General Provider Information and Requirements

Privacy Statement

The Colorado Department of Health Care Policy and Financing (the Department) is committed to ensuring the privacy and security of Health First Colorado (Colorado's Medicaid Program) member protected health information. To support this commitment, the Department has implemented and will continue to maintain appropriate policies, procedures, and mechanisms to protect the privacy and security of Protected Health Information that is used or disclosed by the Department.

As the single state agency responsible for the administration of the Health First Colorado pursuant to Title XIX of the Social Security Act, the Department of Health Care Policy and Financing is specifically considered a Health Plan under the Privacy Regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As such, the Department is a Covered Entity that must adhere to the HIPAA Privacy Regulations as promulgated by the U.S. Department of Health and Human Services.

As part of its HIPAA compliance efforts, the Department has enacted several policies and procedures detailing the rights of Health First Colorado members, the Department's permitted uses and disclosures of member protected health information, and the Department's administrative duties under HIPAA.

How to Use the Manual

This manual provides general information about the Health First Colorado to assist enrolled providers with submitting claims for services rendered to Health First Colorado members. Manuals address specific claim and service types. The manuals are instructional guides and are not Health First Colorado policy manuals. The rules and regulations governing Health First Colorado policy may be found in *Volume VIII, the Medical Assistance Manual of the Colorado Department of Health Care Policy and Financing (Program Rules and Regulations)*. These rules also are available in the *Colorado Code of Regulations (10 CCR 2505-10)* available at most libraries.

The Health First Colorado Provider Billing Manuals contain basic billing and benefit information about the Health First Colorado. The Provider Billing Manuals are the only authorized billing procedure manuals for the Health First Colorado. Providers may download copies of manuals as needed. The manuals are designed to help providers correctly file Health First Colorado claims.

The Billing Manuals are designed to be used by both electronic and paper claim billers as a Health First Colorado policy reference. Providers should file electronic claims whenever possible. Although providers are required to bill electronically, the manual does not provide electronic billing instructions. Electronic billers can use the explanations of the paper claim fields located in individual manuals to clarify field descriptions on electronic claims. Electronic billers should utilize electronic specifications and on-line help screens. In cases where electronic filing is not possible, the manuals provide detailed paper claim filing instructions.

The Health First Colorado Provider Manuals consist of:

- The General Provider Information manual
  - This manual contains Health First Colorado information common to all provider types, including eligibility, covered services, and provider enrollment and participation guidelines.
- The Appendices
  - These documents include contact addresses and phone numbers, prior authorization information, a glossary/acronym list, and additional reference information.
- The Specialty Billing Information manuals
  - This manual contains Health First Colorado information specific to provider types, including paper claims, and electronic claims.
- Pharmacy Billing Instructions
  - This document provides a link to the Pharmacy billing instructions.
- CMS 1500 Specialty Billing Information
  - This document contains program specific benefit, procedural, and billing information for providers billing on the CMS 1500 paper claim form.
- Individual CMS 1500 Specialty Billing Manuals (in progress)
  - These manuals contain provider specific benefit, procedural, and billing information for providers billing on the CMS 1500 paper claim form.
- The Home and Community Based Services (HCBS) Specialty Billing Information manuals

  - These manuals contains program specific benefit, procedural, and billing information for Home and Community Based Services and should be used with the Billing Information section for detailed CMS 1500 claim field completion instructions.
- Individual UB-04 Specialty Billing Manuals
  - These manuals contain provider specific benefit, procedural, and billing information for providers billing on the UB-04 paper claim form.
- For information on Dental Billing please see the DentaQuest Office Reference Manual.
- Additional information and updates can be found in the Provider Bulletins section of the Department's website, located here.

Keep the current Healthcare Common Procedure Coding System (HCPCS) procedure code bulletin for your program with your program specific manual. Replace procedure code bulletins as new bulletins are published. If you need a hard copy of a manual, please download it from the Provider Services Billing Manuals section of the Department's website at Colorado.gov/HCPF.

Providers and their staff should familiarize themselves with the manual and refer to it to answer program and billing questions. Provider manuals and bulletins help clarify covered services, member eligibility, and billing procedures. Using the information in manuals and bulletins helps eliminate program and billing misunderstandings that can result in payment delays, incorrect payments, and payment denials.

Manual Maintenance

Updated Health First Colorado information is published in Health First Colorado Bulletins. A link to the most recent bulletin is sent to the publications email address on file with the Department's fiscal agent, DXC Technology (DXC).

Administration

The Social Security Act provides entitlement to medical services for individuals who meet eligibility requirements. Title XVIII governs the Medicare Program, and Title XIX establishes the State Option Medical Assistance Program, also known as the Health First Colorado. The Colorado Medical Assistance Act provides the legal authority for the Health First Colorado program.

The Health First Colorado program is a state and federal partnership funded by the State of Colorado and federal matching dollars. State funds are appropriated through the Colorado Legislature. Federal funding is dependent upon compliance with federal guidelines.

By statute, Health First Colorado pays for covered health care benefits for eligible members after all other health care resources have been exhausted. The Health First Colorado program is an entitlement program, which means that any person who meets the eligibility criteria is entitled to receive any medically necessary service covered by the program. Covered benefits include most medical services and limited related support services required in the diagnosis and treatment of disease, disability, infirmity, or impairment. In general, Health First Colorado benefits are comprehensive and provide care in most medical disciplines. Detailed benefit information is discussed in the Benefits and Benefit Delivery Programs section.

Department of Health Care Policy and Financing (the Department) Responsibilities

The Department of Health Care Policy and Financing (the Department):

- Establishes the policies, rules, and regulations that govern the Health First Colorado.
- Administers the Health First Colorado to assure compliance with state and federal rules, guidelines and regulations.
- Administers a Modified Medical Program providing limited medical benefits for needy citizens age sixty and older who are not eligible for Health First Colorado coverage. Benefits for these individuals are similar but not identical to Health First Colorado coverage.
- Administers other medical assistance programs such as Child Health Plan Plus (CHP+) and the Colorado Indigent Care Program (CICP).
- Establishes Health First Colorado policy.
- Determines benefit and reimbursement levels for all medical assistance programs according to state and federal legislative intent.
- Directs and monitors the activities of the fiscal agent, DXC.
- Reviews and monitors program utilization.

County Departments of Human/Social Services Responsibilities

The County Departments of Human/Social Services:

- Determine Health First Colorado member eligibility.
- Issue Medical Identification Cards (MIC Card) to eligible members.
- Advise Health First Colorado members of Health First Colorado benefits.

Fiscal Agent (FA) Responsibilities

The Fiscal Agent (FA):

- Enrolls Health First Colorado providers.
- Provides education and billing assistance to enrolled providers.
- Receives, controls, and processes Health First Colorado claims according to department policy.
- Responds to provider inquiries.
- Prepares the Department's required financial and utilization reports.
- Prepares and distributes Remittance Advice (RA).
- Adjusts claims as required.
- Accepts and reviews Reconsideration requests.
- Produces the Health First Colorado Provider Manuals in cooperation with the Department.

Provider Responsibilities

Providers are responsible for:

- Maintaining their copies of the manual in a current, updated manner (provider manual updates and revisions are made to manuals posted in the Provider Services Billing Manuals section of the Department's website. Update notifications are published in Health First Colorado bulletins).
- Keeping provider enrollment information current with the fiscal agent.
- Submitting claims correctly to the fiscal agent.
- Following the procedures and guidelines for program participation established by the Department.

Member Responsibilities

Members are responsible for:

- Understanding their rights.
- Following the Member Handbook.
- Cooperating with and being respectful to other members, providers and their staff.
- Choosing a provider from within their plan network or contacting the Department if they want to see another provider.
- Paying for services that are not covered by Health First Colorado (Colorado's Medicaid program).

- Telling their provider and Health First Colorado if they have other insurance or family or address changes.
- Asking questions when they do not understand or want to learn more.
- Telling their provider, the information needed to render care, such as their symptoms.
- Taking medications as prescribed or telling their provider about side effects or if the medications are not helping.
- Inviting people who will be helpful and supportive to be included in their treatment.

Provider Participation

To perform Health First Colorado benefit services and to receive Health First Colorado payments, providers must enroll in the Health First Colorado. Enrolled providers must have and maintain licensure and certification required by Health First Colorado regulations. Providers seeking to enroll can find information regarding enrollment on the Department's website.

Provider Numbers

- The National Provider Identification (NPI) must be used to submit claims and to communicate with the Health First Colorado.
- Atypical providers that cannot obtain an NPI are an exception to this requirement. Atypical providers that are not able to obtain an NPI will be assigned a Health First Colorado provider number by the Fiscal Agent. This number must be used by Atypical providers to submit claims and to communicate with the Health First Colorado.
- Unauthorized use of provider numbers is not allowed.

Special Participation Conditions

Limited Participation Providers

Providers enrolled solely for the purpose of receiving Health First Colorado payments for services provided to Health First Colorado members also enrolled in the Medicare Program (dually eligible members) must have and maintain Medicare enrollment. Services by these providers (e.g., chiropractors, free-standing physical therapy facilities) usually are not Health First Colorado benefits, or these services are provided under circumstances that do not meet Health First Colorado requirements. Payment is limited to consideration of Medicare deductibles and coinsurance.

Locum Tenens

Practitioners who provide services under a locum tenens agreement must enroll in the Health First Colorado. Claims for services by a locum tenens practitioner must identify the enrolled locum tenens physician as the rendering provider.

Hospitals may enter the member's regular physician's Medical Assistance Program provider ID in the Attending Physician ID field if the locum tenens physician is not enrolled in the Health First Colorado.

Out-of-State Providers

Out-of-State providers enroll in the Health First Colorado under the same rules and regulations applied to Colorado providers. The following benefit services are provided outside Colorado:

- Services to residents of Colorado border localities where the use of medical resources in the adjacent state is common (a listing of recognized Colorado border towns is in Appendix F in the Provider Services Billing Manual section).
- Services to Health First Colorado members who live in other states under special circumstances, such as foster care.
- Emergency services provided to Health First Colorado members who are traveling or visiting outside Colorado (documentation of the emergency must be submitted with the claim).
- Services needed because the individual's health would be endangered if he or she were required to return to Colorado for medical care (services must be prior authorized).

- Services that are unavailable in Colorado (services must be prior authorized).

Ordering, Prescribing, and Referring (OPR) Providers

The Health First Colorado complies with Federal Medicaid Regulations in 42 CFR 455.410(b) which provide that Medicaid must require all ordering or referring physicians or other professionals providing services be enrolled as providers, and 42 CFR 455.440, which provides that Medicaid must require all claims for the payment of items and services that were ordered, referred, and prescribed to include the National Provider Identifier (NPI) of the ordering, referring or prescribing physician or other professional. For more information, please visit Colorado.gov/HCPF/OPR.

Non-Physician Practitioners

Except as listed, benefit services provided by non-physician practitioners must comply with the following requirements:

- Services must be ordered by a licensed physician (MD) or advanced practice nurse (APN).
- Services must be performed under the direct and personal supervision of an on-premise MD/APN who is immediately available when services are provided.
- Claims must be submitted through the enrolled MD, APN or clinic.
- The supervising MD/APN's National Provider ID (NPI) must appear on the claim form as the supervising physician, the referring provider, or the billing provider.
- Claims must be billed using procedure codes specifically designated for non-physician billing.
- Claims must identify the non-physician practitioner with their NPI as the rendering provider.
- The non-physician practitioner must look to the billing provider for reimbursement.

On-premise supervision and non-direct reimbursement exemptions

The following list on-premise supervision and non-direct reimbursement exemptions:

- Dentists and Dental Hygienists
    - Services do not require physician order or physician supervision
    - Dentists receive direct reimbursement
- Podiatrists
    - Services do not require physician order or physician supervision
    - Podiatrists receive direct reimbursement
- Optometrists
    - Services do not require physician order or physician supervision
    - Optometrists receive direct reimbursement

- Certified Nurse Midwives
    - Within the definitions of the Nurse Practice Act, services do not require physician order or on-premise physician supervision
    - Certified Nurse Midwives receive direct reimbursement
    - For reimbursement purposes, nurse midwives may serve as supervisors of lesser licensed practitioners
- State Licensed Psychologists
    - Services defined in Health First Colorado regulations do not require physician order or on-premise physician supervision
    - State licensed psychologists receive direct reimbursement
    - For reimbursement purposes, psychologists cannot serve as supervisors of lesser licensed mental health practitioners
- Certified Registered Nurse Anesthetists
    - Services defined in Health First Colorado regulations do not require physician order or on-premise physician supervision
    - If special enrollment qualifications are met, they may receive direct reimbursement
- Certified Pediatric Nurse Practitioners
    - Services defined in Health First Colorado regulations do not require physician order or on-premise physician supervision
    - If special enrollment qualifications are met, may receive direct reimbursement
- Certified Family Nurse Practitioners
    - Services defined in Health First Colorado regulations do not require physician order or on-premise physician supervision
    - If special enrollment qualifications are met, may receive direct reimbursement
- Audiologists and Speech Pathologists
    - If special enrollment requirements are met, qualified audiologists and speech pathologists do not require on-premise physician supervision and may receive direct reimbursement
- Non-Physician Practitioners
    - Non-Physician Practitioner must be enrolled
    - On-premise physician supervision is not required
    - Claims must be submitted by a billing provider and the ordering provider's NPI must appear on the claim
    - Reimbursement is made directly to the billing provider
- Physical and Occupational Therapists
    - Services defined in Health First Colorado regulations require a physician order
    - Physical and Occupational Therapists receive direct reimbursement

Participation Agreements and Responsibilities

A copy of the current Provider Participation Agreement can be found on the Department's Provider Enrollment web page. All Health First Colorado-enrolled providers must sign the agreement before being accepted as a participating provider; this is done via the Online Provider Enrollment tool during enrollment or revalidation.

- Enrolled providers are required to comply with federal and state laws and regulations applicable to the Health First Colorado.
- Colorado rules and regulations applicable to the Health First Colorado are published in the Code of Colorado Regulations, 10 C.C.R. 2505-10, Department of Health Care Policy and Financing, Staff Manual Volume VIII, Medical Assistance.
- Billing instructions and references to applicable Health First Colorado laws and regulations are published in Provider manuals and Bulletins.
- Providers must comply with instructions and policies described in Health First Colorado publications.

Change of Ownership (CHOW) or Change in Tax Identification Number

- A change of ownership or a change of tax ID number terminates the Medical Assistance Program Provider participation agreement.
- A change of ownership requires the new owner(s) to submit an application, complete a new Medical Assistance Program Provider Participation Agreement, and be fully approved in order to participate in the Health First Colorado.
- Providers with a change in tax ID number must re-apply, complete a new Medical Assistance Program Provider Participation Agreement, and be fully approved in order to participate in the Health First Colorado.

Practice Capacity

Providers are not required to accept all Health First Colorado members. Providers may limit the number of Health First Colorado members associated with their practice agency or facility if the policies and methods of applying limitations are non-discriminatory.

Health First Colorado Member Billing

Providers agree to accept the Health First Colorado payment as payment in full for benefit services. Colorado law (C.R.S. 25.5-4-301(II)) provides that no Health First Colorado member shall be liable for the cost, or the cost remaining after payment by Health First Colorado, Medicare, or a private insurer, of medical benefits authorized under Title XIX of the Social Security Act. This law applies whether or not Health First Colorado has reimbursed the provider, whether claims are rejected or denied by Health First Colorado due to provider error, and whether or not the provider is enrolled in the Health First Colorado. This law applies even if a Health First Colorado member agrees to pay for part or all of a covered service. This law also prohibits providers from billing Health First Colorado members or the estates of deceased Health First Colorado members for Health First Colorado benefit services. Please refer to the Health First Colorado policy on Member Billing found here.

Member Billing Prohibited

Members may **not** be billed for the difference between the provider's charges and Health First Colorado Program, Medicare, or commercial insurance payments (except for members requesting brand name pharmacy items).

Providers may **not** assert a lien - including a hospital lien - on any money, settlement, recovery, or judgment paid to the member or to the member's estate as the result of a personal injury lawsuit.

Constraints against billing Health First Colorado members for benefit services apply **whether or not** Health First Colorado makes or has made payment and **whether or not** the provider participates in the Health First Colorado program.

Providers may **not** bill Health First Colorado members for missed appointments, telephone calls, completion of claim submission forms, or medication refill approvals.

Members may **not** be billed if the failure to obtain Health First Colorado payment is caused by the provider's failure to comply with Health First Colorado billing procedures.

Collection agencies **cannot** submit Health First Colorado claims for payment and **cannot** collect payment from Health First Colorado-eligible members.

Member Billing Permitted

Before providing services that will not be covered by the Health First Colorado program, providers should have the member sign an acknowledgment of financial responsibility. Only if a written agreement is developed, members have the following responsibilities:

- If the service is not a covered benefit of the Health First Colorado program, members may be billed for the service.
- Some members are responsible for Health First Colorado co-payment. **By federal law, providers may not refuse services if the member cannot pay a co-payment when services are rendered.** Members may be billed for unpaid co-payments. Providers may apply standard collection policies if the member fails to satisfy co-payment obligations.
- Members in nursing facilities are responsible for member payment when under Medicare Part A (skilled nursing) coverage. If the member payment amount exceeds the Medicare Part A coinsurance due, the difference is refunded to the member.
- Health First Colorado members enrolled in a Health First Colorado Managed Care Program must follow the rules of the Managed Care Organization (MCO). Members who insist upon obtaining care outside of the MCO network may be charged for non-covered services.

Health First Colorado members who have commercial insurance coverage that requires them to obtain services through a provider network must obtain all available services through the network. Members who insist upon obtaining managed care-covered services outside the network may be charged for such services.

Claim Certification Statements

All claims sent electronically must contain a certification field to indicate that the sender verifies that submitted information is true and correct. The enrolled provider is completely responsible for the claim information and the conditions under which claims are submitted.

Certification statements on Health First Colorado paper claim forms become effective when the provider signs the form. If the form is signed by an authorized agent, the provider remains completely responsible for the information on the claim and the conditions under which the claim is submitted.

According to Title VI of the Civil Rights Act, providers who receive *any* federal funds through programs such as the Medical Assistance Program, Medicare, CHAMPUS, etc., must provide oral interpretation services (excluding a member's family members) to *all* limited English proficient members in their practice, including those for whom you do not receive federal funds. Limited English proficient members are members who do not speak English as their primary language. Examples of oral

interpretation services include oral interpretation services, bilingual staff, telephone interpreter lines, written language services and community volunteers. Written materials must be translated and provided to limited English proficient members if the practice comprises of 10% or 3,000 limited English proficient members, whichever is less. If you have questions, contact the Office of Civil Rights at 888-848-5306.

Authorized Signatures

Claims must be signed by the enrolled billing provider or by an authorized agent or representative designated by the enrolled billing provider.

The enrolled provider is **solely** responsible for submitted claim information.

Reimbursement Policies

Payment for Services

All Health First Colorado payments are made in the name of the enrolled provider (i.e., an individual or organization that meets the licensure and/or certification requirements for program participation). Under no circumstance will payments be made to a collection agency, accounting firm, legal firm, business manager, billing service, or similar organization. Collection agencies, accounting firms, legal firms, and similar organizations cannot submit claims for direct reimbursement. Claims and claim inquiries must be submitted by the enrolled provider.

Electronic Funds Transfer

Enrolled providers are required to receive their Health First Colorado payments through Electronic Funds Transfer (EFT). The only exceptions to this rule are for out of state providers (of any type), case managers (provider type 11), and state entities.

- EFT is efficient and cost effective.
- EFT reduces payment turn-around time.
- EFT authorizes the Health First Colorado program to deposit payments directly into the provider's designated bank account.
- EFT authorization does not allow the Health First Colorado program to remove funds from the provider's bank account. Erroneous transactions (e.g., duplicate deposits) are electronically reversed.

Providers are responsible for furnishing accurate banking information. If EFT information (e.g., bank account numbers, institutional identification numbers, etc.) changes, EFT may be interrupted until the provider submits corrected information. When EFT is interrupted, payments are made by State warrant (paper check). Paper warrants and remittance advice may be mailed separately.

Federal Income Reporting

Health First Colorado payment information is reported each January on the Federal 1099 Income Report. Income is reported under the billing provider's Tax Identification Number (TIN), which is the Social Security Number (SSN) or Employer Identification Number (EIN).

The name of the enrolled provider must match exactly the name associated with the TIN. The IRS requires that Health First Colorado payments made in the name of an individual practitioner be reported under the individual's SSN.

Payments for services by enrolled practitioners may be made in the name of an employer, professional corporation, health care organization, or health delivery agency if:

- The health care employer or organization is a Health First Colorado-enrolled provider.
- There is an agreement between the enrolled practitioner and the employer or organization that requires the practitioner to turn over payments to the employer or organization.
- The individual who actually renders the services is identified on the claim (by NPI number) as the rendering provider.
- The group NPI number appears on the claim as the billing provider.

Civil Rights Anti-discrimination

Providers must comply with applicable civil rights laws and regulations including prohibitions against discrimination on the basis of race, color, sex, age, religion, national origin, political affiliation, sexual orientation, gender identity, or discrimination on the basis of disability under the Americans with Disabilities Act.

Enrollment Information Accuracy

Providers are responsible for:

- Furnishing accurate enrollment information.
- Confirming the accuracy of the fiscal agent's enrollment information.
- Maintaining up-to-date enrollment information via the Provider Portal.
- Responding to requests from the fiscal agent for updated enrollment information.

Providers who are also enrolled in the Medicare Program should update their enrollment information online immediately when Medicare billing information is changed. **All enrollment changes must be made online through the Provider web portal. Telephoned requests cannot be accepted.**

Re-certification

The fiscal agent periodically may require that enrolled providers update their enrollment information. Providers receive written notification of re-certification. Failure to respond to requests for re-certification information may result in provider suspension.

Revalidation

Federal regulations established by the Centers for Medicare and Medicaid Services (CMS) require enhanced screening and revalidation for all existing (and newly enrolling) providers. These regulations are designed to increase compliance and quality of care, and to reduce fraud. Failure to respond to a revalidation request or requirement may result in provider suspension or termination.

Record Keeping and Retention

Providers are required by the Provider Participation Agreement with the Health First Colorado program and Colorado State Rule 8.130.1 (Program Rules and Regulations) to maintain records necessary to disclose the nature and extent of services provided to members.

Providers must maintain records that fully disclose the nature and extent of services provided. Upon request, providers must furnish information about payments claimed for Health First Colorado services. Records must substantiate submitted claim information. Such records include but are not limited to:

- Billing information
- Treatment plans
- Prior authorization requests
- Medical records and service reports, and orders prescribing treatment plans
- Records and original invoices for items, including drugs that are prescribed, ordered, or furnished
- Claims, billings, and records of Health First Colorado payments and amounts received from other payers

Each medical record entry must be signed and dated by the person ordering and providing the service. Computerized signatures and dates may be applied if the electronic record keeping system meets Health First Colorado security requirements.

These records must fully substantiate or verify claims submitted for payment and must be furnished on request to the authorizing agency. Records must be retained for at least six years or longer if required by regulation or a specific contract between the provider and the Health First Colorado program.

Ownership Disclosure

As part of enrollment, revalidation, or upon request providers must disclose information about ownership and control, persons convicted of crime, business transactions, and subcontractor ownership.

The Federal Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) prohibits enrolled physicians from making referrals for certain health services to an entity where the physician or an immediate member of the physician's family has a financial relationship with the service entity. The health service entity may not submit a claim or bill to any individual, third party payer, or other entity for services provided as the result of a prohibited referral.

Advance Directives

Hospitals, nursing facilities, hospice programs, and health maintenance organizations must maintain written advance directive policies that include:

- A description of the procedures for giving Health First Colorado members written information about their legal right to accept or refuse medical treatment and the right to formulate advance directives.
- The provider's policies respecting implementation of such rights.

Termination of Enrollment

Health First Colorado provider enrollment may be terminated under the following circumstances:

- Demonstrated inability to perform under the terms of the provider agreement.
- Breaches of the provider agreement.
- Failure to abide by applicable Colorado and United States laws.
- Failure to abide by the rules and regulations of the U.S. Department of Health and Human Services and the Health First Colorado program.
- Ineligibility or suspension from participation in other Federal or State medical programs.

- Inactivity: No claim activity for 24 months.

Inactivation of enrollment

Health First Colorado provider enrollment may be inactivated under the following circumstances:

- Failure to furnish requested recertification information.

Providers whose enrollment has been inactivated may be re-activated by submitting a completed enrollment application and providing all required information. In some cases, proof of services rendered to a Medical Assistance Program member may be required.

Co-payment

The Health First Colorado program requires members who receive Fee-For-Service (FFS) benefits to pay a small portion of their medical care costs to the provider.

- Providers' bill usual and customary charges for all FFS services and co-payment is automatically deducted during claims processing.
- FFS providers collect co-payments from members when services are rendered.
- If a member is unable to pay the co-payment, providers may collect it later.
- Federal regulations prohibit providers from refusing service because of a member's inability to pay.
- If the co-payment is collected but not deducted from the FFS payment, the provider must refund the co-payment to the member.
- There is no co-pay maximum per calendar year.

Co-payment Amounts

Service	Co-payment Amount
Outpatient Hospital Services	$3.00 per visit
Physician (MD or DO) Home or Office visit	$2.00 per visit
Rural Health Clinic Visit	$2.00 per visit
FQHC Visit	$2.00 per visit
Brief, individual, group, visit and partial care community mental health care visits (except services which fall under Home and Community Based Service Programs)	$2.00 per visit
Pharmacy Services (each prescription or refill) Generic drugs Brand name and single-source drugs	 $1.00 $3.00
Optometrist visit	$2.00 per visit
Podiatrist visit	$2.00 per visit
Inpatient Hospital Services	$10.00 per covered day or 50% of the averaged allowable daily rate whichever is

Service	Co-payment Amount
	less. The average allowable daily rate can be calculated using the 'total allowed charge' for the entire stay and divide by the 'calculated covered days'.
Psychiatric Services	$ .50 per unit of service (1 unit =15 minutes)
DME/Disposable Supply Services	$1.00 per date of service
Laboratory Services	$1.00 per date of service
Radiology Services	$1.00 per date of service

Co-payment-exempt Members and Services

Some co-payment exemptions are processed automatically and others require the provider to complete specific information on the claim transaction or form.

Exemptions Shown on Eligibility Verification

Members who are ages 18 and younger are automatically exempt from co-payments.

Exemptions Claimed through Claim Completion

The following co-payment exemptions are not displayed through Health First Colorado eligibility verification. Co-payment exemption is claimed through the FFS claims submission process. In some instances, providers should question members about their circumstances to determine the appropriateness for the following exemptions:

Institutionalized Members are Exempt from Co-Payment

Members under the age of 21 or over the age of 65 who reside in Skilled Nursing Facilities (SNF) or Intermediate Care Facilities (ICF) or reside in institutions for mental diseases.

Claims require completion of the following claim fields: Claim Form	Required field completion for institutionalized members	
CMS 1500	Field 12 Nursing Facility	
837P	Loop 2300 CLM05-1 = "21"	Skilled Nursing Inpatient
UB-04/837I	Loop 2300 CLM05-1 = "21"	
Pharmacy – NCPDP 5.1 Point Of Sale and Universal Claim Form (UCF)	Point of Sale: Use Member Location "03"	UCF: Use Person Code: "03"

Women in the Maternity Cycle Exempt from Co-Payment

All services to women in the maternity cycle (including prenatal, delivery, and immediate postpartum period not to exceed six weeks) are exempt from co-payment.

- Services do not have to be pregnancy related.

- The member must inform the provider of her condition at the time of service.
- Physicians should note the condition on prescriptions.
- Claims require completion of the following claim fields.

Claim Form	Required field completion for members in maternity cycle	
CMS 1500	Field 12 Pregnancy	
837P	Loop 2000B PAT09 = "Y"	
UB-04/837I	Condition Code B3	
Pharmacy NCPDP 5.1 Point of Sale and Universal Claim Form (UCF)	Point of Sale: Use Pregnancy Indicator "2" and Prior Authorization Type Code: "4"	UCF: Use Prior Authorization Type Code: "4"

Emergency services delivered in any setting require indicated claim completion.

Claim Form	Required field completion for emergency services
CMS 1500	Field 19J: Enter "X" for each billed line
837P	Loop 2400 SV109 = "Y"
UB-04	Type of Admission 1 (Form Locator 19)
837I	Loop 2300 CL101 = 1

Family planning services require indicated claim completion.

Includes oral contraceptives, which should be dispensed in a 3-month supply after a 1-month trial period.

Claim Form	Required field completion for family planning services
CMS 1500	Field 19K: Enter "X" for each billed line
837P	Loop 2400 SV112 = "Y"
UB-04	Diagnosis Coding
Pharmacy	NDC Codes for oral contraceptives

Co-pay exemptions processed automatically

- Dental services
- Home and community based services (HCBS)
- Home health care
- Behavioral Health Organizations (BHOs)
- Transportation

Inquiries

The Department's Customer Contact Center serves Health First Colorado members. Representatives are available Monday through Friday between the hours of 7:30 A.M. and 5:30 P.M. through the following:

- Toll free: 800-221-3943
- Fax: 303-866-4411
- Email: customer.service@hcpf.state.co.us
- TDD: 800-659-2656

Members who have questions about the Health First Colorado co-payments should contact the Department's Customer Contact Center.

Providers with questions about co-payment deductions on processed claims should call Health First Colorado Provider Services.

Contact information for Health First Colorado Provider Services is listed in Appendices A and B in the Appendices of the Provider Services Billing Manuals section.

Health First Colorado Member Eligibility

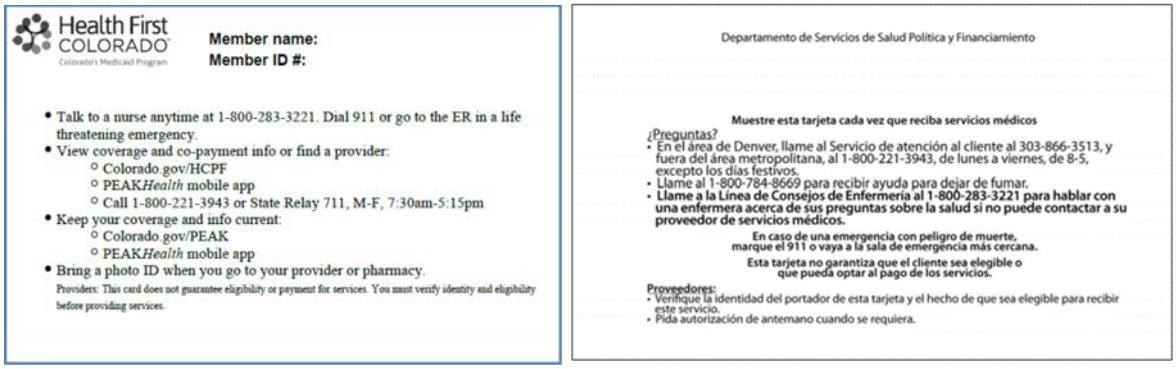
Before rendering services, the provider should verify the member's eligibility to ensure that the member is eligible for benefits. Providers should retain documentation of the verified eligibility for billing purposes.

Member Eligibility

The member's County Department of Human/Social Services establishes member eligibility for Health First Colorado benefits. Case managers advise potential members of proper application procedures and Health First Colorado benefits. Appendices D and E located in the Appendices of the Provider Services Billing Manuals section list the address, phone and fax number for obtaining information.

After member eligibility is established, the county issues a unique State Identification (State ID) number and a Medical Identification Card (MIC).

Medical Identification Cards (MIC)



In March of 2016, the Department began issuing Medical Identification Cards (MICs) with a new look. A sample of the front and back of the new card is shown above.

The new cards do not replace those issued before March of 2016. Please accept both versions.

Delayed/Retroactive Eligibility

A member's Health First Colorado eligibility may be made retroactive prior to the application date. Charges for services are the member's responsibility until eligibility is established. (Example: A member is "pending" Health First Colorado eligibility.) Claims are denied if the member's eligibility status is not available through eligibility verification methods. See Timely Filing in the Claims Submission section for more information.

Newborn Eligibility

A Health First Colorado State ID number is assigned to a newborn when the case manager establishes and approves eligibility. The hospital or physician may initiate the assignment of a newborn's Health First Colorado State ID number by contacting the mother's case manager at the time of delivery and providing the following information:

- Newborn's name, sex, and date of birth
- Mother's State ID number to verify eligibility at the time of delivery

Special Eligibility Programs

The Health First Colorado offers benefits through special programs. Members who qualify for special programs may not be eligible for regular Health First Colorado benefits. However, members may qualify for one of the following special programs:

- Presumptive Eligibility (PE) Children
- Presumptive Eligibility (PE) Pregnant Women
- CHP+ Prenatal Program
- Breast and Cervical Cancer Program (BCCP)
- Modified Medical Program
- Qualified Medicare Beneficiaries (QMBs)
- Undocumented Non-citizen

Presumptive Eligibility (PE) for Pregnant Women

Presumptive Eligibility (PE) is temporary coverage of medical benefits until eligibility for either Health First Colorado (Colorado's Medicaid Program) or the CHP+ Prenatal Program is determined.

Pregnant women who are U.S. citizens or documented non-citizens and have self-declared incomes at or below 133% of the Federal Poverty Level may be eligible for Health First Colorado (PE. Pregnant women who are U.S. citizens or documented non-citizens and have self-declared incomes between 134% and 200% of the Federal Poverty Level may be eligible for CHP+ Prenatal PE. Undocumented women are not eligible for PE. However, PE sites shall assist all members in filling out a Colorado Health Care Application regardless of citizenship, as undocumented members may be eligible for Emergency Medicaid for the delivery. All PE sites shall determine PE eligibility for both Health First Colorado and CHP+ Prenatal. Sites must verify pregnancy before enrolling a member in PE.

PE Period for Pregnant Women

The start date of Health First Colorado PE and CHP+ Prenatal PE is the date on which the PE card is issued and extends for 60 days. If the member does not have required documents at the time of application, she is given a fourteen-day provisional PE span. If the member does not present the required documents within fourteen days, the PE period will terminate at the end of the provisional period. If the application has not been processed by the end of the PE period, the PE site may extend the PE period until the eligibility determination is made. If eligibility is denied, PE expires at the end of the 60 days. When a member presents a PE card after the expiration date, always verify eligibility.

A pregnant woman who is determined to be eligible for the Health First Colorado or CHP+ Prenatal remains eligible through her pregnancy and until the end of the month in which her 60th day postpartum occurs. Income changes during pregnancy do not affect eligibility. The infant has continuous eligibility until his or her first birthday.

PE Benefits for Pregnant Women

A Health First Colorado presumptively eligible pregnant woman is entitled to all medically necessary outpatient services covered by the Health First Colorado program. Inpatient hospital services are not a benefit during the Health First Colorado PE period. Labor and delivery are not covered during the PE period.

If determined to be eligible for Health First Colorado, after the PE period, the pregnant woman is entitled to all medically necessary covered benefits. Pregnant women age 20 and under are also eligible for Early and Periodic Screening Diagnosis and Treatment (EPSDT) services, including dental,

vision care, and EPSDT health checkups. All Health First Colorado eligible pregnant women may receive EPSDT outreach and case management services.

CHP+ Prenatal PE benefits include outpatient and inpatient services as well as labor and delivery. Providers must be designated a CHP+ site in order to offer services. Providers must verify CHP+ Prenatal PE member eligibility through Colorado Access. CHP+ PE billing is processed through Colorado Access. Individual providers submit claims on the CMS 1500. Federally Qualified Health Centers submit claims on the UB-04. Questions regarding this program should be directed to CHP+ Customer Service at 800-359-1991.

Women in the maternity cycle are exempt from co-payment. The provider must mark the pregnancy indicator on the paper claim form or on the electronic format.

PE Card for Pregnant Women

A presumptively eligible pregnant member will receive a PE card that identifies her as eligible for medical services under either Health First Colorado PE or CHP+ Prenatal PE. However, inpatient hospital services are not a Health First Colorado PE benefit. After the full eligibility determination process, Health First Colorado eligible members receive a Medical Identification Card (MIC) and CHP+ Prenatal Program eligible members will receive a program card from the CHP+ Prenatal Program.

Presumptive Eligibility for the Breast and Cervical Cancer Program (BCCP)

The Breast and Cervical Cancer Program (BCCP) provides full Health First Colorado benefits to women screened at a Colorado Women's Cancer Control Initiative (CWCCI) site, who meet the eligibility requirements, and who are found to have breast or cervical cancer treatment needs including pre-cancerous treatment needs.

This program provides immediate Health First Colorado coverage through the PE process initiated at the CWCCI sites throughout Colorado. For BCCP, the PE period begins on the date the diagnostic test is performed. The CWCCI site is responsible for calling the Colorado Benefits Management System (CBMS) Help Desk to enroll the member and obtain a State ID number. The PE form and Health First Colorado application are completed at the CWCCI site. A copy of the PE form and the original application are sent by the CWCCI site to the department of human/social services in the member's county of residence for processing. The PE form, the signature page of the application, and other CWCCI forms are faxed to the Colorado Department of Public Health and Environment at 303-691-7900.

PE Period for BCCP

PE for the BCCP begins on the date the diagnostic test is performed. The CWCCI site may not receive the results of the test for several days. A woman cannot be enrolled in PE until the results of the test are known.

When the results are received and the diagnosis confirms an eligible cancerous or pre-cancerous condition, the CWCCI site may then call the State CBMS Help Desk. It is important that the CWCCI site use the diagnostic test date as the PE start date. The PE period extends until the end of the month in which the 45th day from the PE start date occurs. The State CBMS Help Desk may extend PE for an additional month if the Health First Colorado application has not been processed by the PE end date.

After a Health First Colorado application has been processed and the member is determined to be eligible for BCCP, the member will receive a Medical Identification Card and will remain on this program until active treatment for breast or cervical cancer (or pre-cancerous condition) is complete, or until she no longer meets other eligibility criteria. If a BCCP member has not sought treatment within three months of the PE start date, the member's eligibility will end on the last day of the third month.

PE Benefits for BCCP

A presumptively eligible BCCP member is entitled to all Health First Colorado services determined to be medically necessary.

BCCP Presumptive Eligibility Card

The BCCP no longer requires that a CWCCI site complete a PE card application. The PE form, however, must always be completed and signed by the member.

Modified Medical Program

The Modified Medical Program provides care for Colorado old age pensioners with limited incomes who do not qualify for the Health First Colorado program. Members in this program are not eligible for Home and Community Based Services (HCBS), inpatient psychiatric care, or nursing facility care.

Dual Eligibility

Providers are reminded that Health First Colorado is always the payer of last resort, therefore, services for dual-eligible members - those with coverage from Medicare and Health First Colorado - must be billed first to Medicare. Please refer to the July 2011 Provider Bulletin (B1100303) for an example of exceptions for Home Health services. Providers must be able to show evidence that claims for dual eligible members, where appropriate, have been denied by Medicare prior to submission to the Health First Colorado program. Per the Provider Participation Agreement, this evidence must be retained for six years following the Medicare denial. The Health First Colorado program requires that a copy of the Medicare Standard Paper Remit (SPR) accompany any paper claims for dual-eligible members that are submitted for reimbursement.

Please contact Provider Services at --844-235-2387 (toll free) Monday through Friday, 8:00 A.M. to 5:00 P.M. Mountain Time (MT) with questions.

Qualified Medicare Beneficiaries

Elderly and disabled Medicare beneficiaries with incomes below the Federal poverty level and resources at twice the Supplemental Security Income (SSI) level are eligible for Health First Colorado payment of Medicare deductibles and coinsurance. Individuals who qualify are called Qualified Medicare Beneficiaries (QMBs).

Benefits

Health First Colorado benefits for Medicare QMB-Only members are limited to the Medicare coinsurance and deductibles for all Medicare-covered services.

Benefits for Health First Colorado-Medicare/QMB Beneficiaries (dually eligible) are all Health First Colorado covered services and the coinsurance and deductibles for all Medicare-covered services.

Non-Citizens

Non-citizens are individuals who are in the United States for educational or visitation purposes, for employment purposes permitted with a visa, and for reasons unknown. Some examples of immigration statuses include Legal Permanent Residents, Refugees/Asylees, those who are lawfully-residing in the Unites States, and undocumented individuals.

Application Procedures

Non-citizens must apply for assistance through their local county office application assistance site, online through www.colorado.gov/PEAK, by mail, or by phone (1-800-221-3943 / State Relay: 711), to determine if they must meet the Health First Colorado eligibility requirements.

Because non-citizens may be reluctant to apply for governmental assistance, providers are encouraged to advise potentially eligible individuals to apply for assistance to cover medical services. Confidentiality prevents the Department and eligibility sites from reporting to the United States Citizenship and Immigration Services of an individual's application for/receipt of assistance. Individuals who are undocumented can submit an application for Emergency Medical Assistance, if there is a life or limb threatening emergency.

Benefits

Qualified non-citizens will receive coverage for all medical services covered by the Medical Assistance category for which they are eligible.

Individuals who are not qualified non-citizens may be eligible for benefits to cover emergency medical services. A physician will need to provide a written statement declaring the presence of an emergency condition on the claim form. Coverage is limited to care and services that are necessary to treat immediate emergency medical conditions. This includes labor and delivery, but does not include prenatal or follow-up.

- Important: Organ transplants are not a covered benefit for non-citizens.
- Lab tests for non-citizens must be coded as "Emergency". Tests for non-citizens that are not marked as "Emergency" will not be paid.

Limitation Messages

The message "Good for emergency services only" appears on eligibility inquiries.

Accessing Eligibility Verification Information

After obtaining the birth date and State ID or SSN, providers are encouraged to conduct eligibility requests to determine eligibility.

Eligibility information is updated daily, except for weekends and State holidays, through the State's eligibility database known as the Colorado Benefits Management System (CBMS). Eligibility verification is available electronically 24 hours a day, 7 days a week.

Providers can verify eligibility through one of the following:

HIPAA 270/271 Health Care Eligibility Benefit Inquiry and Response

The HIPAA 270/271 Health Care Eligibility Benefit Inquiry and Response transaction is designed to allow providers to obtain member eligibility information using electronic data transfer. To use this method of eligibility verification, providers must have:

- The ability to send a HIPAA compliant 270/271 transaction from their office or through a clearinghouse or switch vendor.
- A signed Trading Partner Agreement with the clearinghouse, if used, or with the Health First Colorado program if sending the transaction directly from an office.
- Characteristics of the interactive eligibility verification system are:

- Date spans can be verified.
- Eligibility and benefit limitations are provided.
- Eligibility responses can be printed.

Specific directions on how to submit a 270 eligibility inquiry and what to expect in the 271 eligibility response is outlined in the 270/271 Companion Guide located in the Provider Services Specifications section.

Provider web portal (Batch or Interactive):

X12N 270 – Eligibility Inquiry

Health First Colorado Eligibility Response System (CMERS)/ Interactive Voice Response System (IVRS)

844-801-8478 Toll free

Health First Colorado Eligibility Response System (CMERS)/ Interactive Voice Response System (IVRS) is an automated voice response system that furnishes providers with:

- Health First Colorado eligibility
- Provider warrant information
- Claim status information
- Unlimited eligibility inquiries
- Claim status check by Provider ID/National Provider Identifier (NPI) with Member ID and Date of Service, or by Internal Control Number (ICN).
- A guarantee number (audit number) for member eligibility.
- Verbalize eligible service types to the caller
- Include co-pay amounts and descriptions for applicable service types.
- Allow callers the ability to skip through the co-pay messages if the member is exempt from co-pay requirements or if the caller does not want to hear the information.

Please refer to CMERS/IVRS instructions included in this manual.

Response Information

Eligibility verification includes:

- Eligibility dates
- Co-payment status
- Third Party Liability
- Managed Care enrollment

Important eligibility information

Always verify eligibility **before** rendering services.

Why verify eligibility? The provider who checks a member's eligibility on the day of service and finds the member eligible receives an eligibility guarantee number. If eligibility has changed when the claim is submitted, the guarantee number exempts those claims from eligibility edits for that date of service. This simple process can save the provider a lot of paper work in the future.

Medical Identification Card (MIC)

MICs include the member's name and State ID. The card by itself will not verify eligibility; providers must still verify eligibility before services are rendered.

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, 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 a NPI for those provider types that can obtain one. Providers that cannot obtain a 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 program collects electronic claim information interactively through the Health First Colorado Secure Online Portal (Online Portal) or via batch submission through a host system.

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 program. Health First Colorado providers may create and transmit HIPAA compliant 837P (Professional) and 837I (Institutional) claims electronically one at a time. These claims are transmitted through the Health First Colorado Online Portal (OP). Beginning July 1, 2014, all claims for dental services and dentures must be submitted to DentaQuest, the Dental Administrative Service Organization (ASO), on the 2012 ADA Dental Claim form or by submitting the 837D electronic transaction via the DentaQuest Provider web portal. Information about claims

submission for dental services can be found in the Office Reference Manual (ORM) under 'DentaQuest Resources' located on the Dentist page of DentaQuest's website.

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 (iC) 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 will be paid.

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:

- X12N 999 Functional Acknowledgement
- 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.

Batch Electronic Claims Submission

Batch billing refers to the electronic creation and transmission of several claims in a group. Batch billing systems usually extract information from an automated accounting or patient billing system to create a group of claim transactions. Claims may be transmitted from the provider's office or sent through a billing vendor or clearinghouse.

All batch claim submission software must be tested and approved by the Department's fiscal agent. Any entity sending electronic transactions through the Health First Colorado file delivery and retrieval system secure website (SFTP) - located here - for processing or the Provider web portal - Provider web portal - where reports and responses will be delivered must complete an EDI Trading Partner enrollment. This provides EDI the information necessary to assign a Logon Name, Logon ID, and Trading Partner ID, which are required to submit electronic transactions, including claims.

The X12N 837P, 837I, or 837D transaction data may be submitted via SFTP or Provider web portal, each which validates submission of American National Standards Institute (ANSI) X12N format(s). The TA1 Interchange Acknowledgement reports the syntactical analysis of the interchange header and trailer. If the data is corrupt or the trading partner relationship does not exist within the interChange System, the interchange will reject and a TA1 will be made available for research and correction. An X12N 999 Functional Acknowledgement is generated when a file that has passed the header and trailer check passes through X12 validation.

If the file contains syntactical error(s), the segment(s) and element(s) where the error(s) occurred will be reported.

Testing and Vendor Certification

Completion of the testing process must occur prior to submission of electronic batch claims to Production interChange. The EDI testing packet and Companion Guides may be downloaded from EDI Support.

Assistance from the EDI helpdesk is available throughout this process. Each test transmission is inspected thoroughly to ensure no formatting errors are present. Testing is conducted to verify the integrity of the format, not the integrity of the data; however, in order to simulate a production environment, EDI requests that providers send real transmission data.

The number of required test transmissions depends on the number of format errors on a transmission and the relative severity of these errors. Additional testing may be required in the future to verify any changes made to the interChange System have not affected provider submissions. In addition, changes to the ANSI formats may require additional testing.

Provider Reimbursement

The Health First Colorado program only reimburses enrolled Health First Colorado providers. Claims for reimbursement must be submitted by the provider to the fiscal agent on the appropriate claim form or electronic claim format and properly completed according to Health First Colorado policy.

Health First Colorado reimbursement is based on Colorado legislative funding as well as Federal and State regulations. The Health First Colorado program offers benefits through two reimbursement methods: Fee-For-Service (FFS) and Capitation.

Fee- For-Service Reimbursement

Fee-For-Service (FFS) reimbursement provides payment to enrolled providers for each service rendered to Health First Colorado members.

- The FFS reimbursement rates are determined through the Colorado legislative budgetary process.
- FFS claims are processed by the Health First Colorado fiscal agent.
- Providers are responsible for preparing and submitting FFS claims in compliance with Health First Colorado claim filing requirements.

Capitated Reimbursement

The Health First Colorado program enters into contractual agreements with organizations to furnish services to Health First Colorado members under capitated reimbursement arrangements. Under capitation, contracted organizations receive a monthly fee for each Health First Colorado member enrolled in their program.

- Capitated contractors provide services through a network of service providers.
- Service providers are paid by the contracted organization.
- The contractor is financially responsible for all services described in the capitation contract.
- The Health First Colorado fiscal agent denies fee-for-service claims for covered benefit services provided to a member enrolled in a capitated program.
- Capitation reimbursement is common for Managed Care Organizations (MCOs).

Third Party Liability

By regulation, the Health First Colorado program does not duplicate payments made by any other resource. With the exception of Victim Assistance Programs, for each of the reimbursement methods described in this manual, third party payments by other insurance carriers must be reported on the claim and are deducted from any applicable Health First Colorado payments. If the third party payment is equal to or greater than the Health First Colorado allowable benefit, the Health First Colorado program will make no additional payment.

Health First Colorado Co-payment

Applicable Health First Colorado co-payment is automatically deducted from the provider's payment during claims processing. Providers can collect co-payment from the member at the time of service, but services cannot be withheld if the member is unable to pay the co-payment.

Lower of Pricing

The following services and benefits identify multiple reimbursements formulas to calculate the Health First Colorado reimbursement amount. This process is known as "Lower of Pricing". Each service identifies the specific criteria it uses to determine its Lower of Pricing amount.

Inpatient Hospital Services

Inpatient hospital services are reimbursed by applying **one** of the following three payment methods:

- Hospitals designated as Prospective Payment System (PPS) hospitals are paid using the Diagnosis Related Group (DRG) methodology. Each hospital is assigned to a peer group, and a base reimbursement rate is calculated representing the average cost per discharge for Health First Colorado members. This base rate may be increased for disproportionate share based on the percentage of Health First Colorado member days compared to total member days. Each DRG is assigned a relative weight. Reimbursement is calculated as the base rate, including any applicable disproportionate share increase, multiplied by the DRG relative weight. If a hospital stay exceeds the DRG trim point, outlier days are calculated for additional payment at 80% of the established DRG per diem. If the member is transferred from one hospital to another, both facilities are paid a DRG per diem rate up to the maximum reimbursement under the appropriate DRG, based on the length of stay. Both hospitals receive outlier day payments, if applicable.
- Hospitals designated as Non-Prospective Payment System (NPPS) hospitals are reimbursed at an established per diem rate.
- Urban or rural out-of-state hospitals are paid using DRG methodology. Reimbursement is made using a base rate of 90% of the Colorado urban and rural base rate.
- Medicare crossover claims are reimbursed by the Health First Colorado program based on whichever of the following two formulas results in a **lesser amount**:
    - The sum of the reported Medicare coinsurance and deductible
    - The Health First Colorado-allowed benefit minus the Medicare payment

Outpatient Hospital Services

Reimbursement for outpatient hospital services billed prior to the implementation of the Colorado interChange system is calculated by multiplying the submitted charges by the cost to charge ratio of the submitting hospital and then by the Medicare Part B cost ratio.

The Health First Colorado program identifies clinical laboratory services using the Healthcare Common Procedure Coding System (HCPCS) codes. The maximum reimbursement amount for each procedure code is based on Federal and State regulations.

Medicare crossover claims are reimbursed by Health First Colorado based on whichever of the following two formulas results in a **lesser amount**:

- The sum of the reported Medicare coinsurance and deductible.
- The Health First Colorado program allowed benefit minus the Medicare payment.

Outpatient Claim Pricing Methods

Outpatient Claim (TOB 13X) Pricing prior to interChange (iC) Go-Live

Claims with TOB 13X billed for Hospital outpatient service with dates of service prior to the iC Go-Live date will use the BILLPCT method. iC will pull the Cost of Charge Ratio from the Provider's Outpatient Hospital Rate to use for pricing. It will then set up a BAF to be used for the outpatient percentage associated with legacy System Parameter list 4537.

BILLPCT Calculation

Allowed Amount (1) = Billed amount on claim * Provider Outpatient Cost of Charge Ratio
Allowed Amount (2) = Allowed Amount (1) * BAF Percentage (percentages previously on System Parm list 4537)

Outpatient EAPG Eligible Claims –

For EAPG eligible claims the main pricing method will be "*EAPG*". For Laboratory services on EAPG eligible claims, and services that are assigned to EAPGs that have zero weights on file, Max Fee Pricing will be used.

Below are the required inputs to the EAPG grouper.

- Pricing Indicator – EAPG assigned by the reimbursement rules.
- Procedure Code – Detail Procedure Code as received on the claim.
- FDOS – The From Date of Service for the Detail on the claim.
- TDOS – The To Date of Service for the Detail on the Claim.
- Units of Service – Detail units of services as received on the claim.
- Type of Bill – Header TOB used to identify the claim type.
- Client Age – Age as listed on the Member subsystem.
- Client Sex – Sex as listed on the Member subsystem.
- Diagnosis Codes – The DRG grouper requires all diagnosis codes as received on the claim.
- Revenue Code – Detail Revenue Code as received on the claim.
- Modifiers – Detail Modifiers as received on the claim.
- Occurrence Code – Occurrence code as received on the claim.
- Condition Code – Condition code as received on the claim.
- Value Code – Value Codes as received on the claim.
- Value Code Amount – Value Code Amount as received on the claim.

The EAPG grouper/pricer is provided by 3M, a third party vendor. The software is updated quarterly. The EAPG pricing method calls the 3M EAPG grouper/pricer software to determine the allowed amount on each of the claim details that are to be priced under the EAPG pricing method. The EAPG software uses schedules that contain processing options and the provider rate, and a weights file that contains

the listing of all the EAPG codes and a predetermined numeric weight for each that is used in the calculation of the allowed amount.

There are two different calls to the EAPG grouper/pricer within the interChange system. Denied details are not sent into the grouper during either call. The first call is very early on in the system. This was done to obtain the detail allowed amount needed for claim auditing. The second call happens after the billing and reimbursement rules have been processed and audits have been performed. The second call to the grouper is not performed if deemed unnecessary (meaning that none of the EAPG information would change if reprocessed through the grouper a second time). If the second call is necessary, the details will be checked to see which ones should be sent into the grouper. If any details deny due to audits or other edits, or are set to price using a pricing method other than EAPG (per the reimbursement rules), those details will not be sent into the grouper on the second call.

Instead of details being sent to the grouper one detail at a time, all of the claim details (paid status only, denied details are not sent into the grouper) for a claim that are to be priced using EAPG are sent into the EAPG grouper/pricer software at one time. If the reimbursement rule has pricing indicator EAPG, the system will flag the detail for processing through the grouper and will continue on to the next detail. Sending all the details in at once is necessary because the EAPG grouper/pricer uses information from each of the details (along with some header data) in combination to determine the EAPG for each individual detail, and to determine if any consolidation, discounting or packaging will be applied.

Details on EAPG eligible claims without a procedure code will be set to pay $0 and set an edit to Pay and List.

For Laboratory services on EAPG eligible claims, and services that are assigned to EAPGs that have zero weights on file, the Max Fee Pricing Methodology will be used.

Max Fee Pricing Methodology

The pricing indicator assigned by the reimbursement rules that identifies Max Fee Pricing is "***MAXFEE***".

Obtain Max Fee System Rate

Get the Allowed amount from the Max Fee rate table by using the procedure code, the rate type and modifiers for the dates of service. The from and through dates of service are used to find the rate effective at the time the service was rendered. The dates on the claim must be completely covered by a pricing segment to be considered for processing. The dates of service, as received on the claim, are used to get the rows between the effective and end date for the service rendered. If a rate is not found an edit is posted to the detail for adjudication.

The inactive date utilizes the processing date to identify rows that are active by excluding any rows that have a date earlier than the date when the claim is being processed. The claim is processed real time, so the time is part of the criteria. If a rate is inactivated at any given time before the claim is processed the rate will not be used.

Max Fee Calculation

Allowed Amount (1) = (Max Fee Rate * Units Allowed)

If Benefit Adjustment Factors are present

If Benefit Adjustment Factor Before/After flag is set to Before

Allowed Amount (2) = ((Allowed Amount (1) * BAF Percentage) + BAF Incentive Amount)

If Benefit Adjustment Factor Before/After flag is set to After

If the Payment Greater than billed is set to yes, the Allowed Amount (3) = Allowed Amount (1).

If the Payment Greater than Billed is set to no

Allowed Amount (3) = Lesser of Billed Amount or Allowed Amount (1).

Allowed amount (2) = ((Allowed Amount (3) * BAF Percentage) + BAF incentive Amount).

This process is repeated for all BAFs that were assigned by the Reimbursement Rules.

If the Payment Greater than billed flag is set to yes

Allowed Amount (4) = Allowed Amount (1) if the benefit adjustment factor was not applicable.

Allowed Amount (4) = Allowed Amount (2) if the benefit adjustment factor was applicable.

Cutback Amount = (Billed Amount – Allowed Amount (4)).

In this case, negative cutback amounts are valid since the payment greater than billed is applicable. The cutback amount is required to balance the claim during the process and for 835 and Remittance Advice (RA) purposes.

If the Payment Greater than billed flag is set to no

Allowed amount (4) = Lesser of Billed amount or Allowed Amount (1) if the benefit adjustment factor was not applicable.

Allowed amount (4) = Lesser of Billed amount or Allowed Amount (2) if the benefit adjustment factor was applicable.

Set the final allowed amount = Allowed Amount (4). From this point, the only process that could change the allowed amount is audits. Member cost share such as copay, member liability, etc. does not change the allowed amount, but posts cutbacks that reduce the payment amount.

Outpatient Non-EAPG Eligible Claims –

Home Health and PDN claims

Home Health and PDN Outpatient claims will price per detail using the MAXREV Method.

Obtain Max Rev System Rate

Get the Allowed amount from the Revenue rate table by using the revenue code and rate type for the dates of service. The from and through dates of service are used to find the rate effective at the time the service was rendered. The dates on the claim must be completely covered by a pricing segment to be considered for processing. The dates of service, as received on the claim, are used to get the rows between the effective and end date for the service rendered. If a rate is not found an edit is posted to the detail for adjudication.

The inactive date utilizes the processing date to identify rows that are active by excluding any rows that have a date earlier than the date when the claim is being processed. The claim is processed real time, so the time is part of the criteria. If a rate is inactivated at any given time before the claim is processed the rate will not be used.

Max Rev Calculation

Allowed Amount (1) = (Max Rev Rate * Units Allowed)

If Benefit Adjustment Factors are present

If Benefit Adjustment Factor Before/After flag is set to Before

Allowed Amount (2) = ((Allowed Amount (1) * BAF Percentage) + BAF Incentive Amount)

If Benefit Adjustment Factor Before/After flag is set to After

If the Payment Greater than billed is set to yes, the Allowed Amount (3) = Allowed Amount (1).

If the Payment Greater than Billed is set to no

Allowed Amount (3) = Lesser of Billed Amount or Allowed Amount (1).

Allowed amount (2) = ((Allowed Amount (3) * BAF Percentage) + BAF incentive Amount).

This process is repeated for all BAFs that were assigned by the Reimbursement Rules.

If the Payment Greater than billed flag is set to yes

Allowed Amount (4) = Allowed Amount (1) if the benefit adjustment factor was not applicable.

Allowed Amount (4) = Allowed Amount (2) if the benefit adjustment factor was applicable.

Cutback Amount = (Billed Amount – Allowed Amount (4)).

In this case, negative cutback amounts are valid since the payment greater than billed is applicable. The cutback amount is required to balance the claim during the process and for 835 and Remittance Advice (RA) purposes.

If the Payment Greater than billed flag is set to no

Allowed amount (4) = Lesser of Billed amount or Allowed Amount (1) if the benefit adjustment factor was not applicable.

Allowed amount (4) = Lesser of Billed amount or Allowed Amount (2) if the benefit adjustment factor was applicable.

Set the final allowed amount = Allowed Amount (4). From this point, the only process that could change the allowed amount is audits. Member cost share such as copay, member liability, etc. does not change the allowed amount, but posts cutbacks that reduce the payment amount.

FQHC/RHC/IHS Claims

FQHC/RHC/IHS claims are priced off the Provider's Encounter rate. Claims that are submitted by a Provider with a Provider type of FQHC/IHS with a Revenue code 0529 or with a Provider type of RHC and Revenue code 0521 will look at the Provider file for the Encounter Rate. The Detail with the listed Revenue code will pay with the allowed amount set to the Provider's encounter Rate. All other details on the claim will be set to pay $0.

PRTF Claims

Claims Submitted with a TOB 89X will be priced using the Provider's Outpatient Rate. Rates will be set on the provider file for the PRTF Provider based on the region the PRTF is in and the Revenue code 0911.

Dialysis Claims

Claims Submitted with a TOB 72X will be priced using the Provider's Outpatient Rate. Rates will be set on the provider file for the Dialysis Provider based on the region the Dialysis Center is in and the Revenue code 08XX.

Hospice Services

Claims Submitted with a TOB "81X" or "82X" will perform unique rate processing for hospice nursing facility room and board services (line item revenue code equal to "0659"). These line items are reimbursed at 95 percent of the standard rate associated with the nursing facility provider.

interChange will get the Nursing Facility Id from the Claim Header Other Provider 1 field. iC will then pull the NH Rate for that Facility and Calculate the allowed amount as follows:

Allowed Amount = (Nursing Facility Rate * Allowed Units) * .95

Outpatient Crossover Claim -

Outpatient Crossover claims are priced by using one of the Professional Pricing Methods. The Claim is then sent through the Medicare Lower of Logic in final pricing. FQHC, RHC, and IHS are exempt from lower of pricing.

1. Calculate Medicaid Allowed (1) amount based on Medicaid fee schedule and reimbursement rules. (i.e. Max Fee, Percent of Bill etc.)

2. Calculate final detail Medicaid Allowed Amount:

    a. Subtract detail Medicare paid amount from detail Medicaid allowed amount (1).

    b. Compare the difference from step 1 with the sum of detail Medicare coinsurance, detail Medicare copay, Medicare Deductible, and detail Medicare psychiatric reduction.

    c. Take the lesser of the two to be the detail Medicaid allowed amount (2).

Practitioner Services

Practitioner services are billed on the CMS 1500 claim form using the Centers for Medicare and Medicaid Services (CMS) HCPCS.

The Health First Colorado program contracts with providers of specialized services, such as family planning clinics and community mental health centers, to render services at a specified reimbursement rate.

Payment for practitioner services is based on whichever of the following two calculations results in a **lesser amount**:

- The maximum allowable price for the submitted HCPCS code multiplied by the number of units of service.
- The provider's submitted charge.

Anesthesia payments are based on whichever of the following two calculations results in a **lesser amount**:

- The number of units multiplied by the established anesthesia base unit rate.
- The number of units multiplied by the provider's submitted charge.

Each 15-minute block of time or any fraction thereof equals one unit. Each anesthesia procedure has a base unit rate. Providers should bill units (i.e., time) only and not dollar amounts. The fiscal agent will calculate the dollar amount. Therefore, do not add in the actual base rate or additional units because of the member's physical status.

Medicare crossover claims are based on whichever of the following two calculations results in a **lesser amount**:

- The sum of the reported Medicare coinsurance and deductible.
- The Health First Colorado allowed benefit minus the Medicare payment.

Home and Community Based Services (HCBS)

The Health First Colorado program contracts with providers of Home and Community Based Services (HCBS) to render services at specified reimbursement rates. These services are identified by unique HCPCS codes and used by contracted providers to submit Health First Colorado claims. Home health services provided to HCBS members are reimbursed as described below under Home Health Services.

Payment for HCBS is based on whichever of the following three calculations results in a **lesser amount**:

- The Health First Colorado established price for the submitted HCPCS code multiplied by the number of units of service.
- The negotiated rate for the service for a particular member (selected services).

- The provider's submitted charge.

Supplies and Durable Medical Equipment (DME)

There are three ways to determine the price for supplies and DME: the Fee Schedule, the Manufacturer's Suggested Retail Price (MSRP), and By Invoice.

Fee Schedule

Supplies and DME that are on the Fee Schedule have a maximum allowable reimbursement. These items are reimbursed at the lesser of submitted charges or the Fee Schedule amount. If the cost of the supply or DME is less than the maximum allowable rate listed on the Fee Schedule, the provider must submit the claim for the actual cost.

Manufacturer Suggested Retail Price (MSRP)

If there is no maximum purchase price listed on the Fee Schedule, the provider is reimbursed the current MSRP less the current percentage outlined in 10 Code of Colorado Regulations (CCR) Section 8.590.7. The provider must keep a copy of the item invoice and documented MSRP. The documented MSRP must include the name of the provider's employee that received and documented the MSRP, and the date the MSRP was received.

Member must be contacted prior to shipping to ensure member information is correct.

- Providers may not submit for reimbursement either state sales tax collection or shipping costs.
- Providers must add the "SC" modifier when using the MSRP for pricing.
- Providers must attach a copy of the MSRP on all paper claims.
- Providers may not use MSRP pricing for procedure code A9901.

Billing for "By Invoice" Services

DME/Supply items that have no Fee Schedule rate and no Manufacture Suggested Retail Price (MSRP) are reimbursed at the actual acquisition invoice cost plus the percentage amount outlined in 10 CCR 2505-10 8.590.7. Providers must bill code A9901 to cover handling at 20% of the actual acquisition costs of the products. Eyewear reimbursement is based on whichever of the following two calculations results in a **lesser amount**:

- The maximum allowable price for materials and dispensing.
- The provider's submitted charge.

Medicare crossover claims are reimbursed based on whichever of the following two calculations results in a **lesser amount**:

- The sum of the reported Medicare coinsurance and deductible.
- The Health First Colorado allowed benefit minus the Medicare payment.

Nursing Facilities

Nursing facilities are reimbursed at a determined daily (per diem) rate multiplied by the number of covered days of service minus applicable member payments.

Medicare Part A covered services are reimbursed based on whichever of the following two calculations results in a **lesser amount,** minus applicable member payment:

- The Health First Colorado allowed per diem minus the Medicare payment.
- The Medicare-determined coinsurance.

For ancillary services covered under Medicare Part B, the Health First Colorado program pays the determined coinsurance and deductible.

Managed Care Organizations (MCOs)

Health First Colorado-contracted Managed Care Organizations (MCOs), including Health Maintenance Organizations (HMOs) and Behavioral Health Organizations (BHOs), receive a single monthly Health First Colorado capitation payment for each MCO-enrolled Health First Colorado member.

Dental/Oral Surgery Services

Payment for dental/oral surgery services is based on whichever of the following two calculations results in a **lesser amount**:

- The maximum allowable based on the Health First Colorado fee schedule multiplied by the number of units of service.
- The provider's submitted charge.

The Health First Colorado program identifies dental surgery services using HCPCS codes when provided by a dentist. Oral surgery codes are identified by Common Procedural Terminology (CPT) codes when provided by an oral surgeon.

Ambulatory Surgical Centers (ASCs)

The Health First Colorado program identifies surgical procedures performed in an Ambulatory Surgical Center (ASC) using HCPCS codes that group surgical procedures together by scope and complexity. The codes are defined by CMS and published by Medicare and the Health First Colorado program. There is no Health First Colorado reimbursement for procedures not listed in the surgical code grouping.

Health First Colorado reimbursement to ASCs is based on whichever of the following three calculations results in a **lesser amount**:

- An established percentage of the Medicare-allowed payment for the billed ASC group identified by the performed procedure.
- The average Health First Colorado rate for one hospital day.
- The provider's submitted charge.

Medicare crossover claims are reimbursed based on whichever of the following two calculations results in a **lesser amount**:

- The sum of the reported Medicare coinsurance and deductible.
- The Health First Colorado allowed benefit minus the Medicare payment.

Rural Health Clinics (RHCs)

Rural health clinics are paid an encounter fee based upon Medicare rates established for the clinic.

Medicare crossover claims are paid based on whichever of the following two calculations results in a **lesser amount**:

- The Health First Colorado program pays the sum of the reported Medicare coinsurance and deductible.
- The Health First Colorado allowed benefit minus the Medicare payment.

Rehabilitation Services provided by a Freestanding Rehabilitation Clinic

Health First Colorado reimbursement for rehabilitation services provided by a freestanding rehabilitation clinic is limited to Medicare crossover payment. The payment is made by the Health First Colorado program based on whichever of the following two calculations results in a **lesser amount**:

- The sum of the reported Medicare coinsurance and deductible.
- The Health First Colorado allowed benefit minus the Medicare payment.

Home Health and Private Duty Nursing Services

The Health First Colorado program contracts with home health agencies to render services at specified reimbursement rates. These services are identified by specific revenue codes used by the provider to submit Health First Colorado claims.

Payment for home health care is based on whichever of the following two calculations results in a **lesser amount**:

- The established price for the submitted revenue code multiplied by the number of units of service.
- The provider's submitted charge.

Under Medicare Part A benefits, Medicare reimburses 100% of the allowable charge for approved home health services. No crossover benefit is available from the Health First Colorado program. If the member is not entitled to Part A Medicare but does have Part B coverage and the home health service provided is covered by Medicare, the Health First Colorado program pays the Medicare coinsurance. Home health services are not subject to Medicare deductible.

Prescription Drugs

Prescription drugs are a benefit of the Health First Colorado program and must be billed using the National Drug Code (NDC). For specific information, please refer to the Pharmacy Billing Manual.

Dialysis Centers

Dialysis services are reimbursed based on whichever of the following two calculations results in a **lesser amount**:

- The Medicare rate ceiling.
- The individual center's Medicare negotiated facility rate.

Medicare crossover claims are reimbursed based on whichever of the following two calculations results in a **lesser amount**:

- The Health First Colorado program pays the sum of the reported Medicare coinsurance and deductible.
- The Health First Colorado allowed benefit minus the Medicare payment.

Psychiatric Residential Treatment Facilities (PRTFs)

The Health First Colorado program reimburses Psychiatric Residential Treatment Facilities (PRTFs) at a determined daily (per diem) rate for each date billed. These centers use specific revenue codes to submit Health First Colorado claims.

Residential Child Care Facility (RCCF)

Residential Child Care Facilities (RCCF) provides services to mentally ill children and adolescents by treating mental disabilities and restoring members to their best possible functional level.

Health First Colorado mental health benefits are provided on a fee-for-service basis through RCCFs to enrolled members who reside in the facility.

Hospice

Hospice service rates are determined by CMS and are adjusted according to the location of the member. The Health First Colorado program pays based on whichever of the following two calculations results in a **lesser amount**:

- The established hospice rate
- The provider's submitted charge

Medicare crossover claims are reimbursed by the Health First Colorado program as follows:

- The sum of the reported Medicare coinsurance and deductible.
- Nursing Facility room and board that is not covered by Medicare is paid by the Health First Colorado program.

Benefits and Benefit Delivery Programs

Some of the programs and benefits are available through both the FFS and Capitation reimbursement methods. Providers should read information carefully to ensure that they apply appropriate policies to the correct services and programs. Also, see Reimbursement Policies in this manual.

General Benefits/Limitations/Exclusions

The Health First Colorado program pays enrolled providers for medically necessary health care benefits for eligible members after all other health care resources have been exhausted.

The Health First Colorado program is an entitlement program, meaning that any person meeting the eligibility criteria is entitled to receive necessary medical services covered by the program without cost.

The Health First Colorado members are responsible for Health First Colorado co-payment described later in this section.

All benefit services are subject to applicable reimbursement policies including:

- Prior authorization requirements
- Referral requirements
- Utilization review
- Special consent requirements

Acute and Ambulatory Benefits

Acute and ambulatory benefit services may be provided under FFS reimbursement and through capitated Managed Care Programs. In some instances, managed care entities and FFS Health First Colorado share responsibility for service delivery.

FFS Prior Authorization Requirements

Under FFS reimbursement, the Health First Colorado program prior authorizes:

- Expensive services such as transplantation and long term care.
- Procedures where inappropriate utilization has been reported in medical literature.
- Procedures that may be performed both for medical reasons and for cosmetic reasons.

FFS prior authorization approval assures the provider that the service is medically necessary and a Health First Colorado benefit. Capitated MCOs may have different prior authorization requirements. If a member is enrolled in a MCO, providers must follow the MCO rules.

- Approval of the Prior Authorization Request (PAR) does not guarantee Health First Colorado payment.
- PAR approval does not serve as a timely filing waiver.
- PAR approval does not override benefit eligibility requirements or benefit delivery requirements.

The member must meet all applicable eligibility requirements at the time services are rendered.

Example: If the service is approved under the EPSDT Program, the member must be age twenty or younger **at the time services are rendered**.

The member must be eligible for services under the FFS Reimbursement Program at the time services are rendered.

Example: If the member is enrolled in a Health First Colorado capitated prepaid health plan when services are delivered, the provider must look to the MCO for reimbursement.

All claims, including those for prior authorized services, must meet all claim submission requirements (e.g., timely filing, pursuit of Third Party Liability, required attachments included, etc.) before payment can be made.

PARs are reviewed by the designated authorizing agency identified in Appendix B in the Provider Services Billing Manuals section. The authorizing agency approves or denies requested services and sends notification of prior authorization action to each of the following parties:

- The requesting physician
- The proposed rendering provider (if identified on the PAR)
- The Health First Colorado member

The notification letter identifies the action taken on the PAR and, if services have been denied or modified, the member's appeal rights.

Instructions for submitting the PAR are described in the specialty sections specific to the service(s) being provided.

Out-of-State Benefits

The Health First Colorado program provides the out-of-state services noted below. The service provider must be enrolled as a participant in the Health First Colorado program.

- Services to residents of Colorado border localities where the use of medical resources in the adjacent state is common. A listing of recognized Colorado border communities is in Appendix F in the Provider Services Billing Manual section.
- Services to Health First Colorado members who live in other states under special circumstances, such as foster care placement.
- Emergency services provided to Health First Colorado members who are traveling or visiting outside Colorado. Documentation of the emergency must be submitted with the claim.
- Services needed because the individual's health would be endangered if he or she were required to return to Colorado for medical care. Services must be prior authorized.
- Services that are unavailable in Colorado. Services must be prior authorized.

Long Term Care Benefits

All long term care services require prior authorization or pre-admission review by the Department's contractor. Long term care benefits include a variety of home and community based services as alternatives to institutional care.

Long Term Care Single Entry Point System

Colorado's Long Term Care Single Entry point system provides an efficient way for individuals to access long-term care services. The Single Entry Point (SEP) System is administered by Options for Long Term Care agencies (OLTCs) positioned geographically throughout Colorado.

The OLTCs conduct evaluations and needs assessment, care planning with the member, and ongoing case management to monitor the care plan, as well as coordinate service delivery and perform periodic reassessment of member needs. OLTC agencies arrange services for Home and Community Based Services members and evaluate options for members at home who are seeking nursing facility care. OLTCs perform pre-admission review and continuing care assessments and submit Health First Colorado FFS PAR requests as needed.

General Benefit Limits and Exclusions

The program does **not** pay for personal comfort items and unnecessary services.
This exclusion does not apply to immunizations and inoculations.

- Items and services (e.g., free chest x-rays) for which no one incurs a legal obligation to pay are **not** benefits.
- Homeopathic therapy is **not** a benefit.
- Chiropractic services are **not** covered. Reimbursement for deductible and coinsurance will be made on Medicare crossover claims for Qualified Medicare Beneficiaries (QMBs).
- Acupuncture used for the medical management of acute or chronic pain, or as an anesthesia technique is **not** a benefit.
- Cosmetic surgery, intended solely to improve physical appearance, is **not** a benefit. Reconstructive surgery intended to improve function and appearance is a benefit if prior authorized.
- One adult annual physical examination is a benefit. Physical examinations for diagnostic disease evaluation, for nursing facility or Home and Community Based Services (HCBS) admission or placement, or under the Early Periodic Screening Diagnosis and Treatment (EPSDT) Program for members ages 20 and younger are a benefit.
- Non-prescription drugs and food supplements are **not** benefits.
- Under unusual or life threatening situations, over-the-counter drugs and food supplements may be a benefit if prior authorized.
- Hearing aids are **not** a benefit.
  Members ages 20 and younger may qualify for hearing aids under the EPSDT Program.
- Vision eyewear is **not** a benefit except as allowed under the EPSDT Program for members ages 20 and younger. Eyeglasses and contact lenses for members ages 21 and older are covered following related eye surgery.
- Oral surgery related to the jaw or any structure contiguous to the jaw or reduction of fractures of the jaw or facial bones including dental splints or other devices is a covered benefit. Except in emergency circumstances, oral surgery requires prior authorization.

Sterilization, Hysterectomy, and Abortion Benefits

See the special billing instructions for Abortions, Hysterectomies, and Sterilizations in applicable Specialty Manuals located in the Provider Services Billing Manuals section**.**

Please note: Abortion is only a benefit when due to rape, incest, or life endangerment.

Co - payments

See the Provider Reimbursement section in this manual.

Third Party Liability (TPL) Coordination of Benefits

This manual describes policies for commercial health insurance coverage, Medicare coverage, and other liability programs such as accident coverage and victim compensation.

The term Third Party Liability (TPL) describes circumstances when a Health First Colorado member has health insurance or other potential resources -in addition to the Health First Colorado program -that may pay for medical services.

An estimated 10% of Health First Colorado members have other health insurance resources available to pay for medical expenses.

Health First Colorado eligibility is not restricted by having other insurance coverage.

Providers should take special care to apply only the policies and procedures appropriate to the specific resource.

Payer of Last Resort

Health First Colorado is called the payer of last resort because Federal regulations require that all available health insurance benefits be used before Health First Colorado considers payment.

With few exceptions, claims for members with health insurance resources are denied or rejected when the claim does not show insurance payment or denial information.

Commercial health insurance coverage often offers greater benefits than Health First Colorado, so it is advantageous for providers to pursue commercial health insurance payments.

Health First Colorado does not automatically pay commercial health insurance co payments, coinsurance, or deductibles. If the commercial health insurance benefit is the same or more than the Health First Colorado benefit allowance, no additional payment will be made.

Providers cannot bill members for the difference between commercial health insurance payments and their billed charges when Health First Colorado does not make additional payment.

Common Types of Health-Related Coverage

The more common types of health insurance coverage and members who have other resources include the following:

- Employed individuals who have commercial health insurance through employment or union membership.
- Children covered under commercial health insurance carried by an absent parent.
- Disabled individuals with coverage through employment or as a dependent through a family
- member's coverage.
- Individuals eligible for Medicare coverage because of age or disability.
- Individuals who have Medicare coverage and commercial Medicare supplemental plans.

Obtaining Information about Other Resources

Billing information for other resources should be obtained from the member. Providers should always ask the member about other insurance coverage. The Health First Colorado program maintains a reference file of known commercial health insurance and Medicare coverage information used to reject or deny claims that do not show payment or denial by the commercial health insurer.

Eligibility Verification Information

Providers may access the Health First Colorado's TPL reference information through electronic eligibility verification. Eligibility as well as information about commercial health insurance and Medicare may be verified electronically by utilizing the 270/271 Health Care Eligibility Inquiry and Response transaction, or manually by using a touch-tone telephone.

TPL information includes:

- Name and address of the commercial health insurer.
- Individualized commercial health insurance coverage information.
- Commercial health insurance coverage information.
- The individual's Medicare Health Insurance Claim (HIC) number.

TPL information reported through eligibility verification is furnished as a convenience to providers. Because TPL information is member-reported, the commercial health insurance portion of eligibility verification is not a guarantee that the information is accurate or timely. Providers should always question members about other insurance resources. TPL reference information is updated as new or revised coverage information is obtained.

Note: TPL information is not available from the State or from the County. Please do not contact these offices to request third party billing information.

Inaccurate TPL Information

The Health First Colorado program collects information about members' TPLs from several sources.

- Health First Colorado members and applicants are required to identify commercial health insurance coverage.
- The Health First Colorado program exchanges information with other state agencies and some commercial health insurance companies.
- Providers report commercial health insurance coverage on Health First Colorado claims.

The Health First Colorado program makes every attempt to maintain up-to-date TPL information. Providers may find, however, after submitting a commercial health insurance claim, Health First Colorado's records are inaccurate and that the commercial health insurance coverage is not in effect.

Unreported Health Insurance Coverage

Even if Health First Colorado records do not identify commercial health insurance coverage, providers who find that the member has such coverage should pursue those benefits before billing the Health First Colorado program.

Commercial health insurers often offer greater benefits than the Health First Colorado.

When insurance benefits retroactively are identified, the Health First Colorado program retracts previous payments and requires the provider to submit claims to the commercial health insurers.

Providers may report insurance coverage by contacting the Department's fiscal agent or by completing the health insurance information required on the Health First Colorado claim.

Discontinued Health Insurance Coverage

Providers should report members' discontinued insurance coverage to the Department's fiscal agent by sending a copy of the insurance carrier's letter or denial notice and identifying the member by name and State ID number so records can be updated.

Health First Colorado claims are honored if the claim correctly indicates that the other insurance company has denied benefits.

Providers who notify the Department's fiscal agent that TPL coverage has been discontinued are not required to continue sending claims to the commercial health insurers. Until Health First Colorado records are updated and the TPL coverage notation no longer appears on the electronic eligibility verification response, subsequent Health First Colorado claims must continue to show that the commercial insurers have denied benefits.

Commercial Health Insurance Resources

The following resources are not considered commercial health insurance resources, and the policies discussed in this section do not apply to these resources. Subsequent sections describe these resources.

- Medicare
- Workers Compensation
- No-fault automobile coverage
- Victim Assistance Programs
- Migrant Health Services
- Indian Health Services coverage
- Colorado Indigent Care Program
- Colorado Health Care Programs (HCP) for Children

Pursuing Commercial Health Insurance Payments

When members accept Health First Colorado benefits, they assign their rights to health insurance payments to the Health First Colorado. Most insurance companies make direct provider payments when the policyholder assigns benefits to the provider. Providers should take necessary steps to obtain consent to release information and benefit assignment for direct payment.

Insurance coverage information is considered part of treatment, payment and operations as defined in the privacy regulations. Pursuing information regarding other coverage therefore is not in violation of HIPAA privacy as specified at 45 C.F.R. §164.501.

Commercial Managed Care Policies

Providers should not confuse Health First Colorado Managed Care enrollment with commercial managed care policies. Health First Colorado Managed Care enrollment refers to members who receive benefit services from a Health First Colorado-contracted Managed Care Organization (MCO). Commercial managed care policies are health coverage policies that exist in addition to the individual's Health First Colorado entitlement.

Members who have commercial managed care benefits must obtain MCO benefit services from the MCO. Health First Colorado claims for members who have commercial managed care coverage are rejected or denied.

Health First Colorado members are responsible for only co-payment amounts and may not be charged for any fees, including managed care co-payment.

Reporting Payments and Denials

If a member's eligibility response record shows commercial health insurance coverage and the Health First Colorado claims for that member do not show insurance payment or denial information, those claims are rejected or denied.

Providers must report TPL payment and denial information on the claim form.

- Paper claim forms have designated fields for reporting TPL payments and denials.
- Electronic claim formats have designated fields for reporting commercial health insurance coverage.

Reporting commercial health insurance coverage on paper claim forms is slightly different from electronically reporting information. Directions for claim field completion to identify TPL payments and denials are available in the billing instructions for each claim form.

Audit Documentation

Providers must maintain records that support the accuracy of submitted claim information for a period of six years, including copies of commercial health insurance denials and payments. Providers should document, date, and sign notes about reported member discussions regarding TPL. Upon request, records must be submitted for Health First Colorado audit and review. Failure to provide requested audit materials may result in sanctions and recovery of Health First Colorado payments.

Special Claim Submission Circumstances

Commercial Benefit Limits

Commercial health insurance coverage may limit some benefits for a specific time period, often yearly time periods. If a periodic benefit limitation is exhausted, claims for services in excess of the benefit limit may be submitted directly to the Health First Colorado program. The provider does not have to continue submitting claims to the TPL. The claim record must be completed to show that the other coverage denied benefits or that the service is excluded from coverage.

When the limitation period ends, the provider must submit claims to the commercial health insurer until the benefit is exhausted.

If the commercial health insurance coverage includes a lifetime benefit limit and that benefit is exhausted, claims for services provided in excess of the limit may be submitted directly to the Health First Colorado program. Providers should contact Health First Colorado Provider Services for assistance.

In some instances, lifetime limitations can be recorded in the Health First Colorado reference files so that future Health First Colorado claims can be processed without completing TPL fields. In other instances, the provider may be instructed to continue completing the claim record to show that other TPLs have denied benefits or that the service is excluded from coverage.

Apportioned Payments

Under some circumstances, a commercial health insurance payment may be applied to more than one Health First Colorado claim submission. If the provider receives a third party lump-sum payment for multiple services billed to the Health First Colorado program on separate claim records, the payment amount should be apportioned across the affected claims.

If payment cannot be divided and applied to each service, providers should apportion the payment on a percentage basis to the affected claims. Providers must maintain records to support submitted claim information including a detailed explanation of the apportionment method used.

Uncooperative Policyholders

Providers benefit from taking necessary steps to obtain required signatures and authorizations from members and policyholders. Some commercial health insurers refuse payment if the member or policyholder does not respond to requests for information.

Failure to Provide Information

If the member or policyholder refuses to provide required signatures or authorizations or does not respond to requests for information, Health First Colorado claims may be submitted through the reconsideration process. Claims must be received within 365 days of the date of service.

Reconsideration claims must be submitted on paper. Claims must be clearly marked “Reconsideration” and accompanied by a completed Request for Reconsideration form or letter describing the nature of the policyholder’s refusal to cooperate and the steps taken to secure TPL payment from the provider.

The policyholder or member’s refusal to transfer payment to the provider or to cooperate will be reported to State officials who may take further action.

Payments Made to Policyholders

Providers should always obtain an assignment of benefits for direct reimbursement by the commercial health insurers. If the commercial health insurance payment is sent to the member or policyholder, the provider should obtain payment and the payment voucher (e.g., Remittance Advice (RA) or Standard Paper Remit [SPR], etc.) from that member or policyholder for Health First Colorado billing purposes. If the member or policyholder refuses to transfer or make payment to the provider, Health First Colorado claims may be submitted through the reconsideration process. Claims must be received within 365 days of the date of service.

The policyholder or member’s refusal to transfer payment to the provider or to cooperate will be reported to State officials who may take further action.

Invalid TPL Denials

Some reasons given by TPL are invalid for submitting the claim for Health First Colorado payment. Providers should ensure that all TPLs are appropriately pursued before submitting Health First Colorado claims. The following are examples of invalid TPL reasons for submitting Health First Colorado claims:

- No denial reason identified
- Duplicate claim
- Insufficient information for processing
- Claim in process

Retroactive Identification of Commercial Health Insurance Resources

When commercial health insurance coverage is identified after claims are paid, providers receive notification of the intent to recover payment and instructions for submitting claims to the commercial health insurer. The notification letter contains billing information and a complete explanation about the retroactive Health First Colorado payment recovery process.

Medicare Resources

Health First Colorado members may qualify for Medicare benefits because of age or disability. Individuals who have Medicare coverage and Health First Colorado entitlement are called "dually eligible."

The Health First Colorado program administers very specific policies to coordinate benefits for Medicare-covered members. Information in this section applies only to Medicare benefit coordination. Do not apply these policies to other TPL.

Types of Medicare Coverage

Medicare pays benefits through the following two separate programs:

- Part A Medicare pays for institutional care
- Part B Medicare pays for professional services

Health First Colorado members may have the following coverage:

- Part A Medicare coverage only
- Part B Medicare coverage only
- Both Part A and Part B coverage

Qualified Medicare Beneficiaries (QMBs)

In compliance with the 1988 Medicare Catastrophic Coverage Act, the Health First Colorado program pays Medicare deductibles and coinsurance for elderly and disabled individuals who have incomes below the Federal poverty level and resources at twice the Supplemental Security Income (SSI) level. Individuals who qualify for benefits under the Medicare Catastrophic Coverage Act are called Qualified Medicare Beneficiaries (QMBs). QMBs may or may not be entitled to regular Health First Colorado benefits.

Individuals may qualify for the following benefits:

- Regular Medicare benefits with Health First Colorado benefits

- QMB Medicare benefits with Health First Colorado benefits
- QMB only benefits without Health First Colorado benefits

Health First Colorado Crossover Benefits

Regular Medicare + Health First Colorado: The Health First Colorado program processes Medicare crossover claims for Medicare benefits that are also Health First Colorado benefits and all regular Health First Colorado benefits. Calculation of the crossover payment is described below.

QMB Medicare + Health First Colorado: The Health First Colorado program pays Medicare crossover coinsurance and deductible for all Medicare benefits including services that are not covered by regular Health First Colorado (e.g., chiropractic services) and all regular Health First Colorado benefits.

QMB-only benefits: The Health First Colorado program pays Medicare crossover coinsurance and deductible for Medicare covered benefits including services that are not covered by the regular Health First Colorado program.

- There is no coverage for Health First Colorado-only benefits (e.g. pharmacy).
- QMB-only members may not be billed for crossover balances.
- QMB-only members are financially responsible for services that are not covered by Medicare.

Medicare crossover payments

Members are not responsible for remaining balances after Health First Colorado B crossover processing. For members under Medicare A (skilled nursing coverage) in nursing facilities, the member's member payment is applied to the Medicare A coinsurance.

Medicare Part A crossover payments

Hospital inpatient & outpatient charges: Provider payment is Health First Colorado's allowed benefit minus the Medicare payment **or** the Medicare determined deductible and coinsurance, **whichever is less**. If Medicare's payment equals or is greater than the Health First Colorado allowance, crossover claims are paid zero.

Nursing Facility services: Provider payment is the Health First Colorado facility per diem minus the Medicare payment **or** the Medicare determined coinsurance, **whichever is less**. If Medicare's payment is greater than the Health First Colorado allowed facility per diem, crossover claims are paid zero.

For Part B services paid by Part A, the Health First Colorado program pays Medicare deductible and coinsurance.

Clinic and facility services (e.g. Dialysis, Rural Health, Home Health, Independent Rehabilitation): Health First Colorado pays Medicare deductible and coinsurance.

Medicare Part B crossover payments

The Health First Colorado program pays the Medicare deductible and coinsurance or the Health First Colorado-allowed benefit minus the Medicare payment, whichever is less. If Medicare's payment equals or is more than the Health First Colorado allowed benefit, crossover claims are paid zero.

Automatic Medicare Crossover Claims

Automatic crossover is an exchange of claim information between Medicare and the Health First Colorado program. When automatic crossover occurs, providers do not have to submit a crossover claim to the Health First Colorado program.

Medicare identifies claims selected for automatic crossover on a Medicare payment voucher (e.g., RA or SPR). The crossover message states that the claim has been forwarded to the Health First Colorado program for any additional benefits due. If the automatic crossover notice appears on the Medicare payment voucher, providers should allow 30 days for the Health First Colorado program to process the crossover claim.

Providers must submit a copy of the SPR with paper claims. Be sure to retain the original SPR for audit purposes.

If the Medicare crossover message does not appear, providers should assume that automatic crossover will not occur and should submit a crossover claim to the Health First Colorado program.

Automatic crossover is only available for claims processed by the Medicare Administrative Contactor (MAC) for Colorado.

If the Medicare Administrative Contractor is not the designated MAC, providers must submit crossover information.

Automatic crossover is not available for railroad retiree claims processed by Palmetto GBA. Crossover messages that may appear on Palmetto GBA SPR are inaccurate. Providers must submit crossover information for railroad retirees.

Medicare must allow charges on the Medicare claim.

Medicare-denied claims do not cross over because there are no residuals (e.g., coinsurance or deductibles) to be considered for payment by the Health First Colorado program. If Medicare denies benefits, benefits are exhausted, or services are not covered by Medicare, providers may submit a claim directly to the Health First Colorado program for services (not a crossover claim). If the claim is partially allowed by Medicare, the Health First Colorado program will process denied billing lines. Providers should review their RAs carefully to determine the benefits allowed by Medicare and the Health First Colorado program.

If Medicare pays the entire claim at 100% of the allowed benefit, the claim does not cross over because there are no residuals (e.g., coinsurance or deductible) to be considered by the Health First Colorado program. If only a portion of the claim is paid at 100%, automatic crossover does occur but no payment is made on the services paid at 100%.

Medicare adjustments do not cross over.

If Medicare adjusts a claim, the provider must submit a Health First Colorado adjustment. Adjustments may be submitted electronically or on paper. Paper adjustments must be accompanied by the Medicare SPR and adjustment documentation.

The member's HIC number must match Health First Colorado eligibility files.

If the member's Medicare ID number changes, automatic crossover is interrupted temporarily until the Health First Colorado eligibility file is corrected to reflect new information. If automatic crossover does not occur, providers must submit crossover claims.

The provider's Medicare provider number must be recorded in the Health First Colorado provider files.

Providers are responsible for furnishing Medicare provider information to Health First Colorado Provider Services. If the Medicare provider number is not recorded on Health First Colorado's provider enrollment file, automatic Medicare crossover is not possible.

When Medicare provider numbers change, the provider must furnish updated information to Health First Colorado Provider Services. If automatic crossover does not occur, providers must submit crossover claims.

The provider must accept Medicare assignment on claims for Health First Colorado members.

If the provider does not accept Medicare assignment, automatic crossover does not occur. Providers cannot bill Health First Colorado members for Health First Colorado-covered services, including Medicare benefit services.
If the provider does not accept Medicare assignment, the Health First Colorado program will not pay crossover benefits. If the provider has not accepted Medicare assignment in error or Medicare processes the claim as unassigned in error, the provider may obtain the Medicare payment and processing information from the member and submit a crossover claim to the Colorado Medical Assistance Program. By submitting a Health First Colorado crossover claim, the provider is deemed to have accepted Medicare assignment after-the-fact and must accept the combined Medicare and Health First Colorado payments as payment in full.

Automatic Crossover Denials

Claims may cross over automatically but appear on the Health First Colorado Remittance Advice (RA) as denied if the member is enrolled in a Health First Colorado MCO or has commercial health insurance coverage.

Providers should contact the Health First Colorado MCO for billing instructions if additional benefit is available for Health First Colorado Managed Care enrolled members.

Providers should submit claims to the commercial health insurer for individuals who have supplemental health insurance. If the supplemental health insurer denies benefits, the provider may submit a crossover claim with documentation of the commercial health insurance denial.

Delays in Crossover Processing

If Medicare or Health First Colorado system problems create delays in crossover processing, RAs describe the problem and notify providers about appropriate action to take. Please carefully read and follow the instructions on the Health First Colorado Remittance Advice (RA).

Provider-Submitted Crossover Claims

If automatic crossover does not appear on the Health First Colorado RA within 30 days of the Medicare processing date — regardless of the reason and whether or not the Medicare crossover message appears — providers are responsible for submitting crossover claims, electronically or on paper.

Provider-submitted crossover claims (sometimes called hardcopy crossovers) should be submitted electronically. Each electronic claim format contains designated fields to report Medicare processing information. Instructions for completing Medicare crossover information are included in the billing instructions for each claim format.

When crossover claims are submitted electronically, providers must maintain auditable Medicare processing documents that support the accuracy of submitted claim information. The Health First Colorado program must submit copies of audit information for audit and review upon request. Failure to provide requested audit materials may result in sanctions and recovery of Health First Colorado payments.

Crossover Timely Filing

Timely filing for Medicare crossover claims is within 120 days from the date of payment or 60 days from the date of denial. When automatic crossover occurs, timely filing is met. If automatic crossover does not occur, providers are responsible for filing claims in compliance with timely filing regulations.

Health First Colorado claims for Medicare-denied, non-covered, or exhausted benefits are not crossover claims and, for timely filing purposes, must be filed within 120 days of the date of service or within 60 days of the Medicare denial date, whichever is longer.

Claims for Medicare-Exhausted Benefits

Medicare applies dollar-based benefit limits to some practitioner services. Because of the dollar limit, Medicare may make a partial payment when the dollar limit is reached. In those instances, providers should contact the Department's fiscal agent.

Crossover Billing Tips

The following billing tips will help providers correctly submit crossover claims:

- Crossover claims must report the same information submitted to Medicare, including full charges (for Nursing Facility crossover submission, see the Nursing Facility Specialty Manual).
- Crossover claim information (e.g., Medicare payment date, Medicare disallowed charge, Medicare deductible, Medicare coinsurance, Medicare payment, and related computations) on the claim form must be accurate and complete to reflect information on the Medicare payment voucher.
- The net Health First Colorado billed amount must equal the sum of the reported Medicare coinsurance and deductible.
- Do not combine crossover claim services and Medicare denied services or benefits exhausted services on a single claim (paper or electronic). Medicare denied services or benefits exhausted services must be submitted as a "straight" Health First Colorado claim on a separate claim.

Other Third Party Liability

There are a variety of circumstances, other than commercial health insurance coverage, where services provided to a member may be payable by a third party. In some instances, liability is firmly established, such as with Workers Compensation. In others, however, there may be potential liability that has not been confirmed, such as with an automobile policy.

Established Third Party Liability

Where TPL is established, providers should submit claims to the responsible third party.

Workers Compensation

Services known to be billable to Workers Compensation should be billed to the Workers Compensation carrier. Health First Colorado claims instruct providers to identify services that are related to employment. The Health First Colorado program does not deny payment because of potential TPL resulting from employment accidents, but providers cannot receive payment from both programs.

Health Care Programs (HCP) for Children with Special Needs

Providers who render services to children covered by the Colorado Health Care Programs (HCP) for Children with Special Needs should follow HCP billing instructions. The Health First Colorado program does not deny claims for individuals who are enrolled in Colorado HCP, but providers cannot receive payment from both programs.

Potential Third Party Liability

Providers should not delay Health First Colorado claims submission where there is potential TPL. The Health First Colorado program requires that claims be submitted within 120 days from the date of service. If providers subsequently receive payment from a third party, the Health First Colorado payment must be refunded.

Accident Liability

Health First Colorado claims instruct providers to identify services that are related to accidents. The Health First Colorado program does not deny payment because of potential TPL resulting from accidents. Providers should not hesitate to indicate that services are related to an accident for fear that the claim will be denied.

The Health First Colorado program sends a questionnaire to members who have received services for a diagnosis that may be accident-related. The questionnaire asks for information from the member about other liability or benefits available.

If providers receive payment from a third party, they must return any Health First Colorado payment.

The Health First Colorado program appreciates providers' assistance in recovering payments from TPLs. Providers are asked to notify the Department's fiscal agent if the member or the member's representative (e.g., attorney) requests detailed copies of bills for medical services paid by the Health First Colorado program. Please copy and complete the Third Party Liability Reporting Form shown in Appendix G in the Provider Services Billing Manual section.

Victim Assistance Programs

Victim Assistance Programs **do not** represent potential TPL. The Health First Colorado program does not deny claims for services to individuals who may be eligible for compensation from Victim Assistance Programs. Providers should submit claims to the Health First Colorado program when the member is Health First Colorado eligible.

Colorado Indigent Care Program (CICP)

Individuals who are covered under the Colorado Indigent Care Program (CICP) are not eligible for Health First Colorado benefits. If an individual has Health First Colorado benefits, claims should be submitted for Health First Colorado reimbursement.

Returning Health First Colorado Payments

With the exception of Victim Assistance Programs, the Health First Colorado program is the payer of last resort. Regardless of the payment source, when providers receive payment from a third party for services that have previously been paid by the Health First Colorado program, the Health First Colorado payment must be refunded immediately.

- Refunds must be made for the full amount of the Health First Colorado claim payment.
- Providers may not retain a portion of the Health First Colorado payment to supplement a third party payment.
- If the third party payment is the same or more than the Colorado Medical Assistance Program allowance for the billed service, the Health First Colorado program does not make additional payment.
- If partial payment is due from Health First Colorado, the provider should submit the third party payment information as part of an adjustment request. The Health First Colorado program will retract the original payment and reprocess the claim for any additional payment due.

Providers may refund Health First Colorado payments using any of the following procedures:

- Submit an electronic adjustment transaction. The claim payment will be subtracted from the future payments for processed claims.

- Submit a paper Refund to Medicaid or Returned Warrant Form accompanied by a business check for the full amount of the claim. The adjustment must identify the member, the Internal Control number of the claim to be recovered, and the date(s) of service.

Contact the Department's fiscal agent for instructions on specific circumstances.

General Claim Requirements

With few exceptions, Health First Colorado claims must be submitted electronically. Electronic claims may be submitted interactively (one transaction at a time) or in batch format. Batch may be submitted using batch submission software that must be developed by the provider or purchased from a certified software vendor, or by utilizing the HIPAA 837 transaction. Electronic filing reduces claim completion time, expenses, and claim processing time by eliminating paper handling, mailing time, and fiscal agent data entry.

Electronic claim submission is available for all claim types in the following electronic claim formats:

- CMS 1500/ 837 Professional (837P)
- UB-04/ 837 Institutional (837I)
- Dental/ 837 Dental (837D)
- Pharmacy/ NCPDP

Claim Submission

All claims, whether electronic or paper, are processed through the Health First Colorado's interChange System. The fiscal agent processes claims and mails the Remittance Advice (RA) to the provider. RAs are also available to the provider through the Provider web portal. Providers are responsible for reconciling each Remittance Advice (RA) and resubmitting claims that do not appear on Remittance Advice (RA). Claims that are denied or rejected must be corrected and resubmitted by the provider in a timely manner.

Electronic Claims and Paper Claims

- Electronic and paper claims are adjudicated and reported the same way within the interChange System.
- Electronic acceptance reports must be reviewed and reconciled.
- Both types of claims must be submitted timely and accurately.
- The Health First Colorado Remittance Advice (RA) must be reconciled for both electronic and paper claims.

Electronic Claim Submission Exemptions

Electronic claims format shall be required unless hard copy claims submittals are specifically authorized by the Department. Requests may be sent to the Health First Colorado program, P.O. Box 30, Denver, CO 80202. The following claims can be submitted on paper and processed for payment:

- Claims from providers who consistently submit 5 claims or fewer per month (requires prior approval). These providers are recommended to submit claims on the Provider web portal where payment status will be received immediately.
- Claims that, by policy, require attachments
- Reconsideration claims

Service Bureaus, Billing Services, and Claim Submission Software Vendors

Enrolled providers are responsible for the accuracy and timeliness of claim submission activities of agents, service bureaus, billing services, software vendors, and switch vendors.

Electronic Claims Submitted via Provider web portal

The Health First Colorado program allows providers to conduct the following transactions on the Provider web portal:

- Create and transmit claims electronically
- Transmit eligibility verification transactions
- Transmit claim reversals
- Transmit adjustment transactions
- Transmit Prior Authorization Requests (PARs)

See the Provider web portal information in the Electronic Claim section of the Billing Manuals located in the Provider Services Billing Manuals section for more information.

Re-bills

Health First Colorado claim forms and provider agreements contain federally required certification statements that apply to Health First Colorado billings. The provider's signature acknowledges the provider's agreement to the terms and conditions of the certification statements. Paper claims that do not include the certification statements cannot be accepted and are returned to the provider.

If an electronic claim is denied or rejected, the claim should be re-billed electronically.

If a paper claim re-bill is required:

- Resubmission of a previously denied claim must be submitted as an original claim and should include the Previous ICN as discussed in the Timely Filing Section of this manual.
- Photocopies of claims will not be accepted.
- Re-bills must be re-signed and the signature re-dated by the billing provider.

Timely Filing

Health First Colorado claims must be filed in a timely manner. A claim is considered to be filed when the fiscal agent documents **receipt** of the claim.

With few exceptions, electronic claims can be submitted twenty-four hours a day, seven days a week. Electronic claim receipt is documented by the assignment of an Internal Control Number (ICN). Electronic acceptance and rejection messages include the transaction date.

Paper claim receipt is documented by the fiscal agent's date stamp or the imprinted ICN.

Holidays, weekends, and dates of business closure do not extend the timely filing period.

Dated claim signatures, computerized or clerically prepared claim listings, and/or postmarks and certified mail receipts do not constitute proof of receipt for timely filing purposes.

The provider is responsible for assuring that each claim is received within the timely filing period. With the exceptions of paper claims that are returned to the provider because of missing information and rejected electronic claims, all claims filed with the fiscal agent appear on the RA as paid, denied, or "in process" within 30 days of receipt. If claim information does not appear on the RA within 30 days of an electronic transmission or paper claim mailing, the provider is responsible for contacting the fiscal agent to determine the status of the claim and **resubmitting the claim if necessary.**

Agent or software failure to transmit accurate and acceptable claims or failure to identify transmission errors in a timely manner needs to be resolved between the provider and the agent or software vendor. Failure to comply with filing requirements -including timely filing -because of software product failure or the action (or inaction) of a billing agent are not recognized as extenuating circumstances beyond the provider's control.

Original Timely Filing

Timely filing for Health First Colorado claim submission is **120 days from the date of service**.

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

Medicare Crossover Claims

Timely filing for Medicare crossover claims is within 120 days from the date of payment or 60 days from the date of denial.

Complete the Medicare fields on electronic and hardcopy crossover claims using the Medicare processing information on the Medicare payment report.

Maintain the Medicare payment report and the page describing the payment or denial reasons in the member's file.

When automatic crossover (the automated exchange of claims between Medicare and the Health First Colorado fiscal agent) occurs, timely filing requirements are met. If the automatic Medicare crossover claim does not appear on the Health First Colorado RA within 60 days from the Medicare processing date, the provider is responsible for submitting the crossover claim to the Health First Colorado program.

Adverse Action

Adverse action is any claim-specific action that does not result in Health First Colorado-authorized reimbursement for services rendered. The following are examples of adverse action:

- A claim rejection
- A claim denial
- A disputed payment on the Health First Colorado RA
- Fiscal agent correspondence (including form letters) that identifies specific claims
- Claims that have been date-stamped by the fiscal agent or the Department and returned to the provider

Correspondence, reports, or forms that do not identify the member, service date(s), types of service, and billing provider are not recognized as proof of timely filing compliance. Prior authorization is not a timely filing waiver.

Checking Claim Status

Providers may follow up with the fiscal agent regarding claim status by calling Provider Services at the phone number listed in Appendix A in the Provider Services Billing Manual section. Providers can also utilize the HIPAA 276/277 Claim Status Request and Response transaction to inquire about claims. To use this method of determining claim status, the provider must be able to transmit compliant HIPAA transactions, or use a clearinghouse or switch vendor to transmit the data for them. Specific details for submitting and receiving this transaction are outlined in the 276/277 Companion Guide located in the Provider Services Specifications section.

Re-bills and Adjustments and the Sixty-day Rule

Electronic and paper re-bills (resubmissions of previously denied claims) and adjustment requests must be filed with the fiscal agent and received within the timely filing period.

- If the timely filing period expires, a re-bill or adjustment request must be received within 60 days of the last adverse action.
- The Previous ICN must be entered in the appropriate field of the electronic format. Please note that Late Bill Overrides are no longer accepted.

If the provider submits a paper claim, the ICN of the last adverse action must be entered as follows:

- UB-04: Enter Previous ICN in Field 64A.
- CMS 1500: Enter Previous ICN is reported in Field 22-Original Ref and Field 22-Resubmission code of 9F.

- 2006 ADA Dental: Enter Previous ICN in Field 16 and enter 9F in Field 19.

Proof of compliance with **all** timely filing and sixty-day rule requirements must be maintained in the provider's files. Compliance with the sixty-day rule is calculated by using one of the following dates:

- The RA run date
- The electronic claim rejection date
- The correspondence date
- The date-stamp on returned claims

Timely Filing Continuity

Providers may continue to re-bill or adjust claims after the original timely filing period has expired if every submission meets applicable 60-day rule requirements.

If the original timely filing period expires, the next submission must be received within 60 days of the last adverse action. Calculate compliance with the sixty-day rule by counting backward sixty days from the last documented electronic transmission date. To determine timely filing continuity for paper claims, estimate the claim receipt date (allow ample mailing time) and count backward sixty days. If the last adverse action date falls within the sixty-day time period, the sixty-day rule requirement is met.

For example, if a claim is received on December 31st, the last adverse action must be dated after November 1st of the same year. If the last adverse action date occurred before the sixty-day period, the claim or adjustment is not within timely filing.

Copies of **all** RAs, electronic claim rejections, and/or correspondence documenting compliance with timely filing and sixty-day rule requirements must be maintained in the provider's files.

Delayed Processing by Other Insurers

If the timely filing period expires because of delays in getting third party payment or denial documentation, the fiscal agent is authorized to consider the claim to be filed timely if it is received within 60 days from the date of the third party payment or denial **or** within 365 days of the date of service, **whichever occurs first**.

- Providers should not submit or resubmit claims which will be received by the fiscal agent later than 365 days from the date of service.
- Claims delayed by third-party insurers and received later than 365 days from the date of service will be denied.

Providers must complete third party information on the electronic claim format and retain a copy of the third party payment or denial notice in their files. If a paper claim is required, the provider must complete the third party payment/denial fields, write "TPL Paid" or "TPL Denied" on the face of the claim, and retain a copy of the third party payment or denial notice. A copy of the third party payment or denial notice also may be attached to the claim. The provider is responsible for pursuing available third party resources in a timely manner.

Delayed/Retroactive Member Eligibility

If the timely filing period expires because eligibility determination is delayed or back-dated, the fiscal agent is authorized to consider the claim to be filed timely if it is received within 120 days of the date that the member's eligibility is approved. Each claim must have an attached, Department-authorized, load letter.

- The Claim states specifically that eligibility was delayed and/or backdated and indicates the dates of eligibility.
- The Claim states the date that such action was entered into the State's eligibility system.
- The following list is considered acceptable documentation and should be attached to the Claim in the event of delayed eligibility:
    - A claim denial or payment on an RA or 835
    - Fiscal agent correspondence (including form letters) that identifies specific claims
    - Claims that have been date-stamped by the fiscal agent or the Department and returned to the provider
    - Load letter for Retroactive/Delayed Eligibility Determination
    - Affidavit of delayed notification of member eligibility

Do not submit claims without member state identification numbers. If eligibility determination is pending, file the claim with the required documentation described above as soon as an assigned number is available.

Delayed Notification of Health First Colorado eligibility

Providers are expected to take appropriate and reasonable action to identify Health First Colorado eligibility in a timely manner. Some examples of appropriate action include:

- Reviewing past medical and accounting records for eligibility and billing information for services provided.
- Requesting billing information from the referring provider or facility where the member was seen.
- Contacting the member by phone or by mail.

It is not effective to rely solely on billing statements, collection notices, or collection agencies as the only means of obtaining eligibility and billing information. If the timely filing period expires because the provider is not aware that the member is Health First Colorado eligible, the fiscal agent is authorized to extend the timely filing period if the claim is received within 60 days of the date that the provider was notified of Health First Colorado eligibility.

A signed Certification and Request for Timely Filing Extension form must be completed and attached to each claim for which an extension is requested. The State-approved certification form is reproduced in Certification & Request for Timely Filing Extension in the Provider Services Forms section. Providers may copy the form as necessary.

- Any alterations, additions, or deletions to the statements on the form will cause the claim(s) to be denied.
- Each form must be signed by the provider or an authorized agent/representative.
- Rubber stamped or photocopied signatures are not acceptable and will cause claim(s) to be denied.
- Misuse of the certification to obtain unwarranted timely filing extensions will result in recovery of improperly obtained payments.

Requests for Reconsideration

The provider must exhaust all authorized fiscal agent rebilling and adjustment procedures before filing a Request for Reconsideration with the fiscal agent.

- Requests for Reconsideration must be filed in writing with the fiscal agent within 60 days of the last adverse action, if initial timely filing has expired.
- Copies of all RAs, electronic claim rejections, and/or correspondence documenting compliance with timely filing and sixty-day rule requirements must be submitted with the Request for Reconsideration.

Timely Filing Extensions for Circumstances Beyond the Provider's Control

Occasionally, the timely filing period may expire because of delays in obtaining eligibility or third party processing information. The Department authorizes the fiscal agent to extend the timely filing period under the following circumstances:

- Delayed Processing by Third Party Liability
- Delayed/Retroactive Member Eligibility
- Delayed Notification of Health First Colorado Eligibility
- Other Circumstances beyond the Provider's Control

Other Circumstances Beyond the Provider's Control

Reconsiderations that request timely filing waivers must contain a detailed description of the extenuating circumstances **beyond the provider's control** resulting in failure to meet timely filing requirements.

Exceptions are granted only where the provider is able to document that appropriate action to meet filing requirements was taken and that the provider was prevented from filing as the result of exceptional circumstances that could not have been foreseen or controlled. Employee negligence, employer failure to provide sufficient, well-trained employees, or failure to properly monitor the activities of employees and agents (e.g., billing services) are not extenuating circumstances beyond the provider's control.

General Claim Completion Instructions

The following general instructions help assure prompt, accurate claim processing:

Always read the instructions for the specific claim format being completed. The instructions describe each data field and the information required for accurate completion. Paper claims may be completed by computer, typewriter, or by hand. **All claim information must be legible**. Handwritten claims should be neatly printed. Do not strike over typing errors. Keep entries within the designated boxes and lines.

Paper claims that cannot be imaged are returned to the provider. Paper claims and attachments must meet minimum imaging requirements. Use black ink to complete the claim form. Faint printing caused by worn or poor quality typewriters or printer cartridges cannot be imaged.

Never use highlighters to mark paper claims or claim attachments. Highlighted information cannot be imaged. Use a broad black pen to circle or underline information requiring special attention.

If field completion is not required, leave the field blank. Do not enter comments or "N/A."

Do not submit "continuation" claims. Each paper claim form has a set number of billing lines available for completion. **Do not crowd more lines on the form**. Billing lines in excess of the designated number are not processed or acknowledged. Claims with more billing lines than allowed on the form must be split and each page fully completed and totaled.

Each paper claim form must be accompanied by any required attachments. Always attach required claim attachments **behind** the claim form. If several claims require the same attachment, the attachment must be photocopied as many times as necessary and stapled behind **each** of the submitted claim forms.

Claims for more than one occurrence of the same procedure on the same date should be billed on one billing line using multiple units of service and increasing the charges accordingly.

Claim Coding

All Health First Colorado claims require diagnosis codes and procedure codes. The appropriate diagnosis code must be entered on all claims. Procedure codes are dependent on the type of service and claim type.

Diagnosis Coding

The Health First Colorado program recognizes only those diagnosis codes published in the ICD-10-CM by the U.S. Department of Health and Human Services, Public Health Service, and Center for Medicare and Medicaid Services (CMS).

ICD-10-CM codes must be entered properly on the claim form and must relate to the services for which charges are being submitted. The Health First Colorado program provides benefits for services that are medically necessary. The diagnosis code must be specific and indicate an appropriate cause for and relationship to the services provided. In general, non-specific codes (e.g., for radiology examinations or gynecology examinations) are not acceptable for Health First Colorado reimbursement. Common medical practice indicates that some procedures are appropriate only when specific conditions are present. **Providers must assure that the diagnosis entered supports the validity and appropriateness of the billed service. DSMIV codes are not accepted.**

Diagnosis Coding for Members with AIDS or AIDS-related Diagnoses

Federal and State legislation impose severe penalties for failure to keep AIDS-related information confidential. This legislation, however, is not intended to prevent Health First Colorado providers from accurately and appropriately submitting Health First Colorado claims.

Health First Colorado providers, the State, and the fiscal agent are prohibited from disclosing any information related to public assistance applicants or members. Federal Regulation 430.331, State Statute 26-1-114, and HIPAA Privacy CFR 45 provide sanctions for disclosing confidential information. However, these legal documents do allow information to be disclosed for the purpose of administering a public assistance program.

Health First Colorado claim information is necessary for Health First Colorado administration. This information meets Federal and State requirements and is used to process claims, calculate costs, and project future funding. **Information shared for these purposes does not endanger the member's confidentiality.** AIDS or AIDS-related diagnoses codes should be entered on the claim form like any other diagnosis or condition.

Procedure Coding - HCPCS

The Health First Colorado program uses the CMS HCPCS to identify services provided to Health First Colorado members. The HCPCS includes codes identified in the *Physician's Current Procedural Terminology (CPT)* and codes developed by CMS.

The State approves using HCPCS codes when submitting claims for services billed in the following formats:

- CMS 1500
- Institutional-Outpatient
- Dental
- EPSDT

Providers should use the most current CPT version. The Health First Colorado program adds and deletes codes as they are published in annual revisions of CPT. The CPT can be purchased at local university bookstores or from the American Medical Association at the following address:

Book & Pamphlet Fulfillment: OP-341/9
American Medical Association
PO Box 10946
Chicago, IL 60610

Always use the current HCPCS publication when submitting the Health First Colorado claims. Updates and revisions to HCPCS listings are made through Health First Colorado bulletins located in the Provider Services Bulletins section.

HCPCS publications vary in length and are replaced annually. Providers should keep the current HCPCS publication with the Provider Manual.

Revenue Coding

The Health First Colorado Revenue Code Table contains, by type of service, revenue codes for billing services to the Health First Colorado program. The listed revenue codes are not all Health First Colorado benefits. When valid non-benefit revenue codes are used, the claim must be completed according to the billing instructions for non-covered charges**. Claims submitted with revenue codes that are not listed are denied.**

Use the codes listed in the current revenue code table when submitting institutional claims. Notices of updates and revisions to the revenue code table are made in Health First Colorado bulletins. The current revenue code table is located in Appendix Q of the Appendices in the Provider Services Billing Manuals section.

Claims Processing

Claims Processing Overview

The Department contracts with the fiscal agent for the processing of Health First Colorado claims. The fiscal agent receives and processes all Health First Colorado claims in accordance with established Health First Colorado policies. Claims can be submitted via paper, interactively via the Provider web portal or via Electronic Data Interchange (EDI) using the 837 transactions.

Internal Control Number

A unique, 13-digit, Internal Control Number (ICN) is assigned to each claim for identification and tracking.

- The 1st and 2nd digits represent a "Region code". This Region code identifies the method of claim submission.
- The 3rd and 4th digits identify the year of receipt.
- The 5th, 6th, and 7th digits identify the Julian date of receipt.
- The 8th, 9th, and 10th digits identify the batch number on that Julian date.
- The 11th, 12th and 13th digits identify the claim number in that batch.

For Example: ICN 1016270001001

- This claim is a Region code 10 (1st and 2nd digits)
- This claim was received in 2016 (3rd and 4th digits)
- This claim was received on Julian date 270 or September 26th (5th, 6th, and 7th digits)
- This claim was in Batch number 001 for that day (8th, 9th, and 10th digits)
- This claim was number 001 in that batch (11th, 12th and 13th digits)

Paper Claims

When required information is not included or is illegible on paper claims, the claims are returned to the provider for correction and/or completion. Returned claims are date stamped and sent to the provider with a Return To Provider (RTP) form letter. The date-stamped claim is proof of timely filing.

The provider should enter or correct the required information and check additional missing, invalid, or illegible information to avoid further processing delay. If needed, the provider may contact Health First Colorado Provider Services for assistance.

Do not attach the RTP letter or a copy to the corrected claim. Retain the RTP letter for your files.

Electronic Claims

When required information is not included on the claims, the claims are electronically rejected. The 999 Acknowledgement when using any of the HIPAA 837 transactions, lists all the claims that have been accepted and rejected. Rejected claims are not processed and do not appear on the RA.

After each system cycle, accepted claims pay, suspend, or deny.

Claims suspend when they have errors or, according to state guidelines, require manual review. Claims processors review suspended claims and process the claims according to State policy. See the Provider web portal information in the Billing section of this manual.

Payment Cycle

Each Friday, the weekly payment cycle prepares claims for payment, processes the payment, updates the provider's Accounts Receivable (AR), if applicable, posts Electronic Funds Transfer (EFT) the next week, and produces a RA. The fiscal agent receives warrants (checks) from the Colorado Operations Resource Engine (CORE) on Wednesdays, matches them to the RA, and mails them to providers. Except when holidays create a one to two day delay, providers should receive their warrant by the beginning of the following week.

The Health First Colorado RA is the official document that reports the results of claim processing. For every billing provider with claims processed during the week, a RA is either mailed to the provider or posted electronically. If processing results in a payment, the RA is accompanied by a warrant (check) or EFT issued by the State of Colorado.

Information on the RA must be used to post payments, reconcile member accounts, track claims, comply with timely filing requirements, and detect payment or billing errors. The RA should be retained for reference. A service charge is applied to produce a duplicate RA.

Providers may also request to receive the HIPAA 835 Health Care Claim Payment Advice for receiving claim payment information. To receive this transaction, the provider must be able to receive compliant HIPAA transactions, or use a clearinghouse to receive and transmit the data for them. To obtain more information about receiving this transaction, contact the Electronic Data Interchange (EDI) Support Unit at 844-235-2387.

General Information

RA information varies according to the type of claim submitted, the type of provider submitting the claim, and the type of service provided (category of service). Providers who submit claims under more than one provider number receive a separate RA for each billing provider number.

If the provider bills for more than one service category, claims for each category are displayed separately.

The RA for a pharmacy submitting claims for prescription drugs and for medical supplies will have separate displays: One for drugs and one for supplies.

Providers select the order in which claim information is sorted. Within each category of service, claims may be sequenced by member last name, State ID, prescription number (pharmacy only), rendering provider number, rendering provider name, date of service, or member account/invoice number. Requests for changes to the claim information sequence are handled by Health First Colorado Provider Services. See the Appendixes in the Provider Services Billing Manual section for contact information.

As appropriate and applicable, claim status information is printed for each category of service under the following headings: Claims Paid, Claims Denied, Claims In Process, Adjustments Paid, Adjustments Denied, Reconsiderations Paid, Reconsiderations Denied, and Reconsiderations in Process.

Remittance Advice (RA) Sections

Each Remittance Advise (RA) page carries a heading with the following information:

The name of the provider, the provider's NPI or Health First Colorado number, and the category of service for the identified claims.

Information about the RA: The “Run Date,” which identifies the date that the RA was actually printed and is used for timely filing calculations, the “As Of Date,” which identifies the cut-off date applicable to the claim information, and the page number of the RA.

Claim detail information is reported under a number of headings according to the type of claim submitted and the adjudication status of the claim. Payments, Denials, and In-Process Claims are reported using distinctive headings.

If no claims are paid during the week, the RA will not contain a paid claims section.

Each of the following sections appears on the RA with a distinctive heading indicating the type of information presented:

Provider Identification

The first page of the RA displays the provider’s name and mailing address.

Special Messages

The RA notifies providers of special updates and policy and/or claims processing information. These messages contain the timeliest notification of changes in billing and payment conditions and should be read each time a RA is received.

Messages are often repeated for two or more weeks to assure that infrequent billers have access to information in the same way as those providers who submit claims weekly. Even though the messages may appear unchanged over a several week period, providers should always read the RA messages each time the RA is received.

Claims Paid

Information in this section of the RA must be used to reconcile member accounts and make appropriate accounting and adjustment entries. The provider is responsible for reconciling the RA.

The total number of paid claims and total dollar amount of the payment for the identified category of service is listed at the end of the RA.

Claims Denied

Denied claims identify the reason for denial with a reference code. Claims that are denied as a duplicate claim display a second entry identifying the previously paid claim by the ICN and processing date.

Claims denied because of billing errors, incorrect eligibility information, etc., may be rebilled with additional or corrected information at any time during the applicable timely filing period. Rebilled claims appear on the RA as a new claim with a new ICN.

The total number of denied claims is identified at the end of the Claims Denied section of the RA.

Adjustments Paid

Claim payments may be adjusted for increased payment, decreased payment, or recovery without repayment. Adjustments that increase or decrease the payment amount are processed as two separate transactions. The first transaction recovers the previously made payment and the second transaction repays the claim at the corrected rate.

Original transactions are identified by a "0" in the 12th position of the ICN (refer to pages 1-2 of this section). Recovery transactions are identified by a "1" in the 12th position of the ICN and a "CR" notation following the claim payment amount. Repayment transactions are identified by a "2" in the 12th position of the ICN and show the full amount of the corrected payment.

If the previous payment is recovered without repayment, the adjustment is finalized with the recovery transaction and a repayment transaction does not appear. Overpayments are recovered by reducing the total payment amount for claims paid on the RA. If the full recovery amount cannot be collected when the adjustment is finalized, an AR account is established to recover the balance from the future claim payments.

Following the last transaction in the Adjustments Paid section, the total number of adjustments paid is indicated as well as the net result, payment, or recovery for all adjustment transactions. If the net result of all adjustment transactions is a balance due from the provider (recovery), the total payment amount shows the notation "CR" following the dollar amount.

Adjustments Denied

Denied adjustments may result in a balance due. The recovery transaction retracts the original claim payment and, when the entire repayment transaction is denied, the repayment amount is zero.

Denied adjustments identify the reason for denial. Adjustments that are denied as a duplicate of a previously processed adjustment identify the duplicate adjustment by ICN and processing date.

Denied adjustments may be resubmitted with additional or corrected information within the applicable timely filing period of the RA showing the adjustment denial. Resubmitted adjustments display a new ICN.

The total number of denied adjustments is identified at the end of the Adjustments Denied section.

Claims in Process

Claims that are being processed, but have not finalized at the time the weekly RA is prepared, appear on the RA as "Claims in Process".

Do not re-bill or submit adjustment transactions for claims in process. Suspended claims will be adjudicated and appear in the claims paid or claims denied sections on subsequent RA.

Claims Denied for Third Party Liability

Other payment resources must be pursued and third party payment or denial information must be reported on the Health First Colorado claim. When other coverage is available, claims without third party payment or denial information are denied. The RA displays Third Party Liability information to assist providers in submitting claim information to other insurers.

Payment Information

Claim payment information is reported on the RA under the headings of Claims Paid, Adjustments Paid, or Reconsiderations Paid.

The total number of paid claims and the total dollar amount of the payment for the identified category of service is listed at the end of the RA.

Incorrect payments must be adjusted and cannot be re-billed. The fiscal agent must receive requests for adjustment within the applicable timely filing period.

Accounts Receivable (AR) Information

An Accounts Receivable (AR) account is established when circumstances result in a provider owing money to the Health First Colorado program.

A Credit Account is established when the net result of adjustment transactions is a credit balance and amount owing to the State that cannot be fully recovered from claim payments made on the same RA, or when audit results determine that a provider has been overpaid or is otherwise indebted to the Health First Colorado program.

Accounts receivable information for both types of accounts is displayed in the following format:

Beginning amount due the state $ _____

Payment amount applied to AR balance $ _____

New credit amount due the state $ _____

Percentage applied to credit amount _____ %

Beginning credit amount due the State

The balance is due to the Health First Colorado program at the beginning of the weekly payment period. This amount is the same as the ending balance shown on the previous RA. If the AR account is established because of credits taken on the current RA, the beginning amount appears as 0.00.

Payment Amount Applied to AR Balance

The dollar amount applied to the AR balance from the claims paid is on the RA. If the net result of claims and adjustments paid is a credit or recovery, the amount is added to rather than subtracted from the beginning AR balance.

New Interim/Credit Amount due the State

The updated balance due the State from the provider, calculated as the Beginning Credit Amount plus or minus the Payment Amount Applied to the AR Balance or plus additional credits identified on the same RA.

Percentage Applied to Payment/Credit Amount

The percentage of the current payment for paid claims and adjustments applied to the beginning amount due the State. The recovery percentage amount is determined by the State.

Total Check Amount

The amount of the warrant is enclosed with the RA.

Denial Reason (Exc) Codes

A brief explanation of the denial codes if listed in the Denial Reasons column.

The following examples illustrate reconciliation of the AR information:

EXAMPLE 1

Previously established AR with repayment deducted from current paid claims

Claims paid from RA	$400.00
Adjustments Paid from RA	
Total Payments this RA	$200.00
Beginning Amount Due	
Payment Applied	$600.00
New Credit Amount	400.00 (From previous RA)
Percentage Applied	150.00 ($600.00 total payment times 25%) 250.00 (To next week's RA) 25

EXAMPLE 2

Newly created AR from recovery adjustments

Claims paid from RA	0.00
Adjustments Paid from RA	$200.00 CR
Total Payments this RA	0.00
Beginning Amount Due	
Payment Applied	0.00
	200.00 (Negative adjustment amount) *When the net result of paid claims and adjustments is a negative or credit amount, the amount shown is added to rather than subtracted from the beginning balance.*
New Credit Amount	
Percentage Applied	200.00 (To next week's RA) 25

Re-bills

Denied claims can be re-billed. Claims that are paid incorrectly must be adjusted. Do not re-bill claims that appear on the RA as "In-Process."

Re-bills must be received by the fiscal agent within the applicable timely filing period.

Re-bills should be submitted electronically if attachments are not required. Re-bills must be submitted as a newly created claim form. Photocopies of claims are not accepted and will be returned.

Required attachments must accompany each applicable claim form.

Example: If three claims require the same report, the report must be copied three times and a copy of the report attached to each of the three claim forms.

Adjustments

Claims that appear in the Claims Paid section of the RA may be adjusted electronically or on paper. The fiscal agent must receive requests for adjustment to paid claims within the applicable timely filing

period. Copies of all Health First Colorado RA and Acceptance/Rejection reports documenting applicable timely filing must be attached to the paper adjustment request or electronically document timely filing with the Previous ICN as discussed in the Timely Filing section of this manual.

Providers should submit a CMS 1500 to request correction of underpayments, claims paid at zero, overpayments, and claims history information. If these corrections are not submitted as adjustments, but are re-billed, they will be denied as duplicates.

If the provider submits a paper claim as an adjustment, an original claim form must be submitted with a valid signature. The adjustment must include the ICN of the previous claim and should be coded as follows:

- UB-04: Type of Bill (TOB) must end in 7 (adjustment) or 8 (Void). Previous ICN is reported in Field 64A.
- CMS 1500: Enter Previous ICN is reported in Field 22-Original Ref and Field 22-Resubmission code of 7 (adjustment) or 8 (void).
- 2006 ADA Dental: Enter Previous ICN in Field 16 and enter in Field 19 7 (adjustment) or 8 (void).

Payment Errors

The provider is responsible for notifying the fiscal agent immediately when payment errors occur. The CMS 1500 must indicate the appropriate corrected or additional information necessary for claim reprocessing. If a claim has been underpaid, the fiscal agent must receive a CMS 1500 adjustment within the applicable timely filing period.

Underpayments

If a claim has been underpaid, the fiscal agent must receive the CMS 1500 adjustment within the applicable timely filing period.

Claims are underpaid because of incorrect, missing, or inadequate submitted information. The adjustment must indicate the appropriate corrected or additional information necessary for claim reprocessing.

Claims Paid at Zero

A claim payment of $0.00 (zero) is a paid claim even though the provider does not actually receive payment. The most common reason for zero payment is third party payment deduction from the allowable Health First Colorado benefit or a Medicare crossover paid under lower-of-pricing. If a zero payment is incorrect, the provider must submit a CMS 1500. Re-billed zero payment claims are denied as duplicates.

Claims that are line item processed and document-adjudicated may show some line items as paid and others as denied. Line item denials show allowed charges as $0.00 with a code printed to the right of the procedure code modifier for the denied line. Denied line items may be re-billed.

Overpayments

Providers must report all overpayments to the fiscal agent immediately. Overpayments are adjusted and recovered upon discovery even if the timely filing period has expired. Adjustments to overpaid claims may be made in one of the following ways:

Overpayments are recovered through (1) the claims processing system with credit (recovery) amounts subtracted from current claim payments or (2) held as an AR balance designated for recovery against future claim payments.

The provider may send a personal check payable to the State of Colorado for the total claim payment amount. Send the check and a fully completed Refund to Health First Colorado or Returned Warrant form with attachments to the fiscal agent for processing. The check must be for the **full amount of the incorrect claim payment**.

If repayment of the claim is appropriate, the revised claim is processed through the claims processing system and the repayment appears on the RA. The repayment amount is included in the warrant.

Warrants and RAs containing large or numerous payment errors may be returned, non-negotiated, with an explanation to the fiscal agent.

Third Party Payments

The Health First Colorado program is always the payer of last resort. If a third party pays for services that were previously processed and paid by Health First Colorado, notify the fiscal agent and refund the full Health First Colorado claim payment. Third party payment recoveries are processed in the same manner as overpayments.

Medicare Crossover Adjustments

Medicare adjustments to previously processed Medicare claims cannot be processed as automatic crossovers. Medicare adjustments may show the crossover message but automatic crossover processing is not possible. The provider must submit a CMS 1500 adjustment transaction and include the Medicare adjustment Standard Paper Remit (SPR) to correct the Health First Colorado payment.

Changes to Claim History

An adjustment transaction should be submitted to correct processed, non-payment related claim information to assure proper data for utilization review and cost reporting, e.g., a corrected date of service.

Requests for Reconsideration

The fiscal agent is the primary source for providers to obtain satisfactory resolution of submitted and processed claims and is authorized by the single state agency to apply all applicable State and Federal rules and regulations to process Health First Colorado claims.

Extenuating Circumstances

If claim filing requirements are not met because of circumstances beyond the control of the provider and all resources available through routine claim processing procedures have been exhausted, reconsideration is available to providers through the Health First Colorado Claims Processing unit.

The Claims Processing unit is authorized to evaluate and validate alternative information resources when the provider can show both of the following conditions:

- Appropriate action to meet filing requirements was taken
- The failure to meet filing requirements was caused by exceptional circumstances that could not have been foreseen or controlled by the provider

Billing and claim preparation errors are not recognized as beyond the provider's control. Examples include:

- Employee negligence
- The provider's failure to provide sufficient, well-trained employees
- The provider's failure to monitor the activities of employees and agents (billing services)

Reconsideration is available only when extenuating circumstances or mitigating factors prevent compliance with filing requirements.

Request for Reconsideration Form

THE COLORADO MEDICAL ASSISTANCE PROGRAM
P.O. Box 30
Denver, CO 80201-0030

COLORADO
Department of Health Care Policy & Financing

Request for Reconsideration

All required information below must be completed. See the reverse side of the form for additional information.

Provider Identification - Required

Provider Name

Street Address

City, State, Zip Code

Billing Provider ID Number

Billing Provider NPI

Individual to Contact

Provider Telephone Number

Area Code **Number**

Client Identification - Required

Enter client's State ID Number

Date(s) of service

Date of last Provider Claim Report (PCR)

If requesting an adjustment of a paid claim, you must enter the TCN:

Important: Do not use this form to rebill claims or request routine adjustments. Use this form only after all routine processing procedures have been exhausted and the adverse action is the result of circumstances beyond the provider's control.

Identification of Attachments - Required

Please indicate the documents attached to this request. Incomplete requests will be denied or returned.

Required for all requests

- ☐ Fully completed and signed claim form(s) with all required attachments, reports and consent forms for each claim form
- ☐ Documents showing proof of compliance with ***all*** timely filing requirements for each claim form

Required, if applicable to extenuating circumstances

- ☐ Certification of delayed eligibility notification
- ☐ Eligibility documentation
- ☐ Third Party Resource payment or denial information
- ☐ Medicare payment or denial information
- ☐ PRO/PAR documentation
- ☐ Correspondence from State of Colorado
- ☐ Other documentation - Please identify

Description of Extenuating Circumstances and Reason for Reconsideration Request - Required

Provider Signature **Date**

Submitting Requests for Reconsideration

Requests for reconsideration should be submitted in writing on Request for Reconsideration forms. These forms may be ordered from the fiscal agent. Instructions for completing the Request for Reconsideration forms appear on the reverse side of the form.

The Requests for Reconsideration forms should be sent to the fiscal agent at the appropriate address. The forms should be attached to the front or on top of the claim(s) and any related claim information.

Providers may write the word "Reconsideration" on the claim form and submit the required information in a letter. However, requests for reconsideration that are not submitted using the Request for Reconsideration form may be processed using routine claim processing procedures. Reconsideration claims that do not include required information will be denied.

Please reference Appendix B of the Appendices of the Provider Services Billing Manuals section for the address of the Fiscal Agent.

Administrative Procedures

Reconsideration claims are acknowledged on the Health First Colorado RA and appear under three headings: Reconsiderations In Process, Reconsiderations Paid, or Reconsiderations Denied. Reconsideration claims that are processed as adjustments appear in the Adjustment Section of the RA. Health First Colorado RA information constitutes official written notification of reconsideration activity.

Providers should contact Health First Colorado Provider Services for assistance in preparing requests for reconsideration or to ask questions about reconsideration processing.

If a request for reconsideration is denied, the provider may—if additional information or documentation is available to support it—resubmit the request to the Claims Processing unit within the applicable timely filing period. The resubmitted request must include all of the following:

- The Request for Reconsideration form
- Processable claims
- Documents proving compliance with all timely filing requirements
- A letter of explanation

If all means of achieving satisfactory claim resolution through the fiscal agent and the Claims Processing unit have been exhausted, providers may file a written appeal with the Office of Administrative Courts, at the address indicated in Appendix A of the Appendices of the Provider Services Billing Manuals section.

Appeals submitted to the Office of Administrative Courts must be received within thirty days from the mailing date of the last notice of adverse action.

Health First Colorado Eligibility Response System (CMERS) / Interactive Voice Response System (IVRS)

The **Health First Colorado Eligibility Response System (CMERS)** is an automated voice response system that furnishes providers with:

- Health First Colorado Eligibility
- Provider Warrant Information
- Claim Status Information
- Instructions on Using CMERS

In addition to these services, the new **Interactive Voice Response System (IVRS)** also provides:

- Unlimited Eligibility Inquiries – the previous IVRS had a limit of three eligibility inquiries per call.
- Providers are able to check claim status by Provider ID/National Provider Identifier (NPI) with Member ID and Date of Service, or by Internal Control Number (ICN).
- Providers are offered a guarantee number (audit number) for member eligibility.

To access the **CMERS/IVRS** call toll free: **844-801-8478**.

You can also visit us online in the Provider Services section of the Department's website to access provider enrollment documents, Provider Bulletins, Billing Manuals, fee schedules, and forms.

Provider web portal functionality includes: claim submission, claim status inquiries, member eligibility verification, and provider demographic updates.

The Provider web portal can be accessed at the Department's website.

To reset your Provider web portal password please use the “Reset Password” link or call 844-235-2387.

To report technical problems with the Provider web portal, call 844-235-2387.

This section includes the following instructions:

- **Verify Member Eligibility**
  - Using State Member ID
  - Using Member’s SSN
- **Claim Status**
  - By ICN
  - By Member ID
- **Warrant Information**
- **Prior Authorization Information**
- **EDI Services**
  - Report Retrieval
  - Batch Issues
  - Retrieval Batch
  - Verify Training Partner (TP) ID

- **Billing Questions**
- **Program Benefits**
- **Billing Workshop Reservations**

CMERS/IVRS User Instructions

To Verify Member Eligibility:

You can verify eligibility two ways:

- Using the Member ID

  OR-

- Use the Member's Social Security Number and the Member's Date of Birth

Using the Member ID: Provider Validation

1. Call the Health First Colorado Assistance Voice Response System toll free at 844-801-8478.
2. Press 1 to Verify Member Eligibility.

   This action will route your call to the Provider validation section of the IVRS. The system will ask you to enter your 10-digit National Provider Identification Number (NPI) or your 10-digit Provider Number.
3. Enter the applicable ID (Provider or NPI) followed by the pound (#) sign.

   If the Provider Number or NPI you entered is invalid, the system will ask you to reenter the number (Repeat Step 2).

   If the Provider Number or NPI is valid, the system will read back the digits entered and ask you to confirm it is correct.
4. Press 1 if the number is correct.

   OR-

   Press 2 to reenter.

   If the Provider Number you entered is not valid, the system will repeat the number and ask to reenter (Repeat Step 2). After three attempts, if the number cannot be validated, you will automatically be redirected to a Provider Services Agent.

   OR-

   Press 0 to speak to a Provider Services Agent.
5. If Necessary, enter the applicable Taxonomy Number or Medicaid Provider ID.

   In some instances, when a valid NPI has been entered, and the system finds multiple providers, the system will ask for entry of either a Taxonomy Number or a Medicaid provider ID.

   Press 1 to enter a Medicaid Provider ID (Repeat Step 2).

   OR-

   Press 2 to enter the Taxonomy Number.

   Taxonomy Numbers, like Member IDs contain both alpha and numeric characters. To enter an alpha character, you must use the star (*) key and the position of the alpha character on the key pad for entry**.** For example, if the ID is 130202020X you will enter 130202020*92. The *92

represents the letter X. The star is a place holder, the 9 denotes where the letter X is located on the key pad and the 2 denotes the position of the letter under the number 9. The exceptions are the letters Q and Z. See chart below.

LETTER	ENTRY
A	*21
B	*22
C	*23
D	*31
E	*32
F	*33
G	*41
H	*42
I	*43
J	*51
K	*52
L	*53
M	*61
N	*62
O	*63
P	*71
Q	*11
R	*73
S	*74
T	*81
U	*82
V	*83
W	*91
X	*92
Y	*93
Z	*12

6. Enter the 10-digit Taxonomy Number followed by the pound (#) sign.

   Press 1 if the number is correct.

   If the Taxonomy Number is valid, the system will read back the digits you entered and ask you to confirm it is correct.

   OR-

   Press 2 to reenter.

   If the Taxonomy Number you entered is not valid, the system will repeat the number and ask to reenter (Repeat Step 5). After three attempts, if the number cannot be validated, you will automatically be redirected to a Provider Services Agent.

   OR-

   Press 0 to speak to a Provider Services Agent.

7. Enter your five or nine-digit Provider zip code followed by the pound (#) sign.

   Press 1 if the number is correct.

   If the zip code is valid, the system will read back the digits you entered and ask you to confirm it is correct.

   OR-

Press 2 to reenter.

If the zip code is not valid, the system will the system will repeat the number and ask for re-entry (Repeat Step 7). After three attempts, if the number cannot be validated, you will automatically be redirected to a Provider Services Agent.

OR-

Press 0 to speak to a Provider Services Agent.

To Verify Member Eligibility Using the Member ID

When entering the Member ID you will need to enter the member's 7-digit Member ID. Member ID's contain both alpha and numeric characters; you will need to follow the instructions found in Step 5 of section 'Using the Member ID: Provider Validation' for entry of alpha characters.

1. Enter the Member's 7-Digit Member ID followed by the pound (#) sign.

   Press 1 if the number is correct.

   If the Member ID is valid, the system will read back the digits you entered and ask you to confirm it is correct.

   OR-

   Press 2 to reenter.

   If the Member ID is not valid, the system will repeat the number and ask for re-entry (Repeat Step 1). After three attempts, if the number cannot be validated, you will automatically be redirected to a Provider Services Agent.

   OR-

   Press 0 to speak to a Provider Services Agent.

2. Enter the 8-digit From Date of Service followed by the pound (#) sign.

   Enter the From Date of Service using the two-digit month, two-digit day and four-digit year (MMDDYYYY/05172016) format followed by the pound (#) sign. Press the pound (#) sign to enter today's date.

   Possible errors that will require reentry of the From Date are:

   - The entered date is a date greater than one year prior to the current date.
   - The entered date is a future date.
   - The entered date is invalid, e.g. date entered is 51716 instead of 05172016.

3. Enter the 8-digit End Date of Service followed by the pound (#) sign.

   Enter the 8-digit End Date of Service using the two-digit month, two-digit day and four-digit year (MMDDYYYY/05172016) format followed by the pound (#) sign. Press the pound (#) sign to enter today's date.

   Possible errors that will require reentry of the End Date are:

   - The entered date is a date greater than one year prior to the current date.
   - The entered date is a future date.
   - The entered date is invalid, e.g. date entered is 51716 instead of 05172016.

If the Member is located in the system using the information you entered, the system will provide eligibility status.

Using the Member's SSN and DOB: Provider Validation

1. Call the Health First Colorado Voice Response System toll free at 844-801-8478.
2. Press 1 to Verify Member Eligibility.

   This action will route your call to the Provider validation section of the IVRS. The system will ask you to enter your 10-digit National Provider Identification Number (NPI) or your 10-digit Provider Number.
3. Enter the applicable ID (Provider or NPI) followed by the pound (#) sign.

   If the Provider Number or NPI you entered is invalid, the system will repeat the number and ask for re-entry (Repeat Step 2).

   If the Provider Number or NPI is valid, the system will read back the digits you entered and ask you to confirm it is correct.
4. Press 1 if the number is correct.

   OR-

   Press 2 to reenter.

   If the Provider Number you entered is not valid, the system will repeat the number and ask for re-entry (Repeat Step 2). After three attempts, if the number cannot be validated, you will automatically be redirected to a Provider Services Agent.

   OR-

   Press 0 to speak to a Provider Services Agent.

   If necessary, enter the Taxonomy Number. (See Step 5, in 'To Verify Member Eligibility Using the Member ID')
5. Press 2 for entry of the Member's Social Security Number and Date of Birth.
6. Enter the member's Social Security Number followed by the pound (#) sign.

   Do not use dashes between the numbers e.g. 111-11-1111.

   If the Social Security Number entered is an invalid length, the system will ask you to reenter the number.

   If the Social Security Number you entered is valid, the system will read back the number and ask you to confirm it is correct.

To Verify Member's Eligibility Using the Member's Social Security Number:

1. Press 1 if the number is correct.

   OR-

   Press 2 to reenter. This will take you back to Step 6.

   OR-

   Press 0 to speak to a Provider Services Agent.
2. Enter the Member's Date of Birth using the two digit month, two digit day and four digit year (MMDDYYY/05172016) format followed by the pound (#) sign.

Press 1 if the number is correct.

If the Date of Birth is valid, the system will read back the birth date, e.g. May 17, 2016 and ask you to confirm it is correct.

OR-

Press 2 to reenter. This will take you back to the beginning of this step.

If the Date of Birth you entered is not valid, the system will repeat Step 2 for re-entry. After three attempts, if the number cannot be validated, you will automatically be redirected to a Provider Services Agent.

Possible errors that will prompt reentry are:

- The entered date is a future date.
- The entered date is invalid, e.g. date entered is 51716 instead of 05172016.

OR-

Press 0 to speak to a Provider Services Agent.

3. Enter the From Date of Service followed by the pound (#) sign.

Enter the From Date of Service using the two-digit month, two-digit day and four-digit year (MMDDYYYY/10172016) format followed by the pound (#) sign. Press the pound (#) sign to enter today's date.

Possible errors that will prompt reentry are:

- The entered date is a date greater than one year prior to the current date.
- The entered date is a future date.
- The entered date is invalid, e.g. date entered is 101716 instead of 10172016.

4. Enter the 8-digit End Date of Service followed by the pound (#) sign.

Enter the 8-digit End Date of Service using the two-digit month, two-digit day and four-digit year (MMDDYYYY/10172016) format followed by the pound (#) sign. Press the pound (#) sign to enter today's date.

Possible errors that will prompt reentry of the date are:

- The entered date is a date greater than one year prior to the current date.
- The entered date is a future date.
- The entered date is invalid, e.g. date entered is 101716 instead of 10172016.

If the member is located in the system using the information you entered, the system will provide eligibility status.

At the end of the eligibility message the system will play:

Press 1 to repeat the eligibility message.

OR-

Press 2 to hear the audit number for the transaction.

OR-

Press 3 to perform another eligibility transaction.

OR-

Press 9 to return to the main menu.

OR-

Press 0 to speak to a Provider Services Agent.

OR-

Press star (*) to repeat the message.

For Provider Warrant Information

Warrant information may be checked by:

- Entering the 10-digit Provider ID

  OR-

- Entering the 10-digit NPI

1. Call the Health First Colorado Voice Response System toll free at 844-801-8478.
2. Press 2 for Provider Warrant Information.

   This action will route your call to the Provider validation section of the IVRS. The system will ask you to enter your 10-digit National Provider Identification Number (NPI) or your 10-digit Provider Number.
3. Enter the applicable ID (Provider or NPI) followed by the pound (#) sign.

   If the Provider Number or NPI you entered is invalid, the system will repeat the number and ask for re-entry (Repeat Step 2). After three attempts, if the number cannot be validated, you will automatically be redirected to a Provider Services Agent.

   If the Provider Number or NPI is valid, the system will read back the digits you entered and ask you to confirm it is correct
4. Press 1 if the number is correct.

   OR-

   Press 2 to reenter.

   If the Provider Number you entered is not valid, the system will repeat the number and ask for re-entry. After three attempts, if the number cannot be validated, you will automatically be redirected to a Provider Services Agent.

   OR-

   Press 0 to speak to a Provider Services Agent.
5. If necessary, enter the applicable Taxonomy Number or Medicaid Provider ID. (See Step 5, To Verify Member Eligibility Using the Member ID for instructions on entering the Taxonomy Number)
6. **If payment information is found for the Provider ID,** the system will play the last three warrant amounts as follows: A payment was issued for provider ID (PROV-NUM) in the amount of (Warrant-Amt) with warrant number (Warrant-Num) issued on (Warrant-Date).

   If no payment information is found for the Provider ID, the system will play the following message: There is no payment information for this Provider Number (PROV-NUM).

After either (payment or no payment) message plays, the system will play the following options:

- To repeat the warrant message, press 1.
- To check warrant status on a different Provider Number, press 2.
- To return to the main menu, press 9.
- To speak to a Provider Services Agent, press 0.
- To repeat this message, press star (*).

For Claim Status

Claim status may be checked by:

- Using the Claim Number

  OR-

- Using the Member ID

Using the Claim Number: Provider Validation

1. Call the Health First Colorado Voice Response System toll free at 844-801-8478.
2. Press 3 to Request Claim Status.

   This action will route your call to the Provider validation section of the IVRS. The system will ask you to enter your 10-digit National Provider Identification Number (NPI) or your 10-digit Provider Number.
3. Enter the applicable ID (Provider or NPI) followed by the pound (#) sign.

   If the Provider Number or NPI you entered is invalid, the system will repeat the number and ask for re-entry (Repeat Step 2). After three attempts, if the number cannot be validated, you will automatically be redirected to a Provider Services Agent.

   If the Provider Number or NPI is valid, the system will read back the digits you entered and ask you to confirm it is correct.
4. Press 1 if the number is correct.

   OR-

   Press 2 to reenter.

   If the Provider Number you entered is not valid, the system will repeat Step 2 for re-entry. After three attempts, if the number cannot be validated, you will automatically be redirected to a Provider Services Agent.

   OR-

   Press 0 to speak to a Provider Services Agent.

If necessary, enter the Taxonomy Number. (See Step 5, To Verify Member Eligibility Using the Member ID for instructions on entering the Taxonomy Number)

If the Provider Number entered is valid, the system will route the call to the Claim Status section of the IVRS.

To Check Claim Status by Claim Number:

1. Press 1 for Claim Status by Claim Number.

2. Enter the Claim Number followed by the pound (#) sign.

   If the number is valid, the system will read back the claim number and ask you to confirm it is correct.

3. Press 1 if the number is correct.

   OR-

   Press 2 to reenter.

   If the Claim Number is not valid, the system will repeat Step 2 for re-entry. After three attempts, if the number cannot be validated, you will automatically be redirected to a Provider Services Agent.

   OR-

   Press 0 to speak to a Provider Services Agent.

   If a claim is found, the system will repeat the claim number, and provide the status of the claim. Valid statuses are:

   - Paid-Was paid in the amount of (AMT) on (DATE).
   - Suspended- Is suspended.
   - Denied-Was denied on (DATE).
   - Voided-Was voided on (DATE)

   OR-

   If a claim is not found, the system will speak back there is no record of a claim.

   At the end of the claim information message, the system will play:

   - Press 1 to repeat this information.
   - Press 2 to enter another member ID or claim number.
   - Press 3 to enter another Provider Number.
   - Press 4 to return to the main menu.
   - Press 0 to speak to a Provider Services Agent.
   - Press * (star) to repeat this message.

Using the Member ID: Provider Validation

1. **Call the Health First Colorado Voice Response System toll free at 844-801-8478.**
2. **Press 3 to Request Claim Status.**

   This action will route your call to the Provider validation section of the IVRS. The system will ask you to enter your 10-digit National Provider Identification Number (NPI) or your 10-digit Provider Number.

3. Enter the applicable ID (Provider or NPI) followed by the pound (#) sign.

   If the Provider Number or NPI you entered is invalid, the system will ask you to reenter the number (Repeat Step 2).

   If the Provider Number or NPI is valid, the system will read back the digits you entered and ask you to confirm it is correct.

4. Press 1 if the number is correct.

   OR-

   Press 2 to reenter.

   If the Provider Number you entered is not valid, the system will repeat the number and ask for re-entry (Repeat Step 2). After three attempts, if the number cannot be validated, you will automatically be redirected to a Provider Services Agent. After three attempts, if the number cannot be validated, you will automatically be redirected to a Provider Services Agent.

   OR-

   Press 0 to speak to a Provider Services Agent.

   If necessary, enter the Taxonomy Number. (See Step 5, Using the Member ID: Provider Validation for instructions on entering the Taxonomy Number)

   If the Provider Number entered is valid, the system will route the call to the Claim Status section of the IVRS.

5. Enter the Member's 7-Digit Member ID followed by the pound (#) sign.

   When entering the Member ID you will need to enter the member's 7-digit Member ID. Member IDs contain both alpha and numeric characters. You will need to follow the instructions in Step 5 of 'To Verify Member Eligibility Using the Member ID' for entering alpha characters.

   Press 1 if the number is correct.

   If the Member ID is valid, the system will read back the digits you entered and ask you to confirm it is correct.

   OR-

   Press 2 to reenter.

   If the Member ID is not valid, the system will repeat the number and ask for re-entry. After three attempts, if the number cannot be validated, you will automatically be redirected to a Provider Services Agent.

   OR-

   Press 0 to speak to a Provider Services Agent.

6. Enter the From Date of Service followed by the pound (#) sign

   Enter the From Date of Service using the two-digit month, two-digit day and four-digit year (MMDDYYYY/05172016) format followed by the pound (#) sign. Press the pound (#) sign to enter today's date.

   Possible errors that will require reentry of the date are:

   - The entered date is a date greater than one year prior to the current date.
   - The entered date is a future date.
   - The entered date is invalid, e.g. date entered is 51716 instead of 05172016.

7. Enter the 8-digit End Date of Service followed by the pound (#) sign.

   Enter the 8-digit End Date of Service using the two-digit month, two-digit day and four-digit year (MMDDYYYY/05172016) format followed by the pound (#) sign. Press the pound (#) sign to enter today's date.

Possible errors that will require reentry of the date (Repeat Step 8) are:

- The entered date is a date greater than one year prior to the current date.
- The entered date is a future date.
- The entered date is invalid, e.g. date entered is 51716 instead of 05172016.

To Check Claim Status by Member ID:

If a claim is found, the system will speak the Member ID and dates of service. When more than one claim is returned, the system will speak how many claims were returned matching the entered criteria and the claim number will be spoken and the status of the claim. Valid statuses are:

- Paid-Was paid in the amount of (AMT) on (DATE).
- Suspended- Is suspended.
- Denied-Was denied on (DATE).
- Voided-Was voided on (DATE).

If more than 15 claims are returned, the system will ask you to narrow the search by using one of the following methods:

- Press 1 to search again using a different date of service.
- Press 2 if you know the claim number.
- Press 3 if you have entered a group NPI number, we can narrow the search by changing to an individual NPI.
- Press 9 to return to the main menu.
- Press 0 to speak with a Provider Services Agent.

If a claim cannot be found for the combination of member, provider, and date of service entered, the system will speak back there is no claim information for this member, provider, and date of service combination. At the end of either the claim information found or no claim information found, the system will speak back and provide an opportunity for the following:

- Press 1 to repeat this information.
- Press 2 to enter another member ID or claim number.
- Press 3 to enter another Provider Number.
- Press 4 to return to the main menu.
- Press 0 to speak to a Provider Services Agent.
- Press * (star) to repeat this message.

Instructions on using the Voice Response System

1. **Call the Health First Colorado Voice Response System toll free at 844-801-8478.**
2. Press 4 for instructions on using the voice response system.

   The system will play general information and navigational instructions.

No Provider Identification Number

1. **Call the Health First Colorado Voice Response System toll free at 844-801-8478.**

2. **Press 5 if you do not have a Provider Identification Number.**

   The call will be redirected to a Provider Services Agent that can assist you.

Prior Authorization

1. Call the Health First Colorado Voice Response System toll free at 844-801-8478.
2. Press 6 for Prior Authorization Information.

   This action will route your call to the Provider validation section of the IVRS. The system will ask you to enter your 10-digit National Provider Identification Number (NPI) or your 10-digit Provider Number.
3. Enter the applicable ID (Provider or NPI) followed by the pound (#) sign.

   If the Provider Number or NPI you entered is invalid, the system will ask you to reenter the number (Repeat Step 2).

   If the Provider Number or NPI is valid, the system will read back the digits you entered and ask you to confirm it is correct.
4. If Necessary, enter the applicable Taxonomy Number or Medicaid Provider ID. You will need to follow the instructions in Step 5 of 'To Verify Member Eligibility Using the Member ID' for entering alpha characters.
5. Press 1 if the number is correct.

   OR-

   Press 2 to reenter.

   If the Provider Number you entered is not valid, the system will repeat the number and ask for re-entry (Repeat Step 2). After three attempts, if the number cannot be validated, you will automatically be redirected to a Provider Services Agent.

   OR-

   Press 0 to speak to a Provider Services Agent.

   If the Provider Number or NPI entered is valid, the system will route your call to a Provider Services Agent.

More Provider Options-EDI Services, Report Retrieval, Batch Issues or Verify TPL ID

1. Call the Health First Colorado Voice Response System toll free at 844-801-8478.
2. Press 7 for More Provider Options.

   The system will play, 'For EDI services, report retrieval, batch issues, or to verify your TPL ID, Press 1'.

   This action will route your call to the Provider validation section of the IVRS. The system will ask you to enter your 10-digit National Provider Identification Number (NPI) or your 10-digit Provider Number.
3. Enter the applicable ID (Provider or NPI) followed by the pound (#) sign.

   If the Provider Number or NPI you entered is invalid, the system will ask you to reenter the number (Repeat Step 2).

If the Provider Number or NPI is valid, the system will read back the digits entered and ask you to confirm it is correct.

4. Press 1 if the number is correct.

   OR-

   Press 2 to reenter.

   If the Provider Number you entered is not valid, the system will repeat the number and ask for re-entry (Repeat Step 3). After three attempts, if the number cannot be validated, you will automatically be redirected to a Provider Services Agent.

   OR-

   Press 0 to speak to a Provider Services Agent.

5. If Necessary, enter the applicable Taxonomy Number or Medicaid Provider ID. You will need to follow the instructions in Step 5 of 'To Verify Member Eligibility Using the Member ID' for entering alpha characters.

   If the Provider Number you entered is not valid, the system will ask you to reenter the number. After three attempts, if the number cannot be validated, you will automatically be redirected to a Provider Services Agent.

   If the Provider Number or NPI entered is valid, the system will route your call to a Provider Services Agent.

More Provider Options-Billing Questions or Program Benefits

1. Call the Health First Colorado Voice Response System toll free at 844-801-8478.
2. Press 7 for More Provider Options.
3. Press 3 for billing questions or program benefit inquires.

   Enter the applicable ID (Provider or NPI) followed by the pound (#) sign.

   If the Provider Number or NPI you entered is invalid, the system will ask you to reenter the number (Repeat Step 2).

   If the Provider Number or NPI is valid, the system will read back the digits you entered and ask you to confirm it is correct.

4. Press 1 if the number is correct.

   If the number is correct, the call is transferred to a Provider Services Agent.

   OR-

   Press 2 to reenter.

   If the Provider Number you entered is not valid, the system will repeat Step 2 for re-entry. After three attempts, if the number cannot be validated, you will automatically be redirected to a Provider Services agent.

More Provider Options-Training

1. Call the Health First Colorado Voice Response System toll free at 844-801-8478.
2. Press 7 for More Provider Options.
3. Press 4.

The system will play: Please visit https://www.colorado.gov/pacific/hcpf/provider-training for more information about training opportunities.

More Provider Options-Portal Information

1. Call the Health First Colorado Voice Response System toll free at 844-801-8478.
2. Press 7 for More Provider Options.
3. Press 5.

   The system will play: You can also visit us online at www.colorado.gov/hcpf to access provider enrollment, bulletins, billing manuals, fee schedules, forms, and the provider web portal. Provider web portal functionality includes claim submission, claim status inquiries, member eligibility verification, prior authorization status and provider demographic updates.

More Provider Options-Provider Services Agent

1. Call the Health First Colorado Voice Response System toll free at 844-801-8478.
2. Press 7 for More Provider Options.
3. Press 0 (zero) to speak to a Provider Services Agent.

The call is redirected to a Provider Services Agent.

More Provider Options-Repeat Options

1. Call the Health First Colorado Voice Response System toll free at 844-801-8478.
2. Press 7 for More Provider Options.
3. Press star (*) to repeat the options list.

General Provider Information Revisions Log

Revision Date	Section / Action	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 Provider Billing Manual Comment Log v0_3.xlsx*	*Multiple*	*HPE (now DXC)*
1/19/2017	*Updates based on Colorado iC Stage 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)*
5/3/2017	*Updates made to Non-Citizens section by Policy*	*22-23*	*RC*
5/5/2017	*Updates based on Fiscal Agent name change from HPE to DXC*	*3, 10, 26, 90*	*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.