Screening, Brief Intervention, and Referral to Treatment (SBIRT) Program

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Screening, Brief Intervention, and Referral to Treatment (SBIRT) Program

Program Overview

The Health First Colorado only reimburses providers for medically necessary services furnished to eligible members.

The purpose of this billing manual is to provide policy and billing guidance to providers to obtain reimbursement for SBIRT services. This manual is updated periodically to reflect changes in policy and regulations.

Screening, Brief Intervention, and Referral to Treatment is designed to prevent members from developing a substance use disorder, for early detection of a suspected substance use disorder, or to refer members for treatment. These services are not intended to treat members already diagnosed with a substance use disorder or those members already receiving substance use disorder treatment services. Members who are pregnant may be eligible for additional substance use screening and intervention services through Special Connections, Outpatient Substance Use Disorder treatment, and the Prenatal Plus program.

Treatment referrals must be made to the member's regional Behavioral Health Organization (BHO). Please visit the BHO web page for contact information and further details.

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.

Key Clinical Definitions

Pre-Screen (aka Brief Screen)

A pre-screen is defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) as "a rapid, proactive procedure to identify individuals who may have a condition or be at risk for a condition before obvious manifestations occur." It involves short questions relating to alcohol and drug use, and must be administered prior to beginning a full screening. Pre-screens are considered part of routine medical management and are not a separately reimbursable service.

Full Screen

Full screens are administered after a member has preliminarily been identified as at-risk by the brief pre-screen. Full screens entail asking members a validated series of questions to assess the level of a member's substance use. Full screens are only covered for members with positive brief screens and for members with signs, symptoms, and medical conditions that suggest risky or problem alcohol or drug use.

Full screenings should be used as a primary method for educating members about the health effects of using alcohol and other drugs. Health First Colorado (Colorado's Medicaid Program) covers screening services in a wide variety of settings to increase the chance of identifying individuals at risk for future substance abuse.

Providers are required to use an evidence-based screening tool to identify members at risk for substance use problems. The screening tool should be simple enough to be administered by a wide range of health care professionals. The tool must demonstrate sufficient evidence of validity and reliability to accurately identify members at potential risk for substance use disorder. Enough information must be generated from utilizing the tool to customize an appropriate intervention based on the identified level of substance use. Providers may use more than one (1) screening tool during the screening process if appropriate; however, no additional reimbursement will be made.

Health First Colorado has approved several evidence-based screening tools and will update the list as new methods become available.

The current approved evidence-based screening tools are:

- The Alcohol Use Disorders Inventory Test (AUDIT)
- The Drug Abuse Screening Test (DAST)
- The Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)
- The Car, Relax, Alone, Forget, Friends, Trouble Screening Test (CRAFFT), which has been validated for adolescents
- The Problem Oriented Screening Instrument for Teenagers (POSIT)

Brief Intervention

Brief interventions are interactions with members that are intended to induce a change in a health-related behavior. Often one (1) to three (3) follow-up contacts are provided to assess and promote progress and to evaluate the need for additional services. Brief interventions are typically used as a management strategy for members with risky or problem alcohol or drug use who are not dependent.

This includes members who may or may not qualify for a Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) diagnosis of alcohol or drug abuse.

Brief substance use intervention services are covered for members who, through the use of an evidence-based screening tool, are identified as at-risk for a substance use disorder(s). Brief intervention may be single or multiple sessions to increase insight and awareness regarding substance use and motivation for changes in behavior. Alternatively, a brief intervention may also be used to increase motivation and acceptance of a referral for substance use treatment. Intervention services may occur on the same date of service as the screening or on a later date. Brief intervention is not covered prior to screening.

Providers are required to use effective strategies for counseling and intervention.
Examples of demonstrated effective strategies include the following:

- The SBIRT protocols
- "Helping Patients Who Drink Too Much: A Clinician's Guide," Updated 2005 Edition

Follow-Up

Follow-up services include interactions that occur after initial intervention, treatment, or referral services, and are intended to reassess a member's status, assess a member's progress, promote or sustain a reduction in alcohol or drug use, and/or assess a member's need for additional services.

Referral

Members who appear to be alcohol- or drug-dependent are typically referred to alcohol and drug treatment programs. Treatment referrals must be made to the member's regional Behavioral Health Organization (BHO). Please visit the BHO web page for contact information and further details.

Member Eligibility

The SBIRT benefit is available to members ages 12 and older who are enrolled in the Health First Colorado. Members enrolled in a Health First Colorado HMO or managed care organization (MCO) must receive SBIRT services through the HMO or MCO.

Eligible Providers

The following licensed providers are eligible to provide SBIRT or supervise staff who provide SBIRT:

- Physician/psychiatrist
- Psychologist, Psy.D / Ph.D
- Masters level clinicians:
  - Licensed clinical social worker (LSCW)
  - Licensed marriage and family therapist (LMFT)
  - Licensed professional counselor (LPC)
- Nurse Practitioner
- Physician Assistant

Non-licensed providers may deliver SBIRT under the supervision of a licensed provider if such supervision is within the legal scope of practice for that licensed provider.

Providers must be enrolled in the Health First Colorado in order to:

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

Training Requirements for Licensed and Unlicensed Health Care Professionals

In order to directly deliver screening and intervention services, providers are required to participate in a training that provides information about the implementation of evidence-based protocols for screening, brief interventions, and referrals to treatment. Face-to-face trainings and consultations are available through various entities such as SBIRT Colorado, Colorado Community Managed Care Network, and the Emergency Nurses Association.

Unlicensed health care professionals must complete a minimum of 60 hours of professional training (e.g. education) that includes a minimum of four (4) hours of training directly related to SBIRT **and** 30 hours of face-to-face member contact (e.g. practicum or internship) ***within their respective fields***, prior to providing SBIRT services under the supervision of a licensed health care professional.

All providers are required to retain documentation confirming that staff providing SBIRT meet the training, education, and supervision requirements.

Billing Information

The procedure codes used to report SBIRT services for reimbursement are consistent among all provider types. This section will provide a comprehensive overview of the elements necessary to report SBIRT services in various billing scenarios. A provider may not submit a claim containing both Current Procedural Terminology (CPT) and Healthcare Common Procedural Coding System (HCPCS) codes. The provider must use **either** the CPT **or** the HCPCS codes designated for SBIRT services.

Procedure Code Overview

Health First Colorado accepts procedure codes that are approved by the Centers for Medicare & Medicaid Services (CMS). The procedure codes are used to submit 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) are divided into two (2) principal subsystems, referred to as level I and level II of the HCPCS. Level I of the HCPCS is comprised of CPT, a numeric coding system maintained by the American Medical Association (AMA).

The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter followed by four numeric digits, while CPT codes are identified using five numeric digits.

The Health Insurance Portability & Accountability Act requires providers to comply with the coding guidelines of the AMA CPT Procedure Codes and the International Classification of Disease, Clinical Modification Diagnosis Codes. If there is no time designated in the official descriptor, the code represents one (1) unit or session. Providers should regularly consult monthly bulletins located on the

Bulletins web page. To receive electronic provider bulletin notifications, an email address can be entered into the Provider Web Portal in the *(MMIS) Provider Data Maintenance* area or by completing and submitting a publication preference form. Bulletins include updates on approved procedure codes as well as the maximum allowable units billed per procedure.

National Correct Coding Initiative (NCCI) Edits for SBIRT

Policy guidance for NCCI provided in this manual does not supersede Federal NCCI policy. It is published to assist providers in understanding how the Health First Colorado SBIRT benefit is affected by NCCI edits. Health First Colorado's policy is to allow SBIRT codes to be billed on the same day as other Evaluation & Management (E&M) services (10 CCR 2505-10 8.747.6.C)

NCCI Procedure-to-procedure (PTP) billing edits affect SBIRT codes. Pursuant to the National Correct Coding Initiative Policy Manual (revision 1/1/2016 - Chapter XI - Page 9), if a provider reports the SBIRT codes **99408** and **99409** with an E&M, psychiatric diagnostic, or psychotherapy code utilizing an NCCI PTP-associated modifier, the provider is certifying that the SBIRT code service is:

1. A distinct and separate service performed during a separate time period (not necessarily a separate member encounter) than the E&M, psychiatric diagnostic, or psychotherapy service and,
2. Is a service that is not included in the E&M, psychiatric diagnostic, or psychotherapy service based on the clinical reason for the E&M, psychiatric diagnostic, or psychotherapy service.

If the E&M, psychiatric diagnostic, or psychotherapy service would normally include assessment and/or intervention of alcohol or substance abuse based on the member's clinical presentation, SBIRT codes may not be additionally reported.

Providers may attach bypass modifiers (typically '25' or '59') to **99408** and **99409** line items which allow those line items to be reimbursed in addition to the E&M code. Refer to the Medicaid NCCI website for further instruction on NCCI edits and bypass modifier use.

Screening and Brief Intervention Procedure Codes

- **Procedure code 99408** - Alcohol and/or substance use structured screening (e.g., AUDIT, DAST, CRAAFT), and brief intervention services; 15-30 minutes.
- **Procedure code 99409** - Alcohol and/or substance use structured screening (e.g., AUDIT, DAST, CRAAFT), and brief intervention services; greater than 30 minutes.

Screening and Brief Intervention Coding & Billing Requirements					
Procedure Code	**Description**	**Modifier**	**Ancillary Diagnosis**	**Unit of Service**	**Prior Authorization Required**
99408	Alcohol and/or substance (other than tobacco) abuse structured screening **and** brief intervention	*Modifier 59 may be applied to bypass NCCI edits.*	Z71.41 Z71.51	Limit one (1) per day, two (2) per state fiscal year.	No PA

	services; 15 to 30 minutes.				
99409	Alcohol and/or substance (other than tobacco) abuse structured screening **and** brief intervention services; greater than 30 minutes.	*Modifier 59 may be applied to bypass NCCI edits.*	Z71.41 Z71.51	Limit one (1) per day, two (2) per state fiscal year.	No PA

Clinical guidance for procedure codes 99408 and 99409:

Screening and brief intervention describes a different type of member-physician interaction than the provision of general advice. It requires a significant amount of time and additional acquired skills to deliver. Screening and brief intervention techniques are discrete, clearly distinguishable clinical procedures that are effective in identifying problematic alcohol or substance use. Components include but are not limited to:

- Using a standardized screening tool;
- Providing feedback to the member on the screening results;
- Discussing negative consequences that have occurred and the overall severity of the problem;
- Motivating the member toward behavioral change;
- A joint decision-making process regarding alcohol and/or drug use; and
- Discussing and agreeing on plans for follow up with member.

Ancillary staff, including health educators, may perform SBIRT services under the supervision of a credentialed provider. The services should relate to a plan of care and will require billing under the supervising physician. **SBIRT screening and brief intervention that does not meet the minimum 15 minute threshold is not separately reimbursable.** These are time-based codes, therefore documentation must denote start/stop time or total face-to-face time with the member. Due to procedure code 99409 being inclusive of the time spent before 30 minutes is accumulated, the two procedure codes may not be billed together on the same date of service. Both procedure codes account for screening *and* brief intervention, therefore state fiscal yearly limits for *screening* and *brief intervention* apply to each.

Procedure code **99408** / procedure code **99409** may only be billed when all these conditions are met:

1. When they follow a positive pre-screen;
2. When a full screen is positive; and
3. When they account for the time of full screening, brief intervention, and/or referral to treatment.

*Note: The state fiscal year is July 1st through June 30th.

Negative Screening Result Procedure Code

Procedure code H0049 - Alcohol and/or drug screening, (untimed):

Screening Coding & Billing Requirements					
Procedure Code	**Description**	**Modifier**	**Ancillary Diagnosis**	**Units of Service**	**Prior Authorization Required**
H0049	Alcohol and/or drug screening (e.g. AUDIT, DAST, CRAFFT, etc.)	*Modifier 59 may be applied to bypass NCCI edits.*	Z13.9	Limit one (1) per day, two (2) per state fiscal year.	No PA

A full screen will frequently be negative and the member will not require brief intervention or referral to treatment. These instances are still reimbursable using the HCPCS procedure code **H0049**. When using procedure code **H0049**, a unit of service is equivalent to the total amount of time required to administer the screening. Therefore, when billing the screening the units of service should always equal one (1) regardless of time spent completing the screening.

Procedure code **H0049** may only be billed when all these conditions are met:

1. It followed a positive pre-screen;
2. The full screen was negative; and
3. A brief intervention or referral to treatment was not necessary.

Procedure code **H0049** may not be billed in conjunction with procedure code **99408** or procedure code **99409** because those two (2) codes are also inclusive of a full screening.

Diagnosis Codes

Diagnosis codes play a critical role in supporting the medical necessity of the CPT or HCPCS codes that are billed. Below are tables of common ancillary (non-principal) diagnosis codes for reporting SBIRT services, and codes for reporting the allowable places of service for providing SBIRT services.

Required Ancillary ICD-10 Codes for SBIRT

Z13.9	Encounter for screening, unspecified
Z71.41	Alcohol abuse counseling & surveillance of alcoholic
Z71. 51	Drug abuse counseling and surveillance of drug abuser

Allowable Place of Service Codes

03	School
11	Office
12	Home
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital

Emergency Department

SBIRT that is provided in the hospital emergency department may be billed directly to the Health First Colorado by the rendering physician or may be included in the hospital claim, *but never both*.

Federally Qualified Health Centers (FQHCs) / Rural Health Clinics (RHC)

Reimbursement for SBIRT is included in the encounter rate payment. No separate reimbursement for SBIRT is allowable in these settings. Providers must still attach procedure codes **H0049**, **99408**, or **99409** and the appropriate ancillary diagnosis codes to the encounter claim.

Additional Policies

- Screening Brief Intervention Treatment is not designed to address smoking and tobacco cessation services unless it is a co-occurring diagnosis with another substance such as drugs or alcohol. Tobacco-only services are not a SBIRT billable benefit.
- Screening Brief Intervention Treatment must be provided face-to-face with the member or via simultaneous audio and video transmission (telemedicine) with the member.
- A physician order, referral, or prescription is not required for any component of SBIRT.
- A prior authorization request is not required.

Member Benefit Limitations

- Up to two (2) full screens per state fiscal year.
- Up to two (2) sessions of brief intervention/referral per state fiscal year.

Reimbursement

Reimbursement for SBIRT services will be made at the lesser of the provider's usual and customary charge or the Health First Colorado maximum allowable fee for the service. Health First Colorado will pay for separate and additional services on the same day as SBIRT, including medically necessary E&M services. The SBIRT codes will not be separately reimbursed when billing under the Mental Health and Substance Use Disorder Screening benefit using procedure codes **H0002** and **H0004**, or with any other HCPCS or CPT code that represents the same or similar services. Claims cannot be submitted using combined CPT and HCPCS codes designated for SBIRT services (e.g. procedure code **99408** *and* procedure code **H0049**).

CMS 1500 Paper Claim Reference Table

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

CMS Field #	Field Label	Field is?	Instructions
9	**Other Insured's Name**	Conditional	If field 11d is marked "YES," enter the insured's last name, first name and middle initial.
9a	**Other Insured's Policy or Group Number**	Conditional	If field 11d is marked "YES," enter the policy or group number.
9b	**Reserved for NUCC Use**		
9c	**Reserved for NUCC Use**		
9d	**Insurance Plan or Program Name**	Conditional	If field 11d is marked "YES," enter the insurance plan or program name.
10a-c	**Is Patient's Condition Related to?**	Conditional	When appropriate, place an "X" in the correct box to indicate whether one 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.

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

CMS Field #	Field Label	Field is?	Instructions
			digits for the month, two digits for the date, and two digits for the year. Example: 070115 for July 1, 2015. If the member is still hospitalized, the discharge date may be omitted. This information is not edited.
19	**Additional Claim Information**	Conditional	
20	**Outside Lab?** **$ Charges**	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 (1) but no more than twelve diagnosis codes based on the member's diagnosis/condition. Enter applicable ICD indicator to identify which version of ICD codes is being reported. 0 ICD-10-CM (DOS 10/1/15 and after) 9 ICD-9-CM (DOS 9/30/15 and before)
22	**Medicaid Resubmission Code**	Conditional	List the original reference number for adjusted claims. When resubmitting a claim as a replacement or a void, enter the appropriate bill frequency code in the left-hand side of the field. 7 Replacement of prior claim 8 Void/Cancel of prior claim This field is not intended for use for original claim submissions.
23	**Prior Authorization**	Not Required	
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.

CMS Field #	Field Label	Field is?	Instructions
			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: 010116 for January 1, 2016 From To **01 01 16** | | | | | | Or From To **01 01 16 01 01 16** Span dates of service From To **01 01 16 01 31 16** Practitioner claims must be consecutive days. Single Date of Service: Enter the six 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

CMS Field #	Field Label	Field is?	Instructions
			JP Universal/National Tooth Designation JO Dentistry Designation System for Tooth & Areas of Oral Cavity
24B	**Place of Service**	Required	Enter the Place of Service (POS) code that describes the location where services were rendered. The Health First Colorado accepts the CMS place of service codes. 03 School 04 Homeless Shelter 05 IHS Free-Standing Facility 06 Provider-Based Facility 07 Tribal 638 Free-Standing 08 Tribal 638 Provider-Based 11 Office 12 Home 15 Mobile Unit 20 Urgent Care Facility 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room Hospital 24 ASC 25 Birthing Center 26 Military Treatment Center 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Transportation – Land 42 Transportation – Air or Water 50 Federally Qualified Health Center 51 Inpatient Psychiatric Facility 52 Psychiatric Facility Partial Hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility – MR 55 Residential Treatment Facility 60 Mass Immunization Center 61 Comprehensive IP Rehab Facility

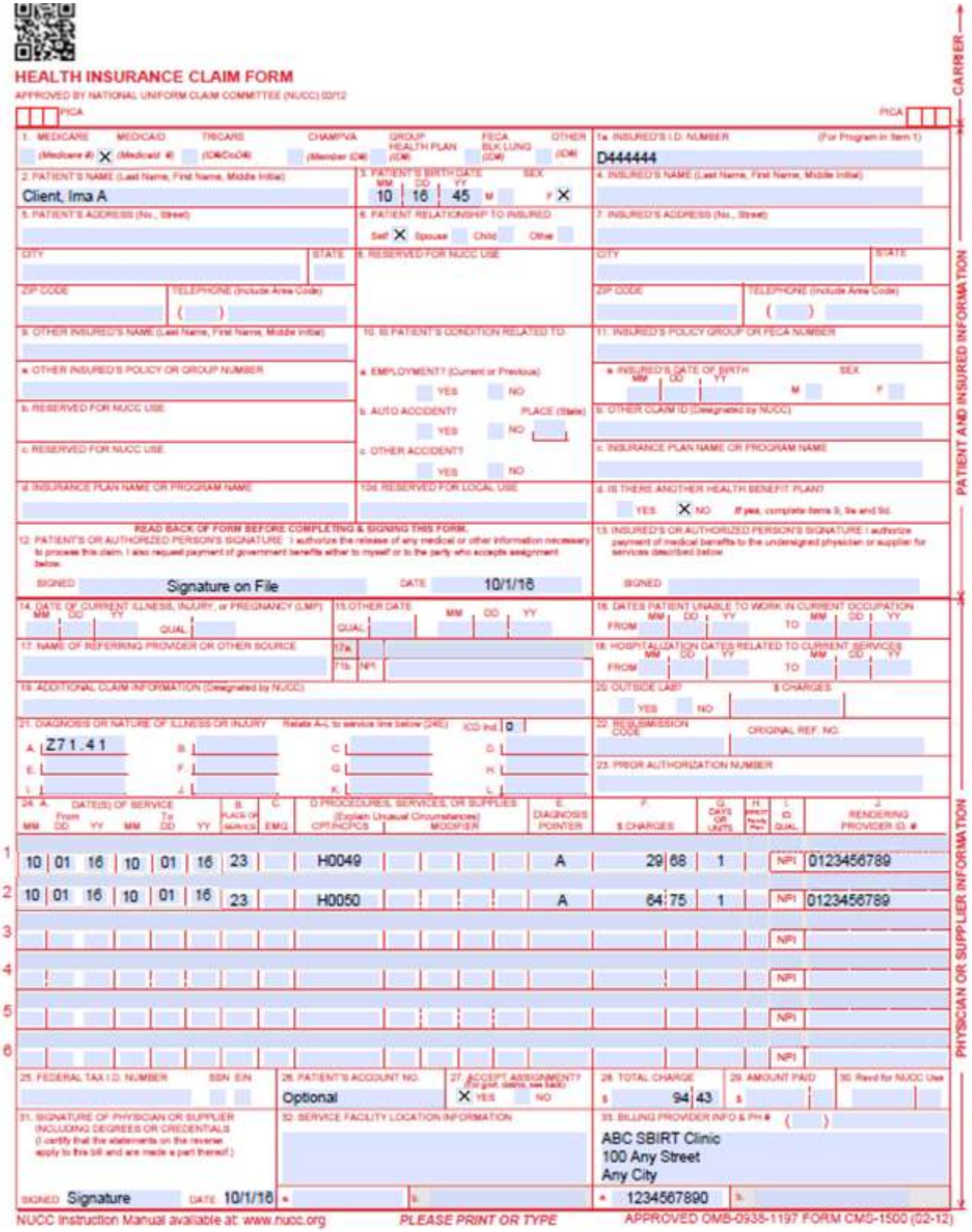
CMS Field #	Field Label	Field is?	Instructions
			62 Comprehensive OP Rehab Facility 65 End Stage Renal Dialysis Trtmt Facility 71 State-Local Public Health Clinic 72 Rural Health Clinic 81 Independent Lab 99 Other Unlisted
24C	**EMG**	Conditional	Enter a "Y" for YES or leave blank for NO in the bottom, 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.
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**	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 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 characters in the unshaded area.

CMS Field #	Field Label	Field is?	Instructions
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.
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) If the service is Family Planning, enter "Y" for YES or "N" for NO in the bottom, unshaded area of the field**.**
24I	**ID Qualifier**	Not Required	

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

CMS Field #	Field Label	Field is?	Instructions
			signed using two digits for the month, two digits for the date, and two digits for the year. Example: 070115 for July 1, 2015. **Unacceptable signature alternatives:** Claim preparation personnel may not sign the enrolled provider's name. Initials are not acceptable as a signature. Typed or computer printed names are not acceptable as a signature. "Signature on file" notation is not acceptable in place of an authorized signature.
32	**32- Service Facility Location Information** **32a- NPI Number** **32b- Other ID #**	Conditional	Complete for services provided in a hospital or nursing facility in the following format: 1st Line Facility Name 2nd Line Address 3rd Line City, State and ZIP Code 32a- NPI Number Enter the NPI of the service facility (if known).
33	**33- Billing Provider Info & Ph #** **33a- NPI Number** **33b- Other ID #**	Required	Enter the name of the individual or organization that will receive payment for the billed services in the following format: 1st Line Name 2nd Line Address 3rd Line City, State and ZIP Code 33a- NPI Number Enter the NPI of the billing provider

CMS 1500 SBIRT Claim Example



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): D444444

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

3. PATIENT'S BIRTH DATE MM DD YY: 10 16 45 SEX M | F X

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

5. PATIENT'S ADDRESS (No., Street):

6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street):

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | X NO If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE 10/1/16

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY | QUAL

15. OTHER DATE MM DD YY | QUAL

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

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

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES | NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. 0

A Z71.41 | 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	23		H0049		A	29 68	1		NPI 0123456789
2	10 01 16	10 01 16	23		H0050		A	64 75	1		NPI 0123456789
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) YES X | NO

28. TOTAL CHARGE $ 94 43

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 SBIRT Clinic
100 Any Street
Any City

a. 1234567890 | b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

Resources:

- SBIRT Colorado Face-to-face training, consultation, and other education opportunities: improvinghealthcolorado.org
- SBIRT Training online at: sbirttraining.com
- Alcohol Screening/Guidelines: alcoholscreening.org/Learn-More.aspx
- Health TeamWorks website with SBIRT Guidelines, CRAFFT, AUDIT, and DAST: healthteamworks.org/guidelines/sbirt.asp
- Colorado Office of Behavioral Health referral resources for substance use and mental health prevention, treatment and recovery: http://www.linkingcare.org/
- Substance Abuse and Mental Health Services Administration Behavioral Health Treatment Services Locator: https://findtreatment.samhsa.gov/
- Online training modules to practice screening and brief intervention skills with virtual members: http://improvinghealthcolorado.org/free-online-training/

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 a claim. For information on the 60-day resubmission rule for denied/rejected claims, see the General Provider Information manual on the Billing Manuals web page 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.

SBIRT Revisions Log

Creation Date	Additions/Changes	Pages	Made by
12/01/2016	*Manual revised for interChange implementation. For manual revisions prior to 12/01/2016, please refer to Archive.*	*All*	*HPE (now DXC)*
12/27/2016	*Updates based on Colorado iC Stage II Provider Billing Manual Comment Log v0_2.xlsx*	*3, 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*	*12, 18*	*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 occurred.