Health First Colorado Managed Care Programs

Health First Colorado Managed Care Programs

Some Health First Colorado members obtain Health First Colorado (Colorado's Medicaid Program) through enrollment in a Health First Colorado Managed Care Organization (MCO). The Health First Colorado offers several Managed Care options described in this section.

- Managed Care Organizations (MCOs)
  - Denver Health Medicaid Choice
  - Colorado Access (Access KP)
  - Rocky Mountain Health Plans Prime
- Program of All-Inclusive Care for the Elderly (PACE)
- Behavioral Health Program (BHO, formerly MHASA)

Identifying Health First Colorado

Managed Care Enrollment

Health First Colorado Managed Care enrollment may be identified through verifying eligibility.

- An inquiry response through the Health First Colorado Provider Web Portal will first display member information under "Member Details", followed by the member's eligibility status under "Member Eligibility Details." Please note that a member may show as Health First Colorado "eligible" on the Provider Web Portal response, but not be eligible for Health First Colorado medical assistance payments. It is important to review the entire response. If the Provider Web Portal displays "Third Party Liability" and Medicare is listed, the message "Member has Medicare covered services only, no drug benefits" means that the member is eligible only for premium assistance. All provider billings to Health First Colorado will be denied for lack of coverage. Only Medicare will pay for services (in essence, Health First Colorado purchases Medicare services for the member, but does not provide any direct Health First Colorado medical benefits at all.
- Co-payment information is displayed next under "Co-payment".
- If the member is enrolled in Managed Care, that information is displayed under the title "Prepaid Health Plan." Almost all Health First Colorado members are enrolled in the mandatory Behavioral Health Capitation Program. The member's behavioral health organization is usually displayed first with the message "MHPROV Services" in large bold letters to identify the Managed Care plan as a behavioral health plan.

Managed Care enrollment information (if any) is often displayed last under the "Prepaid Health Plan" title. A bolded message reminds providers to get authorization from the plan before providing "non-exempt services." (See section below for a list of Services that can be provided without managed care approval).

Providers must always verify eligibility information, including managed care participation, *before* providing services. Failure to verify eligibility information increases the risk of not receiving payment for

rendered services. Fee-for-service claims for members who are enrolled in Health First Colorado MCO will be denied.

Providers must comply with the requirements of Managed Care Organizations.

For MCOs, service providers must be enrolled in the MCO network or have authorization to provide non-exempt services (see information below under Managed Care Organizations). The name and telephone number of the MCO is identified on the eligibility verification response.

Enrollment Services

Members who wish to enroll in managed care can receive counseling and enrollment assistance from Health First Colorado. Members can call 303-839-2120 in the Denver Metro area, or 888-367-6557 outside the metro area, or visit the Health Colorado website at http://www.healthfirstcolorado.com. .

Managed Care Support Services for Providers

Questions about the policies and billing procedures for a specific MCO should be directed to that MCO.

Managed Care Organizations (MCOs)

The Health First Colorado contracts with MCOs to provide benefits to Medical Assistance Program members enrolled in the MCO. MCO-enrolled members must obtain available services from the MCO.

Benefit Availability

MCO Benefits

- Physician services
- Laboratory and X-ray
- Inpatient Hospital
- Prescription Drugs
- Outpatient Hospital
- Family Planning
- Acute Home Health
- EPSDT
- Equipment/Supplies
- Ambulance
- Vision
- NOTE: Adult vision benefits are only available through a MCO

Managed Care Organizations /Medical Assistance Program

- Fee-for-Service Shared Benefits
- Physical Therapy
- Nursing Facility Care

Medical Assistance Program Fee-for-Service Only Benefits

- Long-term care (Nursing facilities or Community based care)
- Dental care*
- Family planning
- Transportation
- Hospice
- Long Term Home Health
- Private Duty Nursing

Managed Care Organizations enrolled members are entitled to the same Health First Colorado benefits as members who are not enrolled in managed care.

- Managed Care Organizations provide most of the Health First Colorado benefits available to enrolled members.
- Some benefits are not available from the MCO and these benefits are provided through Fee-for-Service reimbursement.
- If the MCO offers a limited benefit, MCO enrolled members must obtain available services from the MCO. When the MCO benefit is exhausted, additional medically necessary services are provided through Fee-for-Service reimbursement.

Fee-for-Service Benefits for MCO-Enrolled Members

The Health First Colorado pays Fee-for-Service claims for MCO-enrolled members under the following circumstances:

1. When a Health First Colorado benefit is not provided by the MCO, referred to as a "wrap-around" service,
2. When the member has exhausted MCO benefits and requires additional Health First Colorado benefit services.

When the service is one of the following exempt-from-authorization services:

- Emergency Services
- Emergency Transportation
- Obstetrical services
- Non-emergency transportation
- Family Planning Services

Fee-for-Service claims for services provided to MCO enrolled members must have the following attachments:

- A benefits exhausted statement (explanation of benefits) for MCO exhausted benefits.
- A statement from the MCO indicating the service is not a provided MCO benefit. If the MCO routinely does not provide a specific service (e.g. nursing facility, physical therapy, etc.), the non-benefit statement is optional. Benefit coverage may vary from one (1) MCO to another.

Managed Care Organizations Benefits by Non-MCO Providers

The Health First Colorado will not pay claims for services provided to a MCO enrolled member that are available through the MCO. Providers should always contact the member's MCO before providing services to determine the extent of benefits available through the MCO. Direct questions about MCO covered benefits and billing instructions to the MCO listed on the eligibility verification response.

Emergency Care

Emergency care and out-of-area URGENT care provided by a non-MCO provider is the responsibility of the MCO. The non-MCO provider must comply with all MCO notification requirements.

1. The non-MCO provider must contact the MCO within 48 hours of providing services.
2. The non-MCO provider must contact the MCO for authorization before providing non-emergency services.
3. The MCO may not pay for services determined to be non-emergent.

Inquiries

Inquiries about MCO payments or denials should be directed to the MCO.

Inquiries about claims submitted to the fiscal agent, DXC Technology (DXC) at 844-235-2387 (toll free), for exhausted MCO benefits or non-covered MCO services should be directed to the fiscal agent.

Program of All-Inclusive Care for the Elderly (PACE)

What is PACE?

PACE is a Medicare/Health First Colorado all-inclusive care system that provides health care and support services to frail persons 55 years of age and older. The goal of PACE is to assist individuals in living independently in their communities by providing specialized services based on their needs through an Inter-Disciplinary Team. Except for ER services, PACE members obtain all medical care services through the PACE provider, including nursing home and assisted living facility stays. PACE provides services internally at the PACE Centers and contracts with community providers to provide medically necessary services. Providers that do not contract with PACE are out of network and may not be reimbursed for services provided to a PACE member, unless approved by the Inter-Disciplinary Team. It is the provider's responsibility to determine if the Health First Colorado member is a PACE member.

PACE is available in select areas including parts of Denver Metropolitan area, Delta, Montrose and El Paso, Weld and Larimer Counties. PACE will expand to Boulder and additional parts of Weld county in 2016.

Further details regarding PACE be found on the Department's website.

Community Behavioral Health Services Program (Formerly the Mental Health Program)

The Health First Colorado mental health and substance use disorder benefits are provided through the Community Behavioral Health Services Program (Behavioral Health Program). State contracted Behavioral Health Organizations (BHOs), are responsible for Health First Colorado behavioral health

services provided to enrolled members who reside in the BHOs geographical area. Behavioral health providers must apply to become a network provider with the BHO in their area. If the network is not accepting new providers, providers are limited to providing services to Health First Colorado members with diagnoses that are not covered under the BHO contract. The BHOs contact information is located in the Behavioral Health Organizations section of the Department's website at colorado.gov/hcpf.

Enrollment and Participation

Almost all Health First Colorado members are enrolled in the Behavioral Health Program. Health First Colorado members in the following aid categories are automatically enrolled in the Behavioral Health Program.

1. Old Age Pension, Part A and Part B
2. Temporary Aid to Needy Families
3. Aid to the Needy Disabled
4. Baby Care Kids Care
5. Aid to the Blind
6. Foster Care

Behavioral Health Program Benefits

The BHOs are responsible for the cost of

- Mental health benefits
- Substance Use Disorder (SUD) benefits

The two (2) benefits of mental health and substance use disorder combined are referred to as *behavioral health* benefits as they encompass the varying diagnoses, conditions, and treatments that are found in traditional mental health and substance use disorder benefits. An exhaustive list of covered benefits is provided by the BHO.

Behavioral health providers should always determine Behavioral Health Program eligibility before providing services by checking the member's eligibility in the provider web portal.

Effective January 1, 2014, SUD providers must enroll with a BHO in order to provide outpatient SUD services to Health First Colorado members. This policy applies to both new and existing SUD Health First Colorado providers.

Substance Use Disorder treatment services are considered for any claim with the following criteria:

1. Contains any procedure code found under the "Covered Procedure Codes" section of Appendix T;

   And

2. Contains any diagnosis of a substance use disorder found under the "Covered SUD Diagnosis Codes (ICD-10)" section of Appendix T.

Substance Use Disorder providers must send their claims to the BHO for reimbursement, per the billing guidelines found in Appendix T. Substance Use Disorder Providers are **prohibited** from submitting SUD Fee-for-Service claims through the Provider Web Portal unless:

1. The Health First Colorado member receiving treatment is not enrolled in the Community Behavioral Health Services program, and the BHO has first denied their claim solely on this basis.

   Or

2. The SUD provider has received documented authorization from the Department's Rehabilitation Benefits Policy Specialist allowing them to send SUD claims as Fee-for-Service for a limited, specified time.

Behavioral Health Organizations may have prior authorization (PAR) policies that require provider compliance. Failing to obtain a PAR for SUD services does not permit a provider to bill Fee-for-Service as an alternative or extension to BHO covered services. Any SUD provider that submits claims as Fee-for-Service outside of these guidelines will be contacted and may be subject to corrective action and/or recoupments.

Note: The Health First Colorado does not pay Fee-for-Service claims for benefits covered by the Behavioral Health Program. The BHO's do not pay for unauthorized services.

All routine behavioral health services for Behavioral Health Program members must be obtained through a BHO network provider (with the exception of Medicare-covered behavioral health services provided to Medicare-Health First Colorado members and emergency care as listed below).

Refer to Appendix T in the Department's Provider Services Billing Manuals section to determine if a specific procedure or diagnosis must be provided through the BHO.

Emergency Care

- Non-BHO network providers who render emergency mental health services must bill the BHO.
- Non-BHO network provider must comply with the BHOs billing policies and procedures.
- All providers who render emergency substance use disorder services must bill Fee-for-Service to the Department's fiscal agent.
- BHOs may deny payment for non-emergency services and follow up care provided without prior authorization from the BHO.

Member Enrollment

With the exception of some select populations/individuals, essentially all Health First Colorado members are automatically enrolled in the Community Behavioral Health Program. Exceptions can found in the Code of Colorado Regulations (10 CCR 2505-10 8.212).

Full Benefit Medicare-Health First Colorado Enrollees

- Full Benefit Medicare-Health First Colorado Enrollees may obtain Medicare-covered services from either BHO or non-BHO providers. The fiscal agent accepts and processes submitted Medicare crossover claims.
- If the behavioral health service is covered by the Health First Colorado only, the Full Benefit Medicare-Health First Colorado Enrollee must obtain the service from the BHO.

Behavioral Health Program Non-included Services

- Behavioral health-related prescription drugs. Claims for prescription drugs are submitted to the Department's fiscal agent under the Fee-for-Service Reimbursement Program or to the MCO for MCO-enrolled members.
- Nursing facility residential care. Nursing facility claims are submitted to the Department's fiscal agent for Fee-for-Service reimbursement.
- Services in a Residential Treatment Center (RTC). RTC claims are submitted to the Department's fiscal agent for Fee-for-Service reimbursement.
- Claims submitted to the Department's fiscal agent, DXC Technology (DXC) should be addressed to:

Hewlett Packard Enterprise
Claims Submission
P.O. Box 30
Denver, CO 80201

School Health Services

The Colorado School Health Services Program allows school districts and Boards of Cooperative Education Services (BOCES) to access federal Health First Colorado funds for delivering Health First Colorado allowable school health services to Health First Colorado eligible children. Reimbursement received by a district through the School Health Services Program shall be used by the district to provide additional and expanded health services.

School Health Services Program Manual

For an in depth look at the policy requirements of the School Health Services Program please refer to the School Health Services Program Manual that is located on the Department's Web Site. The manual includes information on covered services, provider enrollment, random moment time study, reimbursement and administrative claiming.

Prior Authorization Requirements

There are no prior authorization requirements for School Health Services.

Procedure Codes

The School Health Services Program uses procedure codes that are approved by the Centers for Medicare & Medicaid Services (CMS). The codes are used for submitting claims for services provided to Health First Colorado members and represent services that may be provided by enrolled certified Health First Colorado providers.

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. Valid codes and descriptions for the School Health Services Program are listed below.

PROCEDURE CODE CODE DESCRIPTIONS		PROCEDURE MODIFIER	
		1	2
Behavioral Health Services			
96150	Mental Health/Behavioral Assessment – LPC/MFT		
96150	Mental Health/Behavioral Assessment – PSY	AH	
96150	Mental Health/Behavioral Assessment – SW	AJ	
96151	Mental Health/Behavior Re-Assessment – LPC/MFT		
96151	Mental Health/Behavior Re-Assessment – PSY	AH	
96151	Mental Health/Behavior Re-Assessment – SW	AJ	
H0004	Behavioral Health Counseling/Therapy – LPC/MFT		
H0004	Behavioral Health Counseling/Therapy – PSY	AH	
H0004	Behavioral Health Counseling/Therapy – SW	AJ	
H0004	Behavioral Health Counseling/Therapy, Group – LPC/MFT	HQ	
H0004	Behavioral Health Counseling/Therapy, Group – PSY	AH	HQ
H0004	Behavioral Health Counseling/Therapy, Group – SW	AJ	HQ
Motor Therapy Services			
97001	Physical Therapy Evaluation (1 unit per evaluation)		
97002	Physical Therapy Re-Evaluation (1 unit per evaluation)		
97110	Physical Therapy – PT	GP	
97110	Physical Therapy – PTA	HM	
97150	Physical Therapy, Group – PT	GP	
97150	Physical Therapy, Group – PTA	HM	
97003	Occupational Therapy Evaluation (1 unit per evaluation)		
97004	Occupational Therapy Re-Evaluation (1 unit per evaluation)		
97530	Occupational Therapy – OT	GO	
97530	Occupational Therapy – COTA	HM	
97139	Occupational Therapy, Group – OT	GO	
97139	Occupational Therapy, Group – COTA	HM	
T1023	Orientation & Mobility Evaluation		
T1023	Orientation & Mobility Re-Evaluation	52	
97116	Gait Training (O&M only)		

97116	Gait Training, Group (O&M only)	HQ
97533	Sensory Integration (O&M only)	
97533	Sensory Integration, Group (O&M only)	HQ

Nursing Services

T1001	Nursing Assessment/Evaluation (RN only)	
T1002	RN Services, Up To 15 Min	
T1002	RN Services, Group, Up To 15 Min	HQ
T1003	LPN Services, Up To 15 Min (delegated RN service)	
T1003	LPN Services, Group, Up To 15 Min (delegated RN service)	HQ
T1004	Qualified Nursing Aide, Up To 15 Min (delegated RN service)	
T1004	Qualified Nursing Aide, Group, Up To 15 Min (delegated RN service)	HQ

Personal Care Services

T1019	Personal Care Services, Individual (per 15 minutes)	
S5125	Personal Care Services, Group (per 15 min) – Safety/Behavior Monitoring Only	

Physician Services

99201	New Member Evaluation and Management (10 minutes)	
99202	New Member Evaluation and Management (20 minutes - expanded)	
99203	New Member Evaluation and Management (30 minutes - detailed)	
99204	New Member Evaluation and Management (45 minutes - comprehensive)	
99205	New Member Evaluation and Management (60 minutes – high complexity)	
99212	Established Member Eval/Management (10 minutes – straightforward)	
99213	Established Member Eval/Management (15 minutes – low complexity)	
99214	Established Member Eval/Management (25 minutes – moderate complexity)	
99215	Established Member Eval/Management (40 minutes – high complexity)	

Speech and Audiology Services

92507	Speech Language Therapy, Individual	
92508	Speech Language Therapy, Group	
92521	Evaluation of Speech Fluency (e.g. stuttering, cluttering)	GN
92522	Evaluation of Speech Sound Production (e.g. articulation, phonological process, apraxia, dysarthria)	GN
92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); **with** evaluation of language comprehension and expression (e.g., receptive and expressive language)	GN

92524	Behavioral and qualitative analysis of voice and resonance	GN
V5008	Audiology Screening/Evaluation (Audiologist only)	
V5299	Audiology Services	
V5299	Audiology Services, Group	HQ
Targeted Case Management Services		
T1017	Targeted Case Management	
Transportation Services		
T2001	Non-Emergency Transportation - Member Attendant/Escort/Aide (per 15 minutes)	
T2001 minutes)	Non-Emergency Transportation, Group - Member Attendant/Escort/Aide (per 15 HQ	
T2003	Non-Emergency Transportation – Trip Encounter (per one-way trip)	

Acronyms

SLP - Speech Language Pathologist

RN - Registered Nurse

LPC - Licensed Practical Counselor

LPN - Licensed Practical Nurse

MFT - Marriage & Family Therapist

PT - Physical Therapist

PSY - Psychologist

PTA - Physical Therapy Assistant

SW - Social Worker

OT - Occupational Therapist

OT - Occupational Therapist

COTA -Certified Occupational Therapy Assistant

Paper Claim Reference Table

The paper claim reference table lists required and conditional fields for the CMS 1500 paper claim form for School Health Services. For complete CMS 1500 paper claim instructions, see the Paper Claim Instructional Reference in the Medicaid Provider Information manual.

Instructions for completing and submitting electronic claims are available through the X12N Technical Report 3 (TR3) for the 837P (wpc-edi.com), 837P Companion Guide (in the Provider Services Specifications section of the Department's Web site), and in the Provider Web Portal User Guide (via within the portal).

School Health Services' claims shall be billed as a single date of service, using the specific date a service is provided. Use number of units to identify repeated services by the same provider, on the same date.

CMS Field #	Special Instructions
1. Insurance Type	Required
1a. Insured's ID Number	Required
2. Patient's Name	Required
3. Patient's Date of Birth / Sex	Required
4. Insured's Name	Conditional Complete if the member is eligible for Medicare benefits.
5. Patient's Address	Not Required
6. Client Relationship to Insured	Conditional Complete if the member is covered by a commercial health care insurance policy.
7. Insured's Address	Not Required
8. Reserved for NUCC Use	Not Required
9. Other Insured's Name	Conditional Complete if the member is covered by a commercial health care insurance policy.

CMS Field #	Special Instructions
9a. Other Insured's Policy or Group Number	Conditional Complete if the member is covered by a commercial health care insurance policy.
9b. Reserved for NUCC Use	
9c. Reserved for NUCC Use	
9d. Insurance Plan or Program Name	Conditional Complete if the member is covered by a commercial health care insurance policy.
10a-c. Complete if the member is covered by a commercial health care insurance policy.	Conditional
10d. Reserved for Local Use	
11. Insured's Policy, Group or FECA Number	Conditional
11a. Insured's Date of Birth, Sex	Conditional
11b. Other Claim ID	Not Required
11c. Insurance Plan Name or Program Name	Not Required
11d. Is there another Health Benefit Plan?	Conditional Complete if the member is covered by a commercial health care insurance policy.
12. Patient's or Authorized Person's signature	Required
13. Insured's or Authorized Person's Signature	Not Required

CMS Field #	Special Instructions
14. Date of Current Illness Injury or Pregnancy	Conditional
15. Other Date	Not Required
16. Date Patient Unable to Work in Current Occupation	Not Required
17. Name of Referring Physician	Conditional
18. Hospitalization Dates Related to Current Service	Conditional
19. Additional Claim Information	Conditional
20. Outside Lab? $ Charges	Conditional
21. Diagnosis or Nature of Illness or Injury	Required
22. Medicaid Resubmission Code	Conditional
23. Prior Authorization	Conditional
24A. Dates of Service	Required
24B. Place of Service	Required
24C. EMG	Conditional
24D. Procedures, Services, or Supplies	Required
24D. Modifier	Conditional

CMS Field #	Special Instructions
24E. Diagnosis Pointer	Required
24F. $ Charges	Required
24G. Days or Units	Required
24H. EPSDT/Family Plan	Conditional
24I. ID Qualifier	Not Required
24J. Rendering Provider ID #	Enter the NPI number of the provider performing the service.
25. Federal Tax ID Number	
26. Patient's Account Number	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
28. Total Charge	Required
29. Amount Paid	Conditional
30. Rsvd for NUCC Use	
31. Signature of Physician or Supplier Including Degrees or Credentials	Required

CMS Field #	Special Instructions
32. 32- Service Facility Location Information **32a- NPI Number** **32b- Other ID #**	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 Required 33b- Other ID # If the Provider Type is not able to obtain an NPI, enter the eight-digit Health First Colorado provider number of the individual or organization.
33. 33- Billing Provider Info & Ph # **33a- NPI Number** **33b- Other ID #**	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 Required 33b- Other ID # If the Provider Type is not able to obtain an NPI, enter the eight-digit Health First Colorado provider number of the individual or organization.

Health First Colorado Managed Care Programs Revision Log

Revision Date	Section/Action	Pages	Made by
12/10/2016	*Manual revised for interChange implementation. For manual revisions prior to 12/01/2016, please refer to Archive.*	*All*	*HPE (now DXC)*
12/27/2016	*Updates based Colorado iC Stage II Provider Billing Manual Comment Log v0_2.xlsx*	*1-4, 15*	*HPE (now DXC)*
1/10/2017	*Updates based on Colorado iC Stage Provider Billing Manual Comment Log v0_3.xlsx*	*Multiple*	*HPE (now DXC)*
1/19/2017	*Updates based on Colorado iC Stage Provider Billing Manual Comment Log v0_4.xlsx*	*Multiple*	*HPE (now DXC)*
1/26/2017	Updates based on Department 1/20/2017 approval email	*Accepted tracked changes throughout*	*HPE (now DXC)*
5/22/2017	*Updates based on Fiscal Agent name change from HPE to DXC*	*4, 7*	*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.*