

Outpatient Behavioral Health Fee-For-Service

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Outpatient Behavioral Health Fee-For-Service

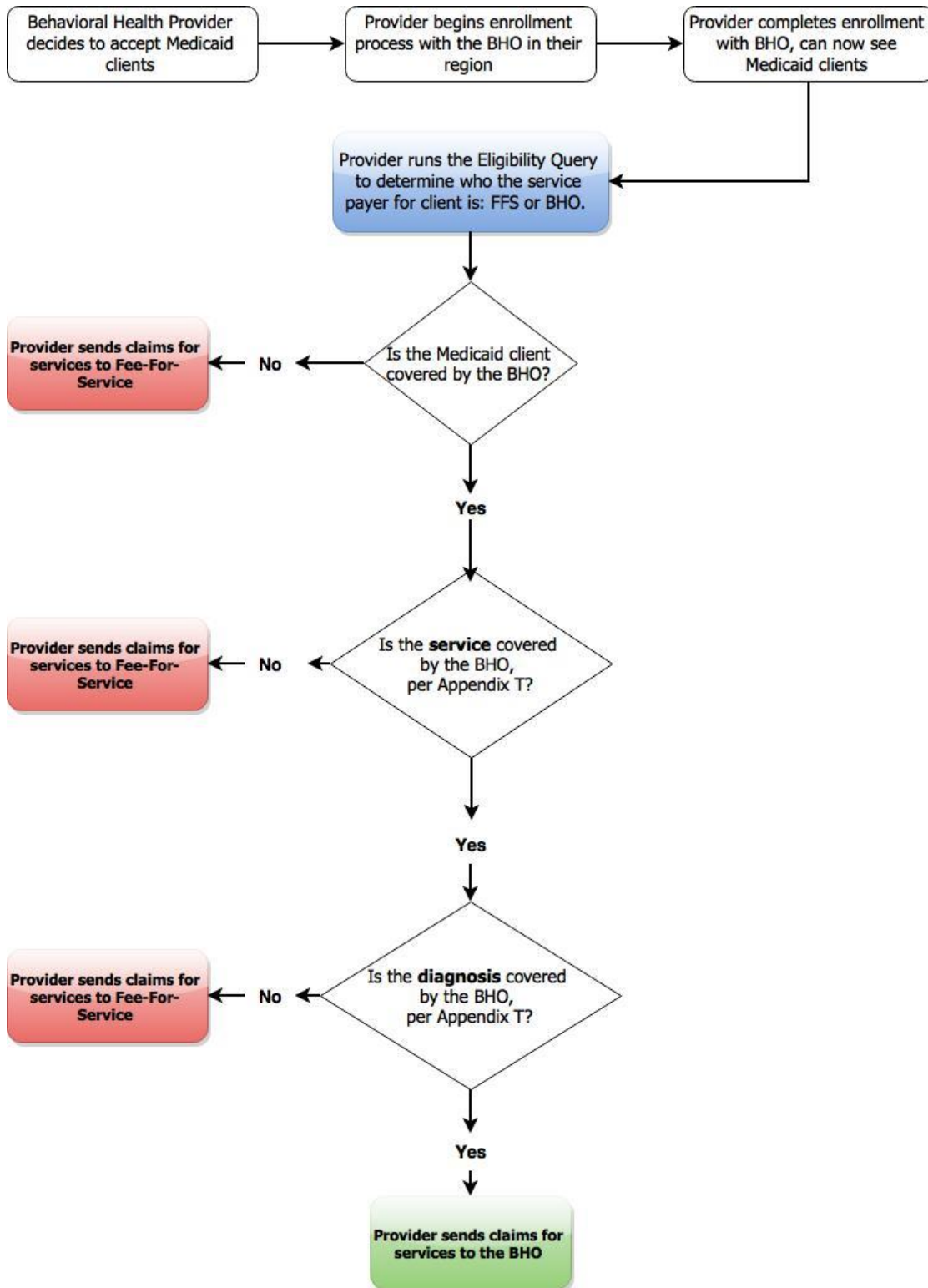
General Policies

- Health First Colorado (Colorado's Medicaid Program) members have their behavioral health services paid for by Behavioral Health Organizations (BHOs). Behavioral Health Organizations are managed care entities responsible for covering behavioral health benefits for nearly all Health First Colorado members.
- See Program Rule [8.212](#) for details about the BHO program, including policy which exempts Health First Colorado members from BHO coverage. Only a small percentage of members meeting very specific criteria will be exempt. Member exemption is determined by the Department.
- See the Department's Behavioral Health Organization page, www.colorado.gov/pacific/hcpf/behavioral-health-organizations for details about BHO coverage.
- To verify if a Health First Colorado member's behavioral health services are covered by a BHO, providers must perform a member eligibility query in the Provider Provider web portal, found at www.colorado.gov/hcpf/our-providers. Each BHO may have its own similar tool for providers to query member eligibility. Both tools are valid for checking member eligibility.

The member eligibility query will display whether the BHO is responsible for covering the member's services. If the member is covered by the BHO, all claims for covered behavioral health services must be sent to the BHO for payment.

- All behavioral health providers must be enrolled with the BHO. Providers must contact the BHO which serves their region to begin the enrollment process. Details are available at the Department's Behavioral Health Organization page, www.colorado.gov/pacific/hcpf/behavioral-health-organizations
- Providers who are denied BHO enrollment **may not** bill fee-for-service (FFS) as an alternative reimbursement route. If the provider is denied BHO enrollment this means that may not treat Health First Colorado members for services covered by the BHO.
- Providers who are denied BHO enrollment may still render and be reimbursed for services *not* covered by the BHO.
- A number of services, such as office administered drugs (e.g. Suboxone) are covered Health First Colorado benefits but are not covered by the BHO. These services must always be billed FFS. Reference the coverage diagram below.
- Providers must reference [Appendix T](#) for a list of BHO covered services and conditions found on the [Billing Manuals](#) website, in the Appendices section.

Coverage Diagram



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.

Batch Electronic Claim 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 Health First Colorado fiscal agent.

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

Benefit Policies

Outpatient Behavioral Health Services are a group of services designed to provide medically necessary behavioral health services to certain Health First Colorado members in order to restore these individuals to their highest possible functioning level. Services may be provided by any willing, qualified provider as described below. Services are provided on an outpatient basis and not during an inpatient hospital stay.

Behavioral Health is split into two (2) benefit categories: Mental Health services and Substance Use Disorder (SUD) services.

Mental Health Services

Eligible Providers

Only the following enrolled provider types and qualifications are eligible to render Mental Health services to Health First Colorado members. Specific procedures may require different provider or qualifications, as listed.

1. **Physician**
 - a. Doctor of Osteopathy and Medicine
 - b. Psychiatrist
2. **Psychologist, Psy.D/Ph.D**
3. **Masters Level Clinician**
 - a. Licensed Professional Counselor (LPC)
 - b. Licensed Marriage and Family Therapist (LMFT)
 - c. Licensed Clinical Social Worker (LCSW)
 - d. Advanced Practice Nurse
4. **Physician Assistant**
5. **Community Mental Health Center (CMHC)**
6. **Federally Qualified Health Center (FQHC)**
7. **Rural Health Clinic (RHC)**
8. **Hospital**

Covered Benefits and Limitations

The following services are covered:

1. **Individual Psychotherapy** - Therapeutic contact with one (1) member of more than 30 minutes, but no more than two (2) hours. This service, in conjunction with Individual Brief Psychotherapy, is limited to 35 visits per state fiscal year.
2. **Individual Brief Psychotherapy** - Therapeutic contact with one (1) member of up to and including 30 minutes. This service, in conjunction with Individual Psychotherapy, is limited to 35 visits per state fiscal year.

3. **Family Psychotherapy** - Therapeutic contact of up to and including two (2) hours with one (1) member, typically a child/youth, with one (1) or more of the member's family members and/or caregivers present and included in the therapeutic process and communications.
4. **Group Psychotherapy** - Therapeutic contact with more than one (1) member of up to and including two (2) hours. Not all members in the group session need be Health First Colorado enrolled.
5. **Behavioral Health Assessment** - An initial or ongoing diagnostic evaluation of a member to determine the presence or absence of a behavioral health diagnosis, to identify behavioral health issues that impact health and functioning, and to develop an individual service/care plan.
6. **Pharmacological Management** - Monitoring of medications prescribed and consultation provided to members by a physician or other medical practitioner authorized to prescribe medications as defined by State law, including associated laboratory services as indicated.
7. **Outpatient Day Treatment** – Therapeutic contact with a member in a structured program of therapeutic activities lasting more than four (4) hours but less than 24 hours per day. When provided in an outpatient hospital program, may be called "partial hospitalization". Services include:
 - a. Assessment and monitoring
 - b. Individual/group/family therapy
 - c. Psychological testing
 - d. Medical/nursing support
 - e. Psychosocial education
 - f. Skill development and socialization training focused on improving functional and behavioral deficits
 - g. Medication management
 - h. Expressive and activity therapies
8. **Emergency / Crisis Services** – Services provided during a mental health emergency which involve unscheduled, immediate, or special interventions in response to a crisis situation with a member, including associated laboratory services, as indicated.

Mental Health Services Procedure Code Table

Service	Code	Code Description	Daily Unit Limit	Yearly Unit Limit	BHO Covered
Individual Psychotherapy	90832	Psychotherapy, 30 minutes with member and/or family member	One (1)	35	Yes
Individual Psychotherapy	90833	Psychotherapy, 30 mins, with member or family member, when performed with an E&M service listed separately	One (1)	35	Yes

Service	Code	Code Description	Daily Unit Limit	Yearly Unit Limit	BHO Covered
Individual Psychotherapy	90834	Psychotherapy, 45 minutes with member and/or family member	One (1)	35	Yes
Individual Psychotherapy	90836	Psychotherapy, 45 mins, with member or family member, when performed with an E&M service listed separately	One (1)	35	Yes
Individual Psychotherapy	90837	Psychotherapy, 60 minutes with member and/or family member	One (1)	35	Yes
Individual Psychotherapy	90838	Psychotherapy, 60 mins, with member or family member, when performed with an E&M service listed separately	One (1)	35	Yes
Individual Brief Psychotherapy	90832	Psychotherapy, 30 minutes with member and/or family member	One (1)	35	Yes
Individual Brief Psychotherapy	90833	Psychotherapy, 30 mins, with member or family member, when performed with an E&M service listed separately	One (1)	35	Yes
Family Psychotherapy	90832	Psychotherapy, 30 minutes with member and/or family member	One (1)	35	Yes
Family Psychotherapy	90833	Psychotherapy, 30 mins, with member or family member, when performed with an E&M service listed separately	One (1)	35	Yes
Family Psychotherapy	90834	Psychotherapy, 45 minutes with member and/or family member	One (1)	35	Yes
Family Psychotherapy	90836	Psychotherapy, 45 mins, with member or family member, when performed with an E&M service listed separately	One (1)	35	Yes
Family Psychotherapy	90837	Psychotherapy, 60 minutes with member and/or family member	One (1)	35	Yes
Family Psychotherapy	90838	Psychotherapy, 60 mins, with member or family member, when performed with an E&M service listed separately	One (1)	35	Yes
Family Psychotherapy	90846	Family psychotherapy (w/o pt)	One (1)	35	Yes
Family Psychotherapy	90847	Family psychotherapy (conjoint)	One (1)	35	Yes
Family Psychotherapy	90849	Multiple-family group psychotherapy	One (1)	35	Yes

Service	Code	Code Description	Daily Unit Limit	Yearly Unit Limit	BHO Covered
Group Psychotherapy	90853	Group psychotherapy (not multi-family)	One (1)	35	Yes
Psychiatric diagnostic evaluation	90791	Psychiatric diagnostic evaluation	One (1)	-	Yes
Psychiatric diagnostic evaluation	90792	Psychiatric diagnostic evaluation with medical services	One (1)	-	Yes
Cognitive Capability Assessment	96101	Psycho testing by psych/phys, per hour	Five (5)	-	Yes
Cognitive Capability Assessment	96102	Psycho testing by technician, per hour	Eight (8)	-	Yes
Cognitive Capability Assessment	96103	Psycho testing admin by comp	Not Covered	Not Covered	Yes
Cognitive Capability Assessment	96105	Assessment of aphasia, per hour	Two (2)	-	No
Cognitive Capability Assessment	96110	Developmental test limited, per instrument used	Two (2)	-	No
Cognitive Capability Assessment	96111	Developmental test extended, with interpretation and report	One (1)	-	No
Cognitive Capability Assessment	96116	Neurobehavioral status exam, per hour	Five (5)	-	Yes
Cognitive Capability Assessment	96118	Neuropsych test by psych/phys, per hour	Five (5)	-	Yes
Cognitive Capability Assessment	96119	Neuropsych testing by technician, per hour	Eight (8)	-	Yes
Cognitive Capability Assessment	96125	Cognitive test by healthcare professional, per hour	Five (5)	-	No
Cognitive Capability Assessment	96127	Brief emotional or behavioral assessment, per standardized instrument	One (1)	-	No
Health and Behavior Assessment	96150	Assess hlth/behav init	Not Covered	Not Covered	No
Health and Behavior Assessment	96151	Assess hlth/behav subseq	Not Covered	Not Covered	No

Service	Code	Code Description	Daily Unit Limit	Yearly Unit Limit	BHO Covered
Biopsychosocial Assessment/Intervention	96152	Intervene hlth/behav indiv	Not Covered	Not Covered	No
Biopsychosocial Assessment/Intervention	96153	Intervene hlth/behav group	Not Covered	Not Covered	No
Biopsychosocial Assessment/Intervention	96154	Interv hlth/behav fam w/pt	Not Covered	Not Covered	No
Biopsychosocial Assessment/Intervention	96155	Interv hlth/behav fam no pt	Not Covered	Not Covered	No
Pharmacological Management	90863	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (list separately in addition to the code for primary procedure)	One (1)	35	Yes – Use 99212 for BHOs
Outpatient Day Treatment	See Appendix Q				Yes
Emergency/Crisis Services	90839	Psychotherapy for crisis; first 60 minutes	One (1)	35	Yes
Emergency/Crisis Services	90840	Psychotherapy for crisis; each additional 30 minutes (list separately in addition to code for primary service)	One (1)	35	Yes

Outpatient Substance Use Disorder Services

Eligible Providers

The following providers are eligible to provide Outpatient Substance Use Disorder (SUD) services to Health First Colorado members.

Column 1	Column 2	Column 3
Licensed physicians who are also:	Licensed non-physicians who are also:	Licensed facilities that are supervised by licensed physicians or licensed non-physicians
a) Certified in addiction medicine by the American Society of Addiction Medicine (ASAM); or b) Certified Addiction Counselors (CAC II or CAC III) or Licensed Addiction Counselors (LAC) by Department of Regulatory Agencies (DORA); or c) Certified by the National Association of Alcohol and Drug Abuse Counselors (NAADAC) as an NCAC II or Master Addiction Counselor (MAC); or d) Certified in addiction psychiatry by the American Board of Psychiatry and Neurology (ABPN) certified in Addiction Psychiatry	a) Psychologists (PhD, PsyD), Nurse Practitioners, Master's Level Clinicians (LCSWs, LPCs, Licensed Marriage and Family Therapists), or LACs; and either: <ol style="list-style-type: none"> 1. Certified by DORA as a CAC II or CAC III; or 2. Certified by NAADAC as an NCAC II or MAC. 	Supervised professional personnel who are also: <ol style="list-style-type: none"> 1. Working at a facility licensed by the Office of Behavioral Health to provide substance use disorder treatment services; AND 2. Are supervised by licensed physicians or licensed non-physicians identified in Columns 1 or 2.

WARNING: Providers must indicate if they are a substance use disorder specialty provider during the enrollment process, and the specialty type code "SubAbuseBt" must be marked on their enrollment profile. Specialty type code "SubAbuseBt" means the provider may only submit claims for the ten procedure codes found in the table below labeled *Outpatient SUD Coding Table*.

Providers designated with a specialty type code "SubAbuseBt" in their provider enrollment **may not** submit claims for any procedure other than the ten listed in the table *Outpatient SUD Coding Table* below. Any paid claim for services outside this policy will be subject to recovery.

Methadone Clinics

Methadone Clinics may enroll as Health First Colorado Providers, however separate enrollments may be necessary to bill for the full range of services provided according to the following guidelines:

Physical Health Services

- 1) To bill for physical health services, the provider must have a *Clinic* billing ID that **does not** have "SubAbuseBt" specialty type code attached to it.

Substance Use Disorder (SUD) Services

- 2) To bill for SUD services for members enrolled in a BHO, the provider must have a BHO billing ID. Claims for these services must be sent to the BHO for reimbursement.
- 3) To bill for SUD services for members **not** enrolled in a BHO, the provider must have a *Substance Use Disorder - Clinic* billing ID that **does** have "SubAbuseBt" specialty type code attached to it.

Individual rendering providers affiliated with the Methadone Clinic must have their own rendering provider IDs.

Even though Suboxone is provided by Methadone Clinics it is not considered a SUD benefit. Rather, it is considered a physical health benefit. Other ancillary medical services provided by Methadone Clinics (physical health assessments, blood draws, etc.) are also considered physical health services. Therefore, these physical health services are never billed to the BHO. They are always billed FFS.

Refer to the following tables:

Methadone Clinics – Which Billing ID to Use	
Physical Health Services <i>Clinic</i> Billing ID	Behavioral Health SUD <i>BHO</i> or <i>Medicaid FFS</i> Billing ID
<p>Example services</p> <ul style="list-style-type: none"> ▪ Suboxone J-codes ▪ Blood draws ▪ Physical health assessment <p>Consult a CPT coding handbook for available codes to bill for your services.</p>	<p>ONLY the following codes</p> <ul style="list-style-type: none"> ▪ H0001 + HF ▪ H0004 + HF ▪ H0005 + HF ▪ H0006 + HF ▪ T1007 + HF ▪ T1019 + HF ▪ T1023 + HF ▪ S3005 + HF ▪ S9445 + HF ▪ H0020 + HF
<p>Available for all Health First Colorado members, regardless of BHO enrollment status.</p>	<p>Depends on whether the member is enrolled in a BHO or not. Check their eligibility status in either the Medicaid or BHO provider web portal. Use the billing ID that corresponds to the member's BHO status.</p>

Methadone Clinics – Where To Send Claims		
	Send claim to BHO?	Send Claim to Fee-For-Service?
Physical Health services	<p>Only for services covered by the BHO.</p>	<p>Only for services not covered by the BHO.</p> <p>Send claims using the <i>Clinic</i> billing ID via the Medicaid Provider provider web portal.</p>
Behavioral Health SUD services	<p>Yes, nearly every member.</p> <p>Send claims using the BHO billing ID via the BHO provider web portal.</p>	<p>Yes, <u>Only for BHO-exempt members.</u></p> <p>Send claims using the <i>Substance Use Disorder – Clinic</i> billing ID via the Medicaid Provider provider web portal.</p>

Covered Benefits and Limitations

See the Outpatient Substance Use Disorder Service Fee-For-Service [Benefit Coverage Standard](#).

Substance Use Disorder Procedure Code Table

Service	Code	Unit	Unit amount/frequency	Modifier Required	BHO Covered
Alcohol/drug assessment	H0001	Untimed	One (1) unit per day, Two (2) per fiscal year	HF	Yes
Individual/family counseling and therapy	H0004	15 minute	Eight (8) units per day, 140 per fiscal year	HF	Yes
Group counseling and therapy	H0005	One (1) hour	Three (3) units per day, 108 per fiscal year	HF	Yes
Targeted case management	H0006	30 minute	Four (4) units per day, 216 per fiscal year	HF	Yes
Alcohol/drug screening counseling	S9445	Untimed	One (1) unit per day, 52 per fiscal year	HF	Yes
Detox: safety assessment	S3005	15 minute	One (1) units per day, 15 per fiscal year	HF	Yes
Detox: assessment of detoxification progression and monitoring	T1007	15 minute	Three (3) units per day, 45 per fiscal year	HF	Yes
Detox: provision of daily needs	T1019	15 minute	Three (3) units per day, 45 per fiscal year	HF	Yes
Detox: level of motivation assessment	T1023	15 minute	Three (3) units per day, 45 per fiscal year	HF	Yes
Medication Assisted Treatment: administration, acquisition, and dispensing of Methadone	H0020	Untimed	One (1) unit per day	HF	Yes

Additional Covered Services

Health First Colorado Fee-For-Service covers additional services which are not covered by the BHO. These services are available to all members. Specific rendering provider requirements may apply to each service.

Additional Covered Services Procedure Code Table

Service	Code	Unit	Unit amount/frequency	Allowed Providers
Buprenorphine, oral	J0571	One (1) mg	5 / Day	Physician, clinic, non-physician practitioner, osteopath, physician assistant, APN
Buprenorphine/naloxone, oral, less than or equal to three (3)mg	J0572	<= three (3) mg	5 / day	Physician, clinic, non-physician practitioner, osteopath, physician assistant, APN

Service	Code	Unit	Unit amount/frequency	Allowed Providers
Buprenorphine/naloxone, oral, greater than three (3)mg, but less than or equal to six (6)mg	J0573	Three (3)mg-six (6)mg	5 / day	Physician, clinic, non-physician practitioner, osteopath, physician assistant, APN
Buprenorphine/naloxone, oral, greater than six (6) mg, but less than or equal to 10 mg	J0574	7-10mg	4 / day	Physician, clinic, non-physician practitioner, osteopath, physician assistant, APN
Buprenorphine/naloxone, oral, greater than 10 mg	J0575	>=10mg	3 / day	Physician, clinic, non-physician practitioner, osteopath, physician assistant, APN
Office administered injection: Naltrexone, depot form, one (1)mg	J2315	One (1)mg	380 mg / day, limit one (1) injection per month	Physician, clinic, non-physician practitioner, osteopath, physician assistant, APN

Non-Covered Behavioral Health FFS Services

1. Covered diagnosis/procedure services provided to members participating in the [Community Behavioral Health Services Program](#) are **not** covered under the Mental Health fee-for-service benefit.
2. Services provided by email, telephone, text message, facsimile transmission, and online research.
3. Room and board services.
4. Educational, vocational and job training services.
5. Habilitation services.
6. Services to inmates in public institutions (i.e. correctional facilities) as defined in 42 CFR § 435.1009.
7. Services to individuals residing in institutions for mental diseases as defined in 42 CFR § 435.1009.
8. Recreational and social activities.
9. Day treatment program services.
10. Peer advocate services.
11. Residential treatment, excluding Residential Treatment Facilities.
12. Court-ordered DUI services.
13. Reimbursement for contractual arrangements between the provider and a third party.

Special Provision: EPSDT Services Can Exceed Policy Limitations For Members Age 20 And Younger

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Health First Colorado program that requires the state Health First Colorado agency to cover services, products, or procedures

for Health First Colorado members ages 20 and younger if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition (health problem) identified through a screening examination (includes any evaluation by a physician or other licensed clinician). EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT does not require the state Health First Colorado agency to provide any service, product, or procedure that is:

- Unsafe, ineffective, or experimental/investigational.
- Not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, and/or other specific criteria described in the above screening policies may be exceeded or may not apply as long as the provider documentation shows how the service, product, or procedure will correct, improve or maintain the recipient's health, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Providers may be subject to post payment review to assure the use of a validated, standardized screening tool and medical justification for screens in excess of the stated benefit limits.

Procedure/HCPCS Codes Overview

The codes used for submitting claims for services provided to Health First Colorado members represent services that are approved by the Centers for Medicare and Medicaid Services (CMS) and services that may be provided by an enrolled Health First Colorado provider.

The Healthcare Common Procedural Coding System (HCPCS) is divided into two principal subsystems, referred to as level I and level II of the HCPCS. Level I of the HCPCS is comprised of Current Procedural Terminology (CPT), a numeric coding system maintained by the American Medical Association (AMA). The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter followed by 4 numeric digits, while CPT codes are identified using 5 numeric digits.

HIPAA requires providers to comply with the coding guidelines of the AMA CPT Procedure Codes and the International Classification of Disease, Clinical Modification Diagnosis Codes. If there is no time designated in the official descriptor, the code represents one unit or session. Providers should regularly consult monthly bulletins in the Provider Services [Bulletins](#) section. To receive electronic provider bulletin notifications, an email address can be entered into the Provider web portal in the *(MMIS) Provider Data Maintenance* area or by filling out a publication preference form. Bulletins include updates on approved procedure codes as well as the maximum allowable units billed per procedure.

The following paper form reference table gives required and/or conditional fields for the paper CMS 1500 claim form for Behavioral Health claims:

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 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	Not Required	
5	Patient's Address	Not Required	
6	Patient's Relationship to Insured	Not Required	
7	Insured's Address	Not Required	
8	Reserved for NUCC Use		
9	Other Insured's Name	Not Required	

CMS Field #	Field Label	Field is?	Instructions
9a	Other Insured's Policy or Group Number	Not Required	
9b	Reserved for NUCC Use		
9c	Reserved for NUCC Use		
9d	Insurance Plan or Program Name	Not Required	
10a-c	Is Patient's Condition Related to?	Not Required	
10d	Reserved for Local Use		
11	Insured's Policy, Group or FECA Number	Not Required	
11a	Insured's Date of Birth, Sex	Not Required	
11b	Other Claim ID	Not Required	
11c	Insurance Plan Name or Program Name	Not Required	
11d	Is there another Health Benefit Plan?	Not Required	

CMS Field #	Field Label	Field is?	Instructions
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	Not Required	
15	Other Date	Not Required	
16	Date Patient Unable to Work in Current Occupation	Not Required	
17	Name of Referring Physician	Conditional	
18	Hospitalization Dates Related to Current Service	Not Required	
19	Additional Claim Information	Conditional	
20	Outside Lab? \$ Charges	Not Required	
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. 9 ICD-9-CM (DOS 9/30/15 and before)

CMS Field #	Field Label	Field is?	Instructions										
			0 ICD-10-CM (DOS 10/1/15 and after)										
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	Conditional	Leave blank										
24	Claim Line Detail	Information	The paper claim form allows entry of up to six detailed billing lines. Fields 24A through 24J apply to each billed line. Do not enter more than six lines of information on the paper claim. If more than six lines of information are entered, the additional lines will not be entered for processing. Each claim form must be fully completed (totaled). Do not file continuation claims (e.g., Page 1 of 2).										
24A	Dates of Service	Required	The field accommodates the entry of two dates: a "From" date of services and a "To" date of service. Enter the date of service using two digits for the month, two digits for the date and two digits for the year. Example: 010116 for January 1, 2016 <div style="text-align: center;"> From To <table border="1" style="margin: auto;"> <tr> <td style="width: 20px;">01</td> <td style="width: 20px;">01</td> <td style="width: 20px;">16</td> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> </tr> </table> Or <table style="margin: auto;"> <tr> <td style="width: 20px;">From</td> <td style="width: 20px;">To</td> </tr> <tr> <td style="width: 20px;"> 01 01 16 </td> <td style="width: 20px;"> 01 01 16 </td> </tr> </table> </div>	01	01	16				From	To	01 01 16	01 01 16
01	01	16											
From	To												
01 01 16	01 01 16												

CMS Field #	Field Label	Field is?	Instructions						
			<p>Span dates of service</p> <p style="text-align: center;">From To</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="padding: 2px;">01</td> <td style="padding: 2px;">01</td> <td style="padding: 2px;">16</td> <td style="padding: 2px;">01</td> <td style="padding: 2px;">31</td> <td style="padding: 2px;">16</td> </tr> </table> <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>	01	01	16	01	31	16
01	01	16	01	31	16				
24B	Place of Service	Required	<p>Enter the Place of Service (POS) code that describes the location where services were rendered. The Health First Colorado accepts the CMS place of service codes.</p> <p style="padding-left: 20px;">11 Office</p>						
24C	EMG	Not Required							
24D	Procedures, Services, or Supplies	Required	<p>Enter the procedure code that specifically describes the service for which payment is requested.</p>						
24D	Modifier	Conditional	<p>Enter the appropriate procedure-related modifier that applies to the billed service. Up to four modifiers may be entered when using the paper claim form.</p>						
24E	Diagnosis Pointer	Required	<p>Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis.</p> <p>At least one diagnosis code reference letter must be entered.</p> <p>When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow.</p> <p>This field allows for the entry of 4 characters in the unshaded area.</p>						

CMS Field #	Field Label	Field is?	Instructions
24F	\$ Charges	Required	<p>Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.</p> <p>Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one procedure from the same group is billed, special multiple pricing rules apply.</p> <p>The base procedure is the procedure with the highest allowable amount. The base code is used to determine the allowable amounts for additional CPT surgical procedures when more than one procedure from the same grouping is performed.</p> <p>Submitted charges cannot be more than charges made to non-Health First Colorado covered individuals for the same service.</p> <p>Do not deduct Health First Colorado co-payment or commercial insurance payments from the usual and customary charges.</p>
24G	Days or Units	Required	<p>Enter the number of services provided for each procedure code.</p> <p>Enter whole numbers only- do not enter fractions or decimals.</p>
24G	Days or Units	General Instructions	<p>A unit represents the number of times the described procedure or service was rendered. Except as instructed in this manual or in Health First Colorado bulletins, the billed unit must correspond to procedure code descriptions. The following examples show the relationship between the procedure description and the entry of units.</p>
24H	EPSDT/Family Plan	Not Required	<p>EPSDT (shaded area) Not Required</p> <p>Family Planning (unshaded area) Not Required</p>
24I	ID Qualifier	Not Required	

CMS Field #	Field Label	Field is?	Instructions
24J	Rendering Provider ID #	Required	In the shaded portion of the field, enter the NPI of the Health First Colorado provider 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	Not Required	
30	Rsvd for NUCC Use		
31	Signature of Physician or Supplier Including Degrees or Credentials	Required	<p>Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent.</p> <p>A holographic signature stamp may be used <u>if</u> authorization for the stamp is on file with the fiscal agent.</p> <p>An authorized agent or representative may sign the claim for the enrolled provider <u>if</u> the name and signature of the agent is on file with the fiscal agent.</p> <p>Each claim must have the date the enrolled provider or registered authorized agent signed the claim form. Enter the date the claim was signed using two digits for the month, two</p>

CMS Field #	Field Label	Field is?	Instructions
			<p>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	<p>32- Service Facility Location Information 32a- NPI Number 32b- Other ID #</p>	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</p> <p>32a- NPI Number Enter the NPI of the service facility (if known).</p>
33	<p>33- Billing Provider Info & Ph # 33a- NPI Number 33b- Other ID #</p>	Required	<p>Enter the name of the individual or organization that will receive payment for the billed services in the following format:</p> <p>1st Line Name 2nd Line Address 3rd Line City, State and ZIP Code</p> <p>33a- NPI Number Enter the NPI of the billing provider</p>

CMS 1500 Behavioral Health Claim Example



HEALTH INSURANCE CLAIM FORM

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

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE (Medicare #) <input checked="" type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE (ID#/DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) D444444									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Client, Ima A										3. PATIENT'S BIRTH DATE MM DD YY 10 16 45 M F <input checked="" type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO-ACCIDENT? PLACE (State) YES NO c. OTHER ACCIDENT? YES NO 10a. RESERVED FOR LOCAL USE					11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M F b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a and 9d.				
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits due to myself or to the party who accepts assignment below.) SIGNED Signature on File DATE 10/1/16										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) SIGNED									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI										15. OTHER DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					20. OUTSIDE LAB? \$ CHARGES YES NO				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY - Relate ALL to service line below (JAE) ICD Ind 0 A. F 19939 B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO.					23. PRIOR AUTHORIZATION NUMBER				
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY PLACE OF SERVICE EMG B. C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OF UNITS H. H PPSST (Pain) I. ID. QUAL. J. RENDERING PROVIDER ID #																			
1 10 01 16 10 01 16 11 H0004 HF A 98 90 2 NPI																			
2																			
3																			
4																			
5																			
6																			
25. FEDERAL TAX ID NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO Optional					27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
28. TOTAL CHARGE \$ 98 90										29. AMOUNT PAID \$					30. Rev'd by NUCC Use				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Signature DATE 10/1/16										32. SERVICE FACILITY LOCATION INFORMATION					33. BILLING PROVIDER INFO & PH # () Behavioral Health Provider 100 Any Street Any City # 1234567890				

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

Timely Filing

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

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

Outpatient Behavioral Health Fee-For-Service Manual 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	6, 7, 11, 14, 16, 19	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)
5/22/2017	Updates based on Fiscal Agent name change from HPE to DXC	4	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 occurred.