Home Health

Home Health Billing Information

The Department of Health Care Policy and Financing (the Department) periodically modifies billing information. Therefore, the information in this manual is subject to change, and the manual is updated as new billing information is implemented.

Provider Qualifications

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

In order to become a Health First Colorado (Colorado's Medicaid Program) Home Health Provider, an agency **must**:

- Hold a current and active Class A Home Care License issued by the State of Colorado;
- Obtain Medicare certification and/or deemed status an accepted Home Health Accreditation entity: Joint Commission (JC), Community Health Accreditation Program (CHAP) or the Accreditation Commission for Health Care, Inc. (ACHC);
- Be enrolled as a Medicare provider; and
- Be in good standing with the Colorado Department of Health Care Policy and Financing, Colorado Department of Public Health and Environment (CDPHE), and Medicare.

After obtaining licensure and certification as a Class A Home Care Agencies, an applicant must submit a completed provider enrollment packet to become a Health First Colorado eligible provider. Providers will find enrollment information on the Provider Services Enrollment section of the Department's website.

Home Health Agencies must comply with rules and regulations for Medicaid Home Health, including but not limited to the Home Health Benefit Coverage Standard and 10 C.C.R. 2505-10 § 8.520-8.529.

All Home Health services provided are subject to post-payment review for medical necessity and regulation compliance.

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 Claims 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 member 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 Department's fiscal agent.

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

General Prior Authorization Requirements

Acute Home Health PARs

Acute Home Health Services do not need to be prior authorized. However, if the member is enrolled in a Medicaid Managed Care Organization (MCO), such as Denver Health, Rocky Mountain Health Plans or Colorado Access Health Plan, please contact the MCO directly to determine the health plan's acute Home Health prior authorization requirements.

Long-Term Home Health (LTHH) PARs

All LTHH Services shall be submitted to the Department's authorizing agency as soon as possible, but no more than 10 business days from the start date of the LTHH PAR. Authorizing agency information is listed in Appendices C and D of the Appendices located in the Provider Services Billing Manuals section of the Department's website. The Home Health PAR form must be completed and reviewed by the Department's authorizing agency before services can be billed.

Long-Term Home Health PARs that are submitted more than 10 business days from the start date of the LTHH PAR shall have the PAR start date amended to the date of submission to the Department's authorizing agency. A PAR is not considered complete until the authorizing agency reviews all information necessary to review the request. All LTHH PAR submissions must include:

- The complete and current plan of care using the HCFA-485 or other document that is identical in content which must include a clear listing of:
  - Member's diagnoses that will be addressed by Home Health, using V-codes whenever appropriate;
  - The specific frequency and expected duration of the visits for each discipline ordered; and
  - The duties/treatments/tasks to be performed by each discipline during each visit.
- All other supporting documentation to support your request including physician's orders, treatment plans, nursing summaries, nurse aide assignment sheets, medications listing, etc.; and
- Any other documentation deemed necessary by the Department or its authorizing agency.

The plan of care must be created by a registered nurse employed with the Home Health Agency or when appropriate by a physical, occupational or speech therapist. The plan of care must be signed by the member's attending physician prior to submitting the final claim for a certification period. For additional

information on Health First Colorado plan of care requirements refer to the Home Health Services Benefit Coverage Standard referenced in 10 C.C.R 2505-10 § 8.522 – Covered Services

Please submit the appropriate completed PAR via:

- Pediatric members -eQSuite®
- Adult members - the Department's designated form

Pediatric PARs

All pediatric LTHH PARs must be submitted via eQSuite®.

ColoradoPAR Program

Prior Authorization (PAR) Vendor for the Health First Colorado
Provider PAR Request Line: 888-801-9355
PAR Fax Line: 866-940-4288

Adult PARs

All adult LTHH PARs must be submitted on the Department's designated Long Term Home Health PAR form. The form is available in the Provider Services Forms section of the Department's website. Instructions for completing the PAR form are included in this manual.

The authorizing agency reviews all completed PARs and approves or denies, by individual line item, each requested service listed on the PAR. PAR status inquiries can be made through the File and Report System (FRS) in the Provider Web Portal and PAR determinations are included on PAR letters sent to both the provider and the member. **Read the determination 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.

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 services requested are 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, third party resources payment pursued, required attachments included, etc.) before payment can be made.

If the PAR is denied, providers should direct inquiries to the authorizing agency who reviewed the PAR.

Do not submit claims before the PAR has been reviewed and approved unless submission is necessary to meet timely filing requirements. Refer to the Department Program Rules - Code of Colorado Regulations located in Boards & Committees in the Medical Services Board section of the Department's website for required attachments.

PAR Revisions

If the number of approved units needs to be amended, the provider must submit a request for a PAR revision **prior** to the PAR end date. Changes requested after a PAR is expired will not be made by the Department or the authorizing agency.

Note: When a PAR is revised, the number on the original PAR must be used on the claim. (Do not use the PAR number assigned to the revision when completing a claim. Use the original PAR number.)

Pediatric Long-Term Home Health PAR revisions should be completed in eQSuite®. Adult LTHH PAR revisions must be made on the Department's designated form and submitted to the authorizing agency for review. Complete the Revision section of the PAR and include the PAR number that you need to be revised.

Note: The number of units should equal more/less the number of units planned for use during the PAR period. The number of units being requested needs to be added to the original number of units approved and include all services that were approved on the original PAR.

Change of Provider Revisions

When a member in long-term home health changes providers during an active PAR certification, the receiving Home Health Providers shall complete a Change of Provider Form in order to transfer the member's care from the previous provider to the receiving agency.

Once the receiving agency completes the Change of Provider form, the form must include the member's signature to indicate that the member is in agreement with the change of provider request.

The completed Change of Provider form must accompany a new Home Health PAR from the receiving agency.

The agency must submit the Change of Provider form along with a new PAR to the authorizing agency. The new PAR start date should coincide with the first day that the new agency plans to provide LTHH care. The provider should not include dates for acute home health or any lapses in care between the last date of service provided by the previous home health agency and the receiving agency.

The previous provider's PAR end date will be revised to match the information provided in the "last date of service" box, and a new PAR will be entered for the receiving agency.

The Change of Provider letter authorizes Department's fiscal agent to end the current PAR so the new Home Health PAR may be entered. Single Entry Points (SEPs) and Community Centered Boards (CCBs) must include the Case Management Agency's (CMA) identification number on the PAR form.

If the receiving agency is unable to obtain the necessary PAR information from the previous agency, the receiving agency may call the Department's fiscal agent at 844-235-2387 (toll free) to find out whether there is a current Home Health PAR in the system. If a current PAR does exist, the Department's fiscal agent will provide the name and phone number of the Home Health Agency who currently has the approved PAR, but will not be able to provide any of the details for the PAR.

The receiving agency should contact the previous agency, when possible, and notify them that the member is transferring agencies and the effective date of the change.

Home Health Agencies should not bill Long-Term Home Health services on another provider's Long-Term Home Health PAR.

Home Health Prior Authorization Information

Medical Assistance Program Home Health is provided on an Acute Home Health basis or Long Term Home Health (LTHH) basis. The Health First Colorado also reimburses Telehealth services for members who qualify for telehealth monitoring (for more information on Home Health Telehealth services refer to the Home Health Benefit Coverage Standard as referenced in 10 C.C.R 250-10 8.522 – Covered Services). .

Acute Home Health

Intermittent Home Health services provided up to 60 consecutive calendar days after an acute onset of an illness, injury or disability, hospitalization or acute onset of exacerbations requiring skilled Home Health care as outlined in the Home Health Benefit Coverage Standard as referenced in 10 C.C.R 2505 - 10 § 8.522. Covered Services. Acute Home Health does not require prior authorization.

- Services Include: Skilled nursing, skilled certified nurse aide, physical therapy, occupational therapy, speech therapy and telehealth services.

- If the member is enrolled in a Health First Colorado managed care organization health plan, such as Denver Health, Rocky Mountain Health Plans or Colorado Access Health Plan, the provider will need to contact the MCO directly to determine the MCO acute Home Health prior authorization requirements.

Long Term Home Health

Intermittent Home Health services required for the care of chronic long-term conditions, and/or on-going care that exceeds the acute HH period (61st calendar day of Home Health service). All Long-Term Home Health services must be prior authorization request.

Services Include: Skilled nursing, skilled certified nurse aide, telehealth services. Pediatric members may also receive physical therapy, occupational therapy and speech therapy.

If a member experiences a new acute event that would warrant acute Home Health service, the agency may move the member to acute care, when:

- At least ten (10) calendar days has elapsed since the member's last acute Home Health episode; **and**
- There is new onset of illness, injury or disability or when the member experiences an acute change in condition from the member's past acute HH episode(s).

Providers should refer to the Code of Colorado Regulations, Program Rules (10 C.C.R. 2505-10), for specific information when providing Home Health care.

PAR Form Instructions

Complete this form for Prior Authorization Requests for Adult Long Term Home Health. Submit the PAR per the instructions listed at the bottom. Please include the Plan of Care and other supporting documentation.

For PAR Revisions:

Complete the **Revision** section at the top of the form only if revising a current approved PAR. The number of units should equal more/less the number of units planned for use during the PAR period. The number of units being requested needs to be added to the original number of units approved and include all services that were approved on the original PAR. Use one of the eight (8) lettered (A-H) dropdown fields found in the first few lines immediately following the last code in Column 9, the "Description" column when a Revision requires:

1) Additional lines of existing codes to indicate varying rates, units, etc.;
2) The inclusion of codes for a timeframe that used codes not listed on the existing form;
3) Change of Provider.

Complete the following required fields:

1. **Member Name:** Enter the member's name.
2. **Member ID:** Enter the member's Medical Assistance Program ID number.
3. **Birthdate:** Enter the member's date of birth.
4. **HCBS Eligible:** Check "yes," if member is currently enrolled in a waiver program. Check "no," if member is not currently enrolled in a waiver program or is on the wait-list for a waiver program (HCPF or DD).
5. **Requesting Provider #:** Enter the requesting provider's Medical Assistance Program provider number.
6. **Requesting Agency:** Enter requesting home health agency.
7. **Case Management Agency #:** Enter the Case Management Agency number.
8. **Dates Covered (From and Through):** Enter the PAR start date and PAR end date.
9. **Description:** List of approved procedure codes.
10. **Specify Frequency:** Enter visit frequency for home health service requested using daily/weekly, etc.
11. **# Units:** Enter the number of units next to the services for which reimbursement is being requested.
12. **Cost Per Unit:** Cost per unit automatically populates.
13. **Total $ Requested:** The total dollar amount requested for the service automatically populates.
14. **Total Units Authorized:** The Authorizing entity enters the total number of a units approved per the line.
15. **PAR Determination:** This box is completed by the designated review agency. Select the appropriate determination. Approved (A), Partially Approved (PA), Denied (D)
16. **Comments - Optional:** Enter any additional useful information. For PAR revisions, this is a required field and should include if a service is authorized for different dates than in Box 8, please include the procedure code and date span here.
17. **Total Requested Expenditures:** Total automatically populates.
18. **Number of Days Covered:** The number of days covered automatically populates.

19. Additional Information - Optional: Home Health Agencies may use this field to explain the reasons for requested frequency, duration, medical necessity, or by CMA to explain reasons for denial or approval of a reduced amount, as needed.

20. Case Manager Name: Enter the name of the Case Manager.
20A. Case Manager Signature: Case Manager signature.
21. Agency: Enter the name of the agency.
22. Phone #: Enter the phone number of the Case Manager.
23. Email: Enter the email address of the Case Manager.
24. Date: Enter the date completed.

"DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY". This is for Department use only.

Send only **New** and **Revised** PARs to:
Adult with DHS Waivers (DD, DHSS, SLS) → CCB
Adult with or without HCPF Waivers (BI, CMHS, EBD, PLWA, SCI) → CMA/SEP

Note: If submitted to the Department's Fiscal Agent, the following correspondence will not be returned to case managers, outreach will not be performed to fulfill the requests, and all such requests will be recycled: 1) Paper PAR forms that do not clearly identify the case management agency or have incorrect member information in the event the form(s) need to be returned and/or 2) PAR revision requests not submitted on Department approved PAR forms, including typed letters with revision instructions. Should questions arise about what Fiscal Agent staff can process, please contact the Home Health Policy Specialist.

PAR Form

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICT AND FINANCING

COLORADO
Department of Health Care Policy & Financing

Medical Assistance Program Prior Authorization

Adult Long Term Home Health

PA Number being revised:

Revision? ☐ Yes ☐ No

1. CLIENT NAME	2. CLIENT ID	3. BIRTHDATE	4. HCBS ELIGIBLE
			☐ Yes ☐ No

5. REQUESTING PROVIDER #	6. REQUESTING AGENCY	7. CASE MANAGEMENT AGENCY #	8. DATES COVERED	
			From:	Through:

STATEMENT OF REQUESTED SERVICES

9. Revenue Code/ Description	10. Specify Frequency	11. # Units	12. Cost Per Unit	13. Total $ Requested	14. Total Units Authorized	15. PAR Determination	16. Comments
551 RN/LPN			**$103.11**				
590 Uncomplicated Nursing Visit, 1			**$72.18**				
599 Uncomplicated Nursing Visit, 2+			**$50.52**				
571 Certified Nursing Assistant (CNA), Basic			**$36.67**				
579 Certified Nursing Assistant (CNA), Extended			**$10.97**				
A							
B							
C							
D							
E							
F							
G							
H							

17. TOTAL REQUESTED ADULT LONG TERM HOME HEALTH EXPENDITURES (SUM OF AMOUNTS IN COLUMN 13 ABOVE) **$0.00**

18. NUMBER OF DAYS COVERED (FROM FIELD 8 ABOVE)

19. ADDITIONAL INFORMATION:

CASE MANAGER USE

20. CASE MANAGER NAME	21. AGENCY	22. PHONE #	23. EMAIL	24. DATE
20A. CASE MANAGER SIGNATURE:				

DO NOT WRITE BELOW – AUTHORIZING AGENT USE ONLY

Revenue Coding

The following table identifies the only valid revenue codes for billing Home Health services to the Health First Colorado. Valid revenue codes are not always a Health First Colorado benefit. When valid non-benefit revenue codes are used, the claim must be completed according to the billing instructions for non-covered charges. Home Health providers billing on the UB-04 claim form for services provided to authorized members must use the appropriate condition code in form locators 18 through 28 (Condition Codes) and use the revenue codes listed below. Claims submitted with revenue codes that are not listed below are denied.

Home Health Revenue Codes

Service Type	Revenue Code		Unit Value
	Acute Home Health	Long Term Home Health	
Supplies (General)	0270		Non-covered benefit (Non-covered charges must be shown in both FL 47 and 48 of the claim form)
RN/LPN Standard Visit	0550	0551	One visit (not to exceed 2 ½ hours)
Uncomplicated Nursing (Visit 1)	n/a	0590	One Visit
Uncomplicated Nursing Visit (Visit 2+)	n/a	0599	One Visit
HHA BASIC	0570	0571	One hour
HHA Extended	0572	0579	For visits lasting more than one hour, extended units of 15-30 minutes
PT	0420	0421 (pediatric LTHH only)	One Visit (not to exceed 2 ½ hours)
OT	0430	0431 (pediatric LTHH only)	One visit (not to exceed 2 ½ hours)
S/LT	0440	0441 (pediatric LTHH only)	One visit (not to exceed 2 ½ hours)
Home health Telehealth Set-up Fee	0583 TG 98969 (proc)	0780 TG 98969 (proc)	Installation and member education of telehealth equipment (1 time only)
Home health Telehealth Daily Monitoring	0583 98969 (proc)	0780 98969 (proc)	One unit per day that telehealth monitoring is obtained (limit 31 units/ month)

Reimbursable Home Health Services

The licensed and certified Class A Home Care shall not utilize staff that has been excluded from participation in federally funded health care programs by the US Department of Health and Human

Services (HHS)/Office of Inspector General (OIG) and shall be in good standing with the Colorado Department of Regulatory Agencies (DORA) or other regulatory agency:

Registered Nurses (RN) and Licensed Practical Nurses (LPN) must have a current, active license in accordance with the DORA Colorado Nurse Practice Act at §12-38-111, C.R.S.

- Acute Home Health: All nursing services provided during the acute Home Health period shall be billed under revenue code 550. **No PAR is required.**
- Long-Term Home Health: Nursing services provided during Long-Term Home Health shall be billed using the appropriate revenue codes based on the purpose and complexity of the nursing visit. Standard, infrequent or complicated nursing visits may be billed using revenue code 551. Nursing visits that are uncomplicated in nature or visits that are uncomplicated with frequent revisits completed by the nurse shall be billed using revenue codes 590 and 599).
  - o Long-Term Home Health nursing visits for the **sole** purpose of assessing a member may be reimbursed for a limited time when managing, and reporting to the member's physician on specific conditions and/or symptoms which are not stable.

Certified Nurse Aides (CNA) must have a current, active license in accordance with the DORA Colorado Nurse Aide Practice Act at §12-38-111, C.R.S.

- Acute Home Health: Skilled certified nurse aide visits are reimbursed based on the amount of time the CNA is providing skilled care to a member. If a certified nurse aide provides care for at least 15 minutes but not more than 60 minutes, the agency shall bill a basic unit with revenue code 570. For each every additional 30 minutes the certified nurse aide provides hands-on assistance to the member the agency may bill an extended CNA unit with revenue code 572. A unit of time that is less than 15 minutes shall not be reimbursable as a basic unit and at least 15 minutes must elapse before an agency may bill an extended unit. No PAR is required.
- Long-Term Home Health: Skilled certified nurse aide visits are reimbursed based on the amount of time the CNA is providing skilled care to a member. If a certified nurse aide care for at least 15 minutes but not more than 60 minutes, the agency shall bill a basic unit with revenue code 571. For each every additional 30 minutes the certified nurse aide provides hands-on assistance to the member the agency may bill an extended CNA unit with revenue code 579. A unit of time that is less than 15 minutes shall not be reimbursable as a basic unit and at least 15 minutes must elapse before an agency may bill an extended unit.

Physical Therapists (PT) must have a current, active license in accordance with the Colorado Physical Therapy Practice Act at §12-41-107, C.R.S.

- Acute Home Health: All physical therapy services may be provided on pediatric and adult Home Health member and are billed using revenue code 420 on a per visit basis. No PAR is required.
- Long-Term Home Health: Physical therapy is available to pediatric members when prior authorized and deemed medically necessary. Physical therapy is reimbursed on a per visit basis using revenue code 421.

Occupational Therapists (OT) must have a current, active registration in accordance with the DORA Colorado Occupational Therapy Practice Act at §12-40.5-106, C.R.S.

- Acute Home Health: All occupational therapy services may be provided to all Health First Colorado Home Health members with a demonstrated need for speech therapy interventions. Occupational therapy services are reimbursed on per visit basis using revenue code 430. No PAR is required.
- Long-Term Home Health: Occupational therapy is available to pediatric members when prior authorized and deemed medically necessary. All Home Health speech therapy is reimbursed on a per visit basis using revenue code 431.

Speech/Language Pathologists (SLP) who have a current, active certification from the American Speech-Language-Hearing Association (ASHA).

- Acute Home Health: All speech therapy services may be provided to all Health First Colorado Home Health members with a demonstrated need for speech therapy interventions. Speech therapy services are reimbursed on per visit basis using revenue code 440. No PAR is required.
- Long-Term Home Health: Speech therapy is available to pediatric members when prior authorized and deemed medically necessary. All Home Health speech therapy is reimbursed on a per visit basis using revenue code 441.

Telehealth Services include the installation and on-going remote monitoring of clinical data through technologic equipment in order to detect minute changes in the member's clinical status that will allow Home Health agencies to intercede before a chronic illness exacerbates requiring emergency intervention or inpatient hospitalization.

- Acute Home Health: Agencies are reimbursed for the initial installation and education of telehealth monitoring equipment by billing revenue code 583 with the procedure code 98969. This initial charge shall only be billed once per member per agency. The agency may bill for every day they receive and review the member's clinical information by billing revenue code 583 along with procedure code 98969 and the modifier 'TG.' **No PAR is required prior to billing for acute telehealth services, but agencies should notify the Department or its designee when a member is enrolled in the service.**
- Long-Term Home Health: Agencies are reimbursed for the initial installation and education of telehealth monitoring equipment by billing revenue code 780 with the procedure code 98969. This initial charge shall only be billed once per member per agency. The agency may bill for every day they receive and review the member's clinical information by billing revenue code 780 along with procedure code 98969 and the modifier 'TG.' **No PAR is required prior to billing for acute telehealth services, but agencies should notify the Department or its designee when a member is enrolled in the service.**

Non-Reimbursable Home Health Services

- Supplies used for routine Home Health are not reimbursed separately through the Home Health or Durable Medical Equipment (DME) benefit. Non-routine or member specific supplies must be reimbursed through the member's DME benefit.
- Nursing Visits for purpose of psychiatric counseling
- Certified nurse aide visits for the purpose of providing only unskilled personal care and/or homemaking services.
- Nursing or CNA visits provided in a shift (visits lasting more than 4½ consecutive hours)
- Nursing visits for the sole purpose of providing supervision of the CNA or other Home Health staff
- Nursing visits for the sole purpose of completing the Home Health plan of care/recertification
- Long-Term Home Health nursing visits for the sole purpose of teaching the member or their family member
- Long-Term Home Health nursing visits for the **sole** purpose of assessing a stable member where management, and reporting to physician of specific conditions and/or symptoms which are not stable

Special Reimbursement Conditions for Home Health Services

- Acute Home Health services provided to Health First Colorado MCO members shall be prior authorized (if required) and reimbursed under Health First Colorado MCO rules.
- If a member is eligible for Medicare and Health First Colorado, Medicare is always the first payer when a member has skilled Home Health needs and the member is unable to leave their residence for non-medical programs and treatments (Homebound). **All Medicare requirements shall be met and exhausted prior to billing Health First Colorado for Home Health services, except when:**
    - Medication box pre-filling is the only service provided;
    - Certified Home Health Aide Services are the only services provided;
    - Occupational Therapy Services when provided as the sole skilled service;
    - Routine Laboratory Draw Services are the only service provided;
    - If the member is (1) stable, (2) not experiencing an acute episode, and (3) routinely leaves the home unassisted for social, recreational, educational and/or employment purposes (not Homebound)
        - Medicare & Medicaid may be billed simultaneously, if Medicare deems that the member is homebound based on the documentation provided the all Health First Colorado funds shall be repaid to Health First Colorado.
    - Any combination of a through e above.
    - The record contains clear and concise documentation describing any exceptions.
- Home Health services provided to members who are eligible for both Medicare & Medicaid or have another third party insurance & Health First Colorado must be billed to Medicare first. All insurance requirements must be met and exhausted prior to billing Home Health services to Health First Colorado.
    - A denial must be kept in the member's record and updated annually on the anniversary of the denial.
    - The third party insurance denials must be based on non-coverage and not due to the failure of adhering to the requirements set forth by the insurance agency.
    - Health First Colorado will not accept a "no-pay" denial (type of bill 320, condition code 21) from Medicare as a valid denial of Medicare coverage.
- The Home Health Agency must maintain a signed Advance Beneficiary Notice (ABN) that is completed as prescribed by Medicare.

Reimbursable Home Health Service Locations

The Home Health program reimburses for skilled nursing, skilled certified nurse aide, physical therapy, occupational therapy, and speech therapy services that are provided on an intermittent or per visit basis to Health First Colorado members in their place of residence.

Health First Colorado pediatric members may receive Home Health services outside of their place of residence when:

- The Home Health services can be provided safely and adequately in a location other than the member's residence;
- Home Health service and interventions will be at least equally effective in a location other than the member's residence;

- It is clinically appropriate for the Home Health services to be provided in a location other than the member's residence;
- It is not primarily for the convenience of the member, member's family, physician or other care provider;
- It is not provided in a group home, nursing facility, hospital or other facility; and
- It is not provided on public school grounds or as a part of an Individualized Education Program.

Other Billing Information:

- The Health First Colorado will reimburse two Home Health staff to care for a member when it is necessary to safely provide member care due to complexity of tasks, member weight, etc. and when it has been prior authorized.
- Member's Home Health Medical records must be retained by the agency for at least six (6) years unless State or Health First Colorado regulations require that the member's records be maintained for more than six (6) years.

Paper Claim Reference Table

The information in the following table provides instructions for completing form locators as they appear on the paper UB-04 claim form. Instructions for completing the UB-04 claim form are based on the current ***National Uniform Billing Committee (NUBC) UB-04 Reference Manual***. Unless otherwise noted, all data form locators on the UB-04 have the same attributes (specifications) for the Health First Colorado as those indicated in the ***NUBC UB-04 Reference Manual***.

All code values listed in the ***NUBC UB-04 Reference Manual*** for each form locator **may not** be used for submitting paper claims to the Health First Colorado. The appropriate code values listed in this manual must be used when billing the Health First Colorado.

The UB-04 Certification document (located after the Late Bill Override Date instructions and in the Provider Services Forms section) must be completed and attached to all claims submitted on the paper UB-04. Completed UB-04 paper Health First Colorado claims, including hardcopy Medicare claims, should be mailed to the correct fiscal agent address located in Appendix A in the Appendices of the Provider Services Billing Manuals section.

Do not submit "continuation" claims. Each claim form has a set number of billing lines available for completion. Do not crowd more lines on the form. Billing lines in excess of the designated number are not processed or acknowledged. Claims with more than one page, may be submitted through the Provider Web Portal.

The Paper Claim Reference Table below lists the required, optional and/or conditional form locators for submitting the paper UB-04 claim form to the Health First Colorado for home health claims.

Form Locator and Label	Completion Format	Instructions
1. Billing Provider Name, Address, Telephone Number	Text	Required Enter the provider or agency name and complete mailing address of the provider who is billing for the services: Street/Post Office box City State Zip Code Abbreviate the state in the address to the standard post office abbreviations. Enter the telephone number.
2. Pay-to Name, Address, City, State	Text	Required only if different from FL 1. Enter the provider or agency name and complete mailing address of the provider who will receive payment for the services: Street/Post Office box City State Zip Code Abbreviate the state in the address to the standard post office abbreviations.
3a. Patient Control Number	Up to 20 characters: Letters, numbers or hyphens	Optional Enter information that identifies the member or claim in the provider's billing system. Submitted information appears on the Remittance Advice.
3b. Medical Record Number	17 digits	Optional Enter the number assigned to the member to assist in retrieval of medical records.

Form Locator and Label	Completion Format	Instructions
4. Type of Bill	3 digits	Required **Home Health/Hospice** Use the following code range for Home Health/Hospice: Effective 3/1/2017 use 32X for Home Health/Private Duty Nursing services. 33X is no longer valid. (These instructions supersede all prior publications') Use 321-324 or 341-344 for Medicare crossover claims. Enter the three-digit number indicating the specific type of bill. The three-digit code requires one digit each in the following sequences (Type of facility, Bill classification, and Frequency): Digit 1 — Type of Facility 1 — Hospital 2 — Skilled Nursing 3 — Home Health Services 4 — Religious Non-Medical Health Care Institution 6 — Intermediate Care 7 — Clinic (Rural Health/FQHC/Dialysis Center) 8 — Special Facility (Hospice, RTCs)

Form Locator and Label	Completion Format	Instructions
4. Type of Bill (continued)	3 digits	Digit 2 — Bill Classification (Except clinics & special facilities): 1 Inpatient (Including Medicare Part A) 2 Inpatient (Medicare Part B only) 3 Outpatient 4 Other (for hospital referenced diagnostic services or home health not under a plan of treatment) 5 Intermediate Care Level I 6 Intermediate Care Level II 7 Sub-Acute Inpatient (revenue code 19X required with this bill type) 8 Swing Beds 9 Other Digit 2 — Bill Classification (Clinics Only): 1 Rural Health/FQHC 2 Hospital Based or Independent Renal Dialysis Center 3 Freestanding 4 Outpatient Rehabilitation Facility (ORF) 5 Comprehensive Outpatient Rehabilitation Facilities (COFRs) 6 Community Mental Health Center Digit 2 — Bill Classification (Special Facilities Only): 1 Hospice (Non-Hospital Based) 2 Hospice (Hospital Based) 3 Ambulatory Surgery Center 4 Freestanding Birthing Center 5 Critical Access Hospital 6 Residential Facility

Form Locator and Label	Completion Format	Instructions
4. Type of Bill (continued)	3 digits	Digit 3 / Frequency: 0 Non-Payment/Zero Claim 1 Admit through discharge claim 2 Interim - First claim 3 Interim - Continuous claim 4 Interim - Last claim 7 Replacement of prior claim 8 Void of prior claim
5. Federal Tax Number	None	Submitted information is not entered into the claim processing system.
6. Statement Covers Period – From/Through	From: 6 digits MMDDYY Through: 6 digits MMDDYY	Required **Home Health-Private Duty Nursing/Hospice** "From" date is the actual start date of services. "From" date cannot be prior to the start date reported on the initial prior authorization, if applicable, or is the first date of an interim bill. "Through" date is the actual discharge date, or final date of an interim bill. "From" and "Through" dates cannot exceed a calendar month (e.g., bill 01/15/10 thru 01/31/10 and 02/01/10 thru 02/15/10, not 01/15/10 thru 02/15/10). Match dates to the prior authorization if applicable. If member is admitted and discharged the same date, that date must appear in both fields. Detail dates of service must be within the "Statement Covers Period" dates.
8a. Patient Identifier		Submitted information is not entered into the claim processing system.
8b. Patient Name	Up to 25 characters: Letters & spaces	Required Enter the member's last name, first name and middle initial.

Form Locator and Label	Completion Format	Instructions
9a. Patient Address – Street	Characters Letters & numbers	Required Enter the member's street/post office box as determined at the time of admission.
9b. Patient Address – City	Text	Required Enter the member's city as determined at the time of admission.
9c. Patient Address – State	Text	Required Enter the member's state as determined at the time of admission.
9d. Patient Address – Zip	Digits	Required Enter the member's zip code as determined at the time of admission.
9e. Patient Address – Country Code	Text	Optional
10. Birthdate	8 digits (MMDDCCYY)	Required Enter the member's birthdate using two digits for the month, two digits for the date, and four digits for the year (MMDDCCYY format). Example: 01012009 for January 1, 2009.
11. Patient Sex	1 letter	Required Enter an M (male) or F (female) to indicate the member's sex.
12. Admission Date	6 digits	Required **Home Health/Hospice** Enter the date care originally started from any funding source (e.g., Medicare, Health First Colorado, Third Party Resource, etc.).
13. Admission Hour		Not Required
14. Admission Type		Not Required

Form Locator and Label	Completion Format	Instructions
15. Source of Admission		Required
16. Discharge Hour		Not Required
17. Patient Discharge Status	2 digits	Required **Home Health/Hospice** Enter member status as ongoing member (code 30) or as of discharge date. Agencies are limited to the following codes: 01 Discharged to Home 3 Discharged/Transferred to SNF 4 Discharged/Transferred to ICF 5 Discharged/Transferred to Another Type of Institution 6 Discharged/Transferred to organized Home Health Care Program (HCBS) 7 Left Against Medical Advice 20 Expired (Deceased - Not for Hospice use) 30 Still member (ongoing) 40 Expired at home 41 Expired in hospital, SNF, ICF, or free-standing hospice 42 Expired - place unknown 50 Hospice - Home 51 Hospice - Medical Facility
18-28. Condition Codes	2 Digits	Conditional Use condition code A1 to bill PDN hours greater than 16 for children
29. Accident State		Optional
31-34. Occurrence Code/Date	2 digits and 6 digits	Required Use occurrence code 52 and enter the Plan of Care start date. Enter the date using MMDDYY format.

Form Locator and Label	Completion Format	Instructions
35-36. Occurrence Span Code From/ Through	None	Leave Blank
38. Responsible Party Name/ Address	None	Leave blank

Form Locator and Label	Completion Format	Instructions
39-41. Value Code and Amount	2 characters and 9 digits	Conditional Enter appropriate codes and related dollar amounts to identify monetary data or number of days using whole numbers, necessary for the processing of this claim. Never enter negative amounts. Fields and codes must be in ascending order. If a value code is entered, a dollar amount or numeric value related to the code must always be entered. 01 Most common semiprivate rate (Accommodation Rate) 06 Medicare blood deductible 14 No fault including auto/other 15 Worker's Compensation 31 Member Liability Amount 32 Multiple Member Ambulance Transport 37 Pints of Blood Furnished 38 Blood Deductible Pints 40 New Coverage Not Implemented by HMO 45 Accident Hour Enter the hour when the accident occurred that necessitated medical treatment. Use the same coding used in FL 18 (Admission Hour). 49 Hematocrit Reading - EPO Related 58 Arterial Blood Gas (PO2/PA2) 68 EPO-Drug 80 Covered Days 81 Non-Covered Days Enter the amount paid by indicated payer: A3 Estimated Responsibility Payer A B3 Estimated Responsibility Payer B C3 Estimated Responsibility Payer C For Rancho Coma Score bill with appropriate diagnosis for head injury.

Form Locator and Label	Completion Format	Instructions
42. Revenue Code	4 digits	Required Enter the revenue code that identifies the specific accommodation or ancillary service provided. List revenue codes in ascending order. A revenue code must appear only once per date of service. If more than one of the same service is provided on the same day, combine the units and charges on one line accordingly. **Home Health** Enter the appropriate Revenue code. *Home health services cannot be provided to Nursing Facility residents.*
43. Revenue Code Description	Text	Required Enter the revenue code description or abbreviated description.
44. HCPCS/Rates/ HIPPS Rate Codes	5 digits	When billing HCPCS codes, the appropriate revenue code must also be billed.
45. Service Date	6 digits	Required Enter the date of service using MMDDYY format for each detail line completed.
46. Service Units	3 digits	Required Enter a unit value on each line completed. Use whole numbers only. Do not enter fractions or decimals and do not show a decimal point followed by a 0 to designate whole numbers (e.g., Do not enter 1.0 to signify one unit)

Form Locator and Label	Completion Format	Instructions
47. Total Charges	9 digits	Required Enter the total charge for each line item. Calculate the total charge as the number of units multiplied by the unit charge. Do not subtract Medicare or third party payments from line charge entries. Do not enter negative amounts. A grand total in line 23 is required for all charges.
48. Non-Covered Charges	Up to 9 digits	Conditional Enter incurred charges that are not payable by the Health First Colorado. Non-covered charges must be entered in both FL 47 (Total Charges) and FL 48 (Non-Covered Charges.) Each column requires a grand total.
50. Payer Name	1 letter and text	Required Enter the payment source code followed by name of each payer organization from which the provider might expect payment. At least one line must indicate The Health First Colorado. Source Payment Codes B Workmen's Compensation C Medicare D Health First Colorado E Other Federal Program F Insurance Company G Blue Cross, including Federal Employee Program H Other - Inpatient (Part B Only) I Other Line A Primary Payer Line B Secondary Payer Line C Tertiary Payer

Form Locator and Label	Completion Format	Instructions
51. Health Plan ID	8 digits	Required Enter the provider's Health Plan ID for each payer name. Enter the eight digit Health First Colorado provider number assigned to the **billing provider**. Payment is made to the enrolled provider or agency that is assigned this number.
52. Release of Information	N/A	Submitted information is not entered into the claim processing system.
53. Assignment of Benefits	N/A	Submitted information is not entered into the claim processing system.
54. Prior Payments	Up to 9 digits	Conditional Complete when there are Medicare or third party payments. Enter third party and/or Medicare payments.
55. Estimated Amount Due	Up to 9 digits	Conditional Complete when there are Medicare or third party payments. Enter the net amount due from The Health First Colorado after provider has received other third party, Medicare or member liability amounts. **Medicare Crossovers** Enter the sum of the Medicare coinsurance plus Medicare deductible less third party payments and member liability amounts.
56. National Provider Identifier (NPI)	10 digits	Required Enter the billing provider's 10-digit National Provider Identifier (NPI).
57. Other Provider ID		Optional Submitted information is not entered into the claim processing system.
58. Insured's Name	Up to 30 characters	Required Enter the member's name on the Health First Colorado line.

Form Locator and Label	Completion Format	Instructions
58. Insured's Name (continued)	Up to 30 characters	**Other Insurance/Medicare** Complete additional lines when there is third party coverage. Enter the policyholder's last name, first name, and middle initial.
60. Insured's Unique ID	Up to 20 characters	Required Enter the insured's unique identification number assigned by the payer organization. Include letter prefixes or suffixes.
61. Insurance Group Name	14 letters	Conditional Complete when there is third party coverage. Enter the name of the group or plan providing the insurance to the insured.
62. Insurance Group Number	17 digits	Conditional Complete when there is third party coverage. Enter the identification number, control number, or code assigned by the carrier or fund administrator identifying the group under which the individual is covered.
63. Treatment Authorization Code	Up to 18 characters	Conditional Complete when the service requires a PAR. Enter the PAR/authorization number in this field, if a PAR is required and has been approved for services.
64. Document Control Number		Conditional
65. Employer Name	Text	Conditional Complete when there is third party coverage. Enter the name of the employer that provides health care coverage for the individual identified in FL 58 (Insured Name).
66. Diagnosis Version Qualifier		Submitted information is not entered into the claim processing system. 0 ICD-10-CM (DOS 10/1/15 and after) 9 ICD-9-CM (DOS 9/30/15 and before)

Form Locator and Label	Completion Format	Instructions
67. Principal Diagnosis Code	Up to 6 digits	Required Enter the exact diagnosis code describing the principal diagnosis that exists at the time of admission or develops subsequently and affects the length of stay. Do not add extra zeros to the diagnosis code.
67A- 67Q. Other Diagnosis	6 digits	Optional Enter the exact diagnosis code corresponding to additional conditions that co-exist at the time of admission or develop subsequently and which effect the treatment received or the length of stay. Do not add extra zeros to the diagnosis code.
69. Admitting Diagnosis Code	6 digits	Not Required Enter the diagnosis code as stated by the physician at the time of admission.
70. Patient Reason Diagnosis		Submitted information is not entered into the claim processing system.
71. PPS Code		Submitted information is not entered into the claim processing system.
72. External Cause of Injury Code (E-code)	6 digits	Optional Enter the diagnosis code for the external cause of an injury, poisoning, or adverse effect. This code must begin with an "E".
74. Principal Procedure Code/ Date	N/A	Not Required
74A. Other Procedure Code/Date	N/A	Not Required

Form Locator and Label	Completion Format	Instructions
76. Attending **NPI – Required**	10 digits	Health First Colorado ID Required NPI - Enter the 10-digit NPI number assigned to the physician having primary responsibility for the member's medical care and treatment. This number is obtained from the physician, and cannot be a clinic or group number. (If the attending physician is not enrolled in the Health First Colorado or if the member leaves the ER before being seen by a physician, the hospital may enter their individual numbers.) Hospitals may enter the member's regular physician's 10-digit NPI in the Attending Physician ID form locator if the locum tenens physician is not enrolled in the Health First Colorado. QUAL – Enter "1D" for Medicaid Enter the attending physician's last and first name. This form locator must be completed for all services.
77. Operating- NPI		Optional Submitted information is not entered into the claim processing system.
78-79. Other ID **NPI – Conditional** **l**	NPI - 10 digits	Conditional – Complete when attending physician is not the PCP or to identify additional physicians. Ordering, Prescribing, or Referring NPI - when applicable NPI - Enter up to two 10-digit NPI numbers, when applicable. This form locator identifies physicians other than the attending physician. If the attending physician is not the PCP or if a clinic is a PCP agent, enter the PCP NPI number as the referring physician. The name of the Health First Colorado member's PCP appears on the eligibility verification. Review either for eligibility and PCP. The Health First Colorado does not require that the PCP number appear more than once on each claim submitted. The attending physician's last and first name are optional.
80. Remarks	Text	Enter specific additional information necessary to process the claim or fulfill reporting requirements.

Form Locator and Label	Completion Format	Instructions
81. Code-Code-QUAL/CODE/VALUE (a-d)		Submitted information is not entered into the claim processing system.

Home Health Claim Example

Home Health Agency
100 Saginaw Street
Anytown, CO 80201
303-333-3333

Type of Bill: 323

Statement Covers Period: From 10/01/2016 Through 10/21/2016

Patient Name: Client, Ima D.

Patient Address: 123 Main Street, Anytown, CO 88888

Birthdate: 02/13/1948 | Sex: F | Admission Date: 10/01/2016 | Src: 01 | Stat: 30 | Condition Code: Z1

Occurrence Code: 27 | Date: 10/01/2016

Value Code	Amount
A2	60.00
A3	240.00

Rev. Cd.	Description	Serv. Date	Serv. Units	Total Charges
551	Skilled Nursing	10/01/16	1	60.00
551	Skilled Nursing	10/11/16	1	60.00
551	Skilled Nursing	10/21/16	1	60.00
551	Skilled Nursing	10/23/16	1	60.00
551	Skilled Nursing	10/25/16	1	60.00
551	Skilled Nursing	10/27/16	1	60.00
571	Aid/Home Health Visit	10/08/16	1	32.00
571	Aid/Home Health Visit	10/10/16	1	32.00
571	Aid/Home Health Visit	10/15/16	1	32.00
571	Aid/Home Health Visit	10/18/16	1	32.00
571	Aid/Home Health Visit	10/20/16	1	32.00

PAGE 1 OF 1 CREATION DATE TOTALS 520.00

Payer Name: D-Medicaid | Health Plan ID: 1234567890

Insured's Name: Client, Ima D. | Insured's Unique ID: A123456

Diagnosis: E119

0

Attending NPI: 1234567890 | Last: Provider | First: Ima

Home Health Crossover Claim Example

Home Health Agency
100 Saginaw Street
Anytown, CO 80201
303-333-3333

321

10/01/2016 10/21/2016

Client, Ima D. | 123 Main Street | Anytown | CO | 88888

02/13/1948 | F | 10/01/2016 | 01 | 30 | Z1

27 10/01/2016

a	A2	60.00				
b	A3	240.00				
c						
d						

551	Skilled Nursing		10/01/16	1	60.00	
551	Skilled Nursing		10/11/16	3	180.00	
551	Skilled Nursing		10/21/16	1	60.00	

PAGE 1 OF 1 CREATION DATE TOTALS 520.00

D Medicaid | 1234567890

Client, Ima D. | A123456

E119

1234567890 | Provider | Ima

NUBC

Note: Medicare crossover claims are valid only with Medicare claims for visits rather than episodes. LUPA payments not episode case mix payment.

COLORADO
Department of Health Care Policy & Financing

Health First Colorado

Institutional Provider Certification

This is to certify that the foregoing information is true, accurate and complete.

This is to certify that I understand that payment of this claim will be from Federal and State funds and that any falsification, or concealment of material fact, may be prosecuted under Federal and State Laws.

*Signature:*_____ *Date:*_____

This document is an addendum to the UB-04 claim form and is required per 42 C.F.R. 445.18 (a)(1-2) to be attached to paper claims submitted on the UB-04.

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 a fine and imprisonment under state and/or federal law.

Home Health Billing Information Revisions Log

Revision Date	Additions/Changes	Pages	Made by
12/01/2016	*Manual revised for interChange implementation. Form annual 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, 16, 20, 25*	*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)*
3/8/2017	*Removed the 4 bullet items in the right column of row 44.*	*6*	*RC*
3/13/2017	*Updated the Type of Bill section in the Paper Claims Table to reflect the NUBC manual*	*16*	*RC*
3/14/2017	*Updated the type of bill in the paper claim examples*	*30, 31*	*RC*
3/15/2017	*Updated Source of admission (Row 15) is Not Required*	*20*	*AK*
5/26/2017	*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.*