

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

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

Providers must be enrolled as a Health First Colorado (Colorado's Medicaid Program) provider in order to:

- Treat a Health First Colorado member
- Submit claims for payment to Health First Colorado

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children and youth ages 20 and under, who are enrolled in Health First Colorado. EPSDT is key to ensuring that children and youth receive appropriate preventive, dental, mental health, developmental and specialty services.

Early	Assessing and identifying problems early
Periodic	Checking children's health at periodic, age-appropriate intervals
Screening	Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
Diagnostic	Performing diagnostic tests to follow up when a risk is identified
Treatment	Control, correct or reduce health problems found

One of the goals of EPSDT is to establish a regular pattern of healthcare through routine health screenings, diagnostic, and treatment services.

All states are required to complete a report to the federal government on April 1 of each year as to the numbers of services received by the EPSDT eligible members. All states have a minimum requirement of 80% of the children and youth receiving at least one screening visit per year.

Providers should refer to the Code of Colorado Regulations, [Program Rules](#) (10 CCR 2505-10.8.280), for specific information when providing EPSDT care.

Accountability of services shall be maintained through medical records and documentation used in informing, screening, diagnosis and treatment services. The provider who is performing the screening must maintain medical records specific to EPSDT screening services that:

- Contain the results of all diagnostic tests and reports of all consultations.
- Contain the reason for visit, e.g., screening, follow-up, etc.
- Contain the date screening services were performed, and documentation of the specific tests or procedures performed, along with the results of these tests and procedures.
- Contain documentation of any screening service that was due but not completed and the medical contraindication or other reason why it was not completed.
- Contain documentation of declination of screening services by parents.
- Contain referrals made for diagnosis, treatment, or other medically necessary health services for conditions as a result of a screening service.
- Date next screening is due.
- Documentation of direct referral for age-appropriate dental services.

General Billing Information

National Provider Identifier (NPI)

The Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities (i.e., health plans, health care clearinghouses, and those health care providers who transmit any health information electronically in connection with a transaction for which the Secretary of Health and Human Services has adopted a standard) use NPIs in standard transactions. Certain Provider Types are not able to obtain an NPI. Those providers will be assigned a Health First Colorado provider number.

Paper Claims

Electronic claims format shall be required unless hard copy claims submittals are specifically prior authorized by the Department. Requests may be sent to DXC Technology (DXC), P.O. Box 30, Denver, CO 80201-0030. The following claims can be submitted on paper and processed for payment:

- Claims from providers who consistently submit five (5) claims or fewer per month (requires prior approval)
- Claims that, by policy, require attachments
 - Note: Attachments may be submitted electronically
- Reconsideration claims

Paper claims require an NPI for those provider types that can obtain one. Providers that cannot obtain an NPI are required to use an assigned Health First Colorado provider number on their claims. Electronically mandated claims submitted on paper are processed, denied, and marked with the message "Electronic Filing Required".

Electronic Claims

Instructions for completing and submitting electronic claims are available through the following:

- X12N Technical Report 3 (TR3) for the 837P, 837I, or 837D (wpc-edi.com)
- Companion Guides for the 837P, 837I, or 837D in the EDI support section of the Department's website ([edi-support](#))
- Online Portal User Guide (via within the Online Portal)

The Health First Colorado collects electronic claim information interactively through the Health First Colorado Secure Online Portal ([Online Portal](#)) or via batch submission through a host system. Please refer to the [Colorado General Provider Information Manual](#) for additional electronic information.

Interactive Claim Submission and Processing

Interactive claim submission through the Online Portal is a real-time exchange of information between the provider and the Health First Colorado. Health First Colorado providers may create and transmit HIPAA compliant 837P (Professional), 837I (Institutional), and 837D (Dental) claims electronically one at a time. These claims are transmitted through the Health First Colorado Online Portal (OP).

The Online Portal contains training, user guides and help that describe claim completion requirements, edits that verify the format and validity of the entered information, and edits that assure that required fields are completed.

The Health First Colorado OP reviews the claim information for compliance with Health First Colorado billing policy and passes the claim to the Colorado interChange system for adjudication and reporting on the Health First Colorado Provider Remittance Advice (RA).

The OP immediately returns a response to the provider about that single transaction indicating whether the claim will be rejected, suspended or paid.

- If the claim is rejected, the OP sends a rejection response that identifies the rejection reason. The rejected claim can immediately be resubmitted.
- If the claim is suspended then it needs additional manual review by the Fiscal Agent.
- If the claim is accepted, the provider receives a message indicating that the claim is will be paid.
OP

The Online Portal provides immediate feedback directly to the submitter. All claims are processed to provide a weekly Health Care Claim Payment/Advice (Accredited Standards Committee [ASC] X12N 835) transaction and/or Remittance Advice to providers. The Online Portal also provides access to reports and transactions generated from claims submitted via paper and through electronic data submission methods other than the Online Portal. The reports and transactions include:

- Accept/Reject Report
- Remittance Advice
- Health Care Claim Payment/Advice (ASC X12N 835)
- Managed Care Reports such as Primary Care Physician Rosters
- Eligibility Inquiry (interactive and batch)
- Claim Status Inquiry

Claims may be adjusted, edited and resubmitted, and voided in real time through the Online Portal. Access the Online Portal through Secured Site at colorado.gov/hcpf. For help with claim submission via the Online Portal, please choose the *User Guide* option available for each Online Portal transaction.

For additional electronic billing information, please refer to the appropriate Companion Guide located in the Provider Services [Specifications](#) section of the Department's website.

General Program Provisions

A comprehensive EPSDT Periodic Screening examination includes the following components:

- Comprehensive health & developmental history
- Immunizations *appropriate to age & health history*
- Comprehensive unclothed physical examination
- Laboratory tests (including lead blood level assessment appropriate to age & risk)
- Assessment of physical, emotional & developmental growth
- Assessment of mental/behavioral health
- Assessment of mouth, oral cavity and teeth, including referral to a dentist
- Hearing assessment
- Assessment of nutritional status
- Family planning services and adolescent maternity care
- Vision assessment
- Health education (including anticipatory guidance)
- Treatment and referrals for any medically necessary further diagnosis and treatment

Types of EPSDT Provider Visits

1) Periodic Screen

The periodic screen includes comprehensive health assessments that are performed soon after birth or as early as possible in a child's life. It is repeated at prescribed intervals until the age of 20, as described in the AAP Bright Futures Periodicity Schedule.

2) Inter-Periodic Visit

An inter-periodic visit is any other healthcare visit the child may need, such as visits for an ear ache, fever or injury. Additional visits, or "interperiodic" screens, may become necessary if circumstances suggest the need for more screens, or to bring a child who has missed one or more periodic screens into compliance. Medically necessary interperiodic screens must be provided to determine the existence of suspected physical, or mental illnesses or conditions. The determination of whether an interperiodic screen is medically necessary may be made by a health, developmental or educational professional who comes into contact with the child outside of the formal health care system (e.g., special education programs, Head Start and day care programs, the Special Supplemental Food Program for Women, Infants and Children (WIC) and other nutritional assistance programs).

Outreach and Case Management – Healthy Communities Program

Each family or member is assigned to a Family Health Coordinator in their local area. The Family Health Coordinator's services are a part of the member's Health First Colorado benefit and offers support services, including the following:

- Ensures that members are informed of program benefits.
- Assists child in accessing health care services within a reasonable time period.
- Offers assistance in identifying participating Health First Colorado doctors, dentists, other medical specialists and managed care programs or Accountable Care Programs. Assists in making and reminds members of appointments, if requested.
- Follows up on appointments that may have been missed, if requested by a provider.
- Assists with connecting child with non-medical community resources.
- Coordinate the following types of health care services wherever possible:
 - Newborn or well-baby check-ups
 - Day care or Head Start physicals
 - Routine well child physical exams
 - Dental Screenings
 - Behavioral Health screenings
 - Developmental screenings

Visit the [Healthy Communities](#) web page on the Department's website to find a [Family Health Coordinator](#) in your area.

As a provider under a Regional Accountable Care Organization (RCCO) you also have the ability to access medical case management through those organizations. Please visit <https://www.colorado.gov/pacific/hcpf/regional-care-collaborative-organizations> for more information.

Services

EPSDT is made up of the following screening, diagnostic, and treatment services:

Screening Services

Comprehensive Health and Developmental History

At the initial screen, the provider should obtain a comprehensive health, developmental, behavioral, mental health and nutritional history from the child's parents or guardians. The comprehensive initial history should include the following information:

- Family medical history
- Member medical history, including prenatal problems, neonatal problems, developmental milestones, surgeries, current medication and current health problems
- Immunization history
- Nutritional history
- Social history
- Living conditions
- Family and member history of behavioral problems

This information should be updated at every well child check.

Comprehensive unclothed physical exam

Unclothed Physical Inspection - Check the general appearance of the child to determine overall health status. This process can pick up obvious physical defects, including orthopedic disorders, hernia, skin disease, and genital abnormalities. Physical inspection includes an examination of all organ systems such as pulmonary, cardiac, and gastrointestinal. Please visit the AAP Bright Futures Periodicity Schedule for more information at <https://brightfutures.aap.org/clinical-practice/Pages/default.aspx>.

Appropriate immunizations (according to the Advisory Committee on Immunization Practices)

The National Vaccines for Children Program (VFC) supplies most vaccines at no cost to physicians enrolled in the VFC program. All PCPs participating in Health First Colorado (including those in MCOs) are eligible to enroll and participate in the VFC program.

Oral Health Screening Services

Dental screening services, such as oral health assessments, can be provided during a well-child visit by the pediatric primary care provider.

Laboratory tests (including lead toxicity testing)

Identify the minimum laboratory tests or analyses to be performed by medical providers for particular age or population groups. Physicians providing screening/assessment services under the EPSDT benefit use their medical judgment in determining the applicability of the laboratory tests or analyses to be performed.

Federal regulations require that all Health First Colorado-enrolled children have a blood lead test at 12 and 24 months of age. CMS requires the use of the blood lead test when screening children for lead poisoning.

If a child between the ages of 24 months and 72 months has not received a screening blood lead test, the child must receive it immediately.

If a child is found to have blood lead levels equal to or greater than 10 ug/dl, providers are to use their professional judgment, with reference to CDC guidelines covering member management and treatment, including follow up blood tests and initiating investigations to determine the source of lead, where indicated. Determining the source of lead may be completed by your local public health agency. For more information please visit the Colorado Department of Public Health and Environment's site at <https://www.colorado.gov/pacific/cdphe/categories/services-and-information/environment/lead>.

Vision and Hearing Screening Services

Subjective vision and hearing screens should be performed at every well-child visit, or based on an assessment of risk. If medically indicated, the subjective screens can lead to inter-periodic screens or a referral to a specialist if a problem is identified.

Developmental Surveillance and Screening Services

According to the American Academy of Pediatrics, developmental surveillance is a flexible, longitudinal, continuous, and cumulative process whereby knowledgeable health care professionals identify children who may have developmental problems. Developmental surveillance should include the following:

- Eliciting and attending to the parents' concerns about their child's development
- Documenting and maintaining a developmental history
- Making accurate observations of the child
- Identifying the risk and protective factors
- Maintaining an accurate record and documenting the process and findings

A developmental screening is a brief assessment using a validated tool designed to identify children who should receive further assessment. A developmental screen is designed to evaluate whether an individual's development processes fall within a normal range of achievement according to age group. A developmental screening tool may be administered by appropriate office staff; however the tool should be scored by the billing provider. If a developmental screening uncovers a potential developmental delay, the provider must make the appropriate referral to the appropriate provider for further evaluation. If a developmental delay is identified in a child ages 0-3 years old, the provider should refer to Colorado's Early Intervention Program. More information available at <http://www.eicolorado.org/>

Developmental screens should be completed according to the Bright Futures periodicity schedule, at 9 months, 18 months, and 30 months of age. The assessment should consist of developmental history, observations, physical and developmental evaluation and assessment of developmental status.

Health Education (anticipatory guidance including child development, healthy lifestyles, and accident and disease prevention)

Other Necessary Health Care Services

Additional health care services that are coverable under the Federal Medicaid program and found to be medically necessary to treat, correct or reduce illnesses and conditions discovered regardless of whether the service is covered in a state's Medicaid plan. It is the responsibility of states to determine medical necessity on a case-by-case basis (see medical necessity below for more information) and providers are to make requests for services that may not be covered by the state plan or by private insurance.

Diagnosis

A presumptive diagnosis may be made at the time of screening, but it is usually necessary to advise the

member of the need for further diagnosis and treatment. Necessary treatments may be rendered by the PCP or MCO practitioner or by referral to an authorized Health First Colorado specialist.

Providers should make requests for services or items they feel best meets the child/youth needs even if they are not listed in the state plan as a benefit or the code is not showing as a benefit in the provider fee schedule.

Treatment

Necessary health care services must be made available for treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedures.

Under EPSDT, Health First Colorado beneficiaries are entitled to a broader scope of services than adults. Providers must make available or refer the member for the health care, treatment or other measures to correct or ameliorate defects and physical and mental illnesses or conditions discovered by EPSDT screening services.

Providers should make requests for services or items they feel best meets the child/youth needs even if they are not listed in the state plan as a benefit or the code is not showing as a benefit in the provider fee schedule.

Medical Necessity

All Health First Colorado coverable, medically necessary services must be provided even if the service is not available under the State plan to other Health First Colorado members. No arbitrary limitations on services are allowed, e.g., one pair of eyeglasses or 10 physical therapy visits per year.

Providers should consult the fee schedule at www.colorado.gov/pacific/hcpf/provider-rates-fee-schedule to determine if the procedure code requires prior authorization. Medical necessity or a medically necessary service is defined as a good or service that will or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. See Code of Colorado Regulations, [Program Rules](#) (10 CCR 2505-10.8.076.1.8), for the complete Medical Necessity Definition. For EPSDT, medical necessity includes a good or service that will or is reasonably expected to, assist the member to achieve or maintain maximum functional capacity in performing one or more Activities of Daily Living, and meets the criteria, Code of Colorado Regulations, [Program Rules](#) (10 CCR 2505-10.8.280.4.E.2)

To request services that a provider feels are medically necessary but are not currently covered, [Billing Manuals](#) section of the Department's website.

Health First Colorado makes the final determination of medical necessity and it is determined on a case-by-case basis. Provider recommendations will be taken in to consideration, but are not the sole determining factor in coverage. Colorado determines which treatment it will cover among equally effective, available alternative among equally effective treatments.

ColoradoPAR Prior Authorization Requests (PARs)

If the non-covered services or supplies being requested contain codes normally prior authorized by the Departments Utilization Management (UM) vendor the provider must submit a PAR through the ColoradoPAR Program. The ColoradoPAR Program is Health First Colorado's Utilization Management (UM) Program. This third-party vendor reviews Prior Authorization Requests (PARs) to ensure services requested meet medical necessity guidelines and are within Health First Colorado's policies.

The ColoradoPAR Program's third-party vendor processes electronic PARs through an online PAR portal. The online PAR portal is a web-based HIPAA-compliant PAR system that offers providers 24/7 access to

the information and functions providers need. Clinical documentation will be accepted in the following formats: doc, docx, xls, xlsx, ppt, pdf, jpg, gif, bmp, tiff, tif, and jpeg.

See ColoradoPAR.com for information and instructions on how to submit PARs electronically through the online PAR portal. For additional assistance or support, contact the ColoradoPAR provider helpline at 888-801-9355. PAR status may be verified in the online PAR portal or by contacting the ColoradoPAR provider helpline. The approved PAR identification number must be submitted with the claim to receive payment.

Claims for prior authorized services must be submitted within 120 days of the date of service. Services rendered prior to the authorized date will be denied reimbursement.

Approval of the PAR does not guarantee payment by Medicaid. The member and the EPSDT provider shall meet all applicable eligibility requirements at the time services are rendered and services shall be delivered in accordance with all applicable service limitations. Medicaid is the payer of last resort and the presence of an approved or partially approved PAR does not release the agency from the requirement to bill Medicare or other third party insurance prior to billing Medicaid.

PAR Requirements

Any provider submitting a PAR must be enrolled in the Health First Colorado Program for. Providers must also verify eligibility at the time service is rendered and include the necessary information with the PAR. All services require prior authorization by Health First Colorado's third-party vendor using the approved prior authorization request online portal. It is the EPSDT provider's responsibility to provide sufficient documentation to support the medical necessity for the requested services. PARs must be submitted to Health First Colorado's third-party vendor in accordance with 10 CCR 2505-10 § 8.058.

- A PAR will be pended by Health First Colorado's third-party vendor if all of the required information is not provided in the PAR, or additional information is required by the third-party vendor to complete the review. If the third-party vendor does not receive the required documentation within four (4) business days, the PAR will be denied for lack of information.
- All other information determined necessary by Health First Colorado's third-party vendor to make a decision on the medical necessity and appropriateness of the proposed treatment plan must be included.
- The PAR will be reviewed by medical experts in children's health who work for the Health First Colorado program's third-party vendor. Nurses and doctors will decide if the request for services or supplies meets the rules for medical necessity and for the Personal Care Benefit.

ColoradoPAR Peer-to-Peer and Reconsideration Process

If an EPSDT requested service or supply is denied or partially denied by the UM vendor the MD, DO, or APN who requested the PAR has the option to discuss the PAR over the phone in a process called a Peer-To-Peer review. If the Peer-To-Peer review still results in a denied or partially denied PAR, the EPSDT provider can work with the UM vendor two (2) options:

- PAR Reconsideration: A PAR Reconsideration is similar to a second opinion and must be requested by the EPSDT provider. A MD, DO, or APN who is different from the one who made the initial PAR denial will re-review the PAR along with the new information and make a final PAR decision. Additional documents not submitted with the original request may be submitted during the Reconsideration process.
- PAR Resubmission: Submit a new PAR that includes additional medical information needed for the PAR review.

The provider will be notified of the final PAR determination for all PARs reviewed by the UM vendor via the online PAR portal. The provider and member will receive the final PAR determination letter from the

Department's fiscal agent. If the PAR is denied, the provider will also receive a detailed explanation of why the PAR was denied. A member who receives a denial notification letter has the option to submit a written request for an appeal to the Office of Administrative Courts.

EPSDT Medical Necessity Does NOT include:

- Experimental or investigational treatments,
- Services or items not in accordance with professionally recognized standards for health care in the United States, or
- Services primarily for caregiver or providers convenience

Services for which Colorado has a waiver are also not considered to be state plan benefits, and therefore are not a benefit under EPSDT. Items such as respite, in-home support services, and home modifications are examples of waiver services.

To request services that a provider feels are medically necessary but are not currently covered by the state plan, a prior authorization request must be completed as well as a letter of medical necessity. Both should be sent to the authorizing agent listed in Appendix D located in the [Billing Manuals](#) section of the Department's website.

Benefits

Developmental, Depression, and Autism Screenings

Developmental

Health First Colorado enrolled children aged 0 – 4 (up to 59 months) following the 3 by 3 framework from the AAP. Three (3) screens per year for children aged 0 – 24 months.

Health First Colorado covers developmental screening for children ages 0 – 4 (up to 59 months), using a standardized, validated developmental screening tool (i.e., PEDS, Ages and Stages, etc.) at the child's periodic visits. In the absence of established risk factors or parental or provider concerns, the AAP recommends developmental screens at the 9-, 18-, and 30-months and not at every visit.

Depression

Health First Colorado covers depression screening for individuals aged 11 and older, using a standardized, validated depression screening tool (i.e., PHQ-9 (Department recommended), Edinburgh Postnatal Depression Scale, Columbia Depression Scale, Beck Depression Inventory, Kutcher Adolescent Depression Scale, etc.) at the member's periodic visits. The exact frequency of validated, standardized screening depends on both the concerns of the child's parents or adult member and also the provider as to whether routine surveillance suggests the member may be at risk for depression.

Autism

Health First Colorado covers autism screening for children aged 18- and 24-months, using a standardized, validated autism screening tool (i.e., M-CHAT, etc.) at the child's periodic visits. When an autism screen identifies a child as being at risk for an Autism Spectrum Disorder, an ASD Diagnostic Evaluation should follow.

Dental Benefits

A non-emergency oral examination, dental prophylaxis, and fluoride topical application once every six months are benefits of the EPSDT program. Health First Colorado recommends regular periodic examinations by a dentist with eruption of the first tooth or at age one, and continuing every six (6)

months or as recommended by a dentist. Referral from the PCP is **not** required for EPSDT dental services.

Orthodontia is available for children who have been diagnosed with a severely handicapping malocclusion. More information can be found on DentaQuest's [website](#).

Dentally necessary radiographs, restorations, endodontics, periodontics, prosthodontics and oral surgery are also benefits. Dental services are billed on the 2012 American Dental Association (ADA) claim form or the 837 D. Complete billing instructions for dental services are included in DentaQuest Provider Office Reference Manual (ORM) found under DentaQuest Resources section of DentaQuest's [website](#). Health First Colorado dental providers can also call DentaQuest's Provider Relations/Services at 1-855-225-1731 (for TTY assistance, please call AT&T's TTY line at 711).

Hearing Assisted Device Benefits

Audiological benefits include identification, diagnostic evaluation, and treatment for children with hearing impairments. Benefits include hearing aids and other assisted devices, auditory training in the use of hearing aids, therapy for children with hearing impairments, and family-focused home based early language intervention for children, (birth to three years of age), with hearing loss through the Colorado Home Intervention Program (CHIP).

Vision Care Benefits

Vision diagnostic and treatment services may be performed by an ophthalmologist or optometrist. Referral is **not** required for vision care. Single and multifocal vision lenses and frames, as well as repair or replacement of broken lenses or frames, are benefits of EPSDT and may be provided by an ophthalmologist, optometrist, or optician. Contact lenses are available in some medically necessary situations and require prior authorization.

Vision care services are billed on the CMS 1500 Health Insurance claim form or the 837P. Complete billing instructions for vision services are included in the vision billing manual.

Billing Guidelines

EPSDT Billing

Providers submitting claims electronically must use the 837P.

Providers submitting claims on paper must use the EPSDT paper claim form.

The EPSDT claim form is used by primary care providers who bill fee-for-service for EPSDT periodic screens.

The Department tracks the EPSDT periodic screens by procedure and diagnosis codes appropriate for the screen. Other children's health care services are billed on the CMS 1500, using national standard codes.

Providers must identify if a visit is a result of a referral from an EPSDT Screen

If a provider is seeing a child as a result of a referral from the EPSDT periodic screen for further diagnosis or treatment, the provider should enter a **"Yes" in Box # L** on the CMS 1500.

If the visit is a referral from an EPSDT periodic screen for further diagnosis and treatment, enter a **"Yes" in the service line** (Loop 2400, Segment SV1, Element SV111). It is important to identify these services as they are reported on the Annual EPSDT Participation Report (416) to the Centers for Medicare and Medicaid Services (CMS) along with the number of EPSDT periodic screens.

- Dental benefits are billed on the 2012 ADA claim form or the 837 D.
- Vision benefits are billed on the CMS 1500 claim form or 837P.
- If the child is ill, services related to the illness should be billed on the CMS 1500 claim form. An appointment for an EPSDT screening should be made at a later date.
- Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) complete the UB-04 claim form for EPSDT-rendered services. Refer to the FQHC/RHC Billing Manual for specific UB-04 billing instructions. FQHCs and RHCs use V72.0 to bill for the EPSDT Periodic Screen.

EPSDT benefits may include medically necessary covered benefits available for children enrolled in the Medical Assistance Program.

Procedure/HCPCS Codes Overview

The Department accepts procedure codes that are approved by the Centers for Medicare & Medicaid Services (CMS). The codes are used for submitting claims for services provided to Health First Colorado members and represent services that may be provided by enrolled certified Health First Colorado providers.

The Healthcare Common Procedural Coding System (HCPCS) is divided into two principal subsystems, referred to as level I and level II of the HCPCS. Level I of the HCPCS is comprised of Current Procedural Terminology (CPT), a numeric coding system maintained by the American Medical Association (AMA). The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals.

Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter followed by 4 numeric digits, while CPT codes are identified using 5 numeric digits.

HIPAA requires providers to comply with the coding guidelines of the AMA CPT Procedure Codes and the International Classification of Disease, Clinical Modification Diagnosis Codes. If there is no time designated in the official descriptor, the code represents one unit or session. Providers should regularly consult monthly bulletins in the Provider Services [Bulletins](#) section. To receive electronic provider bulletin notifications, an email address can be entered into the Web Portal in the *(MMIS) Provider Data Maintenance* area or by completing and submitting a publication preference form. Bulletins include updates on approved procedure codes as well as the maximum allowable units billed per procedure. Always remember that any code or service can be requested, even if the code is not open in the fee schedule or listed in this or other billing manuals.

EPSDT Procedure Coding

Procedure Code(s)	Description
Periodic Screening: Preventive Medicine Codes*	
99381 – 99385	New Member (age specific)
99391 – 99395	Established Member (age specific)
99431	History and examination
99432	Normal newborn care
Periodic Screening: Evaluation and Management Codes	
99203 – 99205	New Member

Procedure Code(s)	Description
99214 – 99215	Established Member
<p>Note: These CPT-4 codes must be used in conjunction with the following Z codes: Z76.2, Z00.121, Z00.129, Z00.110, Z00.111, Z00.00-01, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.81, Z02.82, Z02.83, Z02.89, Z00.8, Z00.6, Z00.5, Z00.70, Z00.71.</p> <p>These codes must be used in conjunction with diagnosis codes for a well-child exam including 99202-99205, 99213-99215</p>	
Inter-periodic Visit Codes	
Range 99201 – 99350	
<p>Note: Used in conjunction with the appropriate diagnosis codes <i>excluding</i> the well-child diagnosis codes: Z76.2, Z00.121, Z00.129, Z00.110, Z00.111, Z00.00-01, Z02.0 –Z02.6, Z02.81-Z02.83, Z02.89, Z00.5, Z00.6, Z00.70, Z00.71, Z00.8</p>	

CMS 1500 Paper Claim Instructions

The following paper form reference table shows required, optional, and conditional fields and detailed field completion instructions for the EPSDT claim form.

CMS Field #	Field Label	Field is?	Instructions
1	Insurance Type	Required	Place an "X" in the box marked as Medicaid.
1a	Insured's ID Number	Required	Enter the member's Health First Colorado seven digit Medicaid ID number as it appears on the Medicaid Identification card. Example: A123456.
2	Patient's Name	Required	Enter the member's last name, first name, and middle initial.
3	Patient's Date of Birth / Sex	Required	Enter the member's birth date using two digits for the month, two digits for the date, and two digits for the year. Example: 070114 for July 1, 2014. Place an "X" in the appropriate box to indicate the sex of the member.
4	Insured's Name	Not Required	
5	Patient's Address	Not Required	
6	Patient's Relationship to Insured	Conditional	Complete if the member is covered by a commercial health insurance policy. Place an "X" in the box that identifies the member's relationship to the policyholder.
7	Insured's Address	Not Required	
8	Reserved for NUCC Use		
9	Other Insured's Name	Conditional	If field 11d is marked "YES", enter the insured's last name, first name and middle initial.

CMS Field #	Field Label	Field is?	Instructions
9a	Other Insured's Policy or Group Number	Conditional	If field 11d is marked "YES", enter the policy or group number.
9b	Reserved for NUCC Use		
9c	Reserved for NUCC Use		
9d	Insurance Plan or Program Name	Conditional	If field 11d is marked "YES", enter the insurance plan or program name.
10a-c	Is Patient's Condition Related to?	Not Required	
10d	Reserved for Local Use		
11	Insured's Policy, Group or FECA Number	Not Required	
11a	Insured's Date of Birth, Sex	Not Required	
11b	Other Claim ID	Not Required	
11c	Insurance Plan Name or Program Name	Not Required	
11d	Is there another Health Benefit Plan?	Conditional	When appropriate, place an "X" in the correct box. If marked "YES", complete 9, 9a and 9d.
12	Patient's or Authorized Person's signature	Required	Enter "Signature on File", "SOF", or legal signature. If there is no signature on file, leave blank or enter "No Signature on File". Enter the date the claim form was signed.

CMS Field #	Field Label	Field is?	Instructions
13	Insured's or Authorized Person's Signature	Not Required	
14	Date of Current Illness Injury or Pregnancy	Not Required	
15	Other Date	Not Required	
16	Date Patient Unable to Work in Current Occupation	Not Required	
17	Name of Referring Physician	Conditional	
18	Hospitalization Dates Related to Current Service	Conditional	Complete for services provided in an inpatient hospital setting. Enter the date of hospital admission and the date of discharge using two digits for the month, two digits for the date and two digits for the year. Example: 0701146 for July 1, 2016. If the member is still hospitalized, the discharge date may be omitted. This information is not edited.
19	Additional Claim Information	Conditional	
20	Outside Lab? \$ Charges	Conditional	Complete if <u>all</u> laboratory work was referred to and performed by an outside laboratory. If this box is checked, no payment will be made to the physician for lab services. Do not complete this field if <u>any</u> laboratory work was performed in the office. Practitioners may not request payment for services performed by an independent or hospital laboratory.
21	Diagnosis or Nature of Illness or Injury	Required	Enter at least one but no more than twelve diagnosis codes based on the member's diagnosis/condition. Enter applicable ICD indicator to identify which version of ICD codes is being reported.

CMS Field #	Field Label	Field is?	Instructions																		
			0 ICD-10-CM (DOS 10/1/15 and after) 9 ICD-9-CM (DOS 9/30/15 and before)																		
22	Medicaid Resubmission Code	Conditional	List the original reference number for resubmitted claims. When resubmitting a claim, enter the appropriate bill frequency code in the left-hand side of the field. 7 Replacement of prior claim 8 Void/Cancel of prior claim This field is not intended for use for original claim submissions.																		
23	Prior Authorization	Not Required																			
24	Claim Line Detail	Information	The paper claim form allows entry of up to six detailed billing lines. Fields 24A through 24J apply to each billed line. Do not enter more than six lines of information on the paper claim. If more than six lines of information are entered, the additional lines will not be entered for processing. Each claim form must be fully completed (totaled). Do not file continuation claims (e.g., Page 1 of 2).																		
24A	Dates of Service	Required	The field accommodates the entry of two dates: a "From" date of services and a "To" date of service. Enter the date of service using two digits for the month, two digits for the date and two digits for the year. Example: 010116 for January 1, 2016 <div style="text-align: center;"> From To <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px;">01</td> <td style="width: 20px;">01</td> <td style="width: 20px;">16</td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> </tr> </table> Or <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px;">01</td> <td style="width: 20px;">01</td> <td style="width: 20px;">16</td> <td style="width: 20px;">01</td> <td style="width: 20px;">01</td> <td style="width: 20px;">16</td> </tr> </table> Span dates of service <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px;">01</td> <td style="width: 20px;">01</td> <td style="width: 20px;">16</td> <td style="width: 20px;">01</td> <td style="width: 20px;">31</td> <td style="width: 20px;">16</td> </tr> </table> EPSDT </div>	01	01	16				01	01	16	01	01	16	01	01	16	01	31	16
01	01	16																			
01	01	16	01	01	16																
01	01	16	01	31	16																

CMS Field #	Field Label	Field is?	Instructions
			All dates of service must be the same date as screening.
24B	Place of Service	Required	<p>Enter the Place of Service (POS) code that describes the location where services were rendered. The Health First Colorado accepts the CMS place of service codes.</p> <ul style="list-style-type: none"> 11 Office 12 Home 21 Inpatient Hospital 22 Outpatient Hospital 32 Nursing Facility 99 Other Unlisted
24C	EMG	Conditional	<p>Enter a "Y" for YES or leave blank for NO in the bottom, unshaded area of the field to indicate the service is rendered for a life-threatening condition or one that requires immediate medical intervention.</p> <p>If a "Y" for YES is entered, the service on this detail line is exempt from co-payment requirements.</p>
24D	Procedures, Services, or Supplies	Required	<p>Enter the HCPCS procedure code that specifically describes the service for which payment is requested.</p> <p>All procedures must be identified with codes in the current edition of Physicians Current Procedural Terminology (CPT). CPT is updated annually.</p> <p>HCPCS Level II Codes</p> <p>The current Medicare coding publication (for Medicare crossover claims only).</p> <p>Only approved codes from the current CPT or HCPCS publications will be accepted.</p>
24D	Modifier	Conditional	<p>Enter the appropriate procedure-related modifier that applies to the billed service. Up to four modifiers may be entered when using the paper claim form.</p> <p>24 Evaluation/Management (E/M) service during the postoperative period</p> <p>Use with E/M codes to report unrelated services by the same physician during the postoperative period. Claim diagnosis code(s) must identify a condition unrelated to the surgical procedure.</p> <p>26 Professional component</p>

CMS Field #	Field Label	Field is?	Instructions
			<p>Use with diagnostic codes to report professional component services (reading and interpretation) billed separately from technical component services.</p> <p>Report separate professional and technical component services <u>only</u> if different providers perform the professional and technical portions of the procedure.</p> <p>Read CPT descriptors carefully. Do not use modifiers if the descriptor specifies professional or technical components.</p> <p>47 Anesthesia by surgeon</p> <p>Use with surgical procedure codes to report general or regional anesthesia by the surgeon. Local anesthesia is included in the surgical reimbursement.</p> <p>50 Bilateral procedures</p> <p>Use to identify the bilateral (second) surgical procedure performed at the same operative session. Read CPT descriptions carefully. Do not use modifier -50 if the procedure descriptor states "Unilateral or bilateral" services.</p> <p>51 Multiple Procedures</p> <p>Use to identify additional procedures that are performed on the same day or at the same session by the same provider. Do not use to designate "add-on" codes.</p> <p>59 Multiple Procedures</p> <p>Use to indicate a service that is distinct or independent from other services that are performed on the same day. These services are not usually reported together but are appropriate under the circumstances. This may represent a different session or member encounter, different procedure or surgery, different site or organ system or separate lesion or injury.</p> <p>76 Repeat procedure by <u>same</u> physician/provider</p> <p>Use to identify subsequent occurrences of the same service on the same day by the same provider. Not valid with E/M codes.</p> <p>77 Repeat procedure by <u>another</u> physician/provider</p>

CMS Field #	Field Label	Field is?	Instructions
			<p>Use to identify subsequent occurrences of the same service on the same day by different rendering providers.</p> <p>79 Unrelated procedure or service by surgeon</p> <p>Unrelated procedures or services (other than E/M services) by the surgeon during the postoperative period. Use to identify unrelated services by the operating surgeon during the postoperative period. Claim diagnosis code(s) must identify a condition unrelated to the surgical procedure.</p> <p>80 Assistant surgeon</p> <p>Use with surgical procedure codes to identify assistant surgeon services. Note: Assistant surgeon services by non-physician practitioners, physician assistants, perfusionists, etc. are not reimbursable.</p> <p>GY Item or services statutorily excluded or does not meet the Medicare benefit.</p> <p>Use with podiatric procedure codes to identify routine, non-Medicare covered podiatric foot care. Modifier -GY takes the place of the required provider certification that the services are not covered by Medicare. The Medicare non-covered services field on the claim record must also be completed.</p> <p>KX Specific required documentation on file</p> <p>Use with laboratory codes to certify that the laboratory's equipment is not functioning or the laboratory is not certified to perform the ordered test. The -KX modifier takes the place of the provider's certification, "I certify that the necessary laboratory equipment was not functioning to perform the requested test ", or "I certify that this laboratory is not certified to perform the requested test."</p> <p>UK Inpatient newborn care billed using mother's State ID and birth date</p> <p>Use to identify inpatient physician services rendered to newborn infants while the mother remains in the hospital. Services</p>

CMS Field #	Field Label	Field is?	Instructions
			<p>provided to a hospitalized newborn after the mother's discharge must be submitted using the Health First Colorado ID number assigned to the child. Modifier -UK takes the place of the required certification, "Newborn care billed using Mother's State ID".</p> <p>55 Postoperative Management only</p> <p>Use with eyewear codes (lenses, lens dispensing, frames, etc.) to identify eyewear provided after eye surgery. Benefit for eyewear, including contact lenses, for members over age 20 must be related to surgery. Modifier -55 takes the place of the required claim comment that identifies the type and date of eye surgery. The provider must retain and, upon request, furnish records that identify the type and date of surgery.</p>
24E	Diagnosis Pointer	Required	<p>Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis.</p> <p>At least one diagnosis code reference letter must be entered.</p> <p>When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow.</p> <p>This field allows for the entry of 4 characters in the unshaded area.</p>
24F	\$ Charges	Required	<p>Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.</p> <p>Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one procedure from the same group is billed, special multiple pricing rules apply.</p> <p>The base procedure is the procedure with the highest allowable amount. The base code is used to determine the allowable amounts for additional CPT surgical</p>

CMS Field #	Field Label	Field is?	Instructions
			<p>procedures when more than one procedure from the same grouping is performed.</p> <p>Submitted charges cannot be more than charges made to non-Health First Colorado covered individuals for the same service.</p> <p>Do not deduct Health First Colorado co-payment or commercial insurance payments from the usual and customary charges.</p>
24G	Days or Units	Required	<p>Enter the number of services provided for each procedure code.</p> <p>Enter whole numbers only- do not enter fractions or decimals.</p>
24H	EPSDT/Family Plan	Conditional	<p>EPSDT (shaded area)</p> <p>For Early & Periodic Screening, Diagnosis, and Treatment related services, enter the response in the shaded portion of the field as follows:</p> <p>AV Available- Not Used S2 Under Treatment ST New Service Requested NU Not Used</p> <p>Family Planning (unshaded area) Not Required</p>
24I	ID Qualifier	Not Required	
24J	Rendering Provider ID #	Required	<p>Enter the NPI number of the provider performing the service.</p>
25	Federal Tax ID Number	Not Required	
26	Patient's Account Number	Optional	<p>Enter information that identifies the member or claim in the provider's billing system. Submitted information appears on the Remittance Advice (RA).</p>
27	Accept Assignment?	Required	<p>The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.</p>

CMS Field #	Field Label	Field is?	Instructions
28	Total Charge	Required	Enter the sum of all charges listed in field 24F. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
29	Amount Paid	Conditional	Enter the total amount paid by Medicare or any other commercial health insurance that has made payment on the billed services. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
30	Rsvd for NUCC Use		
31	Signature of Physician or Supplier Including Degrees or Credentials	Required	<p>Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent.</p> <p>A holographic signature stamp may be used <u>if</u> authorization for the stamp is on file with the fiscal agent.</p> <p>An authorized agent or representative may sign the claim for the enrolled provider <u>if</u> the name and signature of the agent is on file with the fiscal agent.</p> <p>Each claim must have the date the enrolled provider or registered authorized agent signed the claim form. Enter the date the claim was signed using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014.</p> <p>Unacceptable signature alternatives:</p> <p>Claim preparation personnel may not sign the enrolled provider's name.</p> <p>Initials are not acceptable as a signature.</p> <p>Typed or computer printed names are not acceptable as a signature.</p> <p>"Signature on file" notation is not acceptable in place of an authorized signature.</p>
32	32- Service Facility Location Information 32a- NPI Number	Required	<p>Enter the name of the individual or organization that will receive payment for the billed services in the following format:</p> <p>1st Line Name 2nd Line Address 3rd Line City, State and ZIP Code</p>

CMS Field #	Field Label	Field is?	Instructions
	32b- Other ID #		32a- NPI Number Required 32b- Other ID # If the Provider Type is not able to obtain an NPI, enter the eight-digit Health First Colorado provider number of the individual or organization.
33	33- Billing Provider Info & Ph # 33a- NPI Number 33b- Other ID #	Required	Enter the name of the individual or organization that will receive payment for the billed services in the following format: 1 st Line Name 2 nd Line Address 3 rd Line City, State and ZIP Code 33a- NPI Number Required 33b- Other ID # If the Provider Type is not able to obtain an NPI, enter the eight-digit Health First Colorado provider number of the individual or organization.

CMS 1500 EPSDT Claim Example



HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> PICA <input type="checkbox"/> PICA										
1. MEDICARE (Medicare #) <input checked="" type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE (ICM/DuOH) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (For Program in Item 1) D444444					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Client, Ima A					3. PATIENT'S BIRTH DATE MM DD YY 10 16 11		SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)					6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)			
8. RESERVED FOR NUCC USE					9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) <input type="text"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>			
9. OTHER INSURED'S POLICY OR GROUP NUMBER					10a. RESERVED FOR NUCC USE		11. INSURED'S POLICY GROUP OR FECA NUMBER * INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC)			
10. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, complete items 9, 9a and 9d.					11. INSURANCE PLAN NAME OR PROGRAM NAME		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 10/1/18			
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. _____			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind <input type="checkbox"/>					20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____		22. RESUBMISSION CODE ORIGINAL REF. NO. _____			
A. R32 B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____					23. PRIOR AUTHORIZATION NUMBER _____		24. A. DATES OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. ICD Ind I. QUAL. J. RENDERING PROVIDER ID #			
1 10 01 16 10 01 16 11 99393 A 30 00 1 NPI 0123456789					S2		25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. Optional 27. ACCEPT ASSIGNMENT? (For gen. items, see back) X YES NO 28. TOTAL CHARGE \$ 65.00 29. AMOUNT PAID \$ 30. Rev'd for NUCC Use			
2 10 01 16 10 01 16 11 90705 A 25 00 1 NPI 0123456789					S2		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 Signature DATE 10/18			
3 10 01 16 10 01 16 11 69210 A 10 00 1 NPI 0123456789					S2		32. SERVICE FACILITY LOCATION INFORMATION ABC EPSDT Center 100 Any Street Any City			
4 _____ NPI _____					S2		33. BILLING PROVIDER INFO & PH# () * 1234567890 b. 1234567890			
5 _____ NPI _____					S2		34. RESERVED FOR NUCC USE			
6 _____ NPI _____					S2		35. RESERVED FOR NUCC USE			
7 _____ NPI _____					S2		36. RESERVED FOR NUCC USE			

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0935-1197 FORM CMS-1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Timely Filing

The Health First Colorado allows providers to document compliance with timely filing requirements when the initial timely filing period has expired. Health First Colorado providers have 120 days from the date of service to submit their claim. For information on the 60-day resubmission rule for denied/rejected claims, please see the General Provider Information manual in the Provider Services [Billing Manuals](#) section.

Making false statements about timely filing compliance is a misrepresentation and falsification that, upon conviction, makes the individual who prepares the claim and the enrolled provider subject to fine and imprisonment under state and/or federal law.

EPSDT Revisions Log

Revision Date	Additions/Changes	Pages	Made by
12/01/2016	Manual revised for interChange implementation. For manual revisions prior to 12/01/2016 Please refer to Archive.	All	HPE (now DXC)
12/27/2016	Updates based on Colorado iC Stage II Provider Billing Manuals Comment Log v0_2.xlsx.	Multiple	HPE (now DXC)
1/10/2017	Updates based on Colorado iC Stage II Provider Billing Manual Comment Log v0_3.xlsx	Multiple	HPE (now DXC)
1/19/2017	Updates based on Colorado iC Stage II Provider Billing Manual Comment Log v0_4.xlsx	Multiple	HPE (now DXC)
1/26/2017	Updates based on Department 1/20/2017 approval email	Accepted tracked changes throughout	HPE (now DXC)
5/22/2017	Updates based on Fiscal Agent name change from HPE to DXC	3	DXC

Note: In many instances when specific pages are updated, the page numbers change for the entire section. Page numbers listed above, are the page numbers on which the updates/changes occur.