Beginner Billing Training: Professional Claims (CMS 1500)

Health First Colorado

(Colorado's Medicaid Program)

COLORADO
Department of Health Care Policy & Financing

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.

Professional Claim - Who Completes It?

- Audiology
- Home and Community-Based Services (HCBS)
- Imaging & Radiology
- Laboratory Services
- Pediatric Behavioral Therapy
- Physical, Occupational & Speech Therapy
- Physicians & Practitioners
- School-Based Services
- Supply
- Transportation Providers
- Vision

Behavioral Therapy vs. Behavioral Health

- **Behavioral therapy includes services for children/youth under age 21 who have autism spectrum disorder or a similar condition.** More information can be found on Health First Colorado Criteria for Behavioral Therapy.
  - Behavioral therapy includes provider types 37 (Licensed Psychologist), 38 (Licensed Behavioral Health Clinician), 83 (Behavioral Therapy Clinic) and 84 (Board Certified Behavior Analyst).
  - Pediatric behavioral therapy providers submit claims to the Fiscal Agent (Gainwell Technologies).
  - Child Health Plan *Plus* (CHP+) does not cover Applied Behavior Analysis (ABA) therapy (Common Procedural Terminology [CPT] codes 97151, 97153, 97154, 97155, 97158).
- **Behavioral health includes comprehensive mental health and substance use disorder services.**
  - Behavioral health providers submit most claims through the Regional Accountable Entities (RAEs). More information on the RAEs can be found on the Accountable Care Collaborative web page.

Case Management

- Case Management Agencies (CMAs) provide case management for individuals with disabilities in the ten (10) Home and Community-Based Services waiver programs.
- The Care and Case Management (CCM) System is the name used to describe MedCompass®, a configurable care management platform by AssureCare, that will be customized to meet Colorado's unique care management needs.
  - Used for documenting case management activities and members' case management records
  - Consolidates case management functions currently existing in separate applications, such as the Benefits Utilization System (BUS)
  - Interfaces with the Colorado interChange, the claims processing system used by Health First Colorado
- **Training for the new CCM system is not covered in this training.** More information, including CCM-specific training and resources, can be found on the Care and Case Management System web page.

Training Overview

Program Overview

Department Website

Provider Enrollment

Member Eligibility

Prior Authorizations

Billing and Payment

Resources

Claim Submission

Program Overview

CMS.gov
Centers for Medicare & Medicaid Services

STATE OF COLORADO
NIL SINE NUMINE
1876

COLORADO
Department of Health Care Policy & Financing

gainwell

Fiscal Agent

Colorado interChange system interacts with the Provider Web Portal

Health First Colorado/CHP+ Providers

Department Website

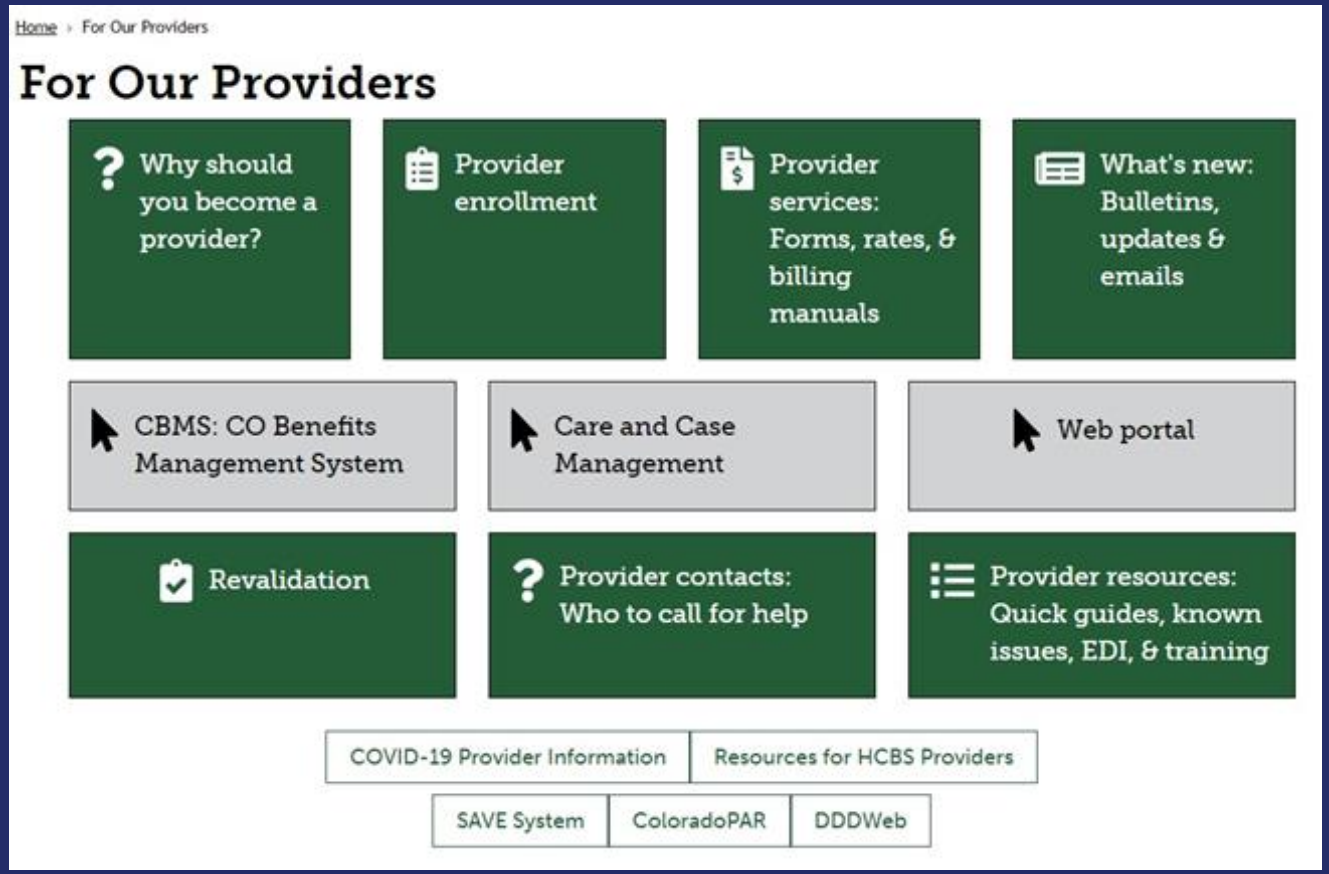
Department of Health Care Policy & Financing

Website

For Our Providers Home Page

Access to billing manuals, fee schedules, enrollment, revalidation, the Provider Web Portal, contacts and resources like Quick Guides

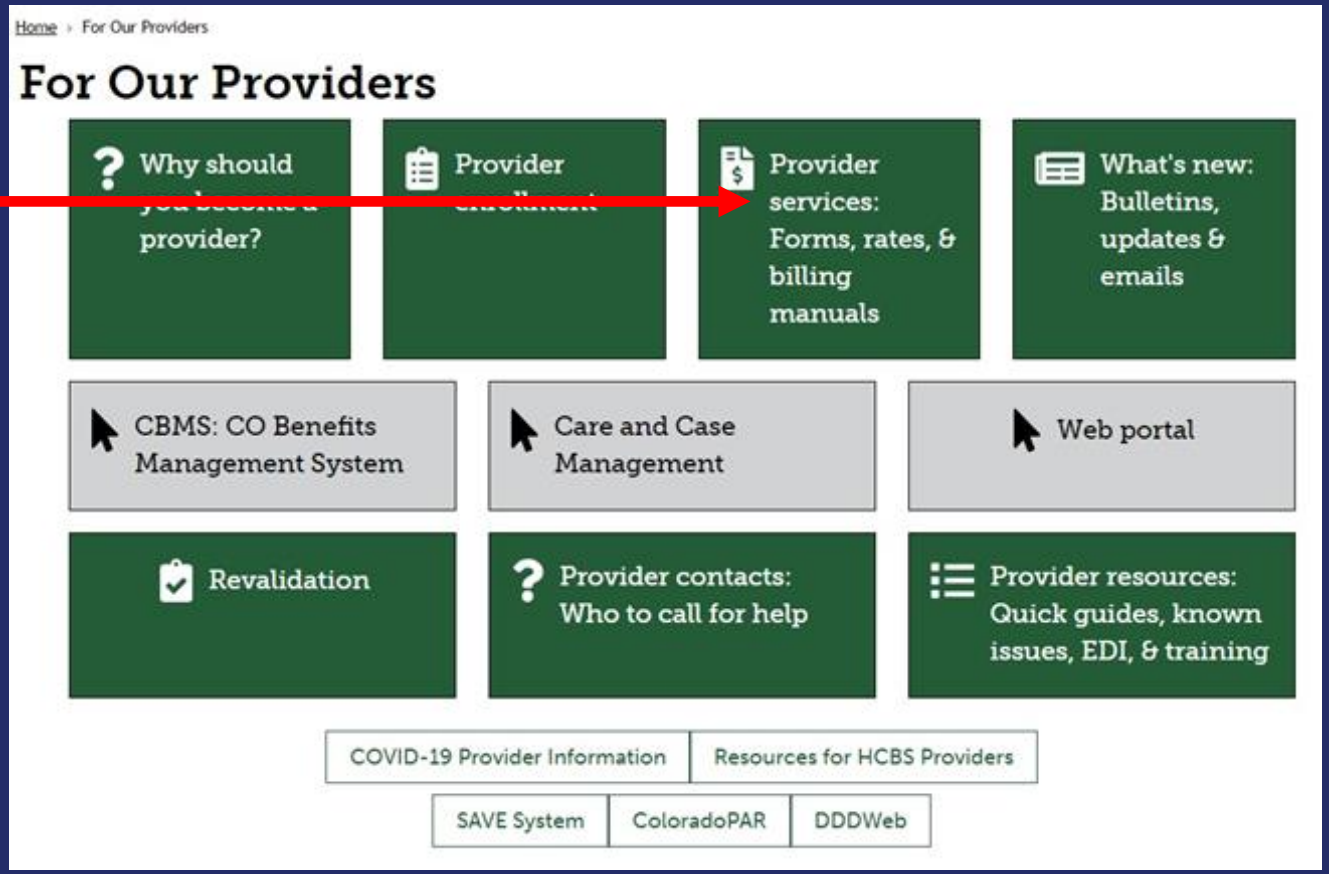
Contains important information regarding Health First Colorado (Colorado's Medicaid program) & other topics of interest to providers and billing professionals



Provider Services

Forms, fee schedules and billing manuals can be found on the Provider Services web page

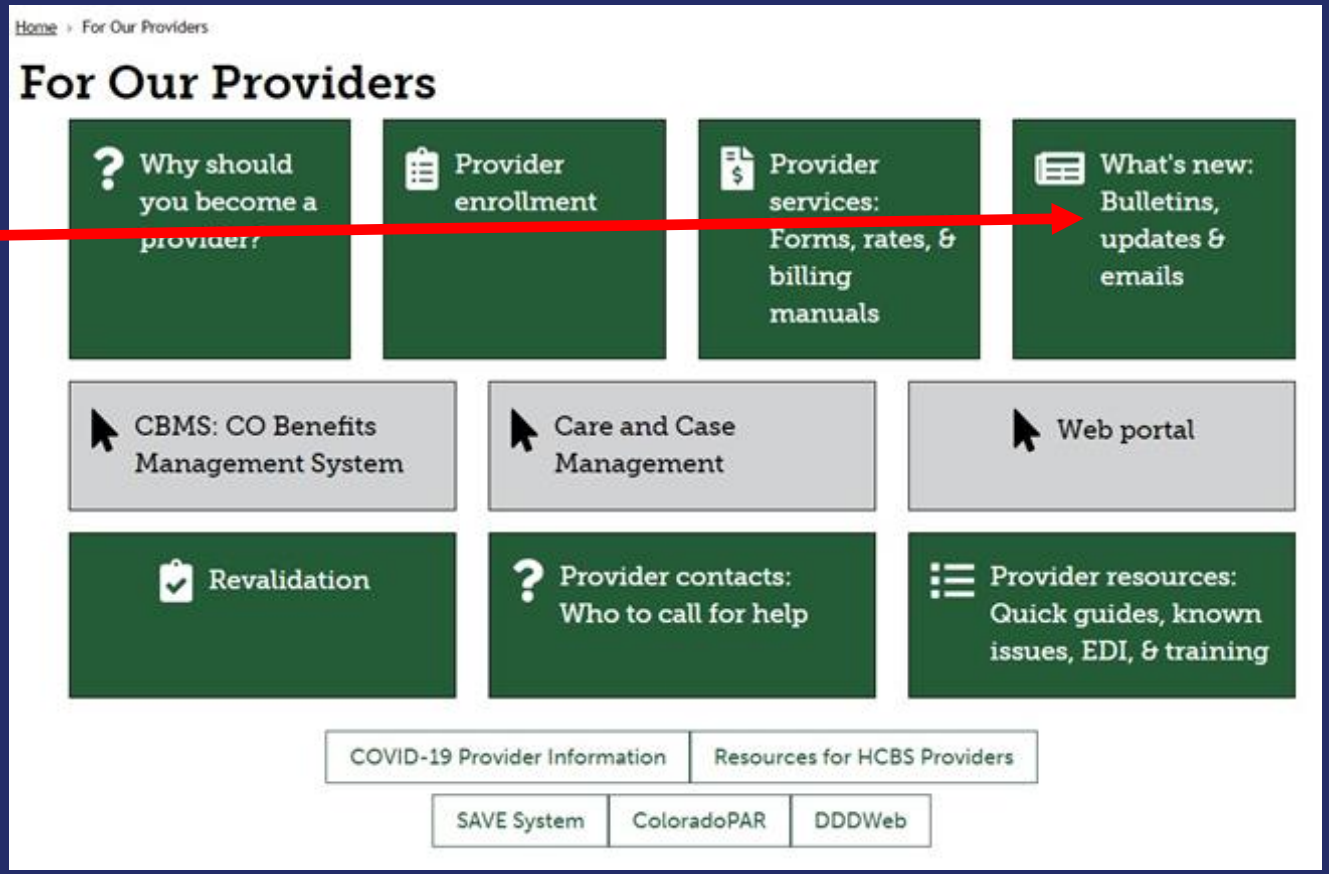
The General Provider Information manual is an overview of the program, including billing and policy information



What's New: Bulletins, Updates & Emails

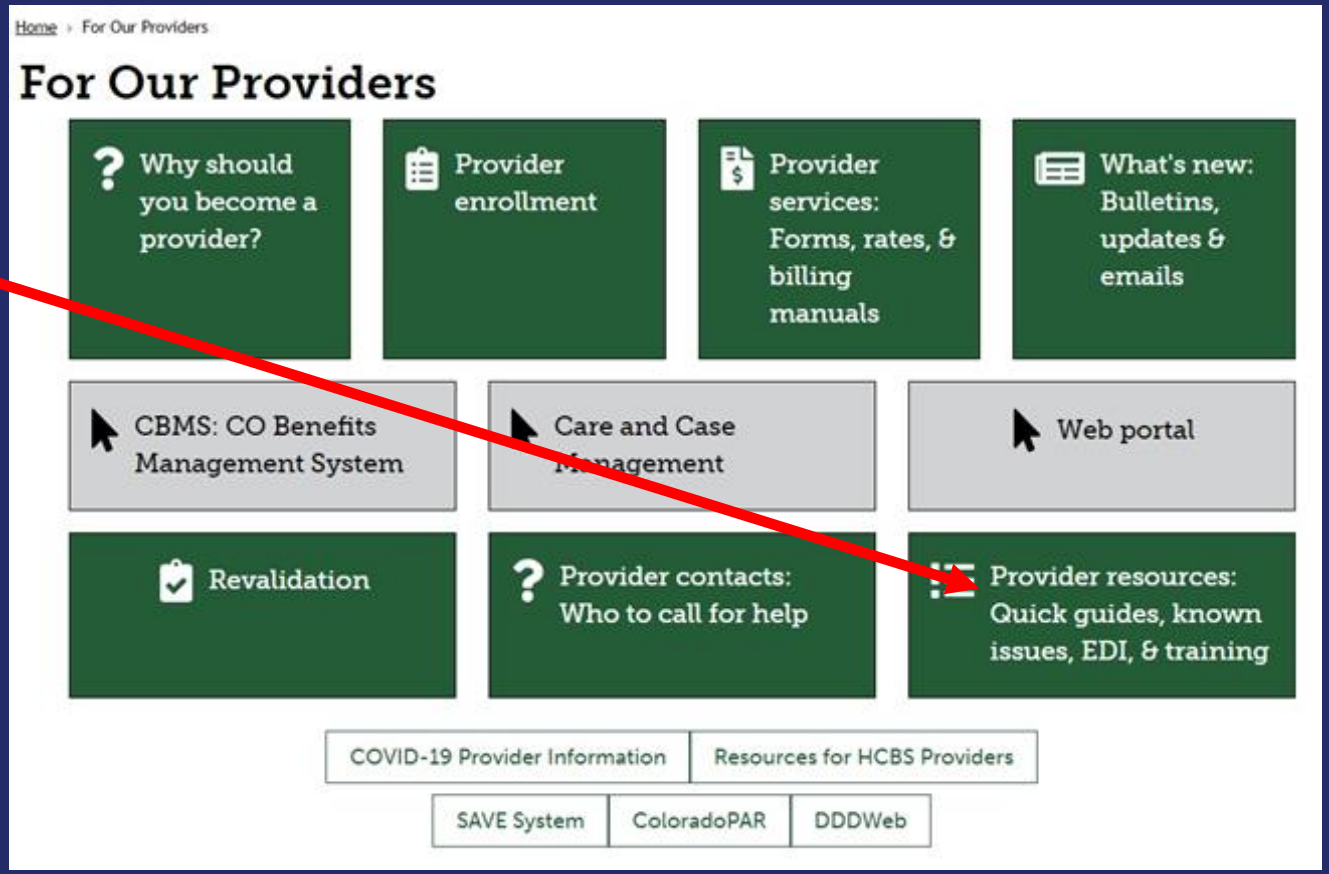
Sign up for publications

Weekly newsletters and monthly bulletins

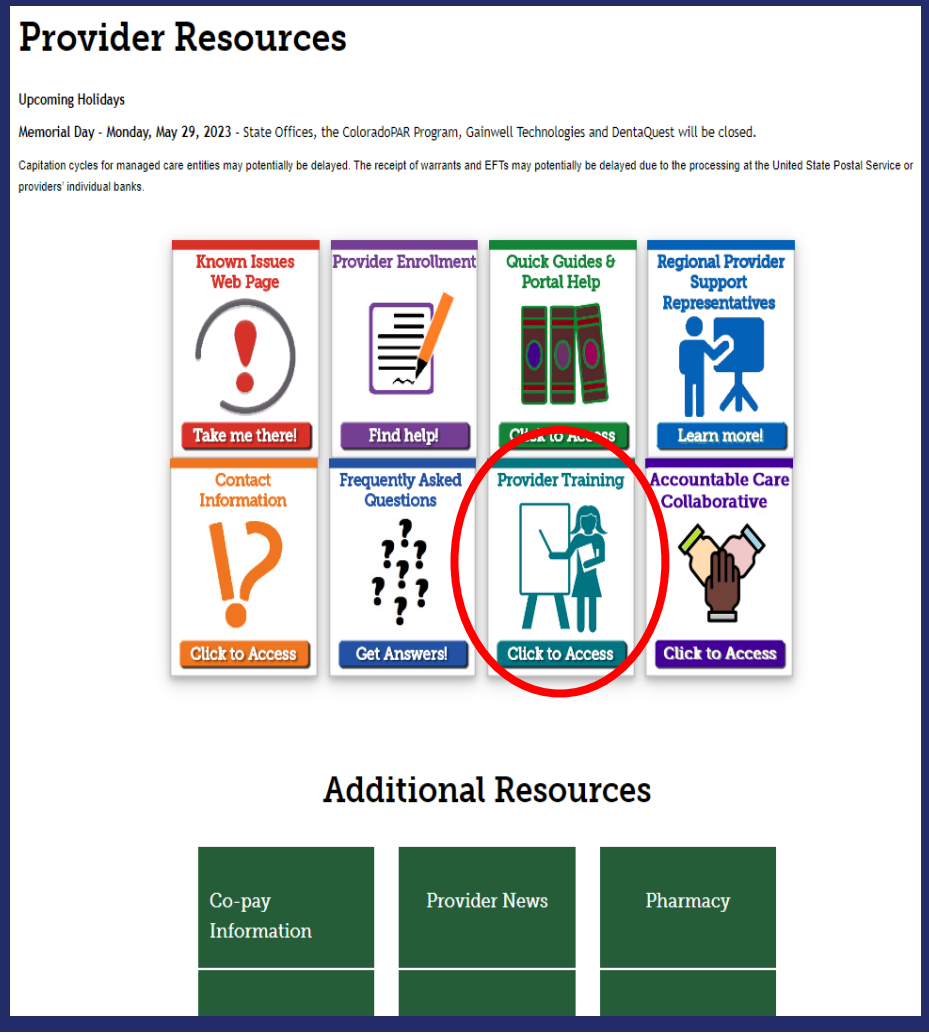


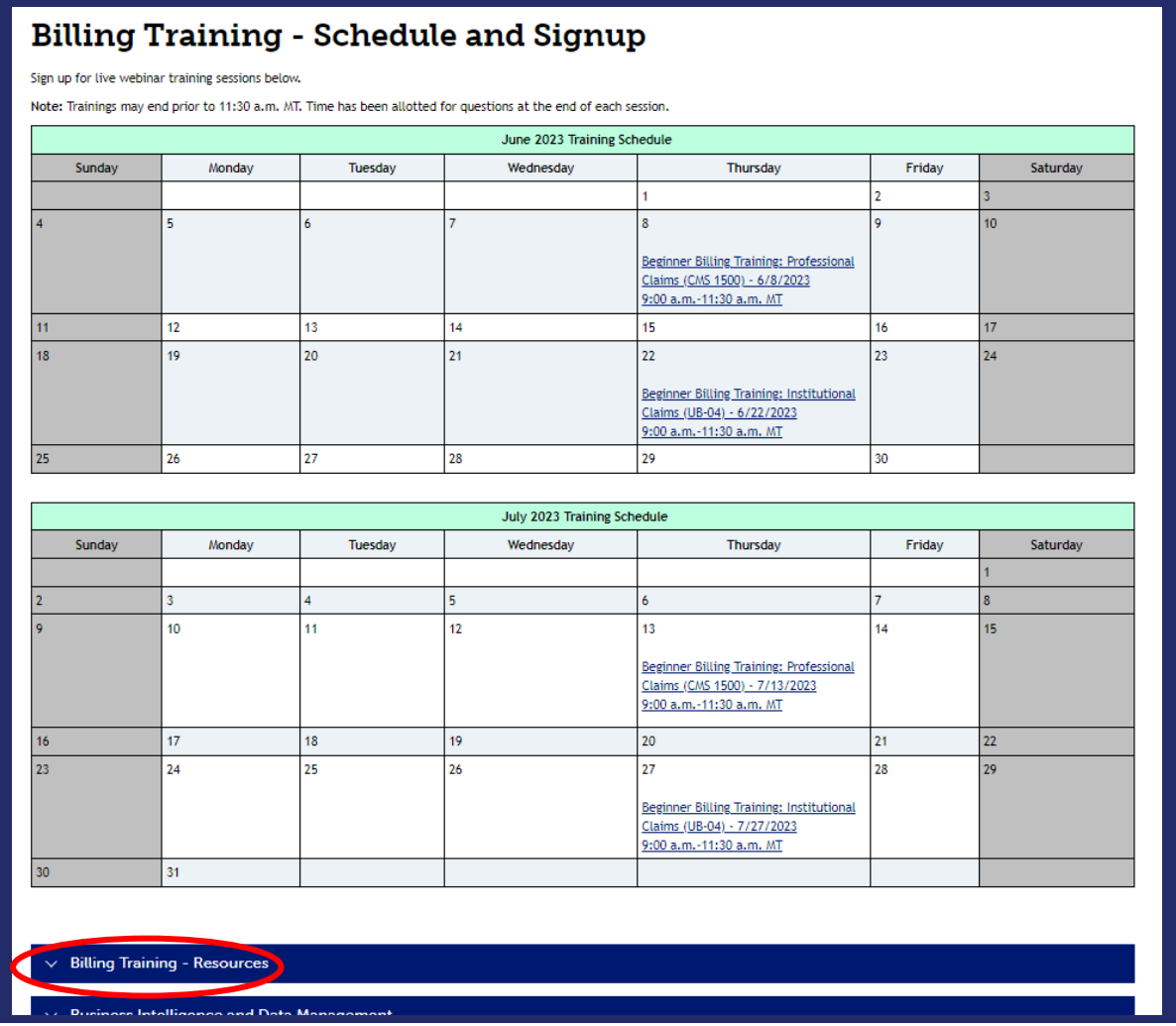
Provider Resources

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



Provider Training





Member Eligibility

Member Eligibility

Verifying Member Eligibility

Viewing Member Information

Health First Colorado Member ID Cards

Eligibility Types

Managed Care

Medicare

Third Party Liability

Co-Pay

Verifying Member Eligibility

- Member's eligibility must be checked on each date of service.
  - Facilities that bill monthly: Eligibility extends through end of the month. It is recommended that providers check eligibility on the first of each month.
- Ways to verify eligibility:

Provider Web Portal

Virtual Agent 1-844-235-2387

Batch 270

Log In to View Member Information

Provider Web Portal

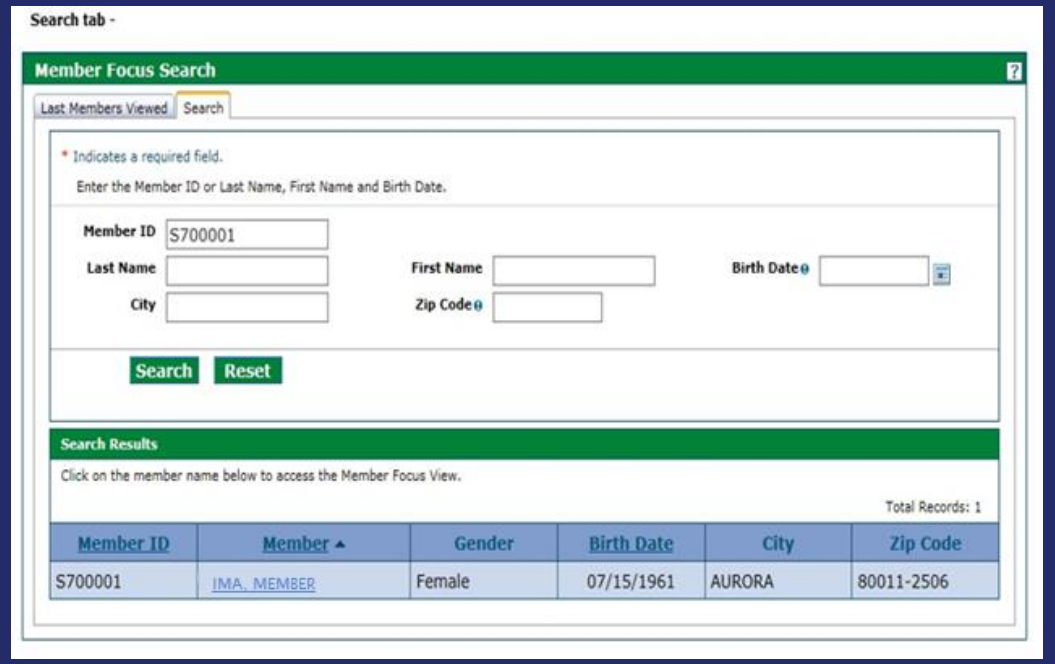
Providers with multiple locations should ensure that the correct location is being used. Having the incorrect location can impact whether a claim will adjudicate—or process a decision—correctly.

Providers with separate National Provider Identification (NPI) numbers are encouraged to verify their NPI before moving past this home page screen.

Viewing Member Information

Provider Web Portal

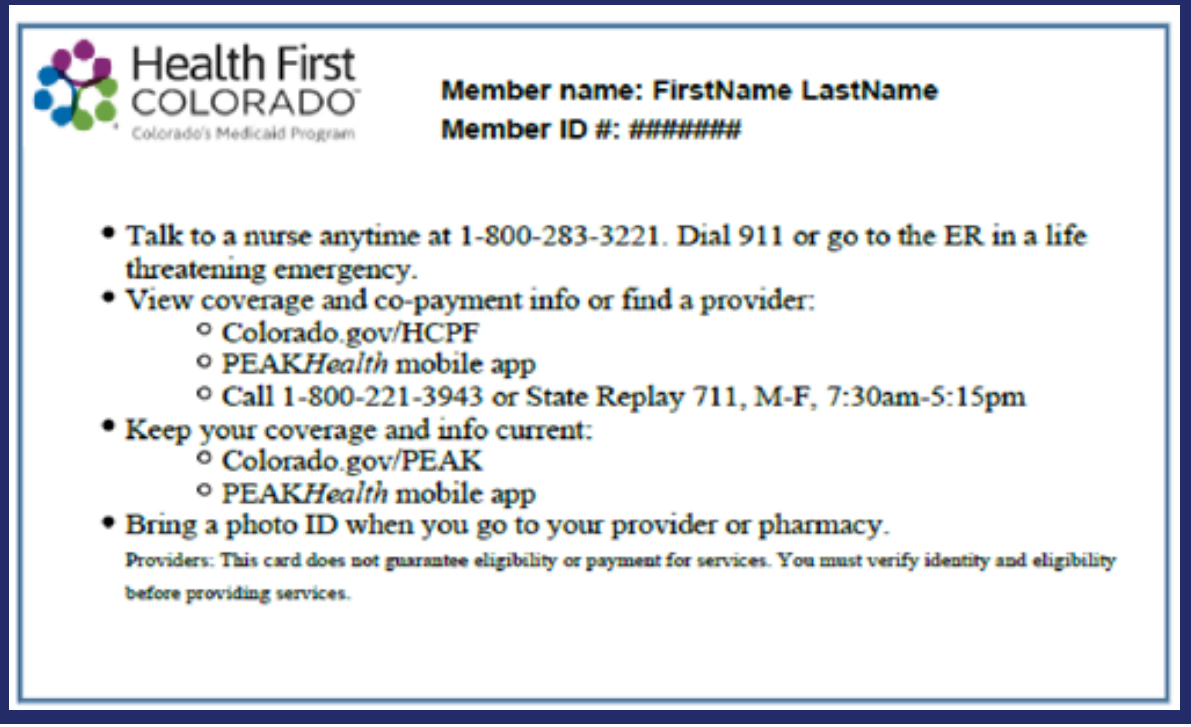
On the Search tab, enter the Member ID or Last Name, First Name and Birthdate.



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

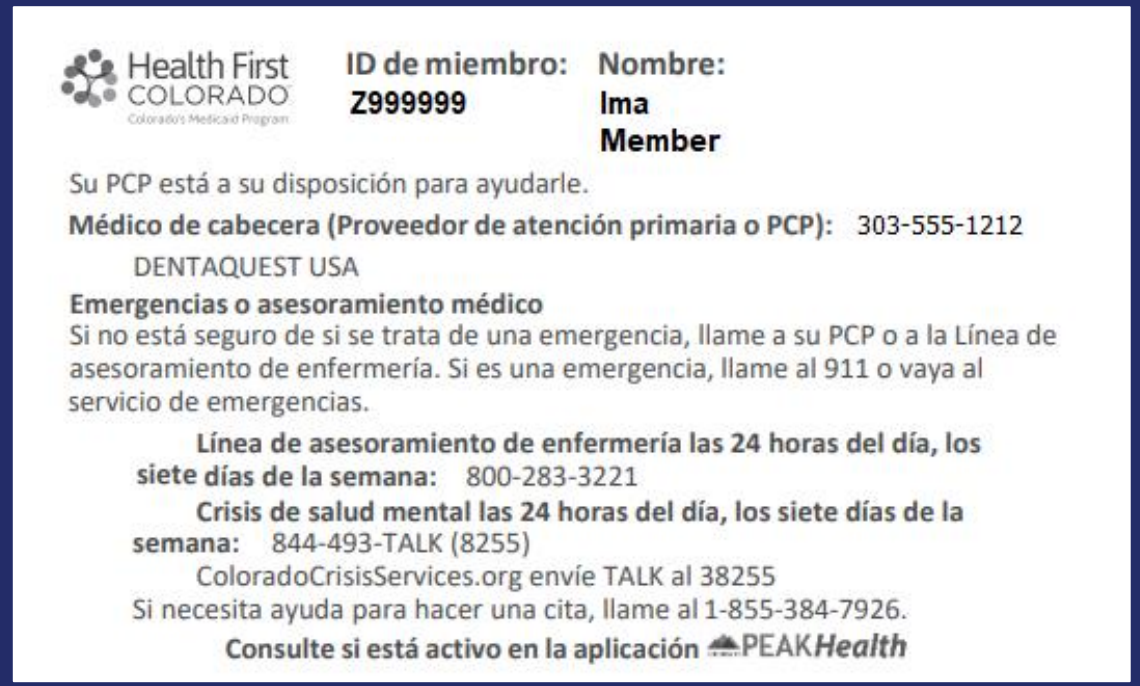
Health First Colorado Identification Cards

- This page shows two older branded cards that are still 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 English and Spanish.
- Identification card does not guarantee eligibility.
- Only the front is shown below.



Eligibility Types

- Most members: Health First Colorado benefits (Title XIX)
- Some members have different eligibility types:
  - Old Age Pension, state only
  - Non-Citizens (individuals without documentation)
  - Presumptive Eligibility
  - Managed Care
- Some members have additional benefits:
  - Medicare
  - Third-party commercial insurance

Eligibility Types

Old Age Pension (OAP) - State Only

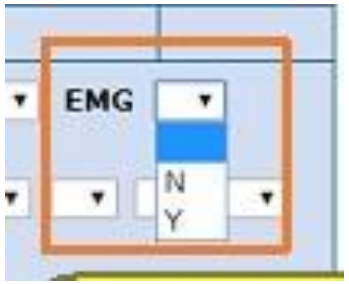
- Members are not eligible for Title XIX due to income.
- Claims will have reduced reimbursement amounts since the program only gets state funds and no federal match.
- Providers cannot bill the member for the difference between the billed amount and the reimbursement amount.
- Maximum member co-pay for OAP-State is $300.
- Does not cover:
  - Home and Community-Based Services (HCBS)
  - Inpatient, psychiatric or nursing facility services

Eligibility Types
Family Planning and Non-Citizens

- Family Planning Expansion
  - Applies to individuals with a higher income than the standard Medicaid limit (between 133%-260% of the federal poverty level [FPL])
  - Covers up to a 12-month supply of contraceptives
  - Family planning coverage for non-citizens available from July 1, 2022
- Non-Citizen Emergency Medicaid Services (EMS)
  - Eligibility type only covers emergency services, including labor and delivery
  - Claim must indicate emergency
  - Emergency services must be certified in writing by the provider and kept on file, but does not need to be submitted with the claim

Who Defines an Emergency?

- The provider determines whether the service is considered an emergency and marks the claim appropriately by checking box 24C on the CMS 1500 paper claim or selecting “Y” for the EMG field on the Provider Web Portal.
- Health First Colorado does not determine emergency status based on diagnosis or procedure codes used on the claim. The box must be checked to indicate emergency.
- Examples of an emergency are:
  - Active labor and delivery
  - Sudden, urgent occurrences requiring immediate action
  - Acute symptoms of sufficient severity and severe pain in which the absence of medical attention might result in serious impairment to bodily functions and/or dysfunction of any bodily organ or part



Eligibility Types
Child Health Plan *Plus* (CHP+)

- Members that are determined to be eligible are later assigned to one of the four CHP+ Managed Care Organizations (MCOs): Colorado Access, Denver Health, Kaiser Permanente or Rocky Mountain Health Plans.
  - Services must be billed as fee-for-service to the Fiscal Agent, Gainwell Technologies, or Magellan for pharmacy services if there is an interim period between the eligibility determination and the MCO assignment
  - Services provided after MCO assignment must be submitted to the MCO
- Providers should contact the MCO for further benefit details once a member is assigned. Benefits through CHP+ may vary from the Title 19 (Medicaid) benefit plan.
  - Applied Behavior Analysis (ABA) therapy is not covered by CHP+
  - Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is not covered by CHP+
  - CHP+ does not divide behavioral health from other services

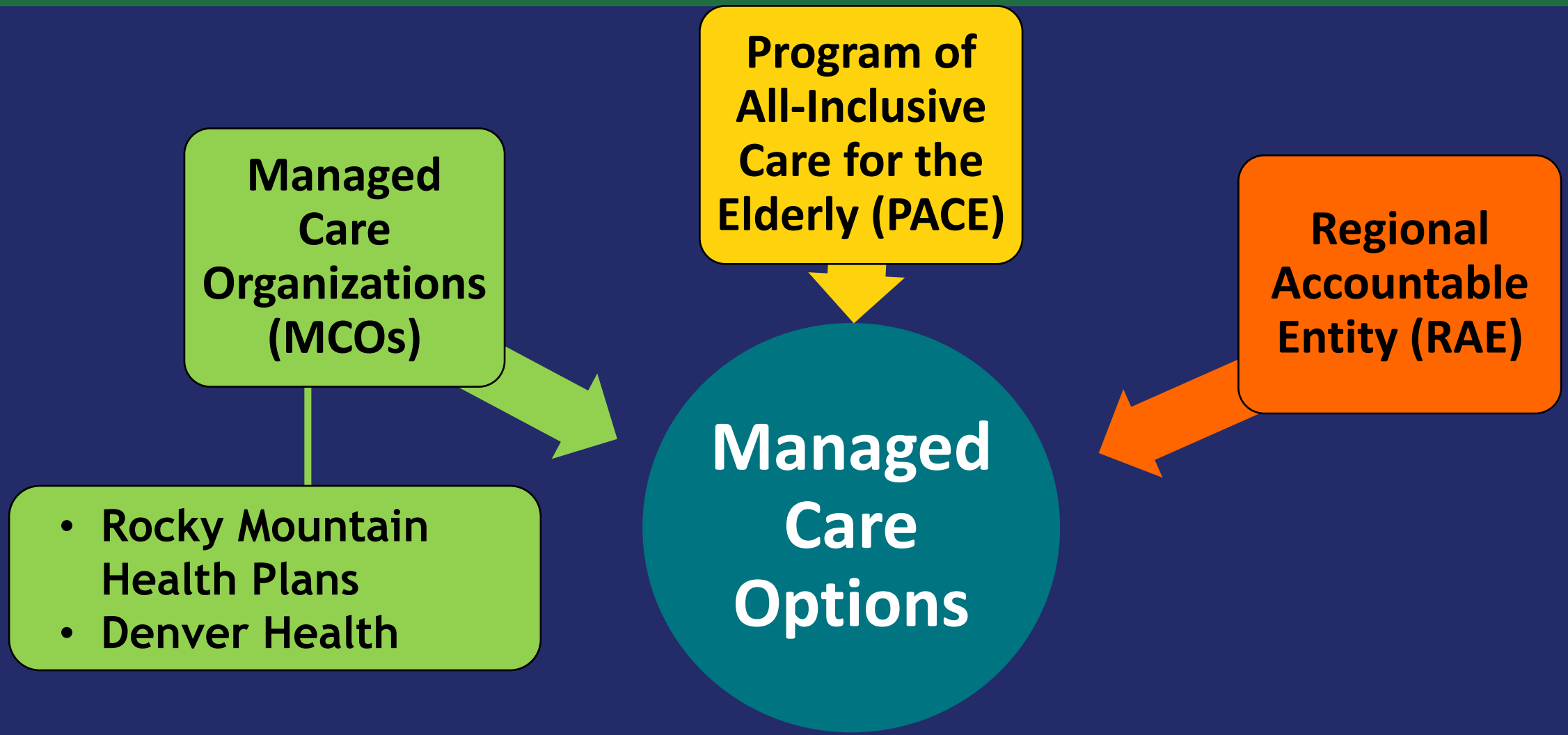
Eligibility Types

Presumptive Eligibility

- Temporary coverage of Health First Colorado or Child Health Plan *Plus* (CHP+) services until eligibility is determined
- Presumptive Eligibility (PE) is only available to those listed in the table:

Population	Eligibility	Covered Benefits
Child or pregnant person that meets Health First Colorado PE requirements	Health First Colorado Eligibility Criteria	All Health First Colorado benefits: includes labor and delivery, excludes inpatient (hospital) care
Child or pregnant person that meets CHP+ PE requirements	CHP+ Eligibility Criteria	All CHP+ benefits excluding dental services
Family Planning Limited (FAMPL) Benefit	FAMPL Eligibility Criteria	Birth control, STI testing and treatment, Cervical cancer screening and prevention, Related counseling and preventative services
Breast and Cervical Cancer Program (BCCP)	BCCP Eligibility Criteria	All Health First Colorado benefits

Managed Care



Managed Care
Managed Care Organizations (MCOs)

- Some services are not included in the managed care contract for Rocky Mountain Health Plans or Denver Health.
  - Those fee-for-service claims can be billed directly to the Fiscal Agent (Gainwell Technologies).

  Example:

  - Denver Health does not pay for hospice. Hospice claims for a member with Denver Health enrollment would be billed directly to Gainwell Technologies.

Managed Care

Regional Accountable Entity (RAE)

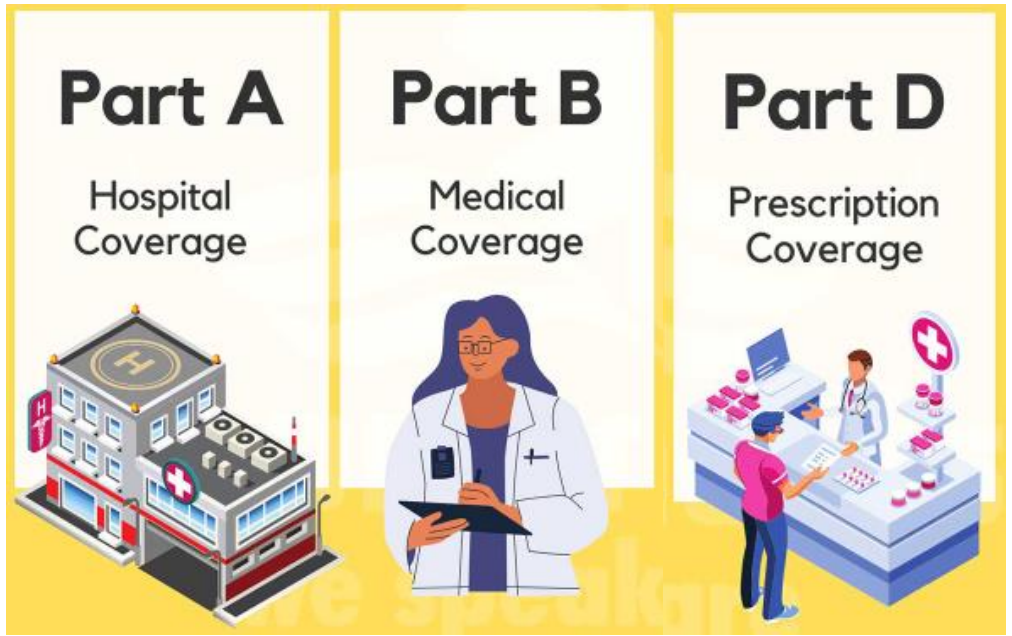
- Members are assigned to the Regional Accountable Entity (RAE) for their geographic area.
  - Contact the RAE in your area to enroll as a Behavioral Health Provider
- Regional Accountable Entities do not pay for pediatric behavioral therapy. Pediatric behavioral therapy claims should be submitted to the Fiscal Agent (Gainwell Technologies). More information on the difference between Behavioral Health and Behavioral Therapy can be found earlier in this presentation.

Dual Eligibility

- Members may be eligible for both Medicare and Health First Colorado.
- Health First Colorado is always the payer of last resort.
  - Bill Medicare first for members with Medicare and Health First Colorado
- Retain proof of:
  - Submission to Medicare prior to Health First Colorado
  - Medicare denials(s) for seven (7) years
- Medicare Explanation of Benefits does not need to be attached to 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



https://boomerbenefits.com/wp-content/uploads/2021/04/parts-of-medicare-1.png

Medicare
Qualified Medicare Beneficiary (QMB)

- QMB programs cover 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.
- Members are only responsible for Health First Colorado co-pay.
- 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.

Which side is lower? That’s what is paid by Medicaid.

Third Party Liability
(Commercial Insurance)

- Health First Colorado is always the 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.
- When a provider agrees to render service to a member, they agree to work with all the member's forms of insurance. Providers working with Health First Colorado members can not:
  - Bill the member the difference between the amount billed and the amount reimbursed
  - Bill the member for the co-pay or deductible assessed by the Third-Party Liability (Commercial Insurance)

Third Party Liability
(Commercial Insurance)

- Health First Colorado pays the difference between Third-Party Liability payment and Program Allowable.

Example 1:

Charge = $500

Program allowable = $400

TPL payment = $300

Program allowable – TPL payment = **Reimbursement**

$400.00 - $300.00 = $100.00

Example 2:

Charge = $500

Program allowable = $400

TPL payment = $400

Program allowable – TPL payment = **Reimbursement**

$400.00 - $400.00 = $0.00

Co-Pay

Website

- Effective July 1, 2023, most member co-pays were reduced to $0.
  - Change effective for members eligible for Title XIX (Medicaid), the Alternative Benefits Plan and the Old Age Pension
  - Exceptions to this change are special programs administered by the Department, such as Child Health Plan *Plus* (CHP+)
- **Outpatient hospital non-emergent emergency room visits continue to carry an $8 co-pay per visit.**
- Providers can check co-pay amounts when verifying member eligibility on the Provider Web Portal.
- A provider may not deny services to individuals 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)

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.

- The Provider Web Portal tracks co-pays only when claims have been submitted.
  - 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

Prior Authorizations

Prior Authorization Requests (PARs)

- The ColoradoPAR Program reviews Prior Authorization Requests (PARs) for the following services or supplies:
  - Audiology
  - Diagnostic imaging
  - Durable medical equipment
  - Some inpatient admissions (including out of state)
  - Medical services (including transplant, back and bariatric surgery)
  - Physical, occupational and speech therapy
  - Physician Administered Drugs (PADs) from January 1, 2022
  - Pediatric behavioral therapy
  - Pediatric home health care
  - Pediatric personal care
  - Synagis (seasonal)

Prior Authorization Requests (PARs)

- PAR and PAR revisions processed by the ColoradoPAR Program must be submitted via the vendor utilization management portal managed by Acentra Health (formerly Kepro).
- Final Prior Authorization Request (PAR) determination letters are mailed to members. Letter inquiries should be directed to ColoradoPAR.
- Providers can review PARs via the Provider Web Portal.

Website:
ColoradoPAR website

Phone:
Phone: 1-888-801-9355 FAX: 1-866-940-4288

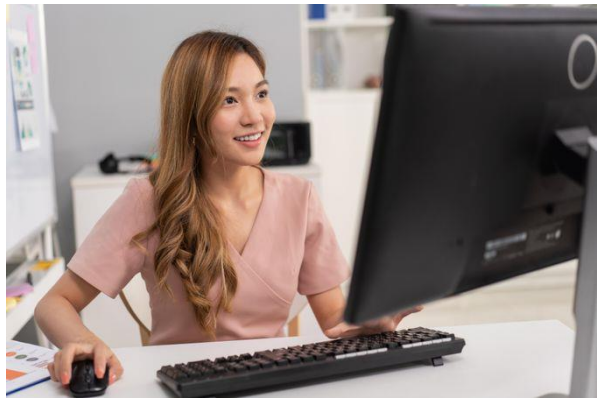
Prior Authorization Requests (PARs)

- All PARs for members ages 20 and under are reviewed according to Early Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. Even if it is not a covered service for an adult, it may be covered under EPSDT if deemed medically necessary for a child/youth.
- ColoradoPAR does not process Prior Authorization Requests (PARs) for adult home health, dental, pharmacy, transportation or behavioral health services covered by the Regional Accountable Entities (RAEs).

Prior Authorization Requests (PARs)

Home and Community-Based Services

- For Home and Community-Based Services (HCBS) Waiver programs, contact the case manager to obtain the member's service plan and prior authorization information before delivering services on behalf of the member.
- Providers can view PARs on the Provider Web Portal.



Billing and Payment

Billing and Payment

Record Retention

Payment Processing and Remittance

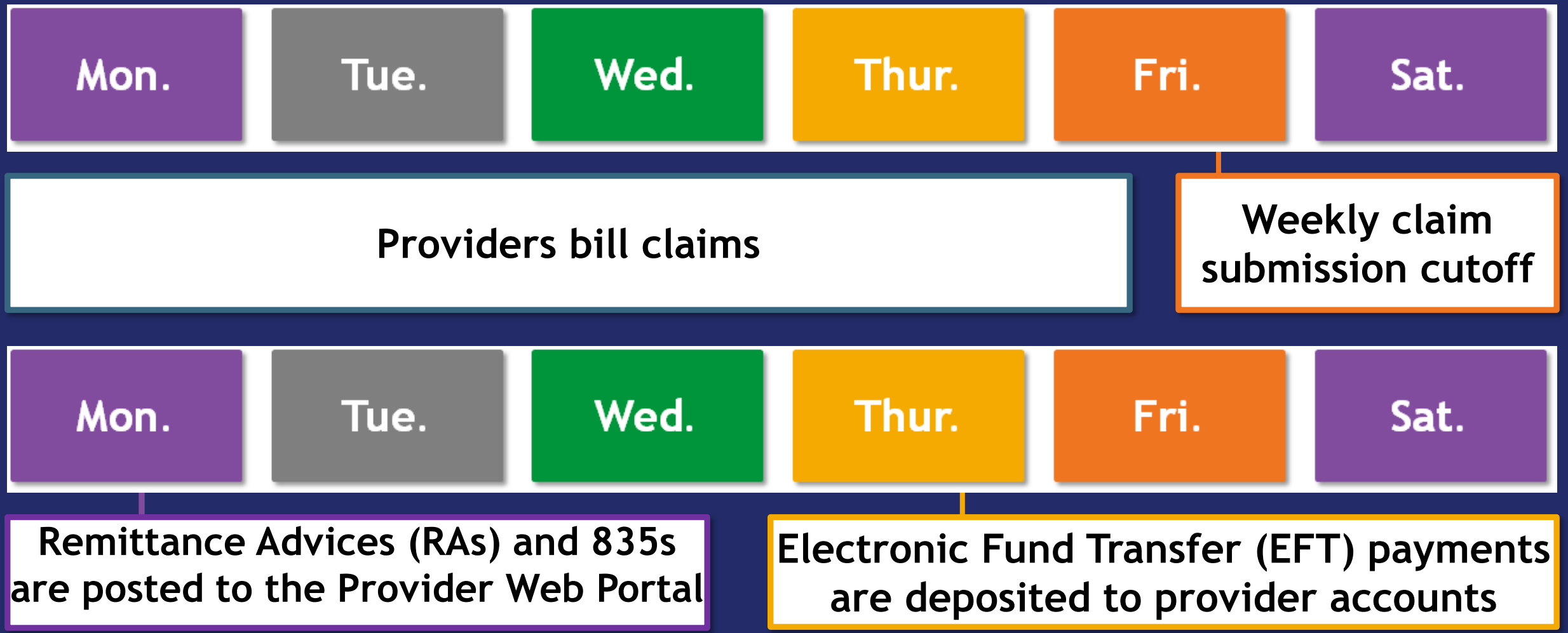
Timely Filing

Extensions for Timely Filing

Record Retention

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

Payment Processing Schedule



Remittance

Retrieval of Remittance Advice or 835

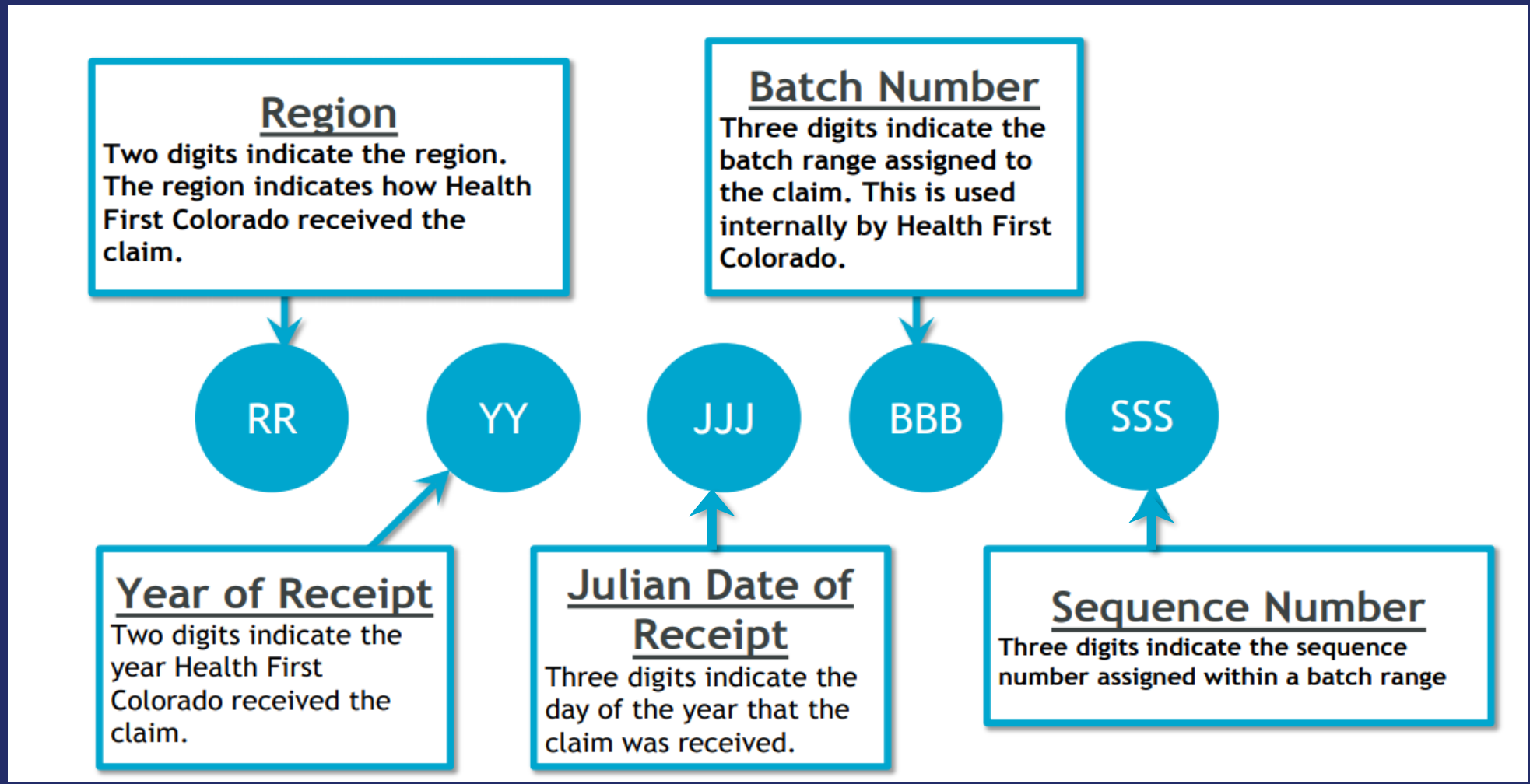
- To pull a Remittance Advice (RA), log into the Provider Web Portal and click on Resources and then Report Download.

- 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

Remittance

Internal Control Number (ICN)



Remittance

Region Codes

The Region Code, the first two digits of the claim Internal Control Number (ICN), indicates how Health First Colorado received the claim.

10 - Paper Claims with No Attachments
11 - Paper Claim with Attachments
20, 21 - Batch Claim
22 - Web Portal Claim with No Attachments
23 - Web Portal Claim with Attachments
25 - PBM Pharmacy Claims
30, 31, 40 - Claims Converted from Old MMIS
50 - Provider Initiated Adjustment (via paper)
51, 52, 53, 55, 58 - System Initiated Adjustments
54 - Mass Void
56 - Mass Void Request or Single Claim Void
57 - Cash Void
59 - Provider Initiated Electronic Adjustment
67 - Cash Adjustments
80 - Claim Resubmission by Gainwell
92 - Batch Reconsideration Claims with Attachments
93 - Provider Initiated Batch Reconsideration Adjustment with Attachments
94 - Web Portal Reconsideration Claims with Attachments
95 - Provider Initiated Web Portal Reconsideration Adjustment with Attachments

Timely Filing

- 365 days from Date of Service (DOS) determined by date of receipt
  - Certified mail is not proof of timely filing.
  - Prior Authorization Requests (PARs) are not proof of timely filing.
  - Contacting the Fiscal Agent (Gainwell Technologies) or waiting for response to a verbal inquiry is not proof of timely filing.
  - Claims must be submitted to keep them within timely filing guidelines, even if the result is a denial.

Timely Filing
Dates of Service

Type of Service	Timely Filing Calculation
Nursing Facility; Home Health, Inpatient, Outpatient; all services filed on the UB-04	From the “through” (last) 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” (last) date of service
Obstetrical services professional fees Global procedure codes	From the delivery date
Equipment rental	From the date of service, which is the last day of the rental period

Timely Filing Extensions

Rebilled Claims

- Providers always have the initial timely filing period of 365 days from the date of service to submit claims. If a claim is denied within the initial 365-day period, providers can resubmit without referencing the Internal Control Number (ICN).
- **If a claim is denied after the 365-day period has expired, providers have an additional 60 days from the date of the last Remittance Advice (RA) or returned paper claim to resubmit.**
  - Reference the last Internal Control Number (ICN)
  - Do not attach copy of Remittance Advice (RA) with claim
  - Keep supporting documentation

Timely Filing Extensions

Primary Payers

- Members who have commercial insurance (Third Party Liability [TPL])
  - Claim cannot be paid if over 365 days from date of service per federal statute.
    - Per state and federal regulation (42 C.F.R. § 447.45(d), 10 CCR 2505-10 8.043.01 and .02A), 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. The provider is responsible for pursuing available third-party resources in a timely manner.
- Members who are enrolled with both Medicare and Health First Colorado
  - Providers have an additional 120 days from Medicare Explanation of Benefit (EOB) date.

Timely Filing Extensions

Delayed Notification & Backdated Eligibility

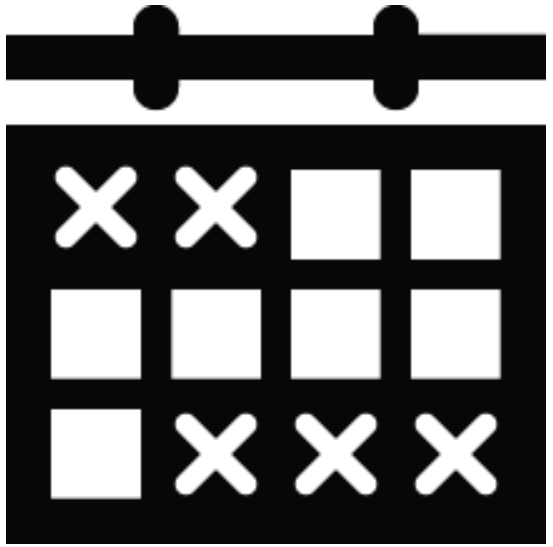
- Delayed Notification
  - Providers are responsible for determining member eligibility within 365 days of date of service even if the member does not notify them of Health First Colorado eligibility. **No further extensions are given for delayed notification of eligibility.**

- Backdated Eligibility
  - Providers can request load letters when a county backdates member eligibility farther than 365 days from date of service. Once load letter is received, a **provider has 60 days from the load letter to submit claims**.
    - Submit with copy of load letter via the Provider Web Portal.

Timely Filing Extensions

Provider Enrollment

- Backdated Approval
  - Providers have 365 days from enrollment approval to file a claim.
  - Providers do not need to submit claims while waiting for enrollment to be approved.



Timely Filing

Is the claim within 365 days of the (final) date of service?

Yes

Health First Colorado: Check member's eligibility and submit claim

Health First Colorado + Third-Party (Commercial Insurance): Bill commercial insurance as soon as possible

Health First Colorado + Medicare: Bill Medicare first

No

✗ **Just found out that patient is a Health First Colorado member?** Provider can not submit claims to Health First Colorado if it is after 365 days from the date of service.

✓ **County backdated member's eligibility farther than 365 days from date of service?** Request load letter and attach to claim submitted within 60 days of letter.

✗ **Just received Explanation of Benefits (EOB) from Third-Party (Commercial Insurance)?** Provider can not submit claims to Health First Colorado if it is after 365 days from the date of service.

✓ **Just received Explanation of Benefits (EOB) from Medicare?** Providers have 120 days from Medicare Explanation of Benefits (EOB) to submit claims to Health First Colorado

Claim Submission

Claim Submission

Claim Submission Methods

Claim Submission Information

CMS 1500 Paper Claim Form & Example

Claim Status & Common Terms

Common Denial Reasons

Claim Adjustments, Voids and Refunds

Claim Submission Methods

- Electronically through the Fiscal Agent's (Gainwell Technologies) Provider Web Portal (free of charge)
    - Interactive, one claim at a time, immediate response with claim status
- Electronically using a batch vendor, clearinghouse or software
    - Submitters must test batch transactions before approval to submit
- Paper
    - Only when pre-approved due to consistently submitting less than five (5) per month
    - Request form must be mailed to the Fiscal Agent (Gainwell Technologies) 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 processed by Health First Colorado if:
  - NPI used on Medicare claim does not match NPI enrollment with Health First Colorado
  - Member is a retired railroad employee
  - Member has incorrect or missing Medicare information on file

Claim Submission Information

Rendering Provider (Individual Within a Group)

Individual that provides services to a Health First Colorado member

Billing Provider

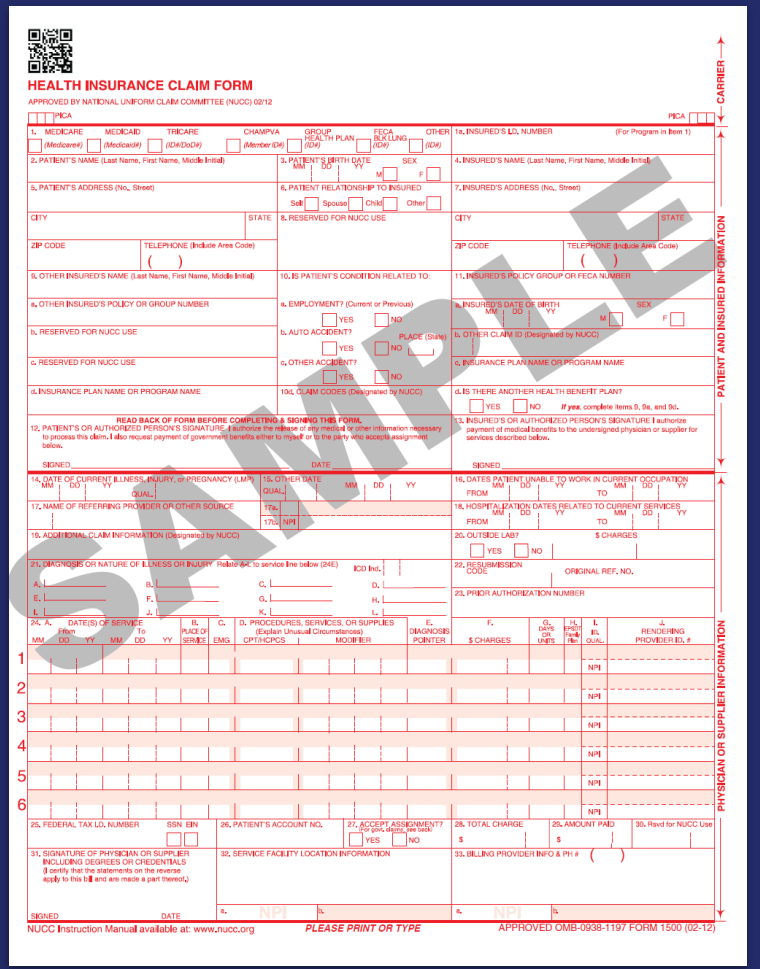
Entity being reimbursed for service

CMS 1500 (Paper Claim)

CMS 1500 is the standard professional claim form used by Health First Colorado and Medicare programs.

Where can a provider get the CMS 1500?

Information available on the Centers for Medicare and Medicaid Services website.


HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE MM DD YY QUAL.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? For govt. claims, see back YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

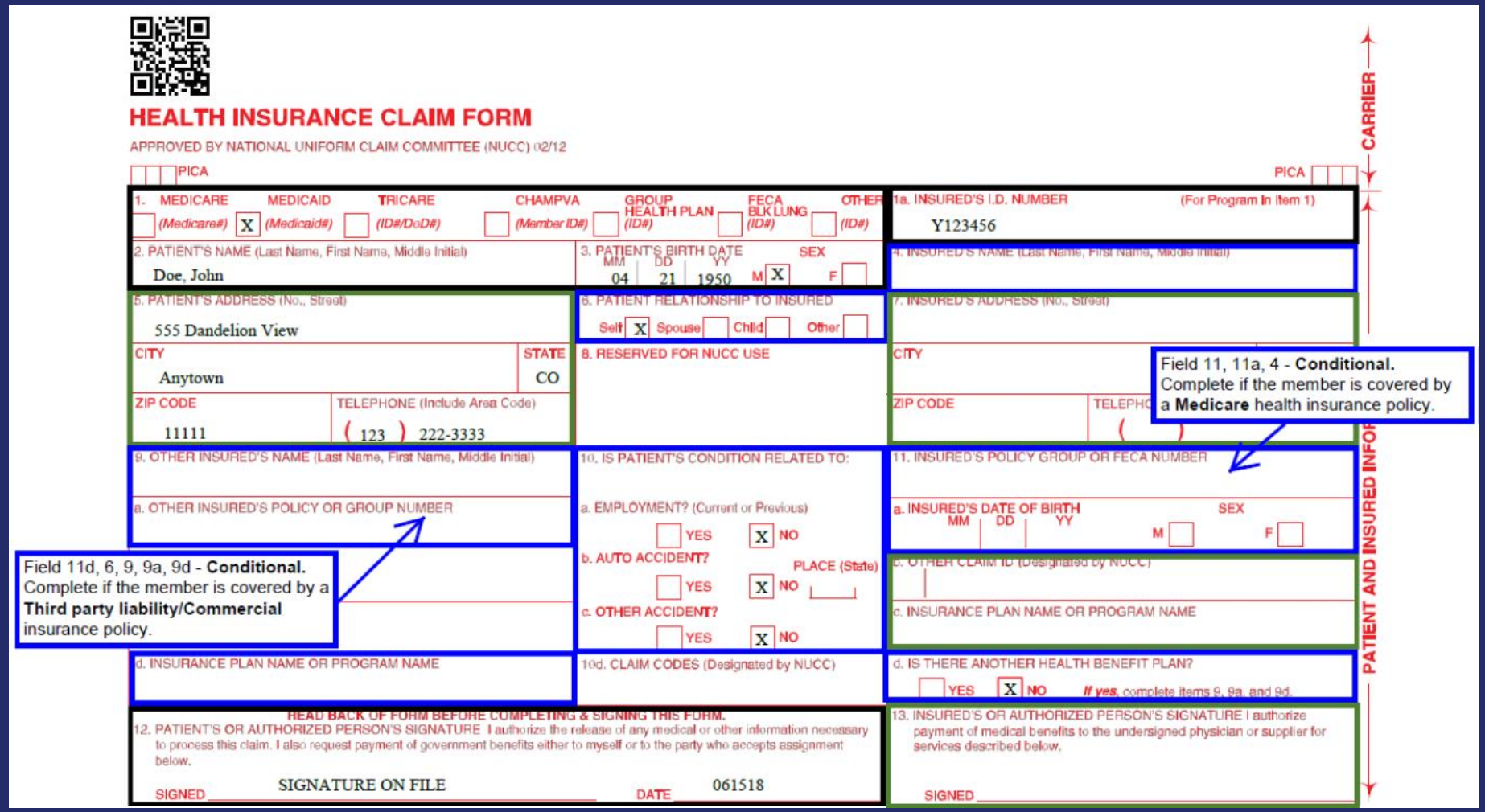
NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

PATIENT AND INSURED INFORMATION — CARRIER

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

Paper Claim - Example 1



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) | MEDICAID X (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program In Item 1): Y123456

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, John

3. PATIENT'S BIRTH DATE MM 04 DD 21 YY 1950 SEX M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 555 Dandelion View

6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY: Anytown STATE: CO

8. RESERVED FOR NUCC USE

CITY

ZIP CODE: 11111 TELEPHONE (Include Area Code): (123) 222-3333

ZIP CODE TELEPHONE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES | X NO

b. AUTO ACCIDENT? YES | X NO PLACE (State)

c. OTHER ACCIDENT? YES | X NO

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | X NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 061518

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

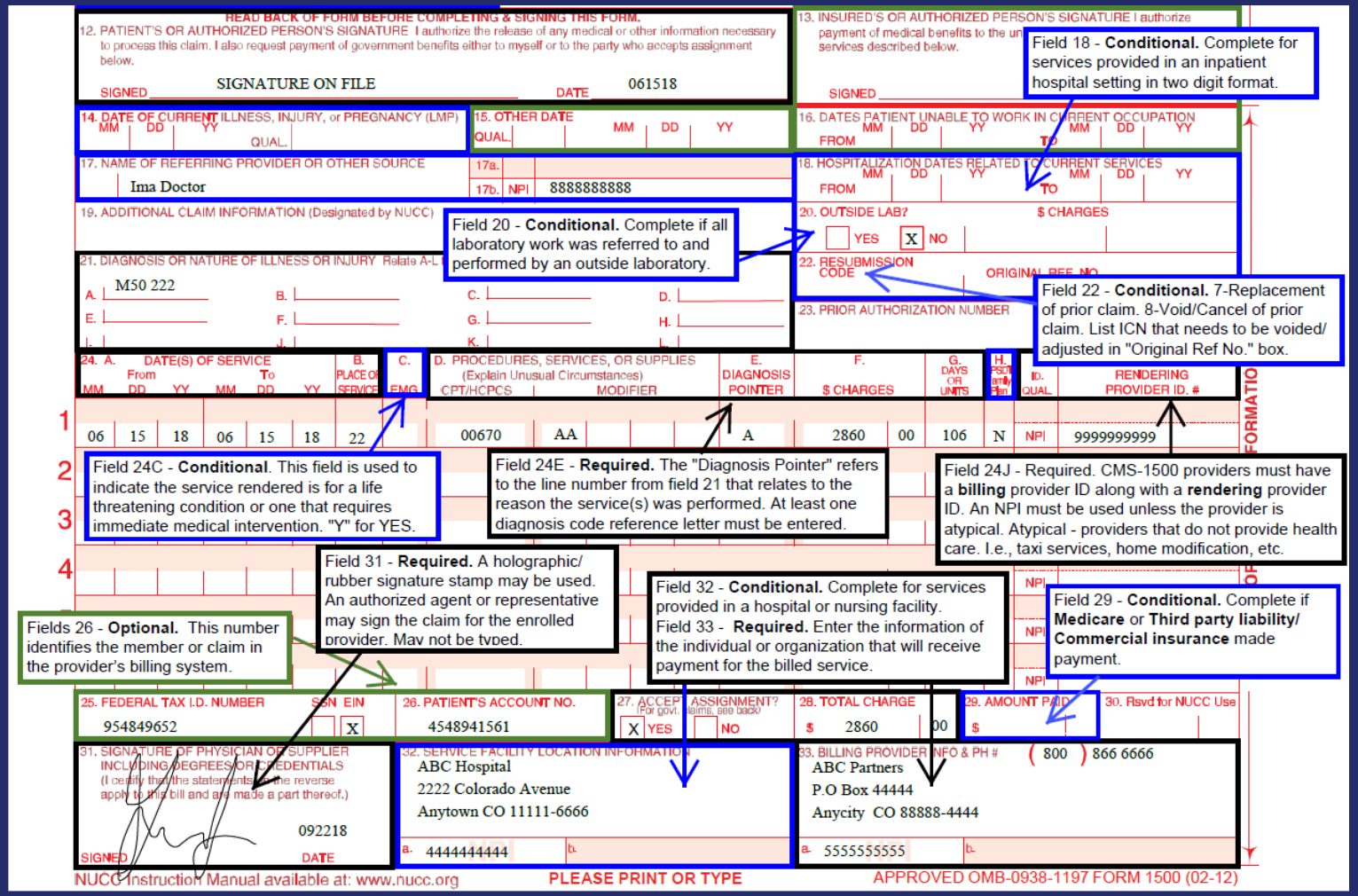
CARRIER

PATIENT AND INSURED INFOR

Field 11, 11a, 4 - **Conditional.** Complete if the member is covered by a **Medicare** health insurance policy.

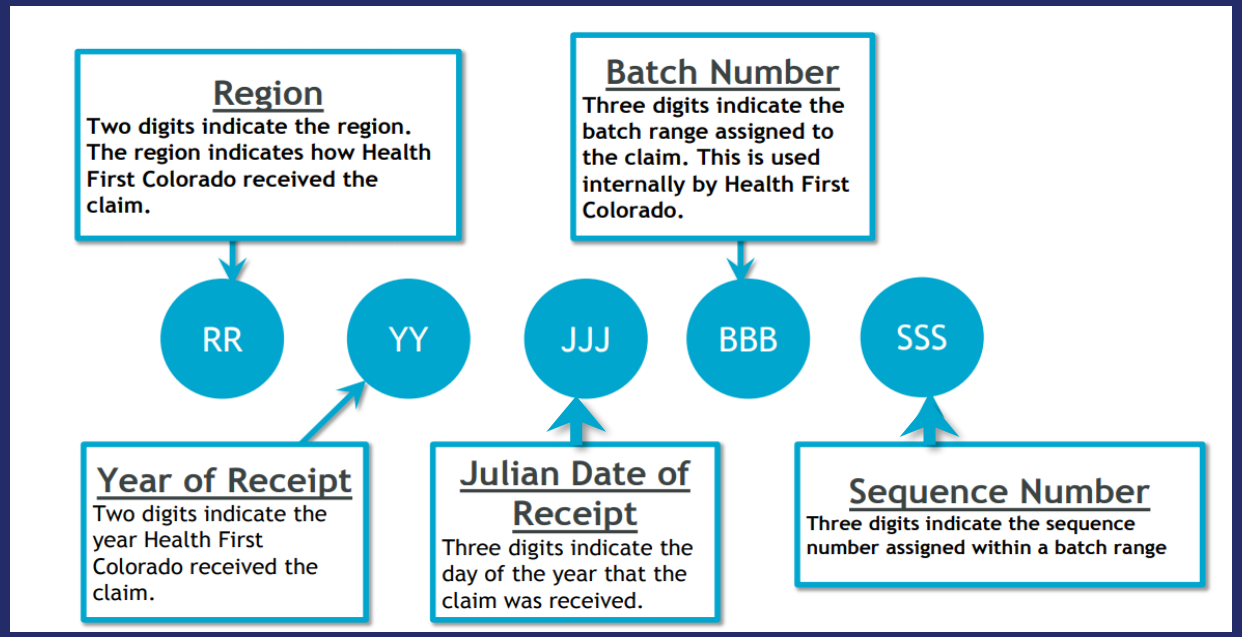
Field 11d, 6, 9, 9a, 9d - **Conditional.** Complete if the member is covered by a **Third party liability/Commercial** insurance policy.

Paper Claim - Example 2



Claim Status

Internal Control Number (ICN) & Region Codes



The Region Code, the first two digits of the claim Internal Control Number (ICN), indicates how Health First Colorado received the claim.

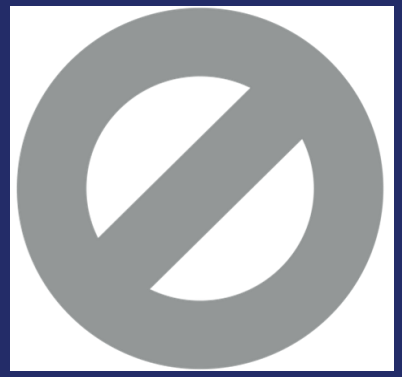
10 - Paper Claims with No Attachments
11 - Paper Claim with Attachments
20, 21 - Batch Claim
22 - Web Portal Claim with No Attachments
23 - Web Portal Claim with Attachments
25 - PBM Pharmacy Claims
30, 31, 40 - Claims Converted from Old MMIS
50 - Provider Initiated Adjustment (via paper)
51, 52, 53, 55, 58 - System Initiated Adjustments
54 - Mass Void
56 - Mass Void Request or Single Claim Void
57 - Cash Void
59 - Provider Initiated Electronic Adjustment
67 - Cash Adjustments
80 - Claim Resubmission by Gainwell
92 - Batch Reconsideration Claims with Attachments
93 - Provider Initiated Batch Reconsideration Adjustment with Attachments
94 - Web Portal Reconsideration Claims with Attachments
95 - Provider Initiated Web Portal Reconsideration Adjustment with Attachments

Claim Status

Common Terms

Paid

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



Denied

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

Common Denial Reasons

Timely Filing	Claim was submitted more than 365 days without reference to a previous Internal Control Number (ICN)
Duplicate Claim	A subsequent claim was submitted after a claim for the same service had 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

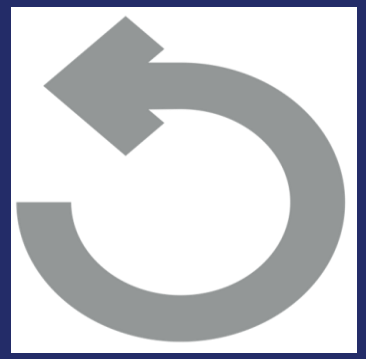
Prior Authorization (PAR) Not on File	No approved prior authorization on file for services that are being submitted, or modifiers, units or PAR type may not match
Total Charges Invalid	Line-item charges do not match the claim total

Claim Status

Common Terms

Adjustment

Correct paid claim



Resubmit

Rebill previously denied claim

Suspend

Claim must be manually reviewed before final decision

Void

Cancel a paid claim

Providers should only void claims if accidentally submitted OR there is an incorrect Member ID or Provider ID

Claim - Resubmission

- Providers may resubmit, also known as rebill, claims that have been denied
  - If the resubmitted claim is outside of timely filing, the original Internal Control Number (ICN) must be referenced

Resubmit a claim when	Do not resubmit claim when
• Claim was denied	• Claim was paid • Claim is suspended

Claim - Resubmission

Date of Service Within 365 Days

<u>Provider Web Portal</u>
or Batch *(Preferred)*

- 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 - Resubmission

Date of Service Past 365 Days

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

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

Claim - Adjustments

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

Adjust a claim when	Do not adjust claim when
• Provider billed incorrect services or charges • Claim paid incorrectly	• Claim was denied • Claim is suspended

Claim - Adjustments

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

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

Claim - Voids and Refunds

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

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

Resubmission, Adjustment & Void Codes

	Provider Web Portal	Batch	Paper
	Search for original claim and	Qualify claim loop with F8 and use the previous Internal Control Number (ICN) as the Payer Claim Control Number along with	Use code listed below in box 22 and the original Internal Control Number (ICN) in the adjacent 22 box
Resubmission (Date of service past 365 days)	Click “Copy” at the bottom; include original ICN in “Previous Claim ICN” field	1 code in the 2300/CLM segment	Code 1 in box 22
Adjustment	Click “Adjust” at the bottom	7 code in the 2300/CLM segment	Code 7 in box 22
Void	Click “Void” at the bottom	8 code in the 2300/CLM segment	Code 8 in box 22

Claim Submission: Resubmit or Adjust?

Was the claim denied?

Yes

Is it within 365 days of the (final) date of service?

Yes

Make corrections and **submit new claim** without referencing the Internal Control Number (ICN)

No

Is it within 60 days of the last Remittance Advice (RA), returned paper claim or load letter?

Yes

Make corrections and **rebill/ resubmit claim**. Be sure to reference the original Internal Control Number (ICN)

No

Contact Provider Services Call Center at 1-844-235-2387

No, it paid

Is it within 365 days of the (final) date of service?

Yes

Make corrections and **adjust claim** by:

1) Indicating adjustment in field 22 on paper claim form CMS 1500
2) Click "Adjust" at the bottom of the screen after searching for claim on the Provider Web Portal

No

Contact Provider Services Call Center at 1-844-235-2387

Quick Guides

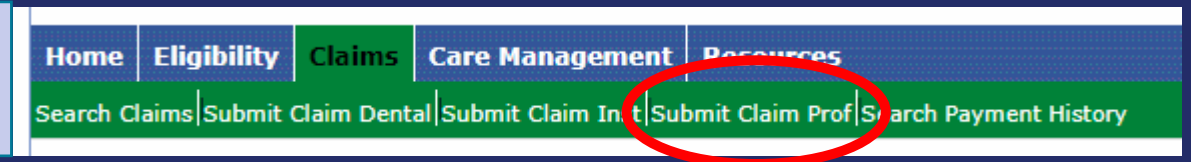
- Copy, Adjust or Void a Claim
- Pulling Remittance Advice (RA)
- Reading the Remittance Advice (RA)
- Submitting a Professional Claim

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

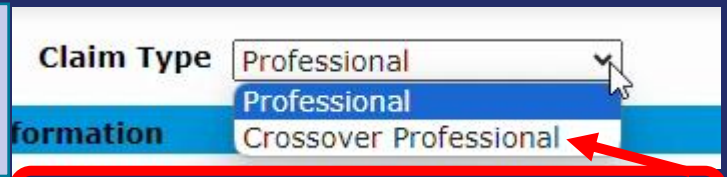
Provider Web Portal Demo

Step 1: Member and Claim Information

1



2

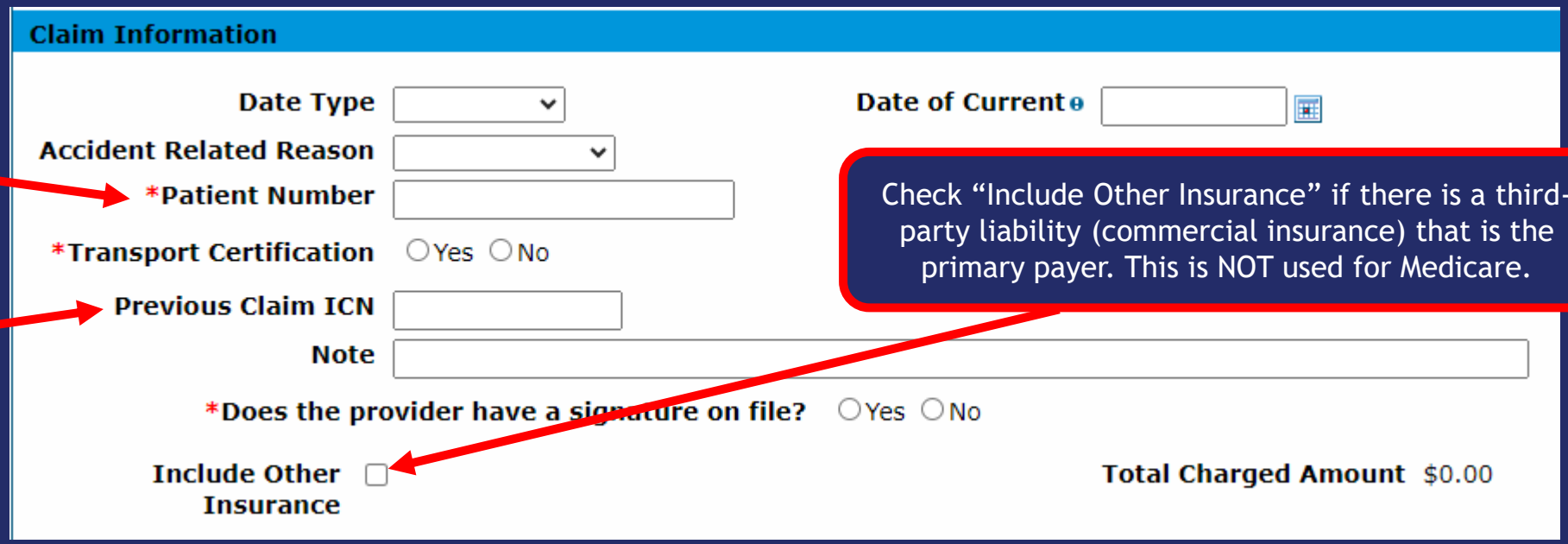


The Crossover Professional claim is used when Medicare is the primary payer.

3

Patient number can be any number the provider assigns for internal records.

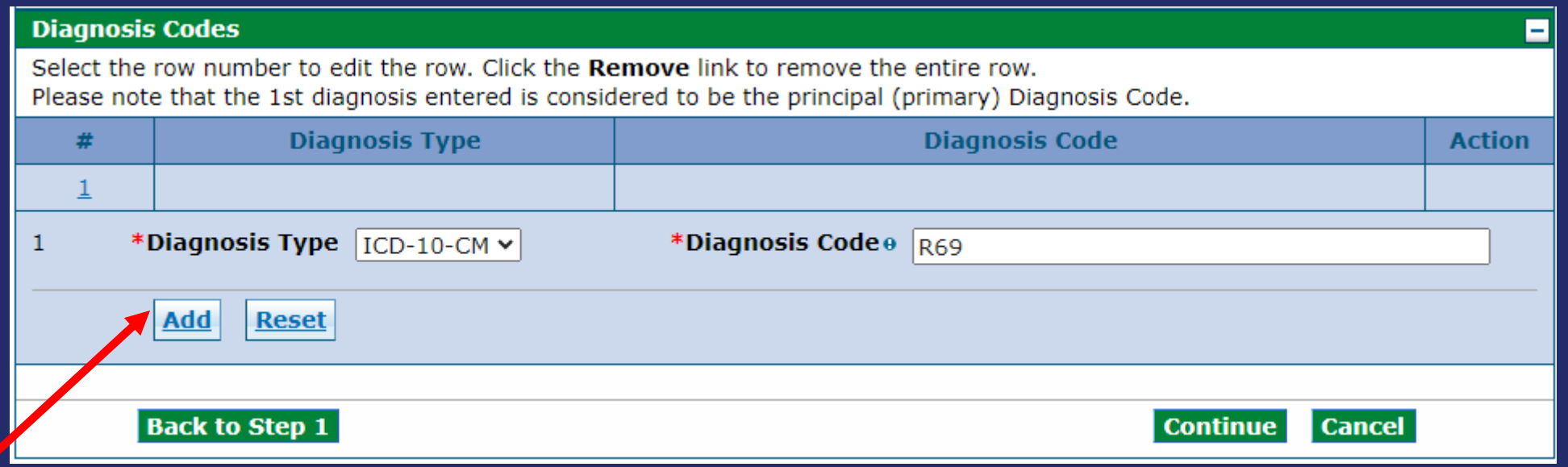
Reference the original Internal Control Number (ICN) if you are resubmitting a claim after it has been denied.



Check "Include Other Insurance" if there is a third-party liability (commercial insurance) that is the primary payer. This is NOT used for Medicare.

Provider Web Portal Demo

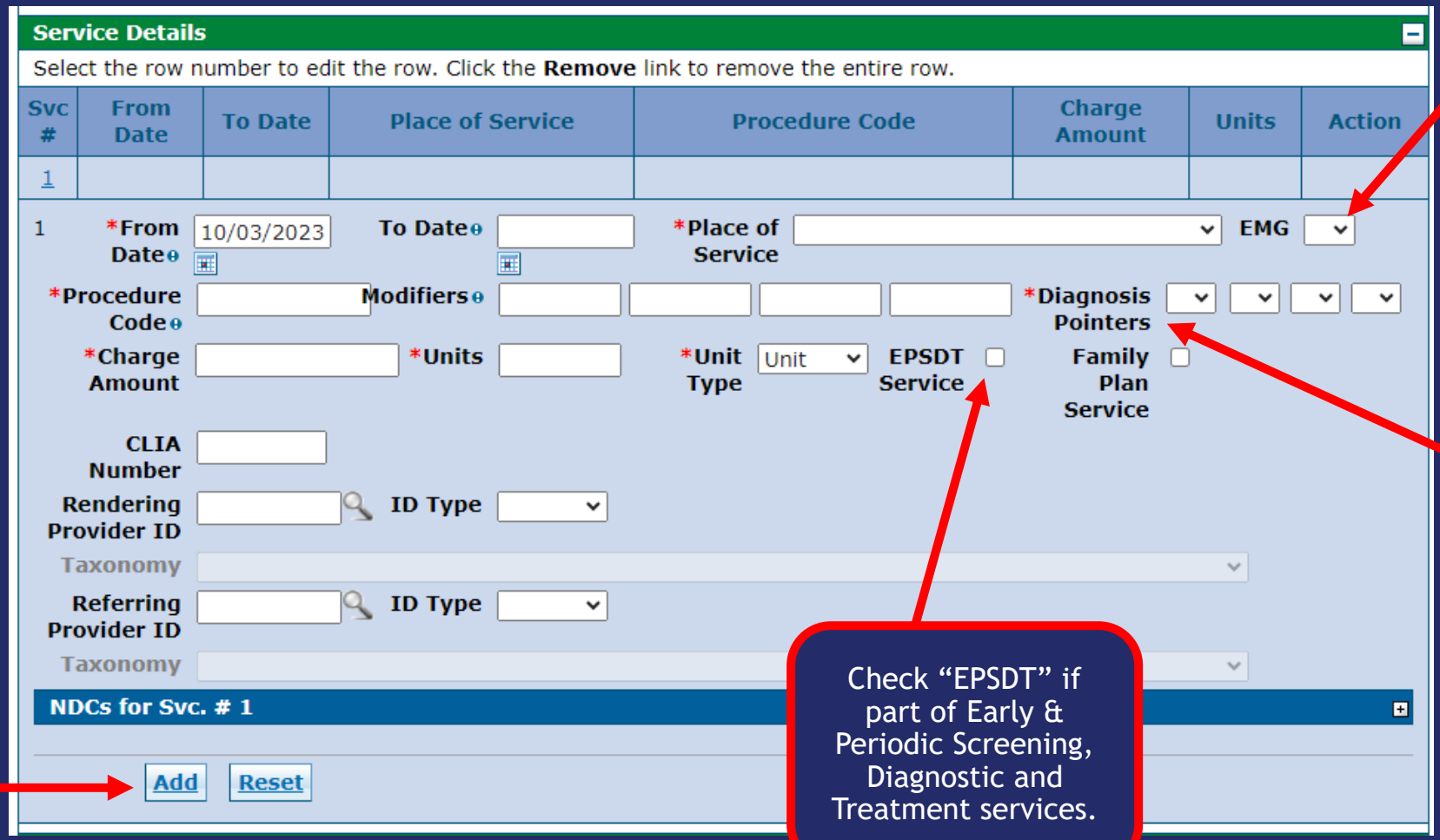
Step 2: Diagnosis Panel



Be sure to click “Add” after inputting the Diagnosis Code and before clicking “Continue.”

Provider Web Portal Demo

Step 3: Service Details Panel



The "EMG" field is for providers to indicate whether the member requires emergency service. Select "Y" to mark emergency status.

Diagnosis pointers connect the diagnosis with the service. They answer the question, "Which diagnosis goes with which service?" The first pointer designates the primary diagnosis for the service line.

Be sure to click "Add" after inputting the Service Details and before clicking "Continue."

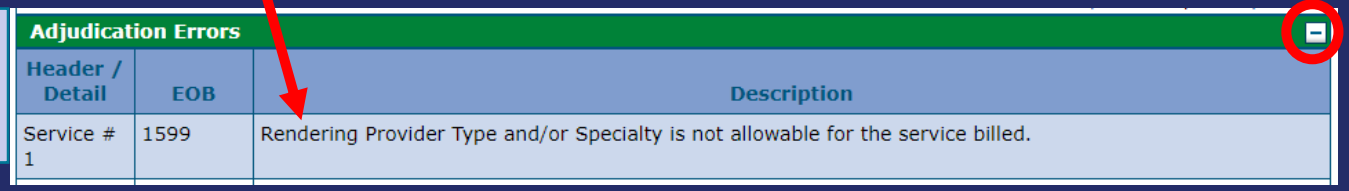
Check "EPSDT" if part of Early & Periodic Screening, Diagnostic and Treatment services.

Provider Web Portal Demo

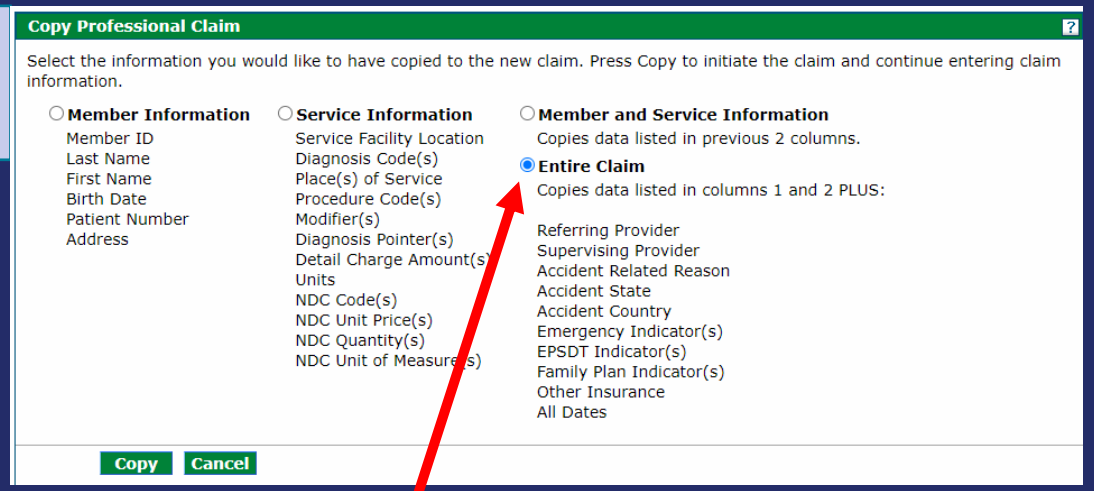
Correcting Denied Claims

Check the "Adjudication Errors" for information on why claim denied.

1



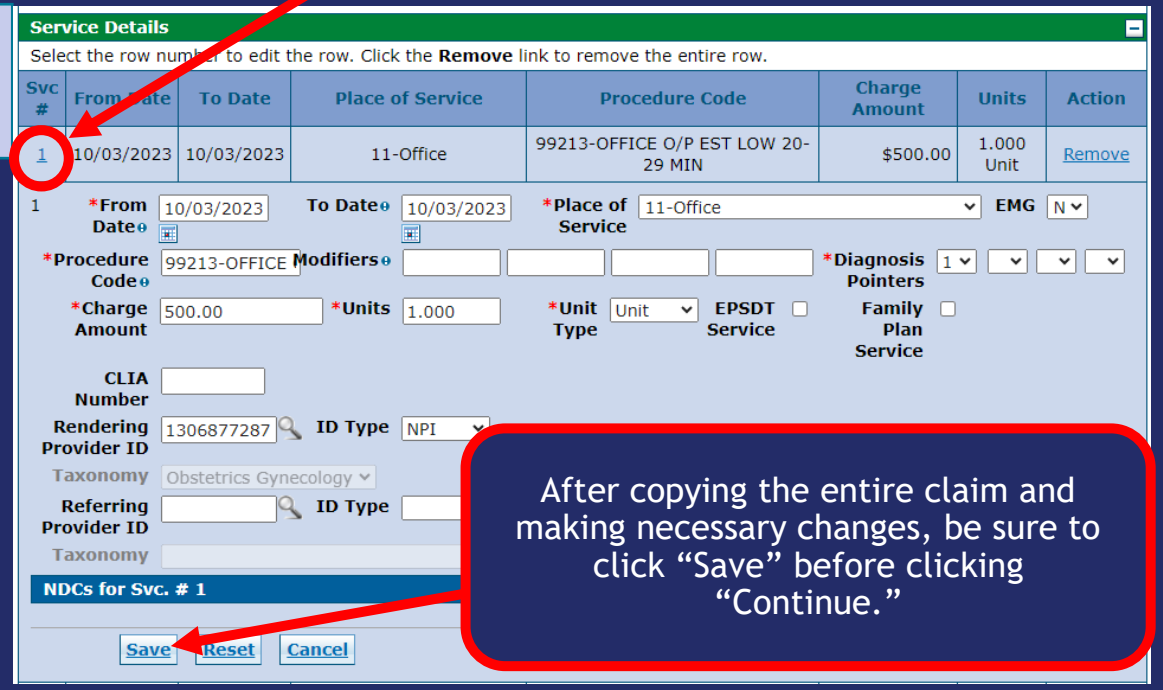
2



Copy the entire claim to make necessary changes.

3

Click on blue numbers to expand and change information within that panel.



After copying the entire claim and making necessary changes, be sure to click "Save" before clicking "Continue."

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?

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

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

COLORADO
Department of Health Care Policy & Financing

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

Resources

Billing Manuals web page

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

Provider Web Portal Quick Guides

Provider Training web page

Provider & Care and Case Manager Contacts web page

Provider Services Call Center

1-844-235-2387

Regional Field Representatives web page

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.”

- Interested in more training? Sign up by visiting the website and clicking “Provider Resources” and then “Provider Training.”

Thank you for the services you provide to Health First Colorado members!

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