Outpatient Imaging and Radiology Services

Outpatient Imaging and Radiology Services

Providers must be enrolled as a Health First Colorado provider (Provider) in order to:

- Treat a Health First Colorado member; and
- Submit claims for payment to the Health First Colorado (Health First Colorado).

Outpatient Imaging and Radiology services are a benefit of Health First Colorado (Colorado's Medicaid Program), for medical conditions requiring radiology services when supervised by a physician. Imaging and Radiology services are a benefit under the following conditions:

1. The services have been authorized by a licensed physician.
2. The services are performed to diagnose conditions and illnesses with specific symptoms.
3. The services are performed to prevent or treat conditions that are Health First Colorado covered benefits.
4. The services are not routine diagnostic tests performed without apparent relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.
5. The radiology services are performed by a provider certified by the Colorado Department of Public Health and Environment (CDPHE) and enrolled as a Health First Colorado Provider.

The Department of Health Care Policy and Financing (the Department) periodically modifies billing information. Therefore, the information in this manual is subject to change, and the manual is updated as new billing information is implemented.

Providers should refer to the Code of Colorado Regulations, Program Rules (10 C.C.R. 2505-10) for specific information when providing hospital care.

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.

Claim Requirements

All claims, including those for prior authorization (PAR) services, must meet eligibility and claim submission requirements (e.g., timely filing, Primary Care Physician [PCP] information completed appropriately, third party resources payments pursued, required attachments included, etc.) before payment can be made.

Submitted claim data is checked against the PAR file, therefore, **do not** submit a copy of the PAR with the claim. The fiscal agent identifies the appropriate PAR record using member identification information and the PAR number noted on the claim.

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.

General Benefit Policies

Co-payments for Imaging and Radiology Procedures

Co-payment eligible members may be charged a $1 co-payment for each day they receive a radiology procedure. Providers must look up a member's Health First Colorado eligibility status to determine if that member is eligible for a co-payment. Many members, including children and pregnant women, are exempt from co-payment responsibilities.

- Providers cannot refuse treatment to a member if the member is unable to immediately pay the co-payment. However, the member still remains liable for the co-payment at a later date. Reference Program Rule 8.754 for specific co-payment guidelines

Payment for Covered Services/Procedures

Regardless of whether Health First Colorado has actually reimbursed the provider, billing members for covered procedures is strictly prohibited. Balance billing is prohibited. If reimbursement is made, providers must accept this payment as *payment in full* (see Program Rule 8.012). The provider may only bill the member for procedures not covered by Health First Colorado.

- Members may be billed for non-covered procedures in accordance with C.R.S. 25.5-4-301(1)(a)(I).
    - *(1) (a) (I) Except as provided in section 25.5-4-302 and subparagraph (III) of this paragraph (a), no recipient or estate of the recipient shall be liable for the cost or the cost remaining after payment by medicaid, medicare, or a private insurer of medical benefits authorized by Title XIX of the social security act, by this title, or by rules promulgated by the state board, which benefits are rendered to the recipient by a provider of medical services authorized to render such service in the state of Colorado, except those contributions required pursuant to section 25.5-4-209 (1). However, a recipient may enter into a documented agreement with a provider under which the recipient agrees to pay for items or services that are nonreimbursable under the medical assistance program. Under these circumstances, a recipient is liable for the cost of such services and items.*
- If a PAR for procedures are required, the following policy applies:
    - Technical/lack of information (LOI) denial does not mean those procedures are not covered. Members may not be billed for procedures denied for LOI.
    - Procedures partially approved are still considered covered procedures. Members may not be billed for the denied portion of the request.
    - Procedures totally denied for not meeting medical necessity criteria are considered non-covered services.

Billing Edits

The provider's adherence to the application of policies in this manual is monitored through either post-payment review of claims by the Department, or computer audits or edits of claims. When computer audits or edits fail to function properly, the application of policies in this manual remain in effect. Therefore, all claims shall be subject to review by the Department.

Covered Imaging and Radiology Procedures

Health First Colorado covered procedures include but are not limited to:

- Angiograms
- Computed Tomography (CT scans)
- Electrocardiograms (ECG)
- Magnetic Resonance Imaging (MRI scans)
- Mammograms
- Positron Emission Tomography (PET scans)
- Radiation treatment for tumors
- Ultrasounds
- X-rays

An exhaustive list of covered procedures may be found on the Department's Fee Schedule.

Preventive Lung Cancer Low Dose Computed Tomography (LDCT) Screening

The United States Preventive Services Task Force recommends annual screening for lung cancer with low-dose computed tomography for adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

Effective July 1, 2015, the following policies must be followed:

1. HCPCS code **S8032** must be used for preventive lung cancer screening procedures performed prior to October 1, 2016. HCPCS code **G0297** must be used for dates of services on and after October 1, 2016.
2. ICD-9 diagnosis code V76.0 must be reported for dates of service prior to 10/1/15
3. ICD-10 diagnosis code Z12.2 must be reported for dates of service beginning 10/1/15
4. S8032 and G0297 always requires Prior Authorization
5. Benefit is limited to one (1) screening (one (1) unit of service) per state fiscal year (July 1 – June 30)

Special Eligibility Criteria for LDCT Lung Cancer Screening

Member must meet all of the following criteria to be eligible for the benefit:

1. Between 55 and 80 years of age
2. Asymptomatic (no signs of lung cancer)
3. History of cigarette smoking of at least 30 pack-years

4. Current smoker or one who has quit smoking within the last 15 years
5. Receives written order for LDCT lung cancer screening from a qualified physician or non-physician practitioner

Non-Covered Imaging and Radiology Procedures

1. Imaging and Radiology procedures for cosmetic treatment or infertility treatment.
2. Imaging and Radiology procedures considered experimental or not approved by the Food and Drug Administration (FDA).
3. Imaging and Radiology procedures not ordered by the member's attending or treating physician.

Coding Guidelines

General Policies

1. Regardless of billing provider type, component modifiers must be indicated on the claim if reimbursement for the procedure is split between the *professional* and *technical components.*
    a. Professional component – modifier 26
    b. Technical component – modifier TC
2. Claims lacking a component modifier are understood to be inclusive of both components and will be reimbursed as payment in full for the entire procedure. Any separate claim for the same procedure, billed on the same date of service, will be considered an overpayment and may be subject to recovery.
3. Outpatient Hospital claims for Imaging and Radiology must be billed via an 837I (UB-04 paper claim); Practitioner procedure claims must be billed via an 837P (CMS1500 paper claim)

Prior Authorization Requirements and Information

Health First Colorado requires all outpatient hospitals and free-standing radiology / X-ray facility centers to obtain a prior authorization (prior authorization request, PAR) for non-emergent CT, non-emergent MRI, and all PET scans. A PAR precedes the submission of a claim and must be approved in advance of the claim. Procedures which require a PAR cannot be claimed for without an approved PAR on record. Reference the Department's Fee Schedule for a list of all procedure codes which require a PAR.

All Imaging and Radiology PARs and revisions are processed by the ColoradoPAR Program and must be submitted using eQSuite ®. PARs submitted via fax or mail **will not** be processed. These PARs will be returned to providers via mail. This requirement only impacts PARs submitted to the ColoradoPAR Program.

To ensure claims are quickly and accurately processed, all claims for procedures which require a PAR must:

- Contain the correct Billing Provider ID number
- Contain procedure codes which match the corresponding PAR on record
- Contain modifier codes which match the corresponding PAR on record

To request more information contact:

888-801-9355 or refer to the Department's ColoradoPAR Program web page.

PAR Revisions

If a procedure is prior authorized but the desired test was changed just prior to the time of the service, the provider is responsible for submitting a PAR revision with adequate documentation within 48 hours of the date of service for the PAR to be processed by the ColoradoPAR Program. PAR revisions can only be submitted using eQSuite®. Contact the ColoradoPAR Program at 888-801-9355 with questions regarding how to process PAR revisions.

PAR Exceptions

To request a PAR exception contact the ColoradoPAR Program at 888-801-9355 or refer to the Department's ColoradoPAR Program web page.

1. Emergency outpatient imaging and radiology procedures are exempt from PAR requirements. To mark a claim as emergency, check the emergency indicator field.
2. All PET and SPECT scan procedures require prior authorization regardless of whether emergency is indicated.
3. A PAR is not required when Medicare, Medicare Advantage plans, or private insurance has made primary payment on the claim. If third party liability (TPL) carriers have not made payment on the claim, the service must be prior authorized to ensure it meets medical necessity standards of the Health First Colorado program.
4. PARs are not required of any Imaging and Radiology procedure for the *professional component* if the procedure billing is split between components. The *technical component* still requires prior authorization.

The Department will allow retroactive authorizations when a member's eligibility is determined after the date that the service is performed. When a member's eligibility is determined after the date of service, the member is issued a Load Letter. The Load Letter must be submitted with the supporting clinical documentation for the PAR for a retroactive request to be processed by ColoradoPAR.

PAR Denials

If the PAR is denied, direct inquiries to the ColoradoPAR Program at 888-801-9355 or refer to the Department's ColoradoPAR Program web page.

Other PAR Policies

- It is the provider's responsibility to maintain clinical documentation to support procedures provided in the member's file in the event of an audit or retroactive review. Submitted PARs without minimally required information or with missing or inadequate clinical information will result in a lack of information (LOI) denial.
- All accepted PARs are reviewed by the authorizing agency. The authorizing agency approves or denies, by individual line item, each requested service or supply listed on the PAR.
- Paper PAR forms and completion instructions are located in the Provider Services Forms section of the Department's website. They must be completed and signed by the member's physician and submitted to the authorizing agency for approval.
- Providers should not render procedures or submit claims for procedures that require prior authorization before the PAR is approved. After the authorizing agency has reviewed the request, the PAR status is transmitted to the fiscal agent's prior approval system.
- The status of the requested procedures is available through the Provider web portal. In addition, after a PAR has been reviewed, both the provider and the member receive a PAR response letter

detailing the status of the requested procedures. Some procedures may be approved and others denied. **Check the PAR response carefully as some line items may be approved and others denied.**

- Approval of a PAR does **not** guarantee Health First Colorado reimbursement and does **not** serve as a timely filing waiver. Authorization only assures that the approved service is a medical necessity and is considered a Health First Colorado covered benefit.

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 (2) 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 four (4) numeric digits, while CPT codes are identified using five (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 (1) unit or session.

The Department updates and revises HCPCS code listings through its billing manuals and bulletins. Providers should regularly consult the billing manuals and monthly bulletins in the Provider Services Billing Manuals and Bulletins section of the Department's website.

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 completing a publication preference form. Bulletins include updates on approved codes as well as the maximum allowable units billed per procedure.

All outpatient radiology procedures must be billed using HCPCS codes.

When submitting claims for radiology to the Health First Colorado, observe the following guidelines:

Always use the most current CPT revision. The Health First Colorado adds and deletes codes as they are published in annual revisions of the CPT.

Use CMS codes only when CPT codes are not available or are not as specific as the CMS codes.

Not all codes listed in the annual Health First Colorado HCPCS code publications are benefits of the Health First Colorado. Read the entire entry to determine the benefit status of the item.

The CPT Manual can be purchased at local university bookstores and from the American Medical Association at the following address:

Book & Pamphlet Fulfillment: OP-341/9
American Medical Association
P.O. Box 10946

Chicago, Illinois 60610

CMS 1500 Paper Claim Reference Table

The following paper form reference table shows required, optional, and conditional fields and detailed field completion instructions for the CMS 1500 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 (2) digits for the month, two (2) digits for the date, and two (2) digits for the year. Example: 070115 for July 1, 2015. Place an "X" in the appropriate box to indicate the sex of the member.
4	**Insured's Name**	Conditional	Complete if the member is covered by a **Medicare** health insurance policy. Enter the insured's full last name, first name, and middle initial. If the insured used a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name.
5	**Patient's Address**	Not Required	
6	**Patient's Relationship to Insured**	Conditional	Complete if the member is covered by a commercial health insurance policy. Place an "X" in the box that identifies the member's relationship to the policyholder.
7	**Insured's Address**	Not Required	
8	**Reserved for NUCC Use**		

CMS Field #	Field Label	Field is?	Instructions
9	**Other Insured's Name**	Conditional	If field 11d is marked "yes", enter the insured's last name, first name and middle initial.
9a	**Other Insured's Policy or Group Number**	Conditional	If field 11d is marked "yes", enter the policy or group number.
9b	**Reserved for NUCC Use**		
9c	**Reserved for NUCC Use**		
9d	**Insurance Plan or Program Name**	Conditional	If field 11d is marked "yes", enter the insurance plan or program name.
10a-c	**Is Patient's Condition Related to?**	Conditional	When appropriate, place an "X" in the correct box to indicate whether one (1) or more of the services described in field 24 are for a condition or injury that occurred on the job, as a result of an auto accident or other.
10d	**Reserved for Local Use**		
11	**Insured's Policy, Group or FECA Number**	Conditional	Complete if the member is covered by a **Medicare** health insurance policy. Enter the insured's policy number as it appears on the ID card. Only complete if field 4 is completed.
11a	**Insured's Date of Birth, Sex**	Conditional	Complete if the member is covered by a **Medicare** health insurance policy. Enter the insured's birth date using two (2) digits for the month, two (2) digits for the date and two (2) digits for the year. Example: 070115 for July 1, 2015. Place an "X" in the appropriate box to indicate the sex of the insured.

CMS Field #	Field Label	Field is?	Instructions
11b	**Other Claim ID**	Not Required	
11c	**Insurance Plan Name or Program Name**	Not Required	
11d	**Is there another Health Benefit Plan?**	Conditional	When appropriate, place an "X" in the correct box. If marked YES, complete 9, 9a and 9d.
12	**Patient's or Authorized Person's signature**	Required	Enter "Signature on File", "SOF", or legal signature. If there is no signature on file, leave blank or enter "No Signature on File". Enter the date the claim form was signed.
13	**Insured's or Authorized Person's Signature**	Not Required	
14	**Date of Current Illness Injury or Pregnancy**	Conditional	Complete if information is known. Enter the date of illness, injury or pregnancy, (date of the last menstrual period) using two (2) digits for the month, two (2) digits for the date and two (2) digits for the year. Example: 070115 for July 1, 2015. Enter the applicable qualifier to identify which date is being reported 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period
15	**Other Date**	Not Required	
16	**Date Patient Unable to Work in Current Occupation**	Not Required	
17	**Name of Referring Physician**	Conditional	

CMS Field #	Field Label	Field is?	Instructions
18	**Hospitalization Dates Related to Current Service**	Conditional	Complete for services provided in an inpatient hospital setting. Enter the date of hospital admission and the date of discharge using two (2) digits for the month, two (2) digits for the date and two (2) digits for the year. Example: 070115 for July 1, 2015. If the member is still hospitalized, the discharge date may be omitted. This information is not edited.
19	**Additional Claim Information**	Conditional	
20	**Outside Lab?** **$ Charges**	Not Required	
21	**Diagnosis or Nature of Illness or Injury**	Required	Enter at least one (1) but no more than twelve diagnosis codes based on the member's diagnosis/condition. Enter applicable ICD indicator to identify which version of ICD codes is being reported. 0 ICD-10-CM (DOS 10/1/15 and after) 9 ICD-9-CM (DOS 9/30/15 and before)
22	**Medicaid Resubmission Code**	Conditional	List the original reference number for adjusted claims. When resubmitting a claim as a replacement or a void, enter the appropriate bill frequency code in the left-hand side of the field. 7 Replacement of prior claim 8 Void/Cancel of prior claim This field is not intended for use for original claim submissions.
23	**Prior Authorization**	Conditional	**CLIA** When applicable, enter the word "CLIA" followed by the number.
24	**Claim Line Detail**	Information	The paper claim form allows entry of up to six (6) detailed billing lines. Fields 24A through 24J apply to each billed line. **Do not enter more than six (6) lines of information** on the paper claim. If more

CMS Field #	Field Label	Field is?	Instructions
			than six (6) 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 (2) dates: a "From" date of services and a "To" date of service. Enter the date of service using two (2) digits for the month, two (2) digits for the date and two (2) digits for the year. Example: 010116 for January 1, 2016 From To **01 01 16** | | | | | | Or From To **01 01 16 01 01 16** Span dates of service From To **01 01 16 01 31 16** Practitioner claims must be consecutive days. Single Date of Service: Enter the six (6) 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 (2) fields. Span billing: permissible if the same service (same procedure code) is provided on consecutive dates. **Supplemental Qualifier** To enter supplemental information, begin at 24A by entering the qualifier and then the information. ZZ Narrative description of unspecified code N4 National Drug Codes VP Vendor Product Number OZ Product Number CTR Contract Rate

CMS Field #	Field Label	Field is?	Instructions
			JP Universal/National Tooth Designation JO Dentistry Designation System for Tooth & Areas of Oral Cavity
24B	**Place of Service**	Required	Enter the Place of Service (POS) code that describes the location where services were rendered. The Health First Colorado accepts the CMS place of service codes. 81 Independent Lab
24C	**EMG**	Conditional	Enter a "Y" for YES or leave blank for NO in the bottom, unshaded area of the field to indicate the service is rendered for a life-threatening condition or one (1) that requires immediate medical intervention. If a "Y" for YES is entered, the service on this detail line is exempt from co-payment requirements.
24D	**Procedures, Services, or Supplies**	Required	Enter the HCPCS procedure code that specifically describes the service for which payment is requested. All procedures must be identified with codes in the current edition of Physicians Current Procedural Terminology (CPT). CPT is updated annually. HCPCS Level II Codes The current Medicare coding publication (for Medicare crossover claims only). Only approved codes from the current CPT or HCPCS publications will be accepted.
24D	**Modifier**	Conditional	Enter the appropriate procedure-related modifier that applies to the billed service. Up to four (4) modifiers may be entered when using the paper claim form. 26 Professional component TC Technical component 76 Repeat procedure, same physician 77 Repeat procedure, different physician 50 Bilateral procedure- Both sides of the body are imaged LT/RT Left side/Right side- Only one (1) side was imaged

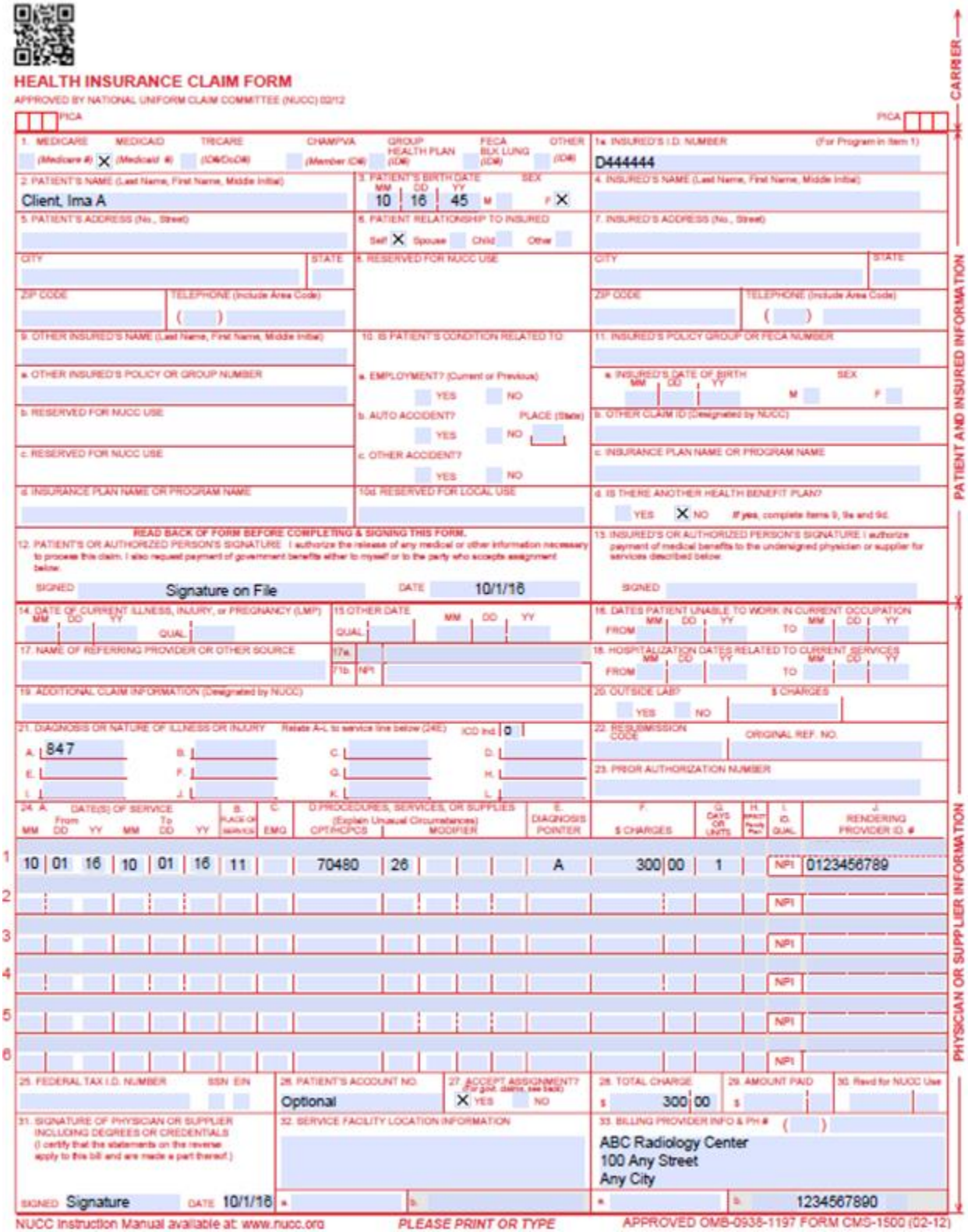
CMS Field #	Field Label	Field is?	Instructions
			59 Indicates that two (2) or more procedures are performed at different anatomic sites or different member encounters. Only use if no other modifier more appropriately describes the relationships of the two (2) or more procedure codes. 52 Reduces services- Under certain circumstances, a services or procedure is reduced or eliminated at the physician's discretion. 53 Discontinued services- Under certain circumstances, a physician may elect to terminate a diagnostic procedure. 25 Separate procedure during an evaluation and management visit- If a radiologist performs office visits and/or consultations and performs procedures (not 7xxxx codes) that are separately identifiable on the same date of service.
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 (1) 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.
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 (1) procedure from the same group is billed, special multiple pricing rules apply.

CMS Field #	Field Label	Field is?	Instructions
			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 (1) procedure from the same grouping is performed. Submitted charges cannot be more than charges made to non-Health First Colorado covered individuals for the same service. Do not deduct Health First Colorado 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 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.
24H	**EPSDT/Family Plan**	Conditional	**EPSDT** (shaded area) For Early & Periodic Screening, Diagnosis, and Treatment related services, enter the response in the shaded portion of the field as follows: AV Available- Not Used S2 Under Treatment ST New Service Requested NU Not Used **Family Planning** (unshaded area) Not Required
24I	**ID Qualifier**	Not Required	
24J	**Rendering Provider ID #**	Required	In the shaded portion of the field, enter the NPI of the Health First Colorado provider assigned to the individual who actually

CMS Field #	Field Label	Field is?	Instructions
			performed or rendered the billed service. This number cannot be assigned to a group or clinic.
25	**Federal Tax ID Number**	Not Required	
26	**Patient's Account Number**	Optional	Enter information that identifies the member or claim in the provider's billing system. Submitted information appears on the Remittance Advice (RA).
27	**Accept Assignment?**	Required	The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.
28	**Total Charge**	Required	Enter the sum of all charges listed in field 24F. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
29	**Amount Paid**	Conditional	Enter the total amount paid by Medicare or any other commercial health insurance that has made payment on the billed services. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
30	**Rsvd for NUCC Use**		
31	**Signature of Physician or Supplier Including Degrees or Credentials**	Required	Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent. A holographic signature stamp may be used 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 (2) digits for the month, two (2) digits for the date and two

CMS Field #	Field Label	Field is?	Instructions
			(2) digits for the year. Example: 070115 for July 1, 2015. **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 #**	Conditional	Complete for services provided in a hospital or nursing facility in the following format: 1st Line Facility Name 2nd Line Address 3rd Line City, State and ZIP Code 32a- NPI Number Enter the NPI of the service facility (if known).
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 Enter the NPI of the billing provider

CMS 1500 Radiology 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

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? PLACE (State) YES NO

9. 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: 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

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

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. 847 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	16	10	01	16	11		70480	26	A	300 00	1		NPI	0123456789
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) X YES NO

28. TOTAL CHARGE $ 300 00

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 10/1/16

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

ABC Radiology Center
100 Any Street
Any City

a. b. 1234567890

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

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 of the Department's website.

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

Outpatient Imaging and Radiology Services Revisions Log

Revision Date	Additions/Changes	Pages	Made by
12/01/2016	*Manual revised for interChange implementation. For manual revisions prior to 12/01/2016 Please refer to Archive.*	*All*	*HPE (now DXC)*
12/27/2016	*Updates Colorado iC Stage II Provider Billing Manual Comment Log v0_2.xlsx*	*7-12, 16*	*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*	*1*	*DXC*

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