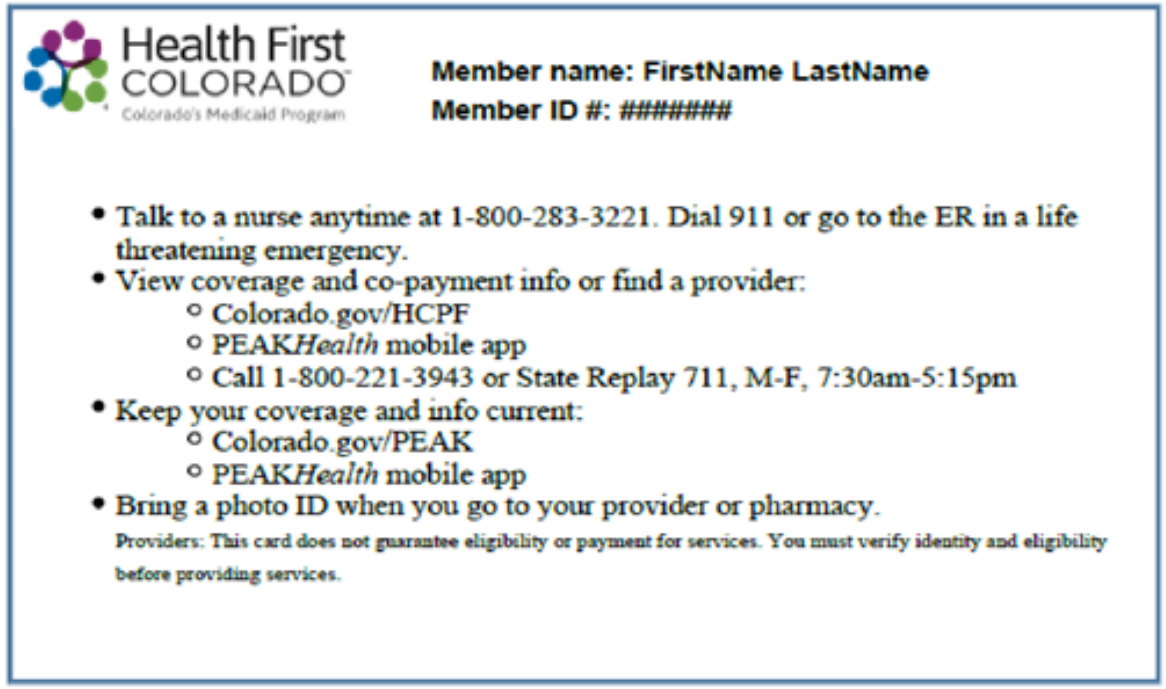
Total Records: 1

Member ID	Member	Gender	Birth Date	City	Zip Code
S700001	IMA, MEMBER	Female	07/15/1961	AURORA	80011-2506

This search will display the Member in Focus page which provides Member Details, Coverage Details, and Member Claims.

Health First Colorado Identification Cards

- This page depicts older branded cards. Older branded cards are valid.
- Identification Card does not guarantee eligibility.
- Only the front is shown below.



Health First Colorado Identification Cards

- This page depicts newer branded cards in Spanish and English.
- Only the front is shown below.

Health First COLORADO
Colorado's Medicaid Program

Member ID: Z999999

Name: Ima Member

Your PCP is available to help.

Primary Care Provider (PCP): (303) 555-1212

HEALTH COLORADO, INC. RAE 4

Emergencies or medical advice

If you aren't sure if it's an emergency, call your PCP or the Nurse Advice Line. If it's an emergency, call 911 or go to the emergency room.

24/7 Nurse Advice Line: 800-283-3221

24/7 Mental health crisis: 844-493-TALK (8255)

ColoradoCrisisServices.org text TALK to 38255

If you need help getting an appointment call 1-888-502-4185.

See if you're active on the PEAK*Health* **App**

Health First COLORADO
Colorado's Medicaid Program

ID de miembro: Z999999

Nombre: Ima Member

Su PCP está a su disposición para ayudarle.

Médico de cabecera (Proveedor de atención primaria o PCP): 303-555-1212

DENTAQUEST USA

Emergencias o asesoramiento médico

Si no está seguro de si se trata de una emergencia, llame a su PCP o a la Línea de asesoramiento de enfermería. Si es una emergencia, llame al 911 o vaya al servicio de emergencias.

Línea de asesoramiento de enfermería las 24 horas del día, los siete días de la semana: 800-283-3221

Crisis de salud mental las 24 horas del día, los siete días de la semana: 844-493-TALK (8255)

ColoradoCrisisServices.org envíe TALK al 38255

Si necesita ayuda para hacer una cita, llame al 1-855-384-7926.

Consulte si está activo en la aplicación PEAK*Health*

Eligibility Types

- Most members = Regular Health First Colorado benefits
- Some members = different eligibility type
  - Old Age Pension, state-only
  - Non-Citizens
  - Presumptive Eligibility
  - Managed care
- Some members = additional benefits
  - Medicare
  - Third Party Insurance (Commercial Insurance)

Eligibility Types

Old Age Pension – State Only

- Members are not eligible for regular benefits due to income
- Some Health First Colorado payments are reduced payment to the providers since the program only gets state funds and no federal match.
- Providers cannot bill the member for the amount not covered
- Maximum member co-pay for OAP-State is $300
- Does not cover:
  - Home Health
  - Home and Community Based Services (HCBS)
  - Inpatient, psychiatric or nursing facility services

Eligibility Types

Non-Citizens EMS or COVID-only EMS

- Eligibility type only covers emergency services
- Claim must indicate emergency by the appropriate admit type
- Emergency services must be certified in writing by provider and kept on file, but do not need to be submitted with the claim
- Emergent medical services (EMT) for COVID only

What Defines an "Emergency?"

- The provider determines whether or not the service is considered an emergency and marks the claim appropriately.
- An emergency is defined as a sudden, urgent, usually unexpected occurrence or occasion requiring immediate action, including acute symptoms of sufficient severity & severe pain in which the absence of medical attention might result in:
  - Placing health in serious jeopardy
  - Serious impairment to bodily functions
  - Dysfunction of any bodily organ or part

Active labor and delivery is an example of an emergency.

Eligibility Types

Presumptive Eligibility

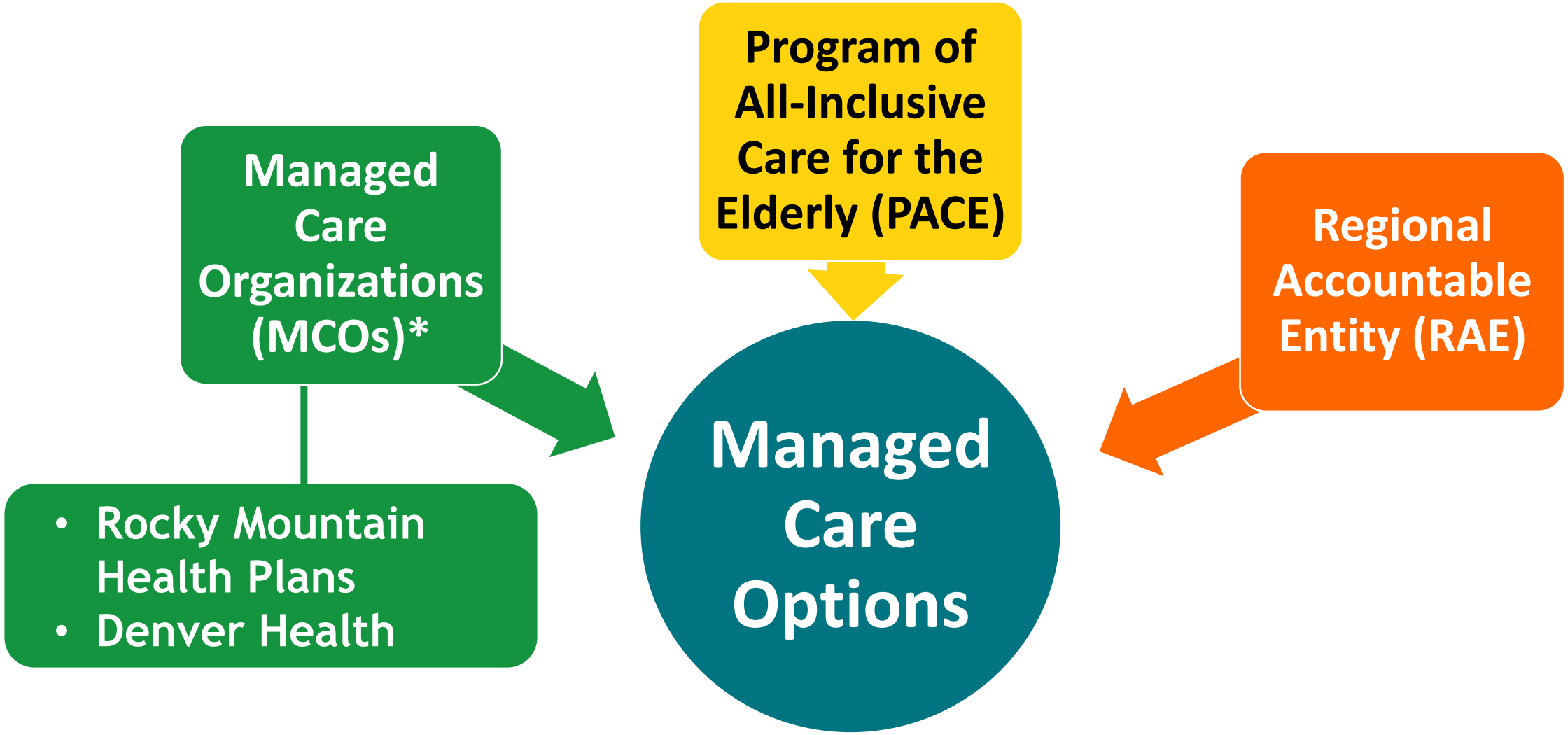
- Temporary coverage of Health First Colorado or CHP+ services until eligibility is determined
- Health First Colorado Presumptive Eligibility is only available to:
  - Pregnant women
    - Covers Durable Medical Equipment (DME) and other outpatient services
    - Covers labor and delivery, but does not cover any OTHER inpatient services
  - Children ages 18 and under
    - Covers all Health First Colorado covered services
- CHP+ Presumptive Eligibility
  - Covers all CHP+ covered services, except dental

Eligibility Types

Presumptive Eligibility (continued)

- Health First Colorado Presumptive Eligibility claims
  - Submit to the Fiscal Agent (Gainwell Technologies)
- CHP+ Presumptive Eligibility and claims
  - Submit to Colorado Access or Denver Health

Managed Care



Managed Care

Managed Care Organization (MCO)

- Some services are not included in the managed care contract.
- Those fee for service claims can be billed directly to fiscal agent.
  - Example:
    - Denver Health does not pay for Hospice

Managed Care
Regional Accountable Entity

- Members are assigned to the Regional Accountable Entity (RAE) for their area
  - Contact RAE in your area to become a Behavioral Health Program Provider
  - https://www.colorado.gov/hcpf/accphase2
- Regional Accountable Entities do not pay for pediatric behavioral therapy

Medicare

- Members may be eligible for both Medicare & Health First Colorado
- Health First Colorado is always payer of last resort
  - Bill Medicare first for Medicare-Health First Colorado members
- Retain proof of:
  - Submission to Medicare prior to Health First Colorado
  - Medicare denials(s) for six (6) years
  - Medicare EOB does not need to be attached to every claim submission

Medicare

- Medicare members may have:
  - Part A only- covers Institutional Services
    - Hospital Insurance
  - Part B only- covers Professional Services
    - Medical Insurance
  - Part A and B- covers both services
  - Part D- covers Prescription Drugs

Medicare

Qualified Medicare Beneficiary (QMB)

- Health First Colorado uses “lower of pricing” logic -either coinsurance and deductible or difference between Medicare paid amount and Health First Colorado allowed amount, whichever is lower.
- Members are only responsible for Health First Colorado co-pay
- Covers any service covered by Medicare.
  - QMB Plus Medicaid (QMB+)- members also receive Health First Colorado benefits (Title XIX)
  - QMB **Only**- members do not receive Health First Colorado benefits. Health first Colorado will only pay if Medicare pays primary.

Third Party Eligibility

- Health First Colorado is always payer of last resort
- Indicate the date the Third Party Liability (Commercial Insurance) paid or denied on each claim

The Explanation of Benefits (EOB) does not need to be attached to the claim

- Provider cannot:
  - Bill member difference
  - Bill member for co-pay/deductible assessed by the Third Party Liability (Commercial Insurance)

Third-Party Liability
(Commercial Insurance)

Health First Colorado (Colorado's Medicaid Program) pays the difference between Third Party Liability payment and Program Allowable

- Example:
  - Charge = $500
  - Program allowable = **$400**
  - TPL payment = **$300**
  - Program allowable – TPL payment = **Reimbursement**

	$400.00
-	$300.00
=	$100.00

Co-Pay

- Auto-deducted during claims processing
  - Do not deduct from charges billed on claim
- A provider may not deny services to an individual when such members are unable to immediately pay the co-pay amount. However, the member remains liable for the co-pay at a later date. (8.754.6.B rule in 10 CCR 2505 volume 8.700)
- Youth from birth to 18 years old are considered children

Co-Pay

- Services that do not require co-pay:
  - Dental
  - Home Health
  - HCBS waiver services
  - Transportation
  - Emergency Services
  - Family Planning Services
  - Behavioral Health Services (mental health and substance use disorder)

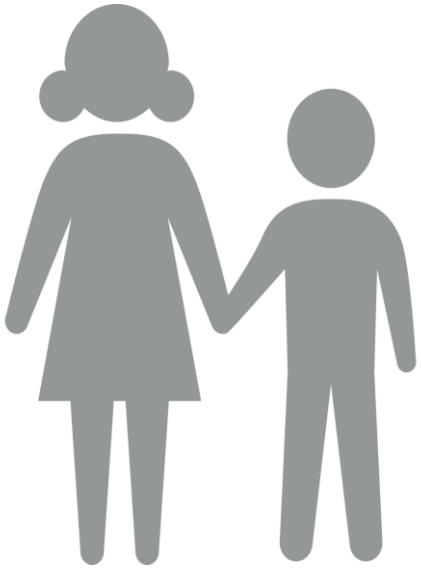
Co-Pay

- The co-pay maximum is 5% of the household monthly income.
- The head of household will receive a letter showing the household has reached the monthly limit.
- Members who track their own co-pay amounts may claim they have reached their maximum for the month before the Provider Web Portal reflects this information. If Health First Colorado members state they have met their monthly co-pay maximum, but the Web Portal indicates they owe a co-pay amount at the time of their visit, it may be because the health care claims from other providers have not been submitted yet.
- Providers are encouraged to submit claims as soon as possible to ensure a co-pay does not need to be refunded to the member.

Co-Pay Exempt Members

Nursing Facility Residents

Pregnant Women



Children and Former Foster Care Eligible*

*former foster care eligible still has a pharmacy co-pay

From the Noun Project:
"Nursing-Home" by Iconathon
"Children" by OCHA Visual Information Unit
"Maternity-Cycle" by HCPF

Specialty Co-Pay

Practitioner, Optometrist, Speech Therapy, RHC / FQHC	$2.00
DME / Supply	$1.00 per date of service
Outpatient	$4.00
Inpatient	$10.00 per covered day or 50% of average allowable daily rate - whichever is less
State Plan Psych Services	.50 per unit of service, 1 unit = 15 minutes

Prior Authorization Requests (PAR)

- The ColoradoPAR Program reviews prior authorization requests (PARs) for the following categories or services & supplies:
  - Diagnostic imaging
  - Durable medical equipment
  - Inpatient admissions
  - Medical services (including transplant, back and bariatric surgery)
  - Physical, occupational, and speech therapy
  - Pediatric behavioral therapy
  - Pediatric long-term home health
- Adult long-term home health PARs are not submitted to eQHealth, but to the case management agency

Prior Authorization Requests (PAR)

- ColoradoPAR does not process prior authorizations for dental, transportation, pharmacy, or behavioral health services covered by the Regional Accountable Entities.
- All PARs for members age 20 and under are reviewed according to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. Even if it's not a covered service for an adult, it may be covered under EPSDT if deemed medically necessary for a child.
- Prior Authorizations and PAR revisions processed by the ColoradoPAR Program must be submitted via the utilization management portal.

Website:

ColoradoPAR website
(www.coloradopar.com)

Phone:

Phone: 1-888-801-9355

FAX: 1-866-940-4288

Prior Authorization Requests (PAR)

- Final prior authorization determination letters
  - Mailed to members
  - Posted to Department's prior authorization vendor's utilization management portal
  - Letter inquiries should be directed to ColoradoPAR
- Providers can review prior authorizations via the utilization management portal.

Billing and Payment

Record Retention

Payment Processing and Remittance

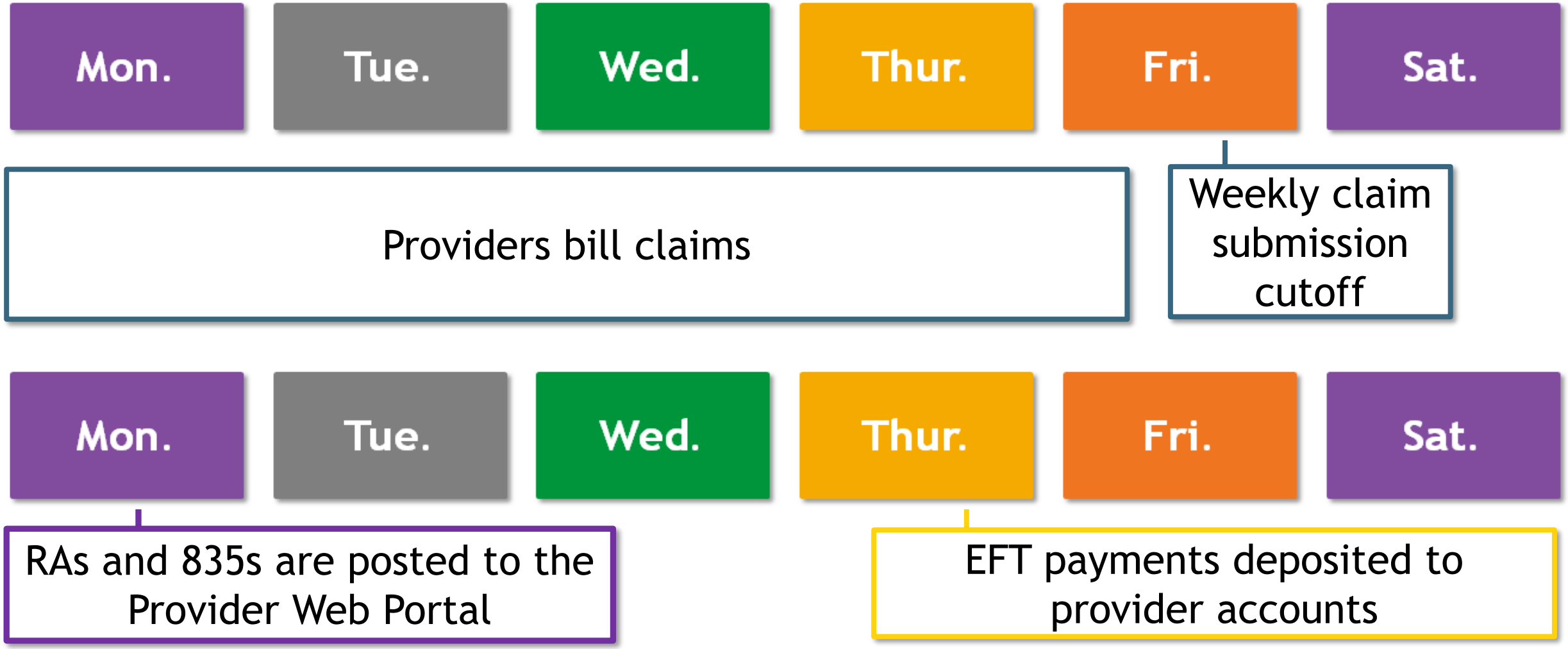
Timely Filing

Extensions for Timely Filing

Record Retention

- Providers must:
  - Maintain records for at least seven (7) years
  - Longer if required by specific contract between provider & Health First Colorado
  - Furnish information upon request about payments claimed for Health First Colorado services
- Medical records must:
  - Substantiate submitted claim information
  - Be signed & dated by person ordering & providing the service
    - Electronic record keeping is also allowed and encouraged

Payment Processing Schedule



Retrieving Remittance Advice or 835

- To pull a remittance advice (RA), log into the Provider Web Portal and click on Resources and then Report Download.

- To pull an electronic remittance advice (ERA) X12 835, click on File Exchange and then Download Reports.

Resources:

- Provider Web Portal Quick Guide – Pulling Remittance Advice (RA)
- Provider Web Portal Quick Guide – Linking the TPID and Pulling an 835

Timely Filing

- 365 days from Date of Service (DOS)
  - Determined by date of receipt
  - Certified mail is not proof of timely filing
  - PARs are not proof of timely filing
  - Contacting the fiscal agent or waiting for fiscal agent response to a verbal inquiry is not proof of timely

Claims must be submitted to keep them within timely filing guidelines, even if the result is a denial.

Timely Filing

Type of Service	Timely Filing Calculation
Nursing Facility; Home Health, Inpatient, Outpatient; all services filed on the UB-04	From the “through” date of service
Dental; EPSDT; Supply; Pharmacy; All services filed on the CMS 1500	From the date of each service (line item)
Home & Community Based Services	From the “through” date of service
Obstetrical services professional fees Global procedure codes: The service date must be the delivery date.	From the delivery date
Equipment rental - The service date must be the last day of the rental period	From the date of service

Timely Filing Extensions

- 365 days from Date of Service (DOS)
  - Determined by date of receipt
  - Certified mail is not proof of timely filing
  - Prior Authorizations are not proof of timely filing
  - Contacting the fiscal agent or waiting for fiscal agent response to a verbal inquiry is not proof of timely

Claims must be submitted to keep them within timely filing guidelines, even if the result is a denial.

Timely Filing Extensions

Rebilled Claims

60 days from date on:

- Remittance Advice (RA) or 835
  - Use last Internal Control Number (ICN). Do not attach copy of RA with claim.
- Returned Claim
  - Date stamped by the fiscal agent

Keep supporting documentation

Timely Filing Extensions

Primary Payers

Commercial Insurance/Third Party Liability (TPL)

- Can not pay if over 365 days from date of service (DOS) per federal statute
- All claims which include commercial insurance (third-party liability) information that are received more than 365 days from the date of service must be denied per state and federal regulation (42 C.F.R. § 447.45(d), 10 CCR 2505-10 8.043.01 and .02A). The provider is responsible for pursuing available third-party resources in a timely manner.

Member who is enrolled with both Medicare and Health First Colorado

- Additional 120 days from Medicare explanation of benefit date

Timely Filing Extensions

Delayed Notification/Backdated Eligibility

Delayed Notification

- Providers are responsible for determining eligibility within 365 days, even if the member does not notify them of Health First Colorado eligibility. No further extensions are given for delayed notification of eligibility.

Load Letters

- 60 days from load letter
  - Used when county backdates eligibility farther than 365 days
- Bill electronically
  - Submit with copy of load letter via Provider Web Portal

Timely Filing Extensions

Provider Enrollment

- 365 days from backdate approval

Providers do not need to submit claims while waiting for enrollment to be approved.

Claim Submission

- Claim Submission Methods
- UB04 Paper Claim Form and Claim Number
- Paper Claim Examples
- Common Denial Reasons
- Claim Status
- Claim Adjustments, Voids and Refunds

Claim Submission Methods

Methods to submit:

- Electronically through Gainwell Technologies' Web Portal (free of charge)
  - Interactive, one claim at a time
- Electronically using Batch Vendor or Clearinghouse or software
  - Submitters must test batch transactions before approval to submit.
- Paper only when:
  - Pre-approved (consistently submits less than five (5) per month). Form must be mailed to the fiscal agent to request paper claim submission approval.

Claim Submission Methods

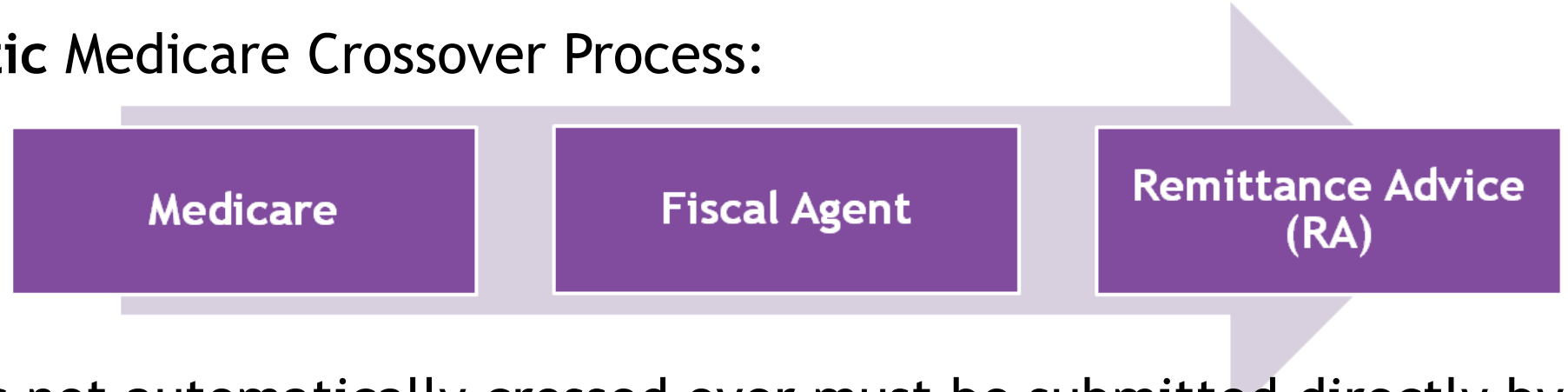
Electronic Data Interchange (EDI)

- Providers do not need to obtain a trading partner ID/submitter ID to access the provider web portal.
- Only a submitter who sends batch transactions or receives batch reports needs to enroll in the Electronic Data Interchange (EDI) for a trading partner ID.
- Visit the EDI Support web page for more information

Claim Submission Methods

Medicare Crossovers

Automatic Medicare Crossover Process:

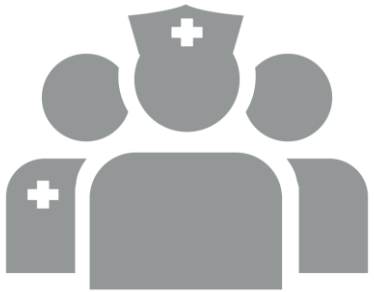


- Claims not automatically crossed over must be submitted directly by the provider
- Crossovers may not be adjudicated by Health First Colorado if:
  - NPI used on Medicare Claim does not match NPI enrollment with Gainwell Technologies
  - Member is a retired railroad employee
  - Member has incorrect or missing Medicare information on file

Claim Submission Information

Attending Provider

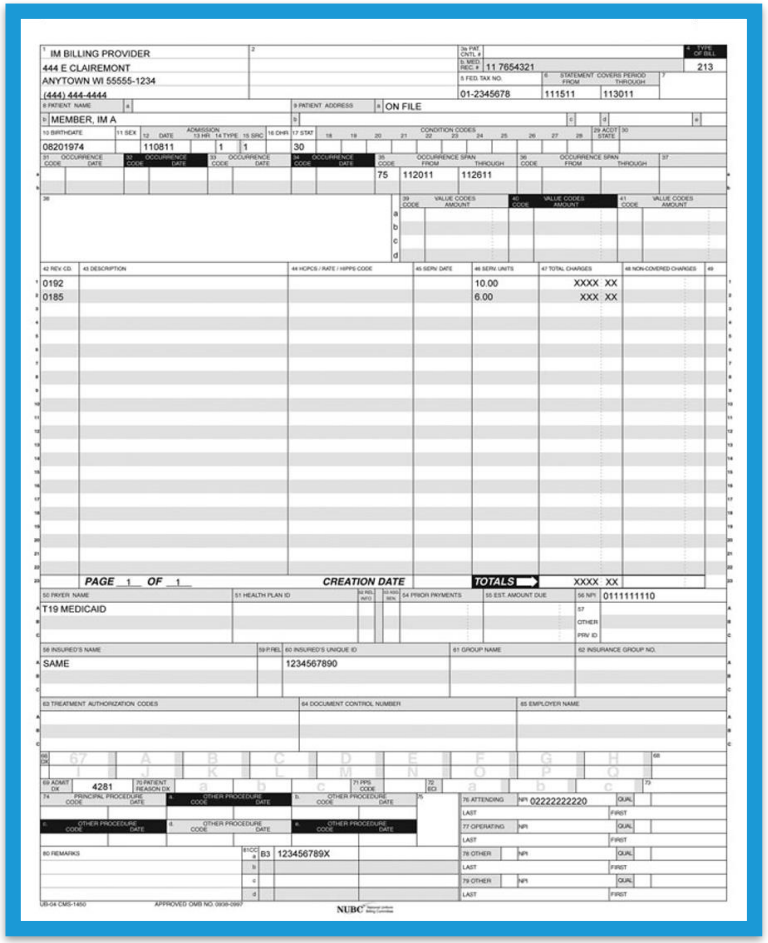
Individual that provides services to a Health First Colorado member



Billing Provider

Entity being reimbursed for service

UB-04 (Paper Claim)



UB-04 is the standard institutional claim form used by Medicare and Health First Colorado Programs

Where can a Health First Colorado provider get the UB-04?

- Available through most office supply stores

UB-04

COLORADO
Department of Health Care Policy & Financing

Health First Colorado

Institutional Provider Certification

This is to certify that the foregoing information is true, accurate and complete.

This is to certify that I understand that payment of this claim will be from Federal and State funds and that any falsification, or concealment of material fact, may be prosecuted under Federal and State Laws.

Signature:_____ Date:_____

This document is an addendum to the UB-04 claim form and is required per 42 C.F.R. § 455.18 (a)(1-2) to be attached to paper claims submitted on the UB-04.

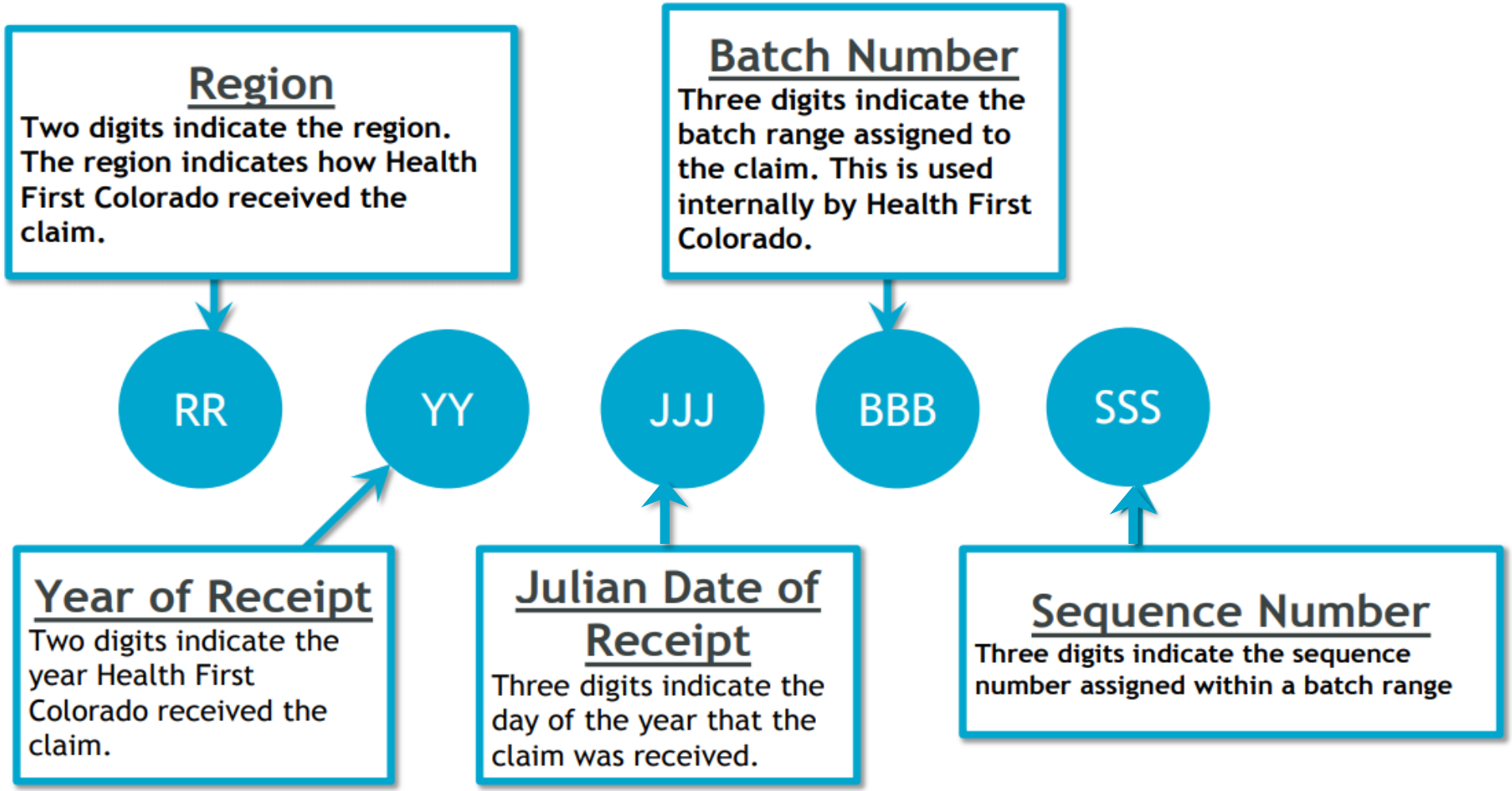
Revised January 2019

Our mission is to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.
www.colorado.gov/hcpf

UB-04 certification must be completed & attached to all claims submitted on the paper UB-04

Print a copy of the certification at:
Colorado.gov/hcpf/provider-forms

Internal Control Number (ICN)



Paper Claim - Example 1

REQUIRED FIELDS

CONDITIONAL FIELDS

OPTIONAL FIELDS

Field 1 - **Optional.** If sharing a billing NPI, the Zip+4 of the location address must be used.

Field 4 - **Required.** (Type of facility, Bill classification, and Frequency). 8--special facility-hospice. 1--inpatient-non hospital based. 3--interim-continuous claim.

Field 18 - **Required.** Z4 necessary for paper claims.

1 ABC Hospice
1234 Alphabet Lane
Anytown, CO 33333-9999
Phone: 999-999-9999

2

3a PAT. CNTL # 11111-000
b. MED. REC. # 123

4 TYPE OF BILL 813

5 FED. TAX NO. 999999999

6 STATEMENT COVERS PERIOD FROM 07012018 THROUGH 07312018

7

8 PATIENT NAME
a
b Doe, John

9 PATIENT ADDRESS
a Greentown Nursing and Rehabilitation 123 Southern Rd, Room 555
b Greentown
c CO
d 11111-4444
e

10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
02121950	M	02132018	12	3	5		30	Z4												

CONDITION CODES

31 CODE	31 OCCURRENCE DATE	32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE
27	051418						

35 CODE	OCCURRENCE SPAN FROM	THROUGH	36 CODE	OCCURRENCE SPAN FROM	THROUGH	37

38

Field 31-34 - **Required.** Enter the appropriate code and the date on which it occurred. Enter the date using MMDDYY format.

Field 15 & 17 - **Required.** For field 15 enter source of admission. For field 17 enter client status as ongoing patient (code 30) or as of discharge date.

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a						
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0651	Routine Low Days		07012018	31	5410 : 12	0 : 00	
2								
3								
4								
5								

Field 39-41 - **Conditional.** 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. If a value code is entered, a dollar amount or numeric value related to the code must always be entered.

Field 48 - **Conditional.** Enter incurred charges that are not payable by the Health First Colorado.

Paper Claim - Example 2

Field 50 & 51 - **Required**. For field 50 enter the payment source code followed by name of each payer organization from which the provider might expect payment. For field 51 enter the eight-digit Health First Colorado Program provider number assigned to the billing provider. This is the distinct number assigned to a provider during Health First Colorado enrollment.

Field 54 & 55 - **Conditional.** For field 54 enter third party and/or Medicare payments. For field 55 enter net amount due from Health First Colorado after provider has received other third party, Medicare or patient liability. For Medicare enter the sum of the Medicare coinsurance plus Medicare deductible less third party payments and patient liability.

Field 58 & 60 - **Required**. For field 58 enter the client's name on the first line for Health First Colorado. Complete additional lines when there is additional coverage. For field 60 enter the insured's unique identification number assigned by the payer organization. Complete additional lines when there is additional coverage.

Field 67 - **Required**. Enter the exact ICD-10-CM diagnosis code describing the principal diagnosis that exists at the time of admission or develops subsequently and affects the length of stay. Do not add extra zeros to the diagnosis code.

Field 63 - **Conditional.** Field is used to enter PAR number; however, PARs automatically link to the claim when there is a PAR on file for the service.

Field 61, 62, 65 - **Conditional**. Complete when there is third party coverage.

PAGE 1 OF 1 | CREATION DATE 07312018 | TOTALS 5410 12 0 00

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 9999999999
D Health First Colorado	12345678	Y	Y			57 OTHER PRV ID

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
Doe, John		A123456		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX	67	A	B	C	D	E	F	G	H	68
J441		R0902	R0600	R630	R634	E45	R5383	Z720	Z9981	
		I	K	L	M	N	O	P	Q	

69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI				73

Paper Claim - Example 3

66 DX J441 | R0902 | R0600 | R630 | R634 | E45 | R5383 | Z720 | Z99

69 ADMIT DX | 70 PATIENT REASON DX | a | b | c | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75

c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI 1234567890 QUAL
LAST Doe FIRST Jane

77 OPERATING NPI QUAL
LAST FIRST

78 OTHER NPI QUAL
LAST FIRST

79 OTHER NPI 0000000000 QUAL
LAST Thomas FIRST Doctor

80 REMARKS

81CC a b c d

Field 76 - **Required**. Enter the 10 digit NPI assigned to the physician having primary responsibility for the member.

Field 74A - **Conditional**. Complete when there are additional significant procedure codes. Enter the date using MMDDYY format.

Field 78 & 79 - **Conditional**. Enter 10 digit NPI when attending physician is not the PCP or to identify additional physicians. Ordering, Prescribing, or Referring NPI - when applicable.

UB-04 CMS-1450 APPROVED OMB NO.

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

NUBC National Uniform Billing Committee
LIC9213257

REQUIRED FIELDS

CONDITIONAL FIELDS

OPTIONAL FIELDS

Claim Status - Common Terms

Denied

Claim processed & denied by claims processing system. Some denied claims may be resubmitted for payment after corrections have been made. Denied claims may not be adjusted but may be resubmitted.

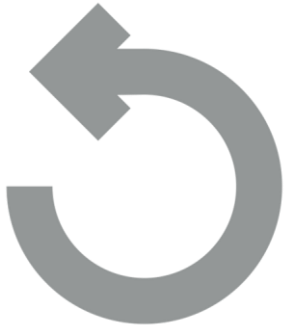
Paid

Claim processed & paid by claims processing system. Claims paid at zero due to lower of pricing are still considered paid.

Claim Status - Common Terms

Adjustment

Correcting paid claims that are still within timely filing



Rebill

Re-bill previously denied claim

Suspend

Claim must be manually reviewed before adjudication

Void

Cancelling a paid claim

Common Denial Reasons

Timely Filing	Claim was submitted more than 365 days without a reference to a previous Internal Control Number (ICN).
Duplicate Claim	A subsequent claim was submitted after a claim for the same service has already been paid.
Bill Medicare or Other Insurance	Health First Colorado is always the payer of last resort. Provider should enroll with and bill all other appropriate carriers first. Primary information must be reported on the claim form.

Common Denial Reasons

Prior Authorization (PAR) Not on File	No approved authorization on file for services that are being submitted. Modifiers, units, or PAR type may not match.
Total Charges Invalid	Line item charges do not match the claim total.
Type of Bill	Claim was submitted with an incorrect or invalid type of bill. Verify appropriate type of bill in billing manual.

Claim - Adjustments

- What is an adjustment?
  - Adjustments create a replacement claim
  - Two step process: Credit & Repayment

Adjust a claim when

- Provider billed incorrect services or charges
- Claim paid incorrectly

Do not adjust when

- Claim was denied
- Claim is suspended

Claim – Voids and Refunds

Web Portal or Batch

- Preferred method
- Easier to submit & track

Paper

- Use adjustment indicator on third digit of type of bill to indicate void.
- Refund check is not needed. Recoupment will show on the remittance advice.

Claim - Adjustment Methods

Web Portal or Batch

- Preferred method
- Easier to submit & track

Paper

- Use adjustment indicator on third digit of type of bill to indicate adjustment

Quick Guides

- Copy, Adjust or Void a Claim
- Pulling Remittance Advice (RA)
- Reading Remittance Advice Dated 1/9/2019 or Later
- Submitting an Institutional Claim

- All Quick Guides can be found on the Department's Quick Guides web page.

Contact Info

Provider Services Call Center
1-844-235-2387

Download the Call Center Queue Guide

7 a.m. - 5 p.m. MT Monday - Friday

Thank you!