Vision Care and Eyewear Manual

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Vision Care & Eyewear Services

Benefits

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

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

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

Providers should refer to the Code of Colorado Regulations, Program Rules (10 CCR 2505-10), for specific information when providing medical/surgical services.

Members Ages 21 and Older

Medically necessary eye examinations are benefits for Health First Colorado members ages 21 and older. Eyeglasses and contact lenses are benefits following eye surgery only and do not require prior authorization. The surgery may have been performed at any time during the member's life. The modifier -55 must be used with eyewear codes to identify surgery-related eyewear (1 unit per lens).

Members Ages 20 and Younger

The Early Periodic Screening Diagnosis and Treatment (EPSDT) Program provides the following vision benefits for members age 20 and under:

- Standard eyeglasses (one or two single or multifocal vision clear glass lenses with one standard frame). Health First Colorado provides payment for one standard frame.
- Glasses dispensed by an optician are a benefit when ordered by an ophthalmologist or optometrist.
- Replacement or repair of frames or lenses (standard eyeglasses), not to exceed the cost of replacement.
- Contact lenses must be medically necessary and prior authorized unless provided for vision correction after surgery. Contact lenses, supplies, and contact lens insurance are not benefits.
- Ocular prosthetics are a benefit.
- There is no yearly maximum for eye exams or eyeglasses.

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.

Batch Electronic Claim Submission

Batch billing refers to the electronic creation and transmission of several claims in a group. Batch billing systems usually extract information from an automated accounting or patient billing system to create a group of claim transactions. Claims may be transmitted from the provider's office or sent through a billing vendor or clearinghouse.

All batch claim submission software must be tested and approved by the Health First Colorado fiscal agent.

For additional electronic billing information, please refer to the appropriate Companion Guide in the Provider Services Specifications section.

Prior Authorization Requests (PARs) for Vision Services

Prior authorization is not required for vision correction after surgery. Providers must identify claims for vision correction after surgery with the approximate date and the modifier -55 for each eyewear procedure code. Eye surgery may have been performed at any time during the member's life.

Prior authorizations are required for designated items including:

- Contact lenses.
- Low vision aids.
- Ocular prosthetics (EPSDT members only) with a statement of medical necessity and the type of prosthetic eye.
- Tint, anti-reflective coating, U-V, oversize, occluder, and progressive lenses.

Health First Colorado Prior Authorization Requests (PARs)

Although many procedures can be processed without prior review and approval, certain procedures require prior authorization. A list of authorizing agencies, addresses, and telephone numbers is located in Appendices C and D in the Appendices of the Provider Services Billing Manuals section of Department's website. Selected surgical procedures and all services provided outside of Colorado, with the exception of emergency services, require prior authorization. Providers must complete, submit, and receive approval of the Prior Authorization Request (PAR) before rendering the service or supply. Surgical procedure codes requiring prior authorization are listed in Appendix M.

Providers are required to submit PARs electronically using the ColoradoPAR program's PAR portal, eQSuite®. Exceptions will only be made if: the provider submits, on average, five or fewer PARs per month and would prefer to submit a PAR by telephone or facsimile; the provider is out-of-state, or the request is for an out-of-state service; or the provider is visually impaired. For more information on signing up for the portal and how to submit PARs, please visit the ColoradoPAR website. Submitted PARs without the required information will be rejected.

PARs submitted to the ColoradoPAR Program must be submitted using the national Centers for Medicare and Medicaid Services (CMS) and Current Procedural Terminology (CPT) codes described in this manual. PARs submitted without utilizing the Healthcare Common Procedural Coding System (HCPCS) codes will not be accepted.

Approval of a PAR does not guarantee Health First Colorado payment and does not serve as a timely filing waiver. Prior authorization only assures that the service is considered a benefit of the Health First Colorado. All claims, including those for prior authorized services, must meet eligibility and claim submission requirements (e.g. timely filing, Primary Care Physician (PCP) information completed appropriately, third party resources payments pursued, required attachments included, etc.) before payment can be made.

After a PAR has been reviewed, a PAR letter is sent to the provider and the member. For approved services, allow sufficient time for the fiscal agent to enter the PAR data into the Health First Colorado processing system before submitting a claim for the authorized service.

The authorizing agent reviews all completed PARs. The authorizing agency approves or denies, by individual line item, each requested service or supply listed on the PAR. The results of the PAR review are available through the Web Portal and included in PAR letters. Read the response carefully as some line items may be approved and others denied.

Do not render or bill for services until the PAR has been processed. The claim must contain the PAR number for payment. If the PAR is denied, direct inquiries to the authorizing agency listed in Appendix D of the Appendices section in Provider Services Billing Manuals.

PAR Revisions

Providers are required to submit revisions to existing PARs through the PAR portal as well, with the noted exceptions above. For instructions on submitting revisions in the PAR portal, please visit the ColoradoPAR website.

Paper PAR Instructional Reference

Should a provider be granted an exception to submitting PARs electronically and complete a paper PAR form, please reference the following information.

Field Label	Completion Format	Instructions
The upper margin of the PAR form must be left blank. This area is for fiscal agent use only.		

Field Label	Completion Format	Instructions
Invoice/Pat Account Number	Text	Optional Enter up to 12 characters (numbers, letters, hyphens) that help identify the claim or member.
1. Member Name	Text	Required Enter the member's last name, first name, and middle initial. Example: Adams, Mary A.
2. Member Identification Number	7 characters, a letter prefix followed by six numbers	Required Enter the member's state identification number. This number consists of a letter prefix followed by six numbers. Example: A123456.
3. Sex	Check box ☐ M ☐ F	Required Enter an "X" in the appropriate box.
4. Date of Birth	6 numbers	Required Enter the member's birth date using MMDDYY format. Example: January 1, 2010 = 010110.
5. Member Address	Characters: numbers and letters	Required Enter the member's full address: Street, city, state, and zip code.
6. Member Telephone Number	10 numbers	Optional Enter the member's telephone number.
7. Prior Authorization Number		System Assigned Do not write in this area. The authorizing agent reviews the PAR and approves or denies the services Enter this PAR number or the system-assigned PAR number in the appropriate field on the claim form when billing for prior authorized services.
8. Dates Covered by This Request	6 numbers for from date and 6 numbers for through date (MMDDYY)	Required Enter the date(s) within which service(s) will be provided. If left blank, the authorizing agent enters the dates. Authorized services must be rendered within these dates.

Field Label	Completion Format	Instructions
9. Does Member Reside in a Nursing Facility?	Check Box ☐Yes ☐No	Required Check the appropriate box.
10. Group Home Name if Patient Resides in a Group Home	Text	Conditional Complete if member resides in a group home. Enter the name of the group home or residence.
11. Diagnosis	Text	Required Enter the diagnosis code and sufficient relevant diagnostic information to justify the PAR and include the prognosis. Provide relevant clinical information, other drugs or alternative therapies tried in treating the condition, results of tests, etc. to justify a Health First Colorado determination of medical necessity. Approval of the PAR is based on documented medical necessity. Attach documents as required.
12. Requesting Authorization for Repairs	None	Not Required
13. Indicate Length of Necessity	None	Not Required
14. Estimated Cost of Equipment	None	Not Required
15. Services To Be Authorized	None	Preprinted Do not alter preprinted lines. No more than five items can be requested on one form.
16. Describe Procedure, Supply, or Drug to be Provided	Text	Required Enter the description of the service/procedure to be provided.

Field Label	Completion Format	Instructions
17. Procedure, Supply or Drug Code	HCPCS code	Required Enter the procedure code for each item that will be billed on the claim form. The authorizing agency may change any code. The approved code(s) on the PAR form must be used on the claim form.
18. Requested Number of Services	Numbers	Required Enter the number of units for supplies or services requested. The authorizing agent completes this field if left blank.
19. Authorized No. of Services	None	Leave Blank The authorizing agency indicates the number of services authorized that may or may not equal the number requested in Field 18 (Number Of Services).
20. A=Approved D=Denied	None	Leave Blank Providers should check the PAR on-line or refer to the PAR letter.
21. Primary Care Physician (PCP) Name	None	Not Required
Telephone Number		Not Required
22. Primary Care Physician Address	Text	Not Required
23. PCP Provider Number	8 numbers	Not Required
24. Name and Address of Provider Requesting Prior Authorization	Text	Required Enter the complete name and address of the provider requesting the PAR. If the clinic is requesting a PAR, enter the provider's complete name and address
25. Name and Address of Provider Who will Render Service	Text	Required Enter the complete name and address of the provider requesting prior authorization. (The physician ordering/writing the prescription.)

Field Label	Completion Format	Instructions
26. Requesting Physician Signature **Telephone Number**	Text	Required The physician requesting the service must sign the PAR. A rubber stamp facsimile signature is not acceptable on the PAR. Required Enter the telephone number of the physician requesting the service.
27. Date Signed	6 numbers	Required Enter the date the PAR form is signed by the requesting physician.
28. Requesting Physician Provider Number	8 numbers	Required Enter the eight-digit Health First Colorado provider number of the requesting provider.
29. Service Provider Number	8 numbers	Required Enter the eight-digit Health First Colorado provider number of the State designated entity. The rendering provider must be enrolled in Health First Colorado.
30. Comments or Reasons For Denial of Benefits	Completed by Authorizing Agent	Leave Blank Refer to the PAR response for comments submitted by the authorizing agency.
31. PA Number Being Revised	None	Leave Blank This field is completed by the authorizing agent

PAR Form Example

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND FINANCING

INVOICE/PAT. ACCOUNT NUMBER

MEDICAID PRIOR AUTHORIZATION REQUEST (PAR)

To avoid delay, please answer all questions completely.

1. CLIENT NAME (Last, First, Middle Initial)	2. CLIENT IDENTIFICATION NUMBER	3. SEX ☐M ☐F	4. DATE OF BIRTH (MMDDYY)

5. CLIENT ADDRESS (Street, City, State, ZIP Code)	6. CLIENT TELEPHONE NUMBER ( )

7. PRIOR AUTHORIZATION NUMBER * SYSTEM ASSIGNED	8. DATES COVERED BY THIS REQUEST FROM (MMDDYY) THROUGH (MMDDYY)	9. DOES CLIENT RESIDE IN A NURSING FACILITY? ☐ YES ☐ NO	10. GROUP HOME NAME - IF PATIENT RESIDES IN A GROUP HOME

11. ICD-9-CM DIAGNOSIS CODE and DESCRIPTION (Must include Diagnosis Code and Description, Prognosis, Clinical Information and Other Medications presently prescribed)

12. REQUESTING AUTHORIZATION FOR REPAIRS EQUIPMENT MUST BE OWNED BY THE CLIENT - THE SERIAL NUMBER MUST BE ENTERED

13. INDICATE LENGTH OF NECESSITY (IN MONTHS AND YEARS) I.E., HOW LONG WILL THIS EQUIPMENT BE NEEDED?

14. ESTIMATED COST OF EQUIPMENT

SERVICES TO BE AUTHORIZED

15. LINE NO.	16. DESCRIBE THE PROCEDURE OR SUPPLY TO BE PROVIDED — INCLUDE MODEL NUMBER FOR DME PURCHASE OR SERIAL NUMBER FOR REPAIR	17. PROCEDURE OR SUPPLY CODE	18. REQUESTED NUMBER OF SERVICES	19. AUTHORIZED NO. OF SERVICES (LEAVE BLANK **)	20. APPROVED/DENIED (LEAVE BLANK **)
01					
02					
03					
04					
05					

21. PRIMARY CARE PHYSICIAN (PCP) NAME		22. PRIMARY CARE PHYSICIAN ADDRESS (Street, City, State, ZIP code)
TELEPHONE NUMBER ( )	23. PCP PROVIDER NUMBER	

24. NAME AND ADDRESS OF PHYSICIAN REQUESTING PRIOR AUTHORIZATION		25. NAME AND ADDRESS OF PROVIDER WHO WILL RENDER SERVICE	
26. REQUESTING PHYSICIAN SIGNATURE	27. DATE SIGNED		
TELEPHONE NUMBER ( )	28. REQUESTING PHYSICIAN PROVIDER NUMBER	TELEPHONE NUMBER ( )	29. SERVICE PROVIDER NUMBER

If services are provided according to the manner prescribed by State of Colorado Laws and Regulations, reimbursement will be provided for authorized services following submission of an appropriately completed Medicaid claim.

30. COMMENTS **

☐ ATTACH COPY OF THIS PAR TO CLAIM(S) **

SIGNATURE OF STATE AGENCY REPRESENTATIVE **	DATE **	31. PA NUMBER BEING REVISED **

* THE ASSIGNED PAR NUMBER APPEARS ON THE PAR LETTER. ENTER THE PAR NUMBER FROM THE LETTER ON THE CLAIM WHEN BILLING FOR THE SERVICES. ** THESE FIELDS ARE COMPLETED BY THE AUTHORIZING AGENT

FORM NO. 10013 (REV. 12/98)
COL — 106

White - AUTHORIZING AGENT Yellow - ORIGINATOR

CMS 1500 Paper Claim Reference Table

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

CMS Field #	Field Label	Field is?	Instructions
1	**Insurance Type**	Required	Place an "X" in the box marked as Medicaid.
1a	**Insured's ID Number**	Required	Enter the member's Health First Colorado seven-digit Medicaid ID number as it appears on the Medicaid Identification card. Example: A123456.
2	**Patient's Name**	Required	Enter the member's last name, first name, and middle initial.
3	**Patient's Date of Birth / Sex**	Required	Enter the member's birth date using two 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**		
9	**Other Insured's Name**	Conditional	If field 11d is marked "YES", enter the insured's last name, first name and middle initial.

CMS Field #	Field Label	Field is?	Instructions
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: 070115 for July 1, 2015. Place an "X" in the appropriate box to indicate the sex of the insured.
11b	**Other Claim ID**	Not Required	
11c	**Insurance Plan Name or Program Name**	Not Required	

CMS Field #	Field Label	Field is?	Instructions
11d	**Is there another Health Benefit Plan?**	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: 070116 for July 1, 2016. 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: 070116 for July 1, 2016. If the member is still hospitalized, the discharge date may be omitted. This information is not edited.
19	**Additional Claim Information**	Conditional	

CMS Field #	Field Label	Field is?	Instructions
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)
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. Each claim form must be fully completed (totaled).

CMS Field #	Field Label	Field is?	Instructions
			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: 070116 for July 1, 2016 From To **07 01 16** Or From To **07 01 16 07 01 16** Span dates of service From To **07 01 16 07 31 16** 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 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

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**	Conditional	Enter a “Y” for YES or leave blank for NO in the bottom, unshaded area of the field to indicate the service is rendered for a life-threatening condition or one that requires immediate medical intervention. If a “Y” for YES is entered, the service on this detail line is exempt from co-payment requirements.

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.
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. 24 **Unrelated Evaluation/Management (E/M) service by the same physician during a postoperative period** Use with E/M codes to report unrelated services by the same physician during the postoperative period. Claim diagnosis code(s) must identify a condition unrelated to the surgical procedure. 26 **Professional component** Use with diagnostic codes to report professional component services (reading and interpretation) billed separately from technical component services. Report separate professional and technical component services only if different providers perform the professional and technical portions of the procedure. Read CPT descriptors carefully. Do not use modifiers if the descriptor specifies professional or technical components. 51 **Multiple Procedures** Use to identify additional procedures that are performed on the same day or at the same session by the same provider. Do not use to designate "add-on" codes.

			55 **Postoperative Management only Surgery related eyewear** Use with eyewear codes (lenses, lens dispensing, frames, etc.) to identify eyewear provided after eye surgery. Benefit for eyewear, including contact lenses, for members over age 20 must be related to surgery. Modifier -55 takes the place of the required claim comment that identifies the type and date of eye surgery. The provider must retain and, upon request, furnish records that identify the type and date of surgery. 59 **Distinct Procedural Service** Use to indicate a service that is distinct or independent from other services that are performed on the same day. These services are not usually reported together but are appropriate under the circumstances. This may represent a different session or member encounter, different procedure or surgery, different site or organ system or separate lesion or injury. 62 **Two surgeons** Use when two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons 76 **Repeat procedure or service by <u>same</u> physician/provider/other qualified health care professional** Use to identify subsequent occurrences of the same service on the same day by the same provider. Not valid with E/M codes. 77 **Repeat procedure by <u>another</u> physician/provider/other qualified health care professional** Use to identify subsequent occurrences of the same service on the same day by different rendering providers. 79 **Unrelate d procedure or service by the same surgeon during the postoperative period**

CMS Field #	Field Label	Field is?	Instructions
			Unrelated procedures or services (other than E/M services) by the surgeon during the postoperative period. Use to identify unrelated services by the operating surgeon during the postoperative period. Claim diagnosis code(s) must identify a condition unrelated to the surgical procedure. 80 **Assistant surgeon** Use with surgical procedure codes to identify assistant surgeon services. Note: Assistant surgeon services by non-physician practitioners, physician assistants, perfusionists, etc. are not reimbursable. GY **Item or services statutorily excluded or does not meet the Medicare benefit.** Use with podiatric procedure codes to identify routine, non-Medicare covered podiatric foot care. Modifier -GY takes the place of the required provider certification that the services are not covered by Medicare. The Medicare non-covered services field on the claim record must also be completed. *KX* **Specific required documentation on file** Use with laboratory codes to certify that the laboratory's equipment is not functioning or the laboratory is not certified to perform the ordered test. The -KX modifier takes the place of the provider's certification, "I certify that the necessary laboratory equipment was not functioning to perform the requested test ", or "I certify that this laboratory is not certified to perform the requested test."
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.

CMS Field #	Field Label	Field is?	Instructions
			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. 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.
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. **Lens materials** One lens equals one unit of service. If two lenses of the same strength are provided, complete one billing claim line, entering two units of service and the total charge for both lenses. Lenses of different strengths are billed on separate claim lines. **Lens dispensing**

CMS Field #	Field Label	Field is?	Instructions
			A dispensing fee is allowed for each lens. For two lenses, complete on claim line with two units of service and charge for both lenses.
24H	**EPSDT/Family Plan**	Conditional	**EPSDT** (shaded area) For Early & Periodic Screening, Diagnosis, and Treatment related services, enter the response in the shaded portion of the field as follows: AV Available- Not Used S2 Under Treatment ST New Service Requested NU Not Used **Family Planning** (unshaded area) Not Required
24I	**ID Qualifier**	Not Required	
24J	**Rendering Provider ID #**	Required	In the shaded portion of the field, enter the NPI of the Health First Colorado provider number 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.
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.

CMS Field #	Field Label	Field is?	Instructions
			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: 070116 for July 1, 2016. **Unacceptable signature alternatives:** Claim preparation personnel may not sign the enrolled provider's name. Initials are not acceptable as a signature. Typed or computer printed names are not acceptable as a signature. "Signature on file" notation is not acceptable in place of an authorized signature.
32	**32- Service Facility Location Information** **32a- NPI Number** **32b- Other ID #**	Conditional	Complete for services provided in a hospital or nursing facility in the following format: 1st Line Facility Name 2nd Line Address 3rd Line City, State and ZIP Code 32a- NPI Number Enter the NPI of the service facility (if known).
33	**33- Billing Provider Info & Ph #** **33a- NPI Number** **33b- Other ID #**	Required	Enter the name of the individual or organization that will receive payment for the billed services in the following format: 1st Line Name 2nd Line Address 3rd Line City, State and ZIP Code

CMS Field #	Field Label	Field is?	Instructions
			33a- NPI Number Enter the NPI of the billing provider

CMS 1500 Vision Claim Example

HEALTH INSURANCE CLAIM FORM

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

PICA | PICA

CARRIER

PATIENT AND INSURED INFORMATION

1\. MEDICARE (Medicare #) | MEDICAID (Medicaid #) X | 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

PHYSICIAN OR SUPPLIER INFORMATION

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 — FROM MM DD YY TO MM DD YY

17\. NAME OF REFERRING PROVIDER OR OTHER SOURCE — 17a. — 17b. NPI

18\. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES — FROM MM DD YY 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. H52.2 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		65205		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.)

SIGNED: Signature — DATE: 10/1/16

32\. SERVICE FACILITY LOCATION INFORMATION — a. — b.

33\. BILLING PROVIDER INFO & PH # ( )

ABC Vision Center
100 Any Street
Any City

a. 1234567890 — b.

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

Procedure/HCPCS Codes Overview

The Department accepts 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.

HIPAA requires providers to comply with the coding guidelines of the AMA CPT Procedure Codes and the International Classification of Disease, Clinical Modification Diagnosis Codes. If there is no time designated in the official descriptor, the code represents one unit or session. Providers should regularly consult monthly bulletins located in the Provider Services Provider Bulletins section. To receive electronic provider bulletin notifications, an email address can be entered into the Online Portal in the (*MMIS) Provider Data Maintenance* area or by completing and submitting a Publication Email Preference Form in the Provider Services Forms section. Bulletins include updates on approved procedures codes as well as the maximum allowable units billed per procedure.

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.

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

Vision and Eyewear Revisions Log

Revision Date	Section/Action	Pages	Made by
12/01/2016	*Manual revised for interChange implementation. For manual revisions prior to 11/01/2016, 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*	*1, 4, 12*	*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*	*2*	*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.