Outpatient Behavioral Health Fee-For-Service

Outpatient Behavioral Health Fee-For-Service

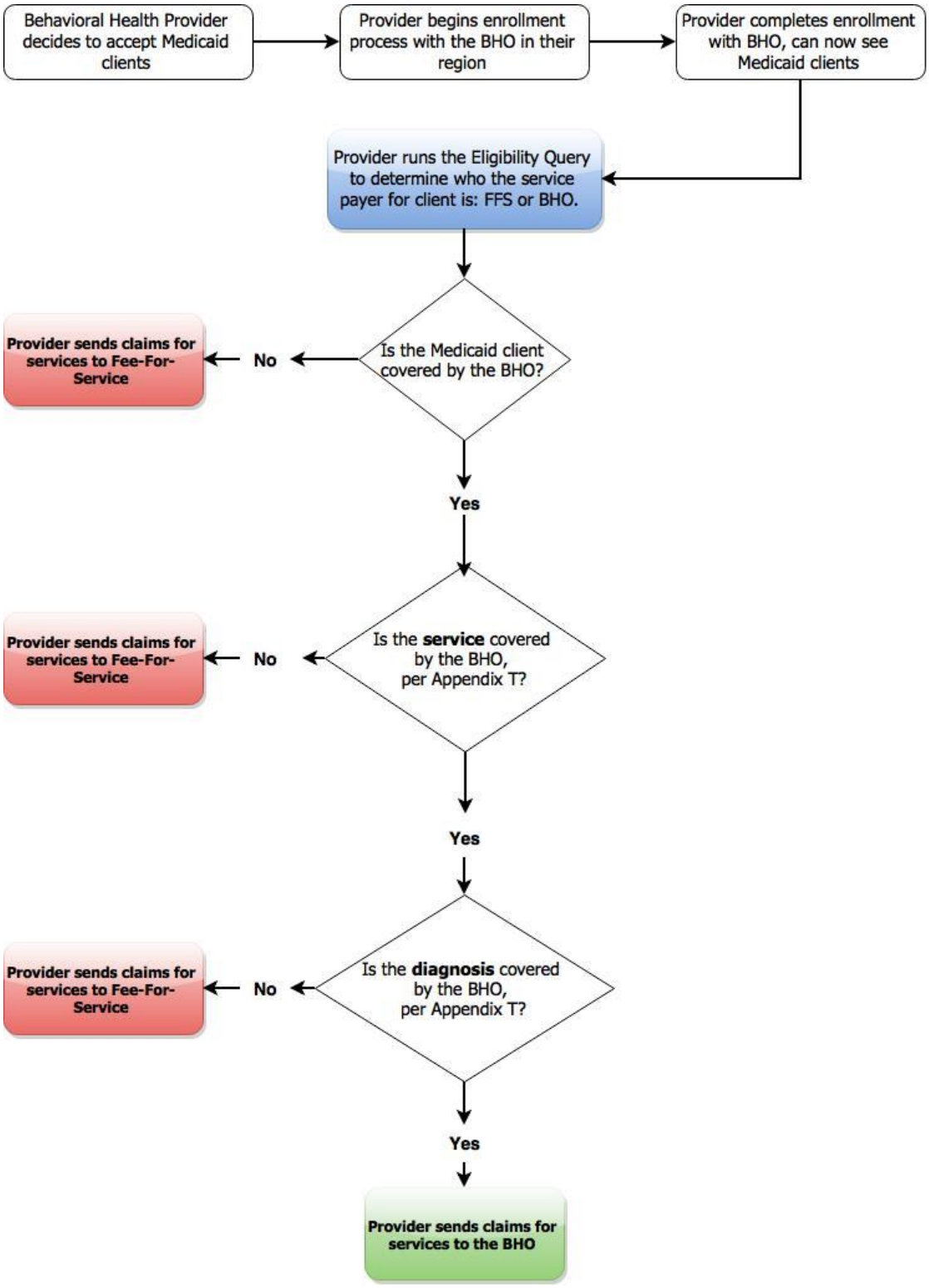
General Policies

- Medicaid 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 Medicaid members.
- See Program Rule 8.212 for details about the BHO program, including policy which exempts Medicaid 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 Medicaid member's behavioral health services are covered by a BHO, providers must perform a member eligibility query in the 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 Medicaid 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 Medicaid 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.

Paper Claims

Electronic claims format shall be required unless hard copy claims submittals are specifically prior authorized by the Department of Health Care Policy and Financing (the Department). Requests for paper claim submission may be sent to the fiscal agent, Xerox State Healthcare (Xerox), P.O. Box 30, Denver, CO 80201-0090. 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

Reconsideration claims

Paper claims do not require an NPI, but do require the Colorado Medical Assistance Program provider number. In addition, the UB-04 Certification document must be completed and attached to all claims submitted on the paper UB-04. 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 Provider Services Specifications section of the Department's website.
- Web Portal User Guide (via within the Web Portal)

The Colorado Medical Assistance Program collects electronic claim information interactively through the Colorado Medical Assistance Program Secure Web Portal (Web Portal) or via batch submission through a host system.

Interactive Claim Submission and Processing

Interactive claim submission through the Web Portal is a real-time exchange of information between the provider and the Colorado Medical Assistance Program. Colorado Medical Assistance Program 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 Colorado Medical Assistance Program Online Transaction Processor (OLTP).

The Colorado Medical Assistance Program OLTP reviews the claim information for compliance with Colorado Medical Assistance Program billing policy and returns a response to the provider's personal computer about that single transaction. If the claim is rejected, the OLTP sends a rejection response that identifies the rejection reason.

If the claim is accepted, the provider receives an acceptance message and the OLTP passes accepted claim information to the Colorado Medical Assistance Program claim processing system for final adjudication and reporting on the Colorado Medical Assistance Program Provider Claim Report (PCR).

The Web Portal contains online training, user guides and help that describe claim completion requirements, a mechanism that allows the user to create and maintain a data base of frequently used information, edits that verify the format and validity of the entered information, and edits that assure that required fields are completed.

Because a claim submitter connects to the Web Portal through the Internet, there is no delay for "dialing up" when submitting claims. The Web 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 Provider Claim Report to providers. The Web Portal also provides access to reports and transactions generated from claims submitted via paper and through electronic data submission methods other than the Web Portal. The reports and transactions include:

Accept/Reject Report

Provider Claim Report

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 Web Portal. Access the Web Portal through Secured Site at colorado.gov/hcpf. For help with claim submission via the Web Portal, please choose the *User Guide* option available for each Web 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 Web site.

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 Colorado Medical Assistance Program fiscal agent.

Any entity sending electronic claims to Xerox Electronic Data Interchange (EDI) Gateway for processing where reports and responses will be delivered must complete an EDI enrollment package.

This provides Xerox EDI Gateway the information necessary to assign a Logon Name, Logon ID, and Trading Partner ID, which are required to submit electronic claims. You may obtain an EDI enrollment

package by contacting the Medical Assistance Program fiscal agent or by downloading it from the Provider Services EDI Support section of the Department's Web site.

The X12N 837 Professional, Institutional, or Dental transaction data will be submitted to the EDI Gateway, 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 Medicaid Management Information System (MMIS), the interchange will reject and a TA1 along with the data will be forwarded to the Xerox State Healthcare Clearinghouse (SHCH) Technical Support for review and follow-up with the sender. An X12N 999 Functional Acknowledgement is generated when a file that has passed the header and trailer check passes through the Xerox SHCH.

If the file contains syntactical error(s), the segment(s) and element(s) where the error(s) occurred will be reported. After validation, the Xerox SHCH will then return the X12N 835 Remittance Advice containing information related to payees, payers, dollar amount, and payments. These X12N transactions will be returned to the Web Portal for retrieval by the trading partner, following the standard claims processing cycle.

Testing and Vendor Certification

Completion of the testing process must occur prior to submission of electronic batch claims to Xerox EDI Gateway. Assistance from Xerox EDI business analysts 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 MMIS system have not affected provider submissions. Also, changes to the ANSI formats may require additional testing.

In order to expedite testing, Xerox EDI Gateway requires providers to submit all X12N test transactions to EDIFECS prior to submitting them to Xerox EDI Gateway. The EDIFECS service is free to providers to certify X12N readiness. EDIFECS offers submission and rapid result turnaround 24 hours a day, seven (7) days a week. For more information, go to www.edifecs.com.

Benefit Policies

Outpatient Behavioral Health Services are a group of services designed to provide medically necessary behavioral health services to certain Medicaid 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 Medicaid 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 Medicaid 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 patient and/or family member	One (1)	35	Yes
Individual Psychotherapy	**90833**	Psychotherapy, 30 mins, with patient or family member, when performed with an E&M service listed separately	One (1)	35	Yes
Individual Psychotherapy	**90834**	Psychotherapy, 45 minutes with patient and/or family member	One (1)	35	Yes

Individual Psychotherapy	**90836**	Psychotherapy, 45 mins, with patient or family member, when performed with an E&M service listed separately	One (1)	35	Yes
Individual Psychotherapy	**90837**	Psychotherapy, 60 minutes with patient and/or family member	One (1)	35	Yes
Individual Psychotherapy	**90838**	Psychotherapy, 60 mins, with patient or family member, when performed with an E&M service listed separately	One (1)	35	Yes
Individual Brief Psychotherapy	**90832**	Psychotherapy, 30 minutes with patient and/or family member	One (1)	35	Yes
Individual Brief Psychotherapy	**90833**	Psychotherapy, 30 mins, with patient or family member, when performed with an E&M service listed separately	One (1)	35	Yes
Family Psychotherapy	**90832**	Psychotherapy, 30 minutes with patient and/or family member	One (1)	35	Yes
Family Psychotherapy	**90833**	Psychotherapy, 30 mins, with patient or family member, when performed with an E&M service listed separately	One (1)	35	Yes
Family Psychotherapy	**90834**	Psychotherapy, 45 minutes with patient and/or family member	One (1)	35	Yes
Family Psychotherapy	**90836**	Psychotherapy, 45 mins, with patient or family member, when performed with an E&M service listed separately	One (1)	35	Yes
Family Psychotherapy	**90837**	Psychotherapy, 60 minutes with patient and/or family member	One (1)	35	Yes
Family Psychotherapy	**90838**	Psychotherapy, 60 mins, with patient 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
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/behave init	Not Covered	Not Covered	No
Health and Behavior Assessment	**96151**	Assess hlth/behave subseq	Not Covered	Not Covered	No
Biopsychosocial Assessment/Intervention	**96152**	Intervene hlth/behave indiv	Not Covered	Not Covered	No
Biopsychosocial Assessment/Intervention	**96153**	Intervene hlth/behave 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 Medicaid 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	a) Psychologists (PhD, PsyD), Nurse Practitioners, Master's Level Clinicians (LCSWs, LPCs, Licensed Marriage and Family Therapists), or LACs; and either: 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: 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.

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		

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 Medicaid 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 *Clinic* Billing ID	**Behavioral Health SUD *BHO* or *Medicaid FFS* Billing ID**
Example services • Suboxone J-codes • Blood draws • Physical health assessment • E&M codes Consult a CPT coding handbook for available codes to bill for your services.	ONLY the following codes • H0001 + HF • H0004 + HF • H0005 + HF • H0006 + HF • T1007 + HF • T1019 + HF • T1023 + HF • S3005 + HF • S9445 + HF • H0020 + HF
Available for all Medicaid members, regardless of BHO enrollment status.	Depends on whether the member is enrolled in a BHO or not. Check their eligibility status in either the Medicaid or BHO web portal. Use the billing ID that corresponds to the member's BHO status.

Methadone Clinics – Where To Send Claims		
	Send claim to BHO?	**Send Claim to Fee-For-Service?**
Physical Health services	No.	Yes, all members. Send claims using the *Clinic* billing ID via the Medicaid Provider web portal.
Behavioral Health SUD services	Yes, nearly every member. Send claims using the BHO billing ID via the BHO web portal.	Yes, *Only for BHO-exempt members.* Send claims using the *Substance Use Disorder – Clinic* billing ID via the Medicaid Provider web portal.

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

Medicaid 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

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 Medicaid program that requires the state Medicaid agency to cover services, products, or procedures for Medicaid 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 Medicaid 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 Colorado Medical Assistance Program members represent services that are approved by the Centers for Medicare and Medicaid Services (CMS) and services that may be provided by an enrolled Colorado Medical Assistance Program 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 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:

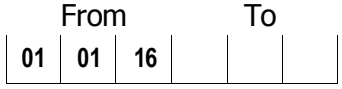
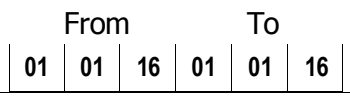
Paper Claim Reference Table

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 Colorado Medical Assistance Program 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 patient'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**		

CMS Field #	Field Label	Field is?	Instructions
9	**Other Insured's Name**	Not Required	
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	

CMS Field #	Field Label	Field is?	Instructions
11d	**Is there another Health Benefit Plan?**	Not Required	
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**	Not Required	
18	**Hospitalization Dates Related to Current Service**	Not Required	
19	**Additional Claim Information**	Conditional	**LBOD** Use to document the Late Bill Override Date for timely filing.
20	**Outside Lab?** **$ Charges**	Not Required	
21	**Diagnosis or Nature of**	Required	Enter at least one but no more than twelve diagnosis codes based on the member's diagnosis/condition.

CMS Field #	Field Label	Field is?	Instructions
	Illness or Injury		Enter applicable ICD indicator to identify which version of ICD codes is being reported. 9 ICD-9-CM (DOS 9/30/15 and before) 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  Or 

CMS Field #	Field Label	Field is?	Instructions
			Span dates of service From To 01 01 16 01 31 16 Single Date of Service: 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. Span billing: permissible if the same service (same procedure code) is provided on consecutive dates.
24B	**Place of Service**	Required	Enter the Place of Service (POS) code that describes the location where services were rendered. The Colorado Medical Assistance Program accepts the CMS place of service codes. 11 Office
24C	**EMG**	Not Required	
24D	**Procedures, Services, or Supplies**	Required	Enter the procedure code that specifically describes the service for which payment is requested.
24D	**Modifier**	Conditional	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.
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. This field allows for the entry of 4 characters in the unshaded area.

CMS Field #	Field Label	Field is?	Instructions
24F	**$ Charges**	Required	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. 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-Colorado Medical Assistance Program covered individuals for the same service. Do not deduct Colorado Medical Assistance Program co-payment or commercial insurance payments from the usual and customary charges.
24G	**Days or Units**	Required	Enter the number of services provided for each procedure code. Enter whole numbers only- do not enter fractions or decimals.
24G	**Days or Units**	General Instructions	A unit represents the number of times the described procedure or service was rendered. Except as instructed in this manual or in Colorado Medical Assistance Program 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.
24H	**EPSDT/Family Plan**	Not Required	**EPSDT** (shaded area) Not Required **Family Planning** (unshaded area) Not Required
24I	**ID Qualifier**	Not Required	

CMS Field #	Field Label	Field is?	Instructions
24J	**Rendering Provider ID #**	Not Required	
25	**Federal Tax ID Number**	Not Required	
26	**Patient's Account Number**	Optional	Enter information that identifies the patient or claim in the provider's billing system. Submitted information appears on the Provider Claim Report (PCR).
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	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 if authorization for the stamp is on file with the fiscal agent. An authorized agent or representative may sign the claim for the enrolled provider if the name and signature of the agent is on file with the fiscal agent. 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.

CMS Field #	Field Label	Field is?	Instructions
			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.
32	**32- Service Facility Location Information** **32a- NPI Number** **32b- Other ID #**	Not Required	
33	**33- Billing Provider Info & Ph #** **33a- NPI Number** **33b- Other ID #**	Required	Enter the name of the individual or organization that will receive payment for the billed services in the following format: 1st Line Name 2nd Line Address 3rd Line City, State and ZIP Code 33a- NPI Number Not Required 33b- Other ID # Enter the eight-digit Colorado Medical Assistance Program provider number of the individual or organization.

Late Bill Override Date

For electronic claims, a delay reason code must be selected and a date must be noted in the "Claim Notes/LBOD" field.

Valid Delay Reason Codes

1 Proof of Eligibility Unknown or Unavailable

3 Authorization Delays

7 Third Party Processing Delay

8 Delay in Eligibility Determination

9 Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules

11 Other

The Late Bill Override Date (LBOD) allows providers to document compliance with timely filing requirements when the initial timely filing period has expired. Colorado Medical Assistance Program 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.

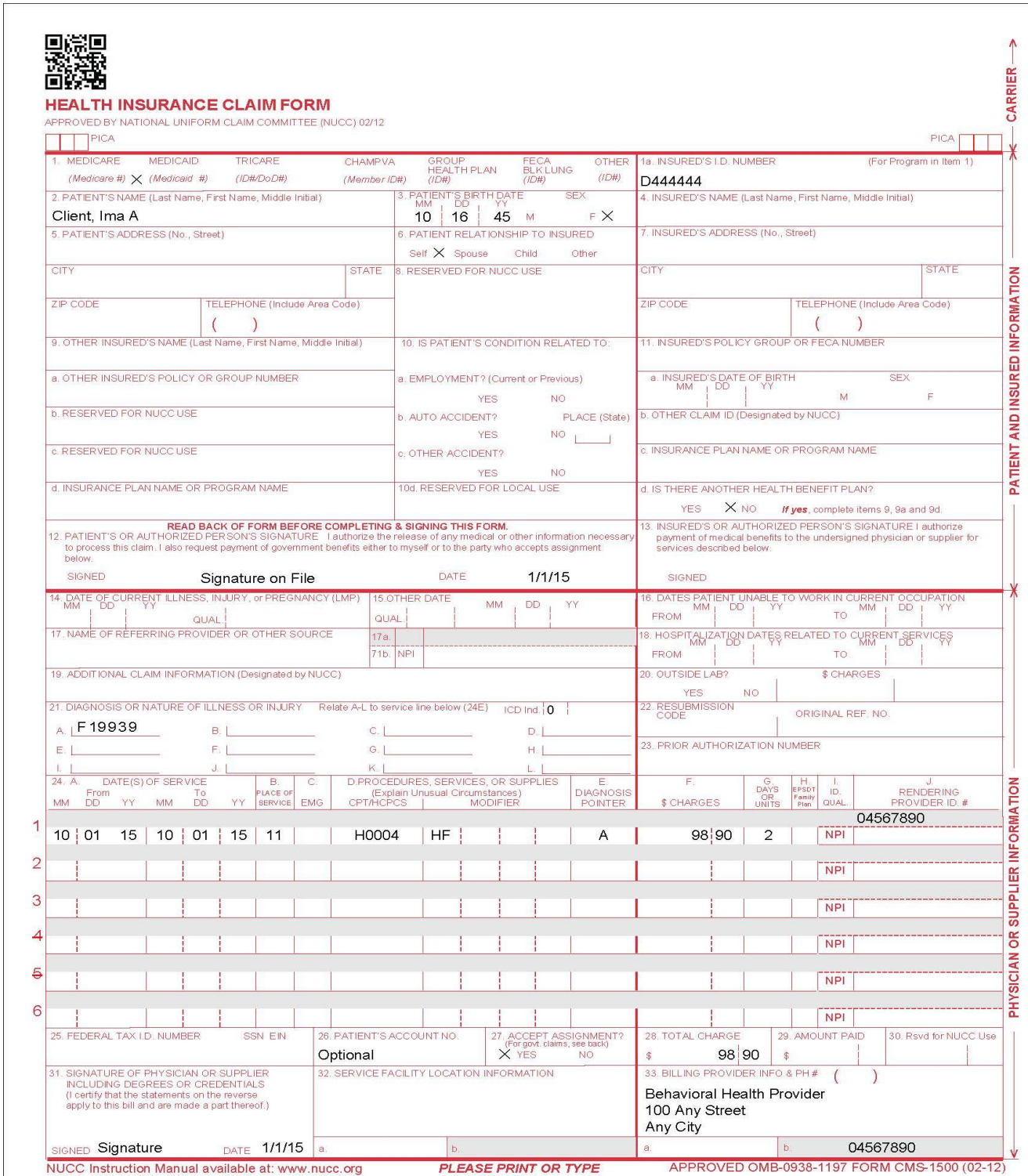
Billing Instruction Detail	Instructions
LBOD Completion Requirements	• Electronic claim formats provide specific fields for documenting the LBOD. • Supporting documentation must be kept on file for 6 years. • For paper claims, follow the instructions appropriate for the claim form you are using. ➢ *UB-04*: Occurrence code 53 and the date are required in FL 31-34. ➢ *CMS 1500*: Indicate "LBOD" and the date in box 19 – Additional Claim Information. ➢ *2006 ADA Dental*: Indicate "LBOD" and the date in box 35 - Remarks
Adjusting Paid Claims	If the initial timely filing period has expired and a previously submitted claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was paid and now needs to be adjusted, resulting in additional payment to the provider. **Adjust the claim within 60 days** of the claim payment. Retain all documents that prove compliance with timely filing requirements. *Note: There is no time limit for providers to adjust paid claims that would result in repayment to the Colorado Medical Assistance Program.* **LBOD** = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the payment.

Billing Instruction Detail	Instructions
Denied Paper Claims	If the initial timely filing period has expired and a previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was denied. **Correct the claim errors and refile within 60 days** of the claim denial or rejection. Retain all documents that prove compliance with timely filing requirements. **LBOD** = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the denial.
Returned Paper Claims	A previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was returned for additional information. **Correct the claim errors and re-file within 60 days** of the date stamped on the returned claim. Retain a copy of the returned claim that shows the receipt or return date stamped by the fiscal agent. **LBOD** = the stamped fiscal agent date on the returned claim.
Rejected Electronic Claims	An electronic claim that was previously entered within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was rejected and information needed to submit the claim was not available to refile at the time of the rejection. **Correct claim errors and refile within 60 days** of the rejection. Maintain a printed copy of the rejection notice that identifies the claim and date of rejection. **LBOD** = the date shown on the claim rejection report.
Denied/Rejected Due to Member Eligibility	An electronic eligibility verification response processed during the original Colorado Medical Assistance Program timely filing period states that the individual was not eligible but you were subsequently able to verify eligibility. Read also instructions for retroactive eligibility. **File the claim within 60 days** of the date of the rejected eligibility verification response. Retain a printed copy of the rejection notice that identifies the member and date of eligibility rejection. **LBOD** = the date shown on the eligibility rejection report.
Retroactive Member Eligibility	The claim is for services provided to an individual whose Colorado Medical Assistance Program eligibility was backdated or made retroactive. File the claim within 120 days of the date that the individual's eligibility information appeared on state eligibility files. Obtain and maintain a letter or form from the county departments of social services that: • Identifies the patient by name • States that eligibility was backdated or retroactive • Identifies the date that eligibility was added to the state eligibility system. **LBOD** = the date shown on the county letter that eligibility was added to or first appeared on the state eligibility system.

Billing Instruction Detail	Instructions
Delayed Notification of Eligibility	The provider was unable to determine that the patient had Colorado Medical Assistance Program coverage until after the timely filing period expired. **File the claim within 60 days** of the date of notification that the individual had Colorado Medical Assistance Program coverage. Retain correspondence, phone logs, or a signed Delayed Eligibility Certification form (see Appendix H of the Appendices in the Provider Services Billing Manuals section) that identifies the member, indicates the effort made to identify eligibility, and shows the date of eligibility notification. • Claims must be filed within 365 days of the date of service. No exceptions are allowed. • This extension is available only if the provider had no way of knowing that the individual had Colorado Medical Assistance Program coverage. • Providers who render services in a hospital or nursing facility are expected to get benefit coverage information from the institution. • The extension does not give additional time to obtain Colorado Medical Assistance Program billing information. • If the provider has previously submitted claims for the member, it is improper to claim that eligibility notification was delayed. **LBOD** = the date the provider was advised the individual had Colorado Medical Assistance Program benefits.
Electronic Medicare Crossover Claims	An electronic claim is being submitted for Medicare crossover benefits within 120 days of the date of Medicare processing/ payment. (Note: On the paper claim form (only), the Medicare SPR/ERA date field documents crossover timely filing and completion of the LBOD is not required.) **File the claim within 120 days** of the Medicare processing/ payment date shown on the SPR/ERA. Maintain the original SPR/ERA on file. **LBOD** = the Medicare processing date shown on the SPR/ERA.
Medicare Denied Services	The claim is for Medicare denied services (Medicare non-benefit services, benefits exhausted services, or the member does not have Medicare coverage) being submitted within 60 days of the date of Medicare processing/denial. *Note: This becomes a regular Colorado Medical Assistance Program claim, not a Medicare crossover claim.* **File the claim within 60 days** of the Medicare processing date shown on the SPR/ERA. Attach a copy of the SPR/ERA if submitting a paper claim and maintain the original SPR/ERA on file. **LBOD** = the Medicare processing date shown on the SPR/ERA.
Commercial Insurance Processing	The claim has been paid or denied by commercial insurance. **File the claim within 60 days** of the insurance payment or denial. Retain the commercial insurance payment or denial notice that identifies the patient, rendered services, and shows the payment or denial date. Claims must be filed within 365 days of the date of service. No exceptions are allowed. If the claim is nearing the 365-day limit and the commercial insurance

Billing Instruction Detail	Instructions
	company has not completed processing, file the claim, receive a denial or rejection, and continue filing in compliance with the 60-day rule until insurance processing information is available. **LBOD** = the date commercial insurance paid or denied.
Correspondence LBOD Authorization	The claim is being submitted in accordance with instructions (authorization) from the Colorado Medical Assistance Program for a 60 day filing extension for a specific member, claim, services, or circumstances. **File the claim within 60 days** of the date on the authorization letter. Retain the authorization letter. **LBOD** = the date on the authorization letter.
Member Changes Providers during Obstetrical Care	The claim is for obstetrical care where the patient transferred to another provider for continuation of OB care. The prenatal visits must be billed using individual visit codes but the service dates are outside the initial timely filing period. **File the claim within 60 days** of the last OB visit. Maintain information in the medical record showing the date of the last prenatal visit and a notation that the patient transferred to another provider for continuation of OB care. **LBOD** = the last date of OB care by the billing provider.

CMS 1500 Behavioral Health Claim Example



HEALTH INSURANCE CLAIM FORM

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

PICA

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 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 SEX M F X

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

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

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

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

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED Signature on File DATE 1/1/15

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

SIGNED

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

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. F19939 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 01 15	10 01 15	11		H0004	HF			A	98 90	2		NPI	04567890
2													NPI	
3													NPI	
4													NPI	
5													NPI	
6													NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. Optional

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

28. TOTAL CHARGE $ 98 90

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED Signature DATE 1/1/15

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

Behavioral Health Provider
100 Any Street
Any City

a. b. 04567890

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

Manual Revisions Log

Revision Date	*Section/Action*	*Pages*	*Made by*
10/7/2015	*Manual Created*	*All*	*AW*
10/26/2015	- *Added Claim Example and updated TOC.* - *Changed "client" to "member" where applicable.* - *Minor grammar and formatting changes for publications consistency.*	*29* *Throughout*	*JH*
05/09/2016	- *Updated unit limits for J0571-75*	*15*	*AW*