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Telemedicine

Program Overview

Providers must be enrolled as a Health First Colorado (Colorado's Medicaid Program) provider in order to:

- Treat a Health First Colorado member
- Submit claims for payment to Health First Colorado

Health First Colorado reimburses providers for medically necessary medical and surgical services furnished to eligible members.

Telemedicine is not a unique service, but a means of providing selected services approved by Health First Colorado through live interactive audio and video telecommunications equipment. Telemedicine Direct Member Services can involve up to two (2) collaborating providers. The member must be present during any Telemedicine Direct Member Services collaboration between two providers where there is an "originating provider" and a "distant provider." The provider where the member is located is the "originating site" or "originating provider." In most cases, the "distant provider" is a clinician who acts as a consultant to the member and originating provider. However, it is also acceptable for the distant provider to be the only provider involved in the service with the member being the only one present at the originating site.

Providers should refer to the Code of Colorado Regulations, Program Rules (10 CCR 2505-10, Section 8.200.3.B), for specific information when providing telemedicine services. For further questions, please contact:

Telemedicine Program Coordinator
Colorado Department of Health Care Policy & Financing
800-221-3943

Refer to the General Provider Information manual for general billing information.

Telehealth Home Health Monitoring

Telehealth monitoring is available for members who are eligible through the Home Health benefit and should not be billed as telemedicine. Providers rendering telehealth monitoring should consult the Home Health provider billing manual.

Not Covered Services

- Telemedicine does not include consultations provided by telephone (interactive audio) or facsimile machines.
- Providers may only bill procedure codes which they are already eligible to bill.
- Services appropriately billed to managed care should continue to be billed to managed care. All managed care requirements must be met for services billed to managed care. Managed care may or may not reimburse telemedicine costs.
- Health First Colorado does not pay for provider or member education when education is the only service provided via telemedicine.

- Services not otherwise covered by Health First Colorado are not covered when delivered via telemedicine.
- The use of telecommunications equipment for delivery of services does not change prior authorization requirements established for the services being provided.

Medicaid Reimbursement for Telemedicine Direct Member Services

As of November 1, 2016, Health First Colorado began accepting Telemedicine Direct Member Services as outlined in this manual. Telemedicine Direct Member Services can involve up to two (2) collaborating providers and must involve the member. For Telemedicine Direct Member Services appointments, the "originating provider" would be the provider present with the member. The "distant provider" would be the clinician located at a different site who acts as a consultant to the member and originating provider.

An originating provider is not required for all Telemedicine Direct Member Services. It is acceptable to use Telemedicine Direct Member Services to facilitate 'live' contact directly between a member and a distant provider via telecommunications equipment.

Telemedicine Direct Member Services Covered for Primary Care Providers

A primary care provider can be reimbursed as the "originating provider" for any eligible Telemedicine Direct Member Services where the member is present with the provider at the "originating site." Please see the 'Originating Site Billing' section for further information on reimbursement requirements for providers at an originating site with a member.

In order for a primary care provider to be reimbursed for Telemedicine Direct Member Services as the "distant provider" the primary care provider must be able to facilitate an in-person visit in the state of Colorado if necessary for treatment of the member's condition. Please see the 'Distant Provider Billing' section for further information.

Telemedicine Direct Member Services Covered for Specialty Care Providers

A medical specialist provider can be reimbursed as the "originating provider" for any Telemedicine Direct Member Services where the member is present with the provider at the "originating site." Please see the 'Originating Site Billing' section for further information on reimbursement requirements for providers at an originating site with a member.

A medical specialist provider can be reimbursed as the "distant provider." Please see the 'Distant Provider Billing' section for further information.

Allowable Locations for Telemedicine Direct Member Services

If no originating provider is present during a Telemedicine Direct Member Services appointment, then the location of the originating site is at the member's discretion and can include the member's home. However, members can be required to choose a location suitable to delivery of telemedicine services that may include adequate lighting and environmental noise levels suitable for easy conversation with a provider.

When Should a Provider Choose Telemedicine?

The primary purpose of telemedicine is to allow a member to receive direct medical services from a health care provider without person-to-person contact with a provider. Telemedicine can also be used by a member's medical provider to receive medical consultation from another medical provider regarding the member that may be accomplished in real-time. Additionally, telemedicine brings providers to people living in rural or frontier communities as well as members facing transportation difficulties. Providers should weigh these advantages against quality of care and member safety considerations. They should also consider the provider's liability. Members may choose which is more convenient for them when providers make telemedicine available.

However, telemedicine should not be selected when face-to-face services are medically necessary. Members should establish relationships with primary care providers who are available on a face-to-face basis.

Telemedicine Confidentiality Requirements

All Medicaid providers using telemedicine to deliver Medicaid services must employ existing quality-of-care protocols and member confidentiality guidelines when providing telemedicine services. Health benefits provided through telemedicine must meet the same standard of care as in-person care. Record-keeping should comply with Medicaid requirements in 10 CCR 2505-10, Section 8.130.

Transmissions must be performed on dedicated secure lines or must utilize an acceptable method of encryption adequate to protect the confidentiality and integrity of the transmission. Transmissions must employ acceptable authentication and identification procedures by both the sender and the receiver.

Providers of telemedicine services must implement confidentiality procedures that include, but are not limited to:

- Specifying the individuals who have access to electronic records.
- Using unique passwords or identifiers for each employee or other person with access to the member records.
- Ensuring a system to routinely track and permanently record such electronic medical information.
- Members must be advised of their right to privacy and that their selection of a location to receive telemedicine services in private or public environments is at the member's discretion.

Waiving the Face-to-Face Requirement & Required Disclosure Statements

The Medicaid requirement for an initial face-to-face contact between provider and member may be waived when treating the member through telemedicine. In-person contact between a health care provider and a member is not required for services delivered through telemedicine that are otherwise eligible for reimbursement.

Prior to treating the member through telemedicine for the first time, the rendering provider must furnish each member with all of the following written statements which must be signed (electronic signatures will be accepted) by the member or the member's legal representative:

- The member retains the option to refuse the delivery of health care services via telemedicine at any time without affecting the member's right to future care or treatment and without risking the loss or withdrawal of any program benefits to which the member would otherwise be entitled.
- All applicable confidentiality protections shall apply to the services.

- The members shall have access to all medical information resulting from the telemedicine services as provided by applicable law for member access to his or her medical records.

These requirements do not apply in an emergency. [C. R. S. 2006, 25.5-5-320 (4) & (5)].

General Billing Instructions

Billing Providers

Telemedicine services will only be reimbursed for providers who are enrolled in Health First Colorado at the time service.

The availability of services through telemedicine in no way alters the scope of practice of any health care provider; nor does it authorize the delivery of health care services in a setting or manner not otherwise authorized by law. [C. R. S. 2006, 25.5-5-414 (7)(a) & (b)].

Originating Site Billing

All telemedicine services are billed on the CMS 1500 paper claim form or as an 837P transaction regardless of provider type.

The originating provider may bill for an office, outpatient, or inpatient Evaluation & Management (E&M) service that precedes a telemedicine consultation and for other Medicaid-covered services. In some cases, the originating provider site will not be providing clinical services, but only providing a site and telecommunications equipment.

Originating providers bill as follows:

- If the originating provider is making a room and telecommunications equipment available but is not providing clinical services, the originating provider bills Q3014, the procedure code for the telemedicine originating site facility fee.
- If the originating provider also provides clinical services to the member, the provider bills the rendering provider's appropriate procedure code and bills Q3014.
- The originating provider may also bill, as appropriate, on the UB-04 paper claim form or as an 837I transaction for any clinical services provided on-site on the same day that a telemedicine originating site claim is made. The originating provider must submit two separate claims for the member's two separate services.

The following provider types may bill procedure code Q3014 (telemedicine originating site facility fee):

Physician	05
Clinic	16
Osteopath	26
Doctorate Psychologist	37
MA Psychologist	38
Physician Assistant	39
Nurse Practitioner	41

Provider types not listed above may facilitate Telemedicine Direct Member services with a distant provider but may not bill procedure code Q3014. Examples include Nursing Facilities, Intermediate Care Facilities, Assisted Living Facilities, etc.

If practitioners at both the originating site and the distant site provide the same service to the member, both providers submit claims using the same procedure code with modifier 77. (Repeat procedure by another physician).

The originating site may not bill for assisting the distant site provider with an examination.

Distant Provider Billing

All distant site rendering providers bill the appropriate procedure code using modifier GT (interactive communication) on the CMS 1500 paper claim form or as an 837P transaction. The previously listed provider types may bill using modifier GT. The procedure codes for billing telemedicine are listed below.

Using modifier GT adds $5.00 to the fee for the procedure code billed.

Rendering Providers

If a rendering provider's number is required on the claim for a face-to-face visit, it is required on the claim for a telemedicine visit.

Clinics and the other provider types are required to enter the rendering provider's Health First Colorado provider number in field 19D.

When an originating site bills Q3014 (originating site facility fee), there is generally no rendering provider actually involved in the service at the originating site.

However, a rendering provider number is still required and must be affiliated with the billing provider. The facility may enter either the member's usual provider's number; or another provider number affiliated with that site as the rendering provider.

When the member sees a rendering provider at the originating site and also uses the site as the telemedicine originating site, the facility bills the rendered service procedure code and Q3014 for the use of the telemedicine facility. The same rendering provider number is entered in field 19D.

Telemedicine Procedure Coding

The following procedure codes, when billed with modifier GT by appropriate providers, pay the telemedicine transmission fee. Any other procedure codes billed with modifier GT will not pay the telemedicine transmission fee:

Procedure Codes	Description	Comments
Outpatient Mental Health		
90791	Diagnostic evaluation	If interactive complexity then report with add on code 90785
90832	Psychotherapy, 30 min (actual time can be 16-37 min	If interactive complexity then report with add on code 90785
90833	Add on Psychotherapy 30 min (actual time can be 16-37 min) Use in conjunction with appropriate E/M code	If interactive complexity then report with add on code 90785
90834	Psychotherapy 45 min (actual time can be 38-52 min)	If interactive complexity then report with add on code 90785
90836	Add on Psychotherapy 45 min (actual time can be 38-52 min) Use in conjunction with appropriate E/M code	If interactive complexity then report with add on code 90785
90837	Psychotherapy 60 min (actual time can be 53+)	Medicare crossover only
90838	Add on Psychotherapy 60 min (actual time can be 53+) Use in conjunction with appropriate E/M code	Medicare crossover only
90863	Add on Pharmacologic management code	can be added to primary psychotherapy code
90846	Family therapy – member not present	
90847	Family therapy – member present	
Evaluation & Management		
99201	Office or other outpatient visit, new member, 10 minutes	
99202	Office or other outpatient visit, new member, 20 minutes	
99203	Office or other outpatient visit, new member, 30 minutes	
99204	Office or other outpatient visit, new member, 45 minutes	
99205	Office or other outpatient visit, new member, 60 minutes	
99211	Office or other outpatient visit, established member, 5 minutes	
99212	Office or other outpatient visit, established member, 10 minutes	

Procedure Codes	Description	Comments
99213	Office or other outpatient visit, established member, 15 minutes	
99214	Office or other outpatient visit, established member, 25 minutes	
99215	Office or other outpatient visit, established member, 40 minutes	
Speech Therapy		
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual, per encounter	
97532	Development of cognitive skills, direct one-on-one member contact, 15 minutes	
Obstetrical Ultrasounds		
76801	Ultrasound, pregnant uterus, real time first trimester	
76802	Each additional gestation	
76805	Ultrasound, pregnant uterus, real time after first trimester	
76810	Each additional gestation	
76811	Ultrasound, pregnant uterus, real time plus detailed fetal anatomical exam, single or first gestation	
76812	Each additional gestation	
76813	Ultrasound, pregnant uterus real time first trimester fetal nuchal translucency measurement	
76814	Each additional gestation	
76815	Ultrasound, pregnant uterus, real time, limited, one or more fetuses	
76816	Ultrasound, pregnant uterus, real time, follow-up	
76817	Ultrasound, pregnant uterus, real time, transvaginal	
Other		
96116	Neurobehavior status exam	

CMS 1500 Paper Claim Reference Table

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

CMS Field #	Field Label	Field is?	Instructions
1	**Insurance Type**	Required	Place an "X" in the box marked as Medicaid.
1a	**Insured's ID Number**	Required	Enter the member's Health First Colorado seven-digit Medicaid ID number as it appears on the Medicaid Identification card. Example: A123456.
2	**Patient's Name**	Required	Enter the member's last name, first name, and middle initial.
3	**Patient's Date of Birth / Sex**	Required	Enter the member's birth date using two digits for the month, two digits for the date, and two digits for the year. Example: 070114 for July 1, 2014. Place an "X" in the appropriate box to indicate the sex of the member.
4	**Insured's Name**	Conditional	Complete if the member is covered by a **Medicare** health insurance policy. Enter the insured's full last name, first name, and middle initial. If the insured used a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name.
5	**Patient's Address**	Not Required	
6	**Patient's Relationship to Insured**	Conditional	Complete if the member is covered by a commercial health insurance policy. Place an "X" in the box that identifies the member's relationship to the policyholder.
7	**Insured's Address**	Not Required	
8	**Reserved for NUCC Use**		

CMS Field #	Field Label	Field is?	Instructions
9	**Other Insured's Name**	Conditional	If field 11d is marked "YES", enter the insured's last name, first name and middle initial.
9a	**Other Insured's Policy or Group Number**	Conditional	If field 11d is marked "YES", enter the policy or group number.
9b	**Reserved for NUCC Use**		
9c	**Reserved for NUCC Use**		
9d	**Insurance Plan or Program Name**	Conditional	If field 11d is marked "YES", enter the insurance plan or program name.
10a-c	**Is Patient's Condition Related to?**	Conditional	When appropriate, place an "X" in the correct box to indicate whether one or more of the services described in field 24 are for a condition or injury that occurred on the job, as a result of an auto accident or other.
10d	**Reserved for Local Use**		
11	**Insured's Policy, Group or FECA Number**	Conditional	Complete if the member is covered by a **Medicare** health insurance policy. Enter the insured's policy number as it appears on the ID card. Only complete if field 4 is completed.
11a	**Insured's Date of Birth, Sex**	Conditional	Complete if the member is covered by a **Medicare** health insurance policy. Enter the insured's birth date using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. Place an "X" in the appropriate box to indicate the sex of the insured.

CMS Field #	Field Label	Field is?	Instructions
11b	**Other Claim ID**	Not Required	
11c	**Insurance Plan Name or Program Name**	Not Required	
11d	**Is there another Health Benefit Plan?**	Conditional	When appropriate, place an "X" in the correct box. If marked "YES", complete 9, 9a and 9d.
12	**Patient's or Authorized Person's signature**	Required	Enter "Signature on File," "SOF," or legal signature. If there is no signature on file, leave blank or enter "No Signature on File." Enter the date the claim form was signed.
13	**Insured's or Authorized Person's Signature**	Not Required	
14	**Date of Current Illness Injury or Pregnancy**	Conditional	Complete if information is known. Enter the date of illness, injury, or pregnancy (date of the last menstrual period) using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. 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	
18	**Hospitalization Dates Related to Current Service**	Not Required	

CMS Field #	Field Label	Field is?	Instructions
19	**Additional Claim Information**	Conditional Not Required	
20	**Outside Lab?** **$ Charges**	Not Required	
21	**Diagnosis or Nature of Illness or Injury**	Required	Enter at least one but no more than twelve diagnosis codes based on the member's diagnosis/condition. Enter applicable ICD indicator to identify which version of ICD codes is being reported. 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	Enter the six-character prior authorization number from the approved Prior Authorization Request (PAR). Do not combine services from more than one approved PAR on a single claim form. Do not attach a copy of the approved PAR unless advised to do so by the authorizing agent or the fiscal agent.
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.

CMS Field #	Field Label	Field is?	Instructions
			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: 010114 for January 1, 2014 From To **01 01 15** | | | | | | Or From To **01 01 15 01 01 15** Span dates of service From To **01 01 15 01 31 15** Practitioner claims must be consecutive days. 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. **Supplemental Qualifier** To enter supplemental information, begin at 24A by entering the qualifier and then the information. ZZ Narrative description of unspecified code VP Vendor Product Number OZ Product Number CTR Contract Rate JP Universal/National Tooth Designation JO Dentistry Designation System for Tooth & Areas of Oral Cavity

CMS Field #	Field Label	Field is?	Instructions
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. 04 Homeless Shelter 11 Office 12 Home 15 Mobile Unit 20 Urgent Care Facility 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room Hospital 25 Birthing Center 26 Military Treatment Center 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Transportation – Land 51 Inpatient Psychiatric Facility 52 Psychiatric Facility Partial Hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility – MR 60 Mass Immunization Center 61 Comprehensive IP Rehab Facility 62 Comprehensive OP Rehab Facility 65 End Stage Renal Dialysis Trtmt Facility 71 State-Local Public Health Clinic 99 Other Unlisted
24C	**EMG**	Not Required	

CMS Field #	Field Label	Field is?	Instructions
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. **Telemedicine** For originating provider use procedure code Q3014 with no modifier. For distant provider use an approved telemedicine procedure code + modifier.
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. GT **Via Interact Audio/Video System**
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.
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.

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 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.
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 eight-digit Health First Colorado provider number assigned to the **individual** who actually performed or rendered the billed service. This number cannot be assigned to a group or clinic. **Note:** When billing a paper claim form, do not use the individual's NPI.
25	**Federal Tax ID Number**	Not Required	

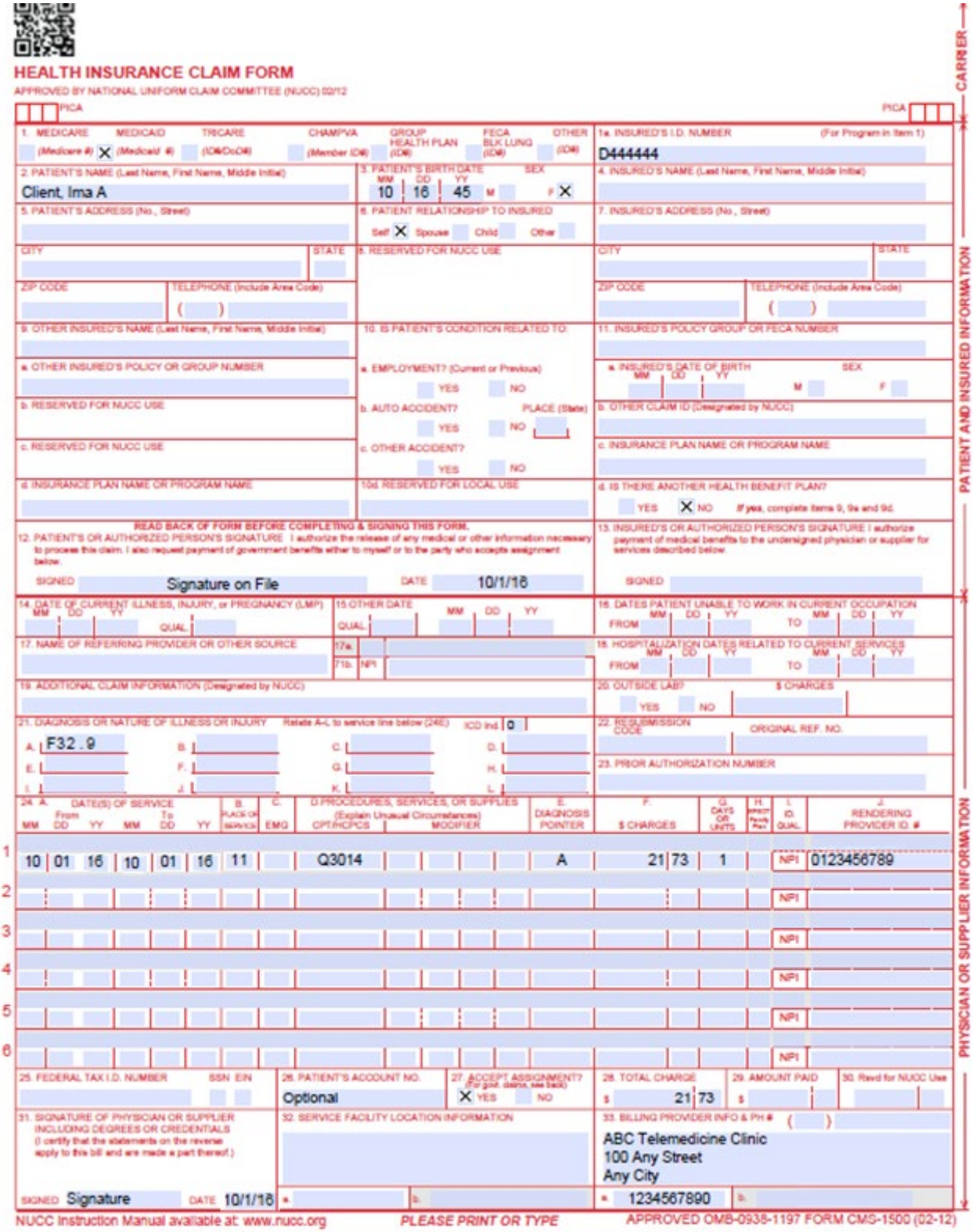
CMS Field #	Field Label	Field is?	Instructions
26	**Patient's Account Number**	Optional	Enter information that identifies the member or claim in the provider's billing system. Submitted information appears on the Remittance Advice (RA).
27	**Accept Assignment?**	Required	The accept assignment indicates 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. 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: 070116 for July 1, 2016.
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 Name 2nd Line Address 3rd Line City, State and ZIP Code 32a- NPI Number Enter the NPI of the service facility (if known). 32b- Other ID #

CMS Field #	Field Label	Field is?	Instructions
			Enter the eight-digit Health First Colorado provider number of the service facility (if known). The information in field 32, 32a, and 32b is not edited.
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 33b- Other ID # Enter the eight-digit Health First Colorado provider number of the individual or organization.

Timely Filing

For more information on timely filing policy, including the resubmission rules for denied claims, please see the General Provider Information manual.

Telemedicine Originator 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 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. F32.9 | 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		Q3014		A	21 73	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 $ 21 73

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 Telemedicine Clinic
100 Any Street
Any City

a. 1234567890 | b.

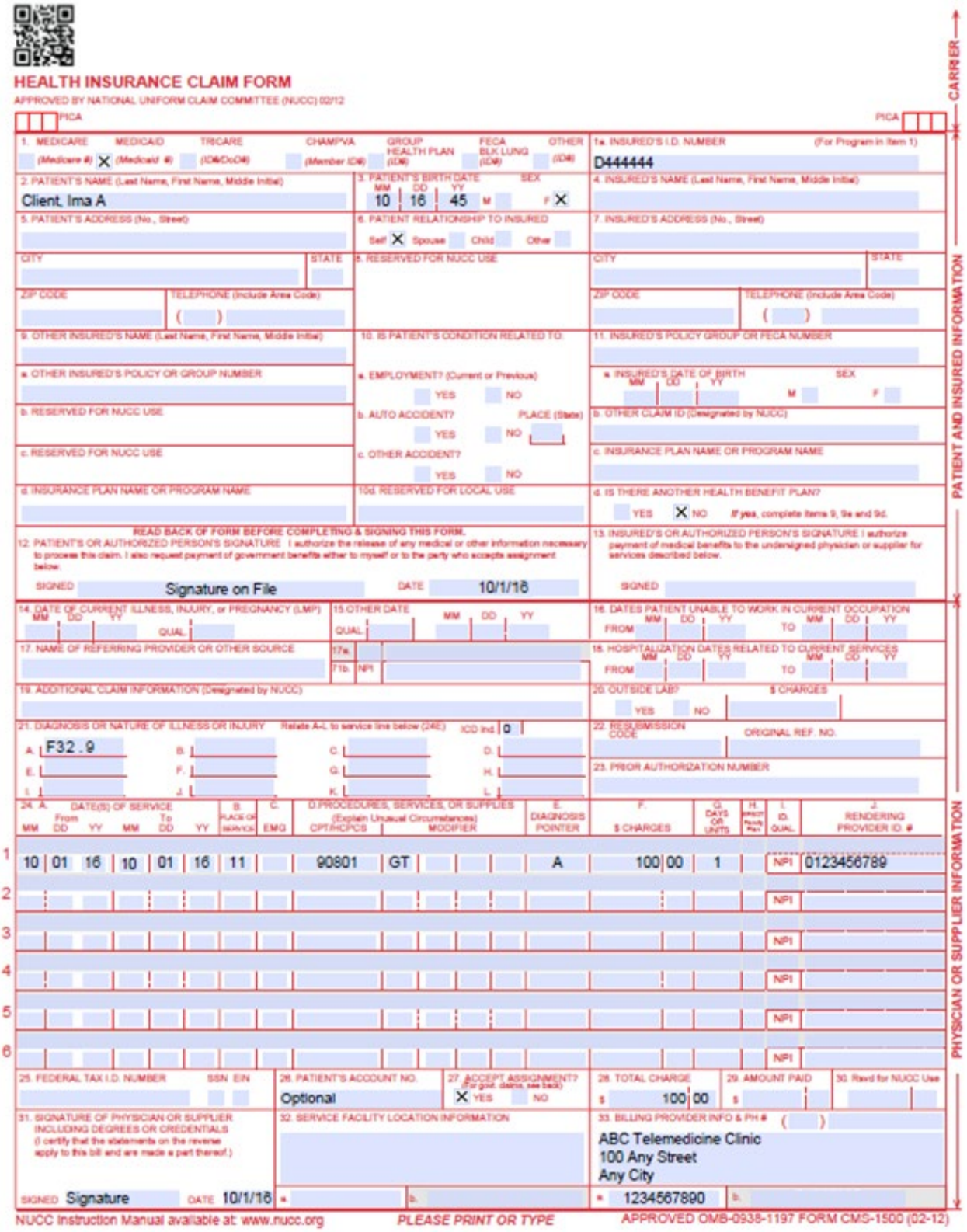
CARRIER

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)

Telemedicine Distant 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: 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: 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 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. F32.9 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		90801	GT		A	100 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 $ 100 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.)

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CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

Telemedicine Revisions Log

Revision Date	*Section*	*Pages/ Action*	*Made by*
12/01/2016	*Manual revised for interChange implementation. For manual revisions prior to 12/01/2016, please refer to Archive.*	*All*	*HPE*
12/27/2016	*Updates based on Colorado iC Stage II Provider Billing Manual Comment Log v0_2.xlsx*	*10*	*HPE*
01/10/2017	*Updates based on Colorado iC Stage Provider Billing Manual Comment Log v0_3.xlsx*	*Multiple*	*HPE*
01/19/2017	*Updates based on Colorado iC Stage Provider Billing Manual Comment Log v0_4.xlsx*	*Multiple*	*HPE*
01/26/2017	*Updates based on Department 1/20/2017 approval email*	*Accepted tracked changes throughout*	*HPE*
05/22/2017	*Updates based on Fiscal Agent name change from HPE to DXC*	*1*	*DXC*
02/20/2018	*Updates based on Departments*	*1-6, 17-18*	*DXC*
02/23/2018	*Removed NDC supplemental qualifier - not relevant for Telemedicine providers*	*13*	*DXC*
06/15/2018	*Updated timely filing information and removed references to LBOD; removed general billing information already available in the General Provider Information manual*	*1-2, 11, 19*	*DXC*
12/20/2018	*Clarification to signature requirements*	*18*	*HCPF*
3/18/2019	*Clarification to signature requirements*	*16*	*HCPF*

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.*