

Immunization Benefit Billing Manual

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Immunization Benefit Billing Manual

This Immunization Benefit Billing Manual provides a summary of benefits and billing guidelines for Colorado Health First Colorado (Colorado's Medicaid Program) providers who administer vaccines to adults and children. The Colorado Department of Health Care Policy and Financing (the Department) periodically reviews and modifies the immunization benefits and services. Therefore, the information in this manual is subject to change, and the manual is updated as new policies are implemented.

To access the most recent fee schedule, please refer to the Provider Rates and Fee Schedules located on Department's [website](#) → For Our Providers → Provider Services → [Rates and Fee Schedules](#).

The Colorado Health First Colorado immunization benefit works to promote and facilitate the prevention of vaccine-preventable diseases. Colorado Health First Colorado maintains an inter-agency agreement with the [Colorado Department of Public Health and Environment](#) (CDPHE) to implement immunization recommendations by the [Advisory Committee on Immunization Practices](#) (ACIP) of the U.S. Department of Health and Human Services.

Covered Services

Immunizations for all Health First Colorado members are a benefit when recommended by the ACIP.

Health First Colorado members ages 18 and under are eligible to receive all immunizations available from the federal Vaccines for Children (VFC) Program, at VFC-enrolled provider offices.

- For more information about the VFC Program, please see the "Vaccines for Children Program" section in Appendix C of this manual.
- Immunizations may be given during an Early Periodic Screening Diagnosis and Treatment (EPSDT) periodic screening visit, an EPSDT inter-periodic visit, or any other medical appointment.
- The CDPHE Immunization Branch administers the VFC Program in Colorado, which provides all ACIP-recommended vaccines to medical providers at no cost to the provider for eligible members.

Health First Colorado members ages 19 and 20 can receive immunizations with no co-pay.

Members ages 21 and older may have an office visit co-pay at the time of service.

- Vaccines for Children vaccines cannot be used for anyone 19 and older.
- The influenza vaccine is covered for members ages 19 and older one time per year.

Members enrolled in a Health First Colorado Health Maintenance Organization (HMO) or Prepaid Inpatient Health Plan (PIHP) must receive immunization services through the plan's providers, not Health First Colorado fee-for-service providers.

Members enrolled in the Accountable Care Collaborative (ACC) must access immunization services through their assigned primary care physician.

Vaccines available from the VFC Program are updated annually and listed in this manual.

Refer to www.colorado.gov/pacific/cdphe/immunization-schedules for the current ACIP recommended schedules for children, teens and adults.

Prior Authorization

There are no prior authorization requirements for any vaccine recommended by the ACIP. Please refer to the **Synagis®** section of this manual for more information about prior authorization of Synagis.

Non-Covered Services and General Limitations

Health First Colorado will not reimburse providers for the cost of vaccines that are available through the VFC Program.

Immunizations for the sole purpose of international travel are not a benefit for Colorado Health First Colorado members.

School District providers participating in the School Health Services (SHS) Program may not bill for immunizations.

Billing Information

National Provider Identifier (NPI)

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

Paper Claims

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

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

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

Electronic Claims

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

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

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

Interactive Claim Submission and Processing

Interactive claim submission through the Online Portal is a real-time exchange of information between the provider and the Health First Colorado. Health First Colorado providers may create and transmit

HIPAA compliant 837P (Professional), 837I (Institutional), and 837D (Dental) claims electronically one at a time. These claims are transmitted through the Health First Colorado Online Portal (OP).

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

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

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

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

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

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

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

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

Billing for Members Ages 18 and Under

Members ages 0-18 may receive vaccines at no cost through the VFC Program, a CDPHE-managed, federally-funded program. For providers to receive federally-funded vaccines to administer to their Health First Colorado members (ages 0-18), they must be enrolled in the VFC Program. Vaccines available through the VFC Program are not reimbursed by Health First Colorado. However, Health First Colorado reimburses providers for each administration of a VFC vaccine.

- If immunizations are given during an EPSDT periodic screening appointment or during any other medical care appointment (also called an "EPSDT inter-periodic visit"), claims must be submitted on the CMS 1500 paper claim form or as an 837 Professional (837P) electronic transaction using the appropriate procedure and diagnosis codes. For an example of the CMS 1500 paper claim form, please see the claim example at the end of this manual. Practitioners must maintain records that document the full nature and extent of the services rendered during this visit.

- If an immunization is the only service provided to a Health First Colorado member ages 18 and under, the administration fee must be billed on the CMS 1500 paper claim form or as an 837P electronic transaction with the appropriate procedure and diagnosis codes.

Billing for Members Ages 19 and Over

Health First Colorado reimburses for both vaccine administration and the vaccine product itself for members ages 19 and over. Administration codes **90471-90474** must be billed as one line item and the vaccine product should be billed as a separate line item. Providers must bill both an administration code and the product code in order to be reimbursed.

Providers must submit claims for adult immunization services on the CMS 1500 paper claim form or as an 837P electronic transaction. Please refer to bottom of the [Provider Services](#) home page on the Department's website for the current fee schedule.

If an immunization is the only service rendered, providers may not submit charges for an Evaluation/Management (E&M) service.

If E&M services are rendered in addition to the immunization administration by an appropriate provider, enter the diagnosis and appropriate procedure codes on the claim.

Vaccine Administration Codes and Reimbursement Rates

The following codes should be used for all vaccine administration, including VFC vaccine administration for members 18 years old and younger. Report these codes in addition to the vaccine and toxoid code(s).

CPT Code	Description	
Use the following codes for VFC vaccine administration, to members 18 and under, with face-to-face counseling of the member/family during the vaccine administration:		
90460	Through 18 years, via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered	
+ 90461	Each additional vaccine or toxoid component administered (list separately in addition to 90460 ; use to indicate multi-component vaccinations)	
Use the following codes for vaccine administration to members of any age when the administration is not accompanied by any face-to-face counseling, or for administration to members over 18 with or without counseling:		
90471	(Including percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccines/toxoid) (do not report in conjunction with 90473)	
+ 90472	Each additional vaccine/toxoid (List separately in addition to 90471 , 90473)	
90473	By intranasal or oral route; one vaccine (single or combination vaccine/toxoid) (do not report in conjunction with 90471)	

CPT Code	Description	
+ 90474	Each additional vaccine/toxoid administered by intranasal or oral route (List separately in addition to 90471, 90473)	

Please always refer to the [fee schedule](#) in the Provider Services section of the Department's website for the most up-to-date rate information.

Using Pediatric Immunization Codes 90460 and 90461

The following chart identifies the number of components in some of the common pediatric vaccines, and how to report the pediatric immunization administration codes for each vaccine:

Table 1

Vaccine	# of Components	Which Administration Codes to Report?
HPV	1	90460
Influenza	1	90460
Meningococcal	1	90460
Pneumococcal	1	90460
Td	2	90460, 90461
DTaP or Tdap	3	90460, 90461, 90461
MMR	3	90460, 90461, 90461
DTaP-Hib-IPV	5	90460, 90461, 90461, 90461, 90461
DTaP-HepB-IPV	5	90460, 90461, 90461, 90461, 90461
DTaP-IPV	4	90460, 90461, 90461, 90461
MMRV	4	90460, 90461, 90461, 90461
DTaP-Hib	4	90460, 90461, 90461, 90461
HepB-Hib	2	90460, 90461
Rotavirus	1	90473
IPV	1	90460
Hib	1	90460

Source: American Academy of Pediatrics "[FAQ Fact Sheet for the 2011 Pediatric Immunization Administration Codes](#)"

To submit claims for immunization services, providers must "roll up/bundle" the total unit count of the immunization administration codes.

- If an immunization administration code is billed for each vaccine that was given during the visit as its own line item, each subsequent line item billed using **90460** after the initial **90460** line item will be denied as a duplicate claim.

Example 1:

The following example demonstrates how to bill for the administration of Hep A, DTaP-HIB-IPV, and MMR vaccines.

Component Calculation and which codes to report (Using Table 1):

Table 2

Vaccine	# of Components	Which Codes to Report?
Hep A	1	90460
DTaP-HIB-IPV	5	90460, 90461, 90461, 90461, 90461
MMR	3	90460, 90461, 90461

How to Bill:

Table 3

Line #	CPT Descriptor	CPT Code	Units
Line 1	First Vaccine Component	90460	3
Line 2	Additional Vaccine Component	90461	6
Line 3	Hep A	90633	1
Line 4	DTaP-HIB-IPV	90698	1
Line 5	MMR	90707	1

- CPT code 90460 is billed for three (3) units because it was reported once for each vaccine that was administered.
- CPT code 90461 is billed for six (6) units because it was reported six (6) times (four (4) times for the DTaP-HIB-IPV vaccine and two (2) times the MMR vaccine).

For further clarification on billing pediatric immunization codes, please refer to the [American Academy of Pediatrics \(AAP\) practice guidelines](#).

For billing questions, please contact the Department's fiscal agent, DXC Technology (DXC) at 844-235-2387 (toll free).

Using Vaccine Administration Codes 90471-90474

The immunization administration codes **90471-90474** need to be billed as one (1) line item, and the vaccine product should be billed as a separate line item. In order for an immunization claim to be reimbursed both an administration code and the vaccine product must be billed. If an immunization is the only service rendered, providers may not submit charges for an E&M service.

Adult immunizations are reimbursed at the lower of: billed charges, or the Health First Colorado fee schedule amount for each immunization.

Note: Providers are not to bill CPT codes **90471-90474** for children ages 0-18 for whom counseling was given (see section "Using Pediatric Immunization Codes **90460** and **90461**" in this manual). CPT Codes **90471-90474** must only be billed for members (ages 19 and older) or members ages 18 and under for whom no counseling was given.

Preventive Medicine Counseling Codes 99401, 99402, and 99211

If a member receives only immunization-related counseling during the visit, the provider may not bill a preventive medicine counseling code, and may only bill the vaccine administration fee. However, if the member receives other prevention counseling (besides the immunizations) such as child health, developmental milestones, sexually transmitted infection safety, etc., the provider may bill the following codes:

- 99401 – Approximately 15 minutes of counseling
- 99402 – Approximately 30 minutes of counseling
- 99211 – Approximately five (5) minutes of counseling (for examples, please see Appendix B – Clinical Examples in the AMA CPT billing manual)
- 99420 - administration and interpretation of a health risk assessment instrument – used for adolescent depression screening.

Keep documentation in the member's chart that shows the duration of counseling and a list of the prevention topics covered during counseling.

When using a modifier is appropriate, refer to the [CMS NCCI Policy Manual](#), Chapter 1, Section E for specific guidance on proper use of modifiers.

Billing Instructions for Specific Providers

Managed Care Programs

Health First Colorado members enrolled in an HMO or PIHP must receive immunization services from the HMO or PIHP, and providers may not bill Colorado Health First Colorado directly for vaccines provided to these members.

Outpatient, Emergency Room, or Inpatient Hospital

Immunization administration may be billed as part of an outpatient or emergency room visit when the visit is for medical reasons.

Outpatient or emergency room visits cannot be billed for the sole purpose of immunization administration. Administration of an immunization at the time of an inpatient stay is included in the APR-DRG.

Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC)

Federally Qualified Health Centers and Rural Health Centers may bill an encounter fee even if the only service provided is administering an immunization. If an immunization is administered in addition to a routine office visit, then an additional encounter fee may not be billed.

Nursing Facilities

Nursing facility residents may receive immunizations if ordered by their physician. The skilled nursing component for immunization administration is included in the facility's rate. The vaccine itself may be billed directly to Colorado Health First Colorado by a Colorado Health First Colorado enrolled pharmacy. The pharmacy must bill the appropriate National Drug Code (NDC) for the individual vaccine dose under the member's Colorado Health First Colorado ID.

Home Health

A member receiving home health services may receive immunizations if the administration is part of a normally scheduled home health visit. A home health visit for the sole purpose of immunization administration is not a benefit.

The pharmacy bills the vaccine as an individual dose under the member's Colorado Health First Colorado ID. The home health agency may not bill for the vaccine.

Alternative Health Care Facilities (ACFs)/Group Homes

Residents of an ACF may receive immunizations from their own physician. They may also receive vaccines under home health as stated above in the home health guideline.

Colorado Health First Colorado does not pay for home health agencies, physicians, or other non-physician practitioners to go to nursing facilities, group homes, or residential treatment centers to administer immunizations (for example: flu vaccines) to groups of members.

Medicare Crossover Claims (Medicare/Medicaid Claims)

For Medicare crossover claims, Colorado Health First Colorado pays the Medicare deductible and coinsurance or Colorado Health First Colorado allowable reimbursement minus the Medicare payment, whichever amount is less. If Medicare's payment for immunization services is the same or greater than the Colorado Health First Colorado allowable benefit, no additional payment is made.

If Medicare pays 100% of the Medicare allowable, Colorado Health First Colorado makes no additional payment.

Immunization Billing Codes

Please see **Appendix B** of this manual.

National Correct Coding Initiative (NCCI) Impacts on Immunization and Evaluation & Management (E&M) Codes

Effective April 1, 2014, the Department will no longer reimburse NCCI procedure-to-procedure (PTP) edits when immunization administration procedure codes (CPT **90460-90474**) are paired with preventative medicine E&M service procedure codes (CPT **99381-99397**).

If a significant separately identifiable E&M service (e.g. new or established member office or other outpatient services [**99201-99215**], office or other outpatient consultation [**99241-99245**], emergency department service [**99281-99285**], preventative medicine service [**99381-99429**] is performed), the appropriate E&M service code should be reported in addition to the vaccine and toxoid administration codes.

Each NCCI PTP edit has an assigned modifier indicator. A modifier indicator of "0" indicates that NCCI PTP-associated modifiers cannot be used to bypass the edit. A modifier indicator of "1" indicates that NCCI PTP-associated modifiers may be used to bypass an edit under appropriate circumstances. A modifier indicator of "9" indicates that the edit has been deleted, and the modifier indicator is not relevant. The Correct Coding Modifier Indicator can be found in the files containing Health First Colorado NCCI PTP edits on the [CMS website](#).

A modifier should not be added to a HCPCS/CPT code solely to bypass an NCCI PTP edit, if the clinical circumstances do not justify its use. If the E&M service is significant and separately identifiable and performed on the same day, the E&M code should be billed with the vaccine and toxoid administration codes using PTP associated modifier '25'. Modifier '25' is only valid when appended to the E&M codes. Do not append to the immunization administration procedure codes **90460-90474**.

Synagis® (palivizumab) Vaccine

Synagis® (Palivizumab) is used to prevent serious lower respiratory tract disease caused by Respiratory Syncytial Virus (RSV) in certain high risk pediatric members. The Department uses coverage criteria based on the American Academy of Pediatrics (AAP) 2014 and the Colorado Chapter of the AAP recommendations for RSV prophylactic therapy. Synagis® (Palivizumab) is not provided by the VFC program.

Limitations on Synagis®

Synagis® is administered by intramuscular injections, at 15 mg per kg of body weight, once a month during expected periods of RSV frequency in the community. Providers should be aware that the Colorado RSV season typically has a later onset, starting closer to December, and should schedule their Synagis® doses accordingly. Synagis® administration must be prior authorized.

The 2015-2016 Synagis® season begins December 1, 2015 and ends April 30, 2015. For more information, please see the October 2015 Synagis® and Influenza Vaccines provider bulletin on the [Provider Bulletin](#) website.

Billing for Synagis®

- The Department will provide pricing information during each Synagis® season.
- Providers may not ask members to obtain Synagis® from a pharmacy and bring it to the practitioner's office for administration.
- Synagis® given in a doctor's office, hospital, or dialysis unit is to be billed directly by those facilities as a medical benefit. **Synagis® may only be a pharmacy benefit if the medication is administered in the member's home or long-term care facility.**

Note: A separate Synagis® PAR process exists for the CHP+ State Managed Care Network members. Any questions regarding this process should be directed to Colorado Access at 303-751-9005 or 800-511-5010, or US Bioservices at 303-706-0053.

Seasonal Influenza Vaccine

Seasonal influenza vaccine is a benefit for children and adults, and is recommended for individuals who are six (6) months of age or older. Influenza vaccine is available through the VFC Program for providers enrolled in the program to administer to Colorado Health First Colorado enrolled children/adolescents (aged 18 and under). (See Appendix B).

For more Colorado Health First Colorado information on the seasonal influenza vaccine for both children and adults, please see the October 2015 Synagis® and Influenza Vaccines Provider Bulletin on the [Provider Bulletin](#) website.

Colorado Department of Public Health and Environment (CDPHE) Vaccines for Children (VFC) Program

The VFC Program, administered by CDPHE, partners with Colorado Health First Colorado to provide free vaccines for providers to administer to Health First Colorado-enrolled children.

Participation in the VFC Program is strongly encouraged by the Department. Providers, including but not limited to: private practitioners, managed care providers, local public health agencies, Rural Health Centers (RHCs), hospital outpatient clinics, school-based health centers, and Federally Qualified Health Centers (FQHCs), who wish to participate in the immunization program must enroll with CDPHE.

Providers can get information on the CDPHE VFC program at [the program website found here](#), or by calling 303-692-2650.

CMS 1500 Paper Claim Reference Table

The following paper form reference table shows required, optional, and conditional fields and detailed field completion instructions for the CMS 1500 paper claim form.

CMS Field #	Field Label	Field is?	Instructions
1	Insurance Type	Required	Place an "X" in the box marked as Medicaid.
1a	Insured's ID Number	Required	Enter the member's Health First Colorado seven-digit Medicaid ID number as it appears on the Medicaid Identification card. Example: A123456.
2	Patient's Name	Required	Enter the member's last name, first name, and middle initial.
3	Patient's Date of Birth / Sex	Required	Enter the member's birth date using two digits for the month, two digits for the date, and two digits for the year. Example: 070115 for July 1, 2015. Place an "X" in the appropriate box to indicate the sex of the member.
4	Insured's Name	Conditional	Complete if the member is covered by a Medicare health insurance policy. Enter the insured's full last name, first name, and middle initial. If the insured used a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name.
5	Patient's Address	Not Required	
6	Patient's Relationship to Insured	Conditional	Complete if the member is covered by a commercial health insurance policy. Place an "X" in the box that identifies the member's relationship to the policyholder.
7	Insured's Address	Not Required	
8	Reserved for NUCC Use		

CMS Field #	Field Label	Field is?	Instructions
9	Other Insured's Name	Conditional	If field 11d is marked "YES", enter the insured's last name, first name and middle initial.
9a	Other Insured's Policy or Group Number	Conditional	If field 11d is marked "YES", enter the policy or group number.
9b	Reserved for NUCC Use		
9c	Reserved for NUCC Use		
9d	Insurance Plan or Program Name	Conditional	If field 11d is marked "YES", enter the insurance plan or program name.
10a-c	Is Patient's Condition Related to?	Conditional	When appropriate, place an "X" in the correct box to indicate whether one or more of the services described in field 24 are for a condition or injury that occurred on the job, as a result of an auto accident or other.
10d	Reserved for Local Use		
11	Insured's Policy, Group or FECA Number	Conditional	Complete if the member is covered by a Medicare health insurance policy. Enter the insured's policy number as it appears on the ID card. Only complete if field 4 is completed.
11a	Insured's Date of Birth, Sex	Conditional	Complete if the member is covered by a Medicare health insurance policy. Enter the insured's birth date using two digits for the month, two digits for the date and two digits for the year. Example: 070115 for July 1, 2015. Place an "X" in the appropriate box to indicate the sex of the insured.

CMS Field #	Field Label	Field is?	Instructions
11b	Other Claim ID	Not Required	
11c	Insurance Plan Name or Program Name	Not Required	
11d	Is there another Health Benefit Plan?	Conditional	When appropriate, place an "X" in the correct box. If marked "YES", complete 9, 9a and 9d.
12	Patient's or Authorized Person's signature	Required	Enter "Signature on File", "SOF", or legal signature. If there is no signature on file, leave blank or enter "No Signature on File". Enter the date the claim form was signed.
13	Insured's or Authorized Person's Signature	Not Required	
14	Date of Current Illness Injury or Pregnancy	Conditional	Complete if information is known. Enter the date of illness, injury or pregnancy, (date of the last menstrual period) using two digits for the month, two digits for the date and two digits for the year. Example: 070115 for July 1, 2015. Enter the applicable qualifier to identify which date is being reported 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period
15	Other Date	Not Required	
16	Date Patient Unable to Work in Current Occupation	Not Required	
17	Name of Referring Physician	Conditional	

CMS Field #	Field Label	Field is?	Instructions
18	Hospitalization Dates Related to Current Service	Conditional	Complete for services provided in an inpatient hospital setting. Enter the date of hospital admission and the date of discharge using two digits for the month, two digits for the date and two digits for the year. Example: 070116 for July 1, 2016. If the member is still hospitalized, the discharge date may be omitted. This information is not edited.
19	Additional Claim Information	Conditional	
20	Outside Lab? \$ Charges	Conditional	Complete if <u>all</u> laboratory work was referred to and performed by an outside laboratory. If this box is checked, no payment will be made to the physician for lab services. Do not complete this field if <u>any</u> laboratory work was performed in the office. Practitioners may not request payment for services performed by an independent or hospital laboratory.
21	Diagnosis or Nature of Illness or Injury	Required	Enter at least one but no more than twelve diagnosis codes based on the member's diagnosis/condition. Enter applicable ICD indicator to identify which version of ICD codes is being reported. 0 ICD-10-CM (DOS 10/1/15 and after) 9 ICD-9 CM (DOS 9/30/15 and before)
22	Medicaid Resubmission Code	Conditional	List the original reference number for adjusted claims. When resubmitting a claim as a replacement or a void, enter the appropriate bill frequency code in the left-hand side of the field. 7 Replacement of prior claim 8 Void/Cancel of prior claim This field is not intended for use for original claim submissions.
23	Prior Authorization	Not Required	

CMS Field #	Field Label	Field is?	Instructions																																				
24	Claim Line Detail	Information	<p>The paper claim form allows entry of up to six detailed billing lines. Fields 24A through 24J apply to each billed line.</p> <p>Do not enter more than six lines of information on the paper claim. If more than six lines of information are entered, the additional lines will not be entered for processing.</p> <p>Each claim form must be fully completed (totaled).</p> <p>Do not file continuation claims (e.g., Page 1 of 2).</p>																																				
24A	Dates of Service	Required	<p>The field accommodates the entry of two dates: a "From" date of services and a "To" date of service. Enter the date of service using two digits for the month, two digits for the date and two digits for the year.</p> <p>Example: 010116 for January 1, 2016</p> <table border="1" data-bbox="911 947 1247 1031"> <tr> <td colspan="3">From</td> <td colspan="3">To</td> </tr> <tr> <td>01</td><td>01</td><td>16</td> <td></td><td></td><td></td> </tr> </table> <p>Or</p> <table border="1" data-bbox="911 1087 1247 1171"> <tr> <td colspan="3">From</td> <td colspan="3">To</td> </tr> <tr> <td>01</td><td>01</td><td>16</td> <td>01</td><td>01</td><td>16</td> </tr> </table> <p>Span dates of service</p> <table border="1" data-bbox="911 1228 1247 1312"> <tr> <td colspan="3">From</td> <td colspan="3">To</td> </tr> <tr> <td>01</td><td>01</td><td>16</td> <td>01</td><td>31</td><td>16</td> </tr> </table> <p>Practitioner claims must be consecutive days.</p> <p><u>Single Date of Service</u>: Enter the six digit date of service in the "From" field. Completion of the "To" field is not required. Do not spread the date entry across the two fields.</p> <p><u>Span billing</u>: permissible if the same service (same procedure code) is provided on consecutive dates.</p> <p>Supplemental Qualifier</p> <p>To enter supplemental information, begin at 24A by entering the qualifier and then the information.</p> <p>ZZ Narrative description of unspecified code</p> <p>N4 National Drug Codes</p>	From			To			01	01	16				From			To			01	01	16	01	01	16	From			To			01	01	16	01	31	16
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CMS Field #	Field Label	Field is?	Instructions
			VP Vendor Product Number OZ Product Number CTR Contract Rate JP Universal/National Tooth Designation JO Dentistry Designation System for Tooth & Areas of Oral Cavity
24B	Place of Service	Required	Enter the Place of Service (POS) code that describes the location where services were rendered. Health First Colorado accepts the CMS place of service codes. 03 School 04 Homeless Shelter 05 IHS Free-Standing Facility 06 Provider-Based Facility 07 Tribal 638 Free-Standing 08 Tribal 638 Provider-Based 11 Office 12 Home 15 Mobile Unit 20 Urgent Care Facility 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room Hospital 24 ASC 25 Birthing Center 26 Military Treatment Center 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Transportation – Land 42 Transportation – Air or Water 50 Federally Qualified Health Center 51 Inpatient Psychiatric Facility 52 Psychiatric Facility Partial Hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility – MR 55 Residential Treatment Facility

CMS Field #	Field Label	Field is?	Instructions
			60 Mass Immunization Center 61 Comprehensive IP Rehab Facility 62 Comprehensive OP Rehab Facility 65 End Stage Renal Dialysis Trtmt Facility 71 State-Local Public Health Clinic 72 Rural Health Clinic 81 Independent Lab 99 Other Unlisted
24C	EMG	Conditional	Enter a "Y" for YES or leave blank for NO in the bottom, unshaded area of the field to indicate the service is rendered for a life-threatening condition or one that requires immediate medical intervention. If a "Y" for YES is entered, the service on this detail line is exempt from co-payment requirements.
24D	Procedures, Services, or Supplies	Required	Enter the HCPCS procedure code that specifically describes the service for which payment is requested. All procedures must be identified with codes in the current edition of Physicians Current Procedural Terminology (CPT). CPT is updated annually. HCPCS Level II Codes The current Medicare coding publication (for Medicare crossover claims only). Only approved codes from the current CPT or HCPCS publications will be accepted.
24D	Modifier	Not Required	
24E	Diagnosis Pointer	Required	Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis. At least one diagnosis code reference letter must be entered. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow.

CMS Field #	Field Label	Field is?	Instructions
			This field allows for the entry of four (4) characters in the unshaded area.
24F	\$ Charges	Required	<p>Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number. Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one procedure from the same group is billed, special multiple pricing rules apply.</p> <p>The base procedure is the procedure with the highest allowable amount. The base code is used to determine the allowable amounts for additional CPT surgical procedures when more than one procedure from the same grouping is performed. Submitted charges cannot be more than charges made to non-Health First Colorado covered individuals for the same service. Do not deduct Colorado Health First co-payment or commercial insurance payments from the usual and customary charges.</p>
24G	Days or Units	Required	<p>Enter the number of services provided for each procedure code.</p> <p>Enter whole numbers only- do not enter fractions or decimals.</p>
24H	EPSDT/Family Plan	Conditional	<p>EPSDT (shaded area) For Early & Periodic Screening, Diagnosis, and Treatment related services, enter the response in the shaded portion of the field as follows:</p> <ul style="list-style-type: none"> AV Available- Not Used S2 Under Treatment ST New Service Requested NU Not Used <p>Family Planning (unshaded area) If the service is Family Planning, enter "Y" for YES or "N" for NO in the bottom, unshaded area of the field.</p>

CMS Field #	Field Label	Field is?	Instructions
24I	ID Qualifier	Not Required	
24J	Rendering Provider ID #	Required	In the shaded portion of the field, enter the NPI of the Health First Colorado provider number assigned to the <u>individual</u> who actually performed or rendered the billed service. This number cannot be assigned to a group or clinic.
25	Federal Tax ID Number	Not Required	
26	Patient's Account Number	Optional	Enter information that identifies the member or claim in the provider's billing system. Submitted information appears on the Remittance Advice (RA).
27	Accept Assignment?	Required	The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.
28	Total Charge	Required	Enter the sum of all charges listed in field 24F. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
29	Amount Paid	Conditional	Enter the total amount paid by Medicare or any other commercial health insurance that has made payment on the billed services. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
30	Rsvd for NUCC Use		
31	Signature of Physician or Supplier Including Degrees or Credentials	Required	Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent. A holographic signature stamp may be used <u>if</u> authorization for the stamp is on file with the fiscal agent. An authorized agent or representative may sign the claim for the enrolled provider <u>if</u> the

CMS Field #	Field Label	Field is?	Instructions
			<p>name and signature of the agent is on file with the fiscal agent.</p> <p>Each claim must have the date the enrolled provider or registered authorized agent signed the claim form. Enter the date the claim was signed using two digits for the month, two digits for the date and two digits for the year. Example: 070115 for July 1, 2015.</p> <p>Unacceptable signature alternatives: Claim preparation personnel may not sign the enrolled provider's name. Initials are not acceptable as a signature. Typed or computer printed names are not acceptable as a signature. "Signature on file" notation is not acceptable in place of an authorized signature.</p>
32	32- Service Facility Location Information 32a- NPI Number 32b- Other ID #	Conditional	<p>Complete for services provided in a hospital or nursing facility in the following format:</p> <p>1st Line Facility Name 2nd Line Address 3rd Line City, State and ZIP Code 32a- NPI Number Enter the NPI of the service facility (if known).</p>
33	33- Billing Provider Info & Ph # 33a- NPI Number 33b- Other ID #	Required	<p>Enter the name of the individual or organization that will receive payment for the billed services in the following format:</p> <p>1st Line Name 2nd Line Address 3rd Line City, State and ZIP Code 33a- NPI Number Enter the NPI of the billing provider</p>

Timely Filing

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

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

Appendices

Appendix A - Immunization Schedules

- Recommended [Immunization schedule](#) for persons aged 0 through 18 years.
- Recommended [Immunization schedule](#) for adults aged 19 and older.

Appendix B - Vaccines for Children Program

Vaccines for Children Program (VFC) Information

Updated information about the VFC program can be found at the following website:

www.colorado.gov/pacific/cdphe/vaccines-childrenb

Immunization Manual Revisions Log

Revision Date	Additions/Changes	Pages	Made by
<i>12/01/2016</i>	<i>Manual revised for interChange implementation. For manual revisions prior to 12/01/2016, please refer to Archive.</i>	<i>All</i>	<i>HPE (now DXC)</i>
<i>12/27/2016</i>	<i>Updates based on Colorado iC Stage II Provider Billing Manuals Comment Log v0_2.xlsx.</i>	<i>1-5, 7, 8, 12</i>	<i>HPE (now DXC)</i>
<i>1/10/2017</i>	<i>Updates based on Colorado iC Stage Provider Billing Manual Comment Log v0_3.xlsx</i>	<i>Multiple</i>	<i>HPE (now DXC)</i>
<i>1/19/2017</i>	<i>Updates based on Colorado iC Stage Provider Billing Manual Comment Log v0_4.xlsx</i>	<i>Multiple</i>	<i>HPE (now DXC)</i>
<i>1/26/2017</i>	<i>Updates based on Department 1/20/2017 approval email</i>	<i>Accepted tracked changes throughout</i>	<i>HPE (now DXC)</i>
<i>5/22/2017</i>	<i>Updates based on Fiscal Agent name change from HPE to DXC</i>	<i>2, 6</i>	<i>DXC</i>

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.*