Transportation

Transportation

Benefits

Medical transportation is a Health First Colorado benefit when the member requires transportation. The transportation services must be medically necessary and provided within the scope of the provider's certification and license. Transportation for Health First Colorado members to and from a medical provider is a benefit when the medical service provided is a benefit of the Health First Colorado.

Medical Transportation includes both emergent and non-emergent services.

Billing Information

National Provider Identifier (NPI)

The Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities (i.e., health plans, health care clearinghouses, and those health care providers who transmit any health information electronically in connection with a transaction for which the Secretary of Health and Human Services has adopted a standard) use NPIs in standard transactions. Certain Provider Types are not able to obtain an NPI. Those providers will be assigned a Health First Colorado provider number.

Paper Claims

Electronic claims format shall be required unless hard copy claims submittals are specifically prior authorized by the Department. Requests may be sent to DXC Technology (DXC), P.O. Box 30, Denver, CO 80201-0030. The following claims can be submitted on paper and processed for payment:

- Claims from providers who consistently submit five (5) claims or fewer per month (requires prior approval)
- Claims that, by policy, require attachments
    - Note: Attachments can 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.

Emergency Transportation

Emergency Ambulance and Air Ambulance Transport

All emergency ambulance and air ambulance transportation claims are billed directly to the fiscal agent by the transportation provider. Emergency transportation services require a trip report that must be retained by the transportation provider and is subject to audit for a period up to six (6) years from the date of service.

Exclusions

The following services are not Health First Colorado emergency transportation benefits:

- Waiting time, cancellations, or additional passengers (e.g., family members) except in the case of approved escorts
- Response calls when, upon arrival at the site of the call, no transportation is needed or provided
- Charges when the member is not in the vehicle
- Non-benefit services (e.g., first aid) provided at the scene when transportation is not necessary
- Transportation services when medical treatment is not required or provided upon arrival
- Transportation to services located on military reservations
- Transportation to local treatment programs not enrolled in the Health First Colorado
- Pick up or delivery of prescriptions and/or supplies
- Transportation arranged for the member's convenience as opposed to medical necessity

Types of Emergency Transportation

Ambulance services

Emergency ambulance service is a Health First Colorado benefit when the member's condition requires immediate attention.

Air ambulance

Air ambulance benefits are provided when:

- The point of pick up is inaccessible by a land vehicle.
- Great distances or other obstacles prohibit transporting the member by land to the nearest appropriate facility and the member's condition requires immediate attention.
- The member is suffering from an illness or injury making other forms of transportation inadvisable.

Submit hospital–based emergency ambulance and air ambulance services as an 837 Institutional (837I) electronic transaction.

Non-Emergent Medical Transportation

Non-emergent medical transportation (NEMT) is a Health First Colorado administrative service only for members with no other means of transportation, to transport members to and from medical

appointments for Health First Colorado (Colorado's Medicaid Program) covered services. NEMT must be to the closest qualified Health First Colorado provider for a benefit of the Health First Colorado.

The Department has established State designated entities responsible for administering NEMT throughout Colorado. A member's State designated entity is based on the member's county of residence. The State designated entity is:

- The County Department of Human Services, or their designee; or
- The State contracted NEMT broker in Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson, Larimer, and Weld counties.

The State designated entity explores and utilizes the least costly, medically appropriate means of transportation for each member and arranges those transportation services.

Types of Non-Emergent Medical Transportation

General Instructions

The State designated entity must ensure that all scheduled trips are for Health First Colorado covered services. The entity maintains records of all appropriate documentation on file for a period of six (6) years. These records must be available and produced for audit and inspection upon request. Transportation providers shall maintain a record of the State designated entity authorization. The authorization must cover the service dates.

Transportation Services Billed by the State Designated Entity

The State designated entity, or designee, submits claims for non-emergent medical transportation services. Services include:

- Mobility vehicle
- Private vehicle
- Wheelchair van
- Non-emergent ambulance
- Public/Mass Transportation
- Train services
- Air services
- Ancillary services

A transportation provider must be an enrolled Health First Colorado provider. The only exceptions are reimbursements or mileage paid to members, members' family, or members' friends for covered services; volunteer mileage reimbursement; public/mass transportation; lodging providers; and commercial air and train tickets.

Private Vehicle

A private vehicle may be provided by a volunteer, (individual or organization, with no member vested interest) or a vehicle provided by an individual, (family member, self, neighbor), with a member vested interest. Mileage reimbursement for a private vehicle is reimbursed per vehicle, without regard to the number of members or escorts in the vehicle, and is only reimbursed using the most direct route to and from the appointment.

Mobility Vehicle

A mobility vehicle is a passenger carrying vehicle for hire, including those designed, constructed, modified or equipped to meet the needs of passengers with medical, physical or mobility impairments and, when medically necessary, their certified escorts. Mobility vehicles, including mobility van, mini-bus, mountain area transports and other non-profit transportation systems, are defined as vehicles certified as a common or contract carrier and regulated by the Public Utilities Commission (PUC), with a call-and-demand limousine authority, or a specialized intra-governmental agency bus substitute service or specialized mobility service. Mobility vans are not regulated by the PUC when used exclusively for individuals confined to a wheelchair.

Based upon this PUC regulation, a mobility vehicle may transport "mixed parties" without the consent of the other passengers and therefore may transport several members at the same time. A mobility vehicle does not calculate charges based upon a meter. Taxi service is not a mobility vehicle; however, a taxi company may also have call-and-demand limousine authority from the PUC and may operate its vehicles under that authority as mobility vehicles.

In this case, the taxi company agrees to the Health First Colorado reimbursement for mobility vehicles. Mobility vehicle services are transportation services provided to individuals who are not wheelchair confined.

Mobility vehicle transportation is a Health First Colorado benefit when the member's physician-certified medical or physical condition precludes the use of member-purchased public or private transportation, or other less costly means of Health First Colorado transportation.

A mobility vehicle may bill using wheelchair van codes only when the member is a physician-certified wheelchair user and the vehicle has been modified with appropriate wheelchair equipment. If these requirements are not met, the mobility vehicle may not bill using wheelchair van codes.

Wheelchair Van

A wheelchair van is a vehicle for hire that has been specifically designed, constructed, modified, or equipped to accommodate the needs of wheelchair users. Wheelchair van services are a Health First Colorado benefit when ordered by a physician and the member's, physician-certified, medical or physical condition precludes the utilization of member-purchased public or private transportation, or a less costly means of Health First Colorado transportation. Wheelchair van transportation is only for wheelchair-confined members, as certified by a physician, within a vehicle that has been modified to accommodate the wheelchair.

Wheelchair van service is not regulated by the PUC as long as the van is used exclusively for wheelchair members. Any company with a vehicle for hire that has been modified to accommodate a wheelchair may transport wheelchair members without regard to any other authority the company may have from the PUC. When operating as a wheelchair van, the provider agrees to wheelchair van reimbursement.

Oxygen administration is allowed when medically necessary. Wheelchair vans must bill using mobility vehicle codes if the member is not a physician-certified wheelchair user, in which case, the mobility vehicle must also meet PUC requirements for mobility vehicle services. (See Mobility Vehicle)

Non-Emergent Ambulance Services

Non-emergent, pre-planned ambulance service is a Health First Colorado service when the member's condition is such that he or she requires an ambulance in order to be transported safely. Non-emergent ambulance must be certified by a physician and authorized by the State designated entity.

Air Ambulance

Air ambulance benefits are provided when:

- Non-emergency, pre-planned services are authorized by the State authorizing agency.
- Great distances or other obstacles prohibit transporting the member by land to the nearest appropriate facility and the member's condition requires immediate attention.
- The member is suffering from an illness or injury making other forms of transportation inadvisable.

Air/Train

Air and train transport are benefits of the Health First Colorado only when a member's, physician-certified, medical or physical condition precludes the use of member-purchased public or private transportation, or when other less costly, medically appropriate means of Health First Colorado transportation are not available. Air and train transport are permissible for out-of-state travel. In extreme circumstances air transport may be available for in state travel when it is the most cost effective, medically appropriate means of transportation for the member's condition.

Procedure for all NEMT Train (intrastate), Air, and Out-of-State Travel

Train (intrastate), air, and out-of-state travel must be prior authorized by the Department. Members and/or medical professionals requesting train, air, or out-of-state travel must contact their State designated entity. The State designated entity will request the required documentation and submit to the Department for review and decision. The decision will be communicated to the State designated entity.

All rules and practices for in-state travel apply to travel for routine medical services provided to members in Colorado border communities performed across the state line in a Border Town/City indicated in Appendix F because of closer proximity to the closest qualified provider.

Public/Mass Transportation

Public/mass transportation, including bus transportation, may be available when these modes of transportation are the least costly and most appropriate to the member's condition. Transit passes may be issued when the cumulative cost of bus trips exceeds the cost of a pass.

Ancillary Services

An escort may accompany a member when:

- The member is a child or an at-risk adult, and is unable to make personal/medical determinations or provide necessary self-care as certified in writing by the member's attending Medicaid enrolled provider.
- The escort or attendant must be physically and cognitively capable of providing the needed services for the member.

Minors who are at least thirteen (13) years old, but younger than eighteen (18) years old, may travel alone with a written release from their parent or guardian, as long as an adult is present to receive the minor at the destination and at the return location. Minors under thirteen (13) years old shall not travel without an escort except children in a day treatment program, may travel without an escort, as long as there is a written release from their parent or guardian, stating that an adult will be present to receive the minor at the destination and return location. Children are not eligible for NEMT travel to and from school funded day treatment programs.

Meals/Lodging:

- Available for in-state treatment when travel cannot be completed in one calendar day.
- Available for authorized out-of-state treatment if not included as part of the inpatient stay.
- Meals, lodging, and transportation expenses may be covered for the escort when the member is a child or an at-risk adult who requires the escort's continued stay.
- Reimbursement will only be made for meals and lodging that members and escorts are actually charged for, up to the daily per diem rate established by the Department; if a member is not normally billed meals and lodging will not be reimbursed.

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Exclusions

The following services are not Health First Colorado non-emergent medical transportation benefits:

- Waiting time, cancellations, or additional passengers (e.g., family members) except in the case of approved escorts
- Response calls when, upon arrival at the site of the call, no transportation is needed or provided.
- Charges when the member is not in the vehicle, except for lodging and meals.
- Transportation to/from non-covered medical services, including services that do not qualify due to coverage limitations (e.g., transportation to a medical service after the limit on number of appointments has been reached)
- Transportation which is covered by another entity (e.g., transportation provided by the Veterans Administration or a school).
- Services provided only as a convenience to the member as opposed to medical necessity.
- Ancillary services when member is receiving in-patient treatment and receives these benefits as part of the in-patient stay.
- Metered taxi services
- Transportation for nursing facility or group home residents to medical or rehabilitative services required in the facility's program, unless the facility does not have an available vehicle. Nursing facilities and group homes should instead report transportation as part of their allowable costs on their state-approved cost report.

Authorization Requests for Transportation

NEMT requests must be sent to the State Designated Entity (SDE). A member's State designated entity is based on the member's county of residence. The State designated entity is:

- The County Department of Human Services, or their designee; or
- The State contracted NEMT broker in Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson, Larimer, and Weld counties.

Transportation provided without authorization from the SDE, or designee, will not be reimbursed or paid.

Procedure Coding

Transportation HCPCS codes

The Health First Colorado uses the Centers for Medicare & Medicaid Services (CMS) Healthcare Common Procedural Coding System (HCPCS). 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.

HCPCS are used to identify and reimburse transportation services.

The Department updates and revises HCPCS codes through Health First Colorado the appropriate billing manuals.

The series of local procedure codes used to bill for mobility van services (X6022-X6030) are no longer available. Providers should use HCPCS A0120 plus modifier TK (Extra member or passenger) to bill for mobility van services. Use the appropriate number of units to identify the actual number of riders.

The XU-Split unit modifier is no longer valid.

Transportation Codes

Code	Description
A0021	Ambulance service, outside state per mile, transport
A0080	Nonemergency transportation, per mile - vehicle provided by volunteer (individual or organization), with no vested interest
A0090	Nonemergency transportation, per mile - vehicle provided by individual (family member, self, neighbor) with vested interest
A0100	Nonemergency transportation; taxi
A0110	Nonemergency transportation: public/mass transportation
A0120	Nonemergency transportation: Mobility van, mini-bus, mountain area transports, or other transportation systems
A0130	Nonemergency transportation: wheelchair van
A0140	Nonemergency transportation: train and/or air travel
A0180	Nonemergency transportation: Ancillary services - Member lodging
A0190	Nonemergency transportation: Ancillary services – Member meals
A0200	Nonemergency transportation: Ancillary services – Escort lodging
A0210	Nonemergency transportation: Ancillary services – Escort meals
A0225	Ambulance service, neonatal transport, base rate, emergency transport, one way

Code	Description
A0422	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation
A0425	Ground mileage, per statute mile
A0426	Nonemergency transportation: Ambulance service- Advanced Life Support (ALS), level 1
A0427	Ambulance service- emergency transport, Advanced Life Support (ALS), level 1
A0428	Nonemergency transportation: Ambulance service- Basic Life Support (BLS)
A0429	Ambulance service- emergency transport, Basic Life Support (BLS)
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)
A0433	Ambulance service- emergency transport, Advanced Life Support (ALS), level 2
A0434	Specialty care transport (SCT)
S0209	Nonemergency transportation: Wheelchair van, mileage, per mile
S9960	Nonemergency transportation: Ambulance service, conventional air services, transport, one way (fixed wing
S9961	Nonemergency transportation: Ambulance service, conventional air services, transport, one way (fixed wing)
T2001	Nonemergency transportation: Ancillary services- escort transportation
T2005	Nonemergency transportation; stretcher van
T2049	Nonemergency transportation; stretcher van, mileage; per mile

Transportation Billing Instructions

The 837 Professional (837P) transaction should be utilized for electronic billing.

Diagnosis Codes

A diagnosis is required on all claims. Enter code R68.89 for all claims. Do not fill unused spaces with zeroes. The diagnosis must be referenced to each detail line by placing a "1" in the diagnosis indicator field.

Dates of Services

Each detail line includes space to enter two (2) dates of service: a 'From' Date Of Service (FDOS) and a 'To' Date Of Service (TDOS). Both dates must be completed on the electronic record. For services rendered on a single date, complete the FDOS and the TDOS with the same date.

Span Billing

Span billing is not allowed for transportation services.

Place of Service Codes

Use CMS place of service codes. Use place of service code 41-land transportation and code 42-air transportation.

Procedure Codes

Each detail line must include a valid procedure code.

Units of Service

Units represent the number of services provided.

Transportation by Bus, Train, or Air and Special Transportation Services

Units represent the number of one-way trips taken. Do not bill for mileage.

Meals and Lodging

Please refer to the latest Fee Schedule for the most current rates.

Required Attachments

Claims that require attachments must be billed on paper.

Timely Filing

The Health First Colorado timely filing period is 120 days from the date of service.

If the original timely filing (120 day) period expires, claims must be submitted within 60 days of the last remittance statement or adverse action. Refer to the General Claim Requirements section for complete information on timely filing.

CMS 1500 Paper Claim Reference Table

The following paper claim form reference table shows required, optional, and conditional fields and detailed field completion instructions for transportation claims on the CMS 1500 claim form.

CMS Field #	Field Label	Field is?	Instructions
1	**Insurance Type**	Required	Place an "X" in the box marked as Medicaid.
1a	**Insured's ID Number**	Required	Enter the member's Health First Colorado seven-digit Medicaid ID number as it appears on the Medicaid Identification card. Example: A123456.
2	**Patient's Name**	Required	Enter the member's last name, first name, and middle initial.
3	**Patient's Date of Birth / Sex**	Required	Enter the member's birth date using two digits for the month, two digits for the date, and two digits for the year. Example: 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.
11b	**Other Claim ID**	Not Required	

CMS Field #	Field Label	Field is?	Instructions
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 for electronic claims. Paper claims must have a wet signature. 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**	Conditional	Complete for services provided in an inpatient hospital setting. Enter the date of hospital admission and the date of discharge using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. If the

CMS Field #	Field Label	Field is?	Instructions
			member is still hospitalized, the discharge date may be omitted. This information is not edited.
19	**Additional Claim Information**	Conditional	**TRANSPORTATION** When applicable, enter the word "TRANSPORT CERT" to certify that you have a transportation certificate or trip sheet on file for this service.
20	**Outside Lab?** **$ Charges**	Conditional	Complete if all laboratory work was referred to and performed by an outside laboratory. If this box is checked, no payment will be made to the physician for lab services. Do not complete this field if any laboratory work was performed in the office. Practitioners may not request payment for services performed by an independent or hospital laboratory.
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) **Transportation** Enter diagnosis code R68.89.
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.

CMS Field #	Field Label	Field is?	Instructions
24	**Claim Line Detail**	Information	The paper claim form allows entry of up to six detailed billing lines. Fields 24A through 24J apply to each billed line. **Do not enter more than six lines of information** on the paper claim. If more than six lines of information are entered, the additional lines will not be entered for processing. Each claim form must be fully completed (totaled). **Do not file continuation claims** (e.g., Page 1 of 2).
24A	**Dates of Service**	Required	The field accommodates the entry of two dates: a "From" date of services and a "To" date of service. Enter the date of service using two digits for the month, two digits for the date and two digits for the year. Example: 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 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. **County transportation and Waiver services** Providers should refer to specific billing instructions on the use of span billing. **Supplemental Qualifier**

CMS Field #	Field Label	Field is?	Instructions
			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 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. 41 Transportation – Land 42 Transportation – Air or Water
24C	**EMG**	Conditional	Enter a "Y" for YES to indicate the service is rendered for a life-threatening condition or one that requires immediate medical intervention. Enter an "N" or leave blank for in the bottom, unshaded area of the field to indicate the service was non-emergency medical transportation.
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.

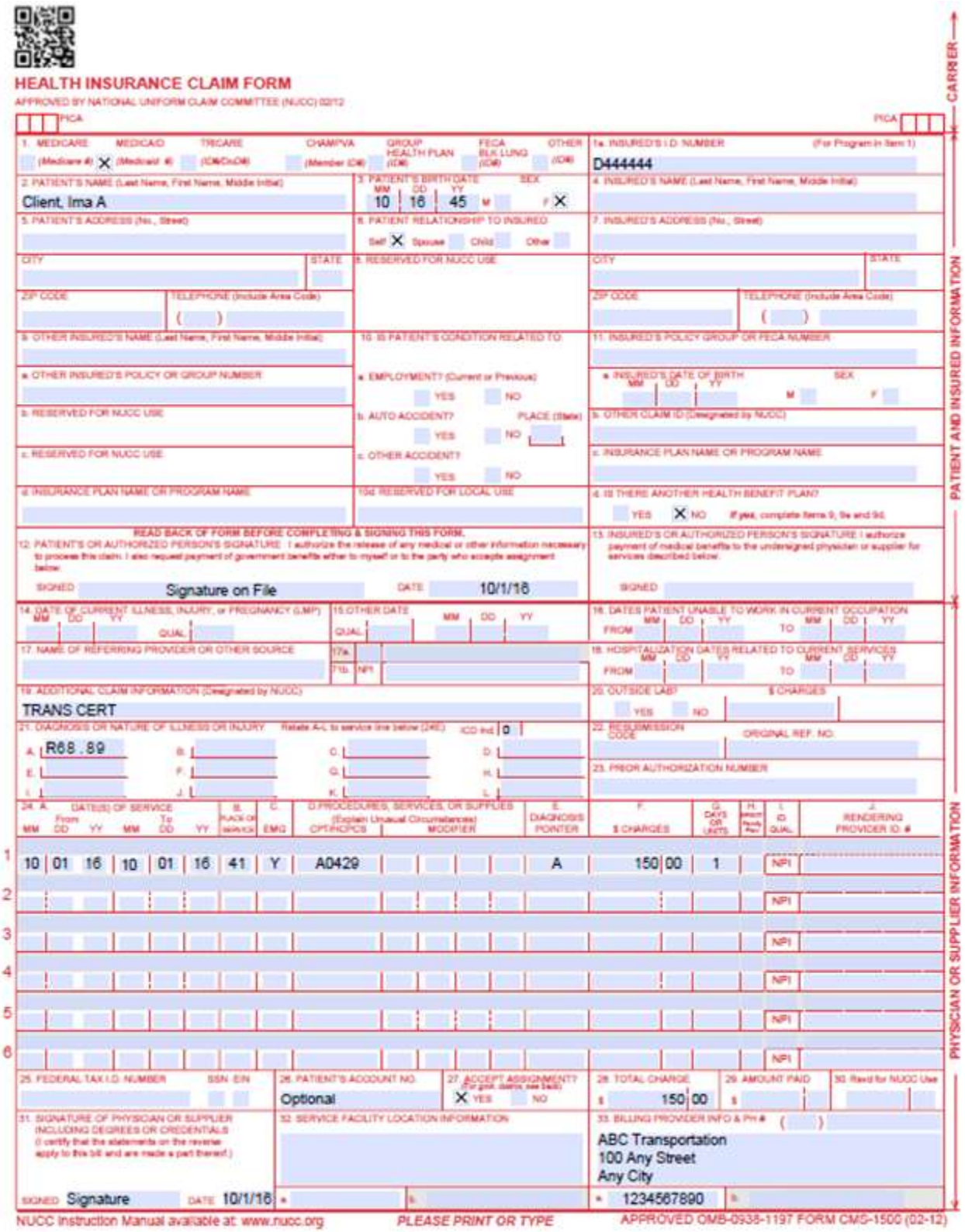
CMS Field #	Field Label	Field is?	Instructions
24D	**Modifier**	Not Required	
24E	**Diagnosis Pointer**	Required	Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis. At least one (1) diagnosis code reference letter must 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 four (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. 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.

CMS Field #	Field Label	Field is?	Instructions
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. **Transportation** Units represent the number of one-way trips taken. Do not bill for mileage. **Meals and Lodging** Report units as the number of days of lodging and days of meals provided. Do not complete units to represent the number of meals provided. When the HCPCS code narrative indicates a round trip, bill one unit.
24H	**EPSDT/Family Plan**	Not Required	
24I	**ID Qualifier**	Not Required	
24J	**Rendering Provider ID #**	Required	In the shaded portion of the field, enter the NPI of the Colorado Medicaid provider assigned to the individual who actually performed or rendered the billed service. This number cannot be assigned to a group or clinic.
25	**Federal Tax ID Number**	Not Required	
26	**Patient's Account Number**	Optional	Enter information that identifies the member or claim in the provider's billing system. Submitted information appears on the Remittance Advice (RA).
27	**Accept Assignment?**	Required	The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.

CMS Field #	Field Label	Field is?	Instructions
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 digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. **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**	Conditional	Complete for services provided in a hospital or nursing facility in the following format: 1st Line Facility Name 2nd Line Address

CMS Field #	Field Label	Field is?	Instructions
	32a- NPI Number **32b- Other ID #**		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 Transportation 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): TRANS CERT

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. R68.89 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	41	Y	A0429				A	150 00	1		NPI	
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 $ 150 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 Transportation
100 Any Street
Any City

a. 1234567890 b.

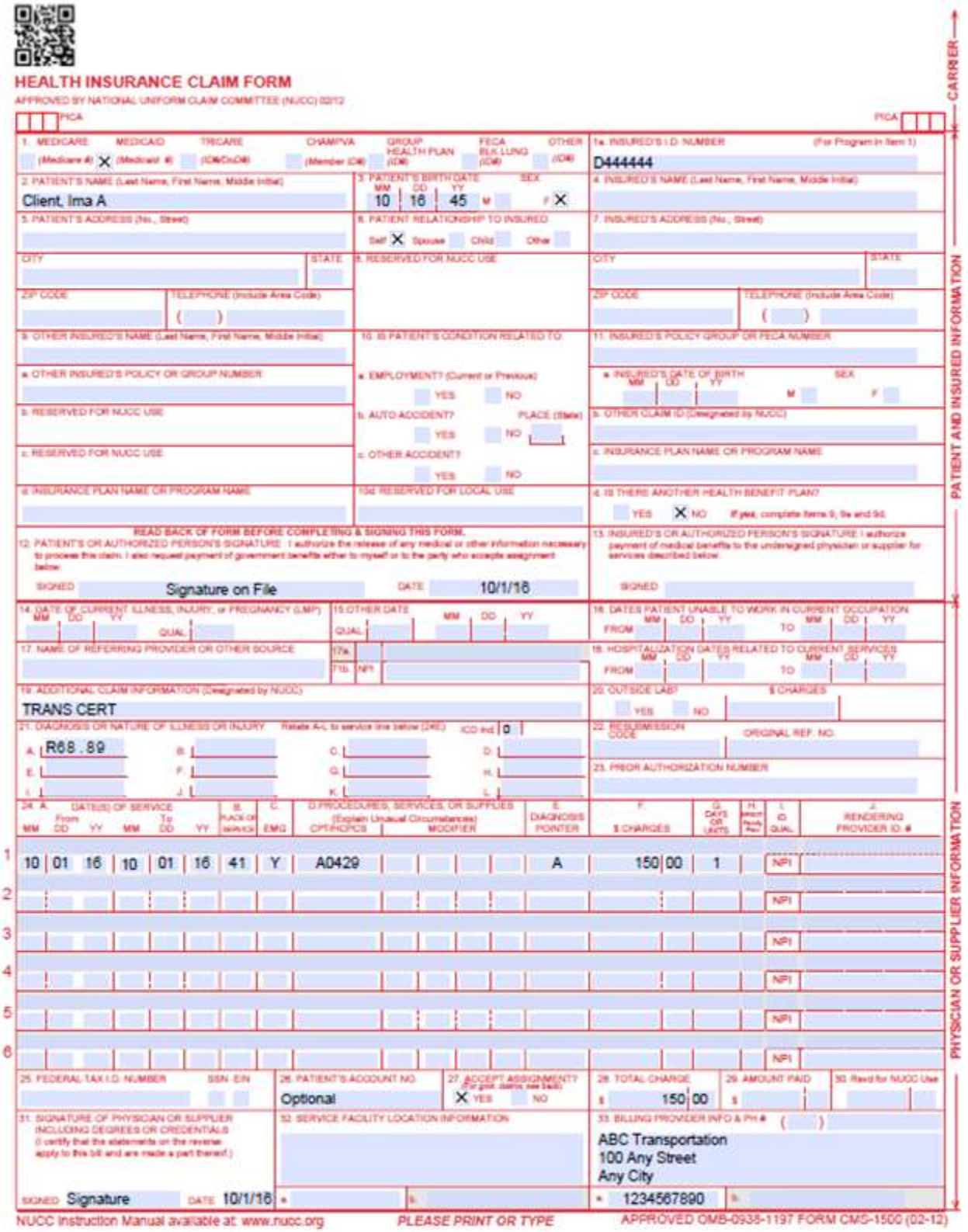
CARRIER

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)

Transportation Third Party Claim - No Mileage 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

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): TRANS CERT

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. R68.89 | 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	41	Y	A0429		A	150 00	1		NPI
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: $ 150 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

33. BILLING PROVIDER INFO & PH # ( )

ABC Transportation
100 Any Street
Any City

a. 1234567890 | b.

CARRIER

PATIENT AND INSURED INFORMATION

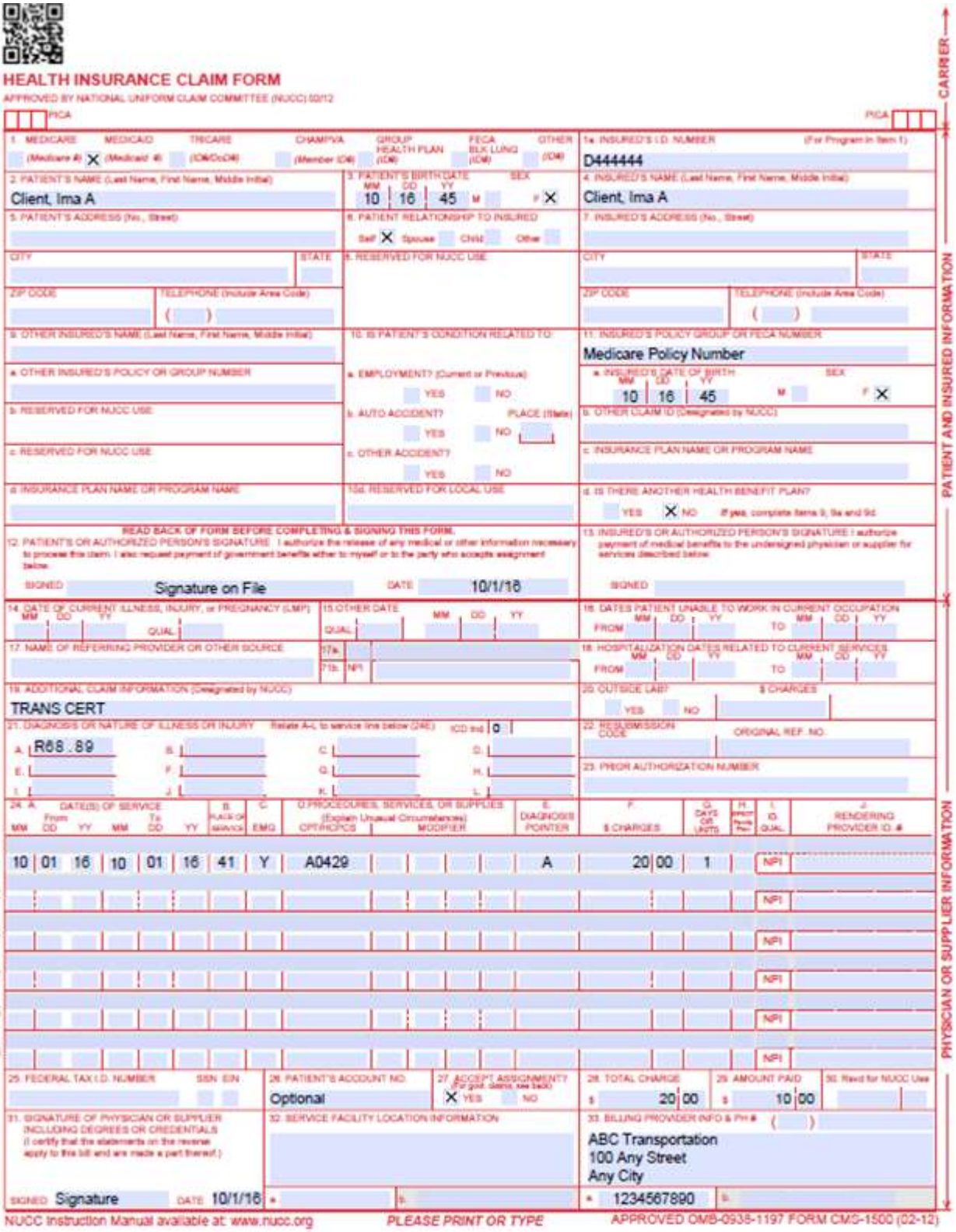
PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

Transportation Crossover 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 10 DD 16 YY 45 SEX: M | F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Client, Ima A

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: Medicare Policy Number

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH: MM 10 DD 16 YY 45 SEX: M | F X

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES | NO

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): TRANS CERT

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. R68.89 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	41	Y	A0429			A	20 00	1		NPI	
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 $ 20 00

29. AMOUNT PAID $ 10 00

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 Transportation
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)

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.

Transportation Billing Manual Revisions Log

Revision Date	Section/Action	Pages	Made by
12/01/2016	*Manual revised for interChange implementation. For manual revisions prior to 12/01/2016, please refer to Archive.*	*All*	*HPE (now DXC)*
12/27/2016	*Updates based on Colorado iC Stage II Provider Billing Manual Comment Log v0_2.xlsx*	*4, 6, 7, 14*	*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*	*5, 13*	*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.*