Beginner Billing Training: Institutional Claims (UB-04)

Health First Colorado

(Colorado's Medicaid Program)

Navigating This Presentation

- Underlined words or phrases often will link viewers to more information, such as web pages. If you are viewing this presentation in normal mode (not slideshow mode), you may need to press the Ctrl key while you click on the link in order to open it.
- Use color-coded table of contents slides to navigate to specific areas of interest in the presentation.
  - Use back arrows provided in the bottom right corner of some slides to return to table of contents slides.

Institutional Claim - Who Completes It?

- Dialysis Centers
- Federally Qualified Health Centers
- Home Health
- Hospice
- Indian Health Services
- Inpatient / Outpatient Hospital
- Nursing Facility
- Private Duty Nursing
- Psychiatric Residential Treatment Facilities
- Rural Health Clinics

Home Health vs. HCBS

- Home Health Care: Provider type 10, skilled care delivered directly to a patient's home. This type of care is provided by licensed medical professionals including nurses, therapists, and aides for the purpose of *treating* or *managing* an **illness**, **injury** or **medical condition**. Uses form UB-04 for institutional claims.
- Home Services (HCBS): Provider type 36, professional support services that allow a person to live independently and safely in their home. HCBS is only for members with that specific benefit plan. *It is not open to all members*. Uses form CMS 1500 for professional claims.
  - Help with daily activities such as dressing and bathing
  - Assistance with managing routine tasks around the house
  - Companionship
  - Non-medical transportation

Training Overview

Program Overview

Department Website

Provider Enrollment

Member Eligibility

Prior Authorizations

Billing and Payment

Resources

Claim Submission

Program Overview

COLORADO
Department of Health Care
Policy & Financing

Fiscal Agent

Colorado interChange system interacts with the Provider Web Portal

Health First Colorado/CHP+ Providers

Department Website

Department of Health Care Policy & Financing

Website

https://hcpf.colorado.gov

1

hcpf.colorado.gov

COLORADO
Department of Health Care
Policy & Financing

2

For Our Providers

For Our Members | For Our Providers | For Our Stakeholders | About Us

We administer Health First Colorado (Colorado's Medicaid program), Child Health Plan *Plus*, and other health care programs.

Apply Now | Explore Programs | Find a Doctor | Get Help

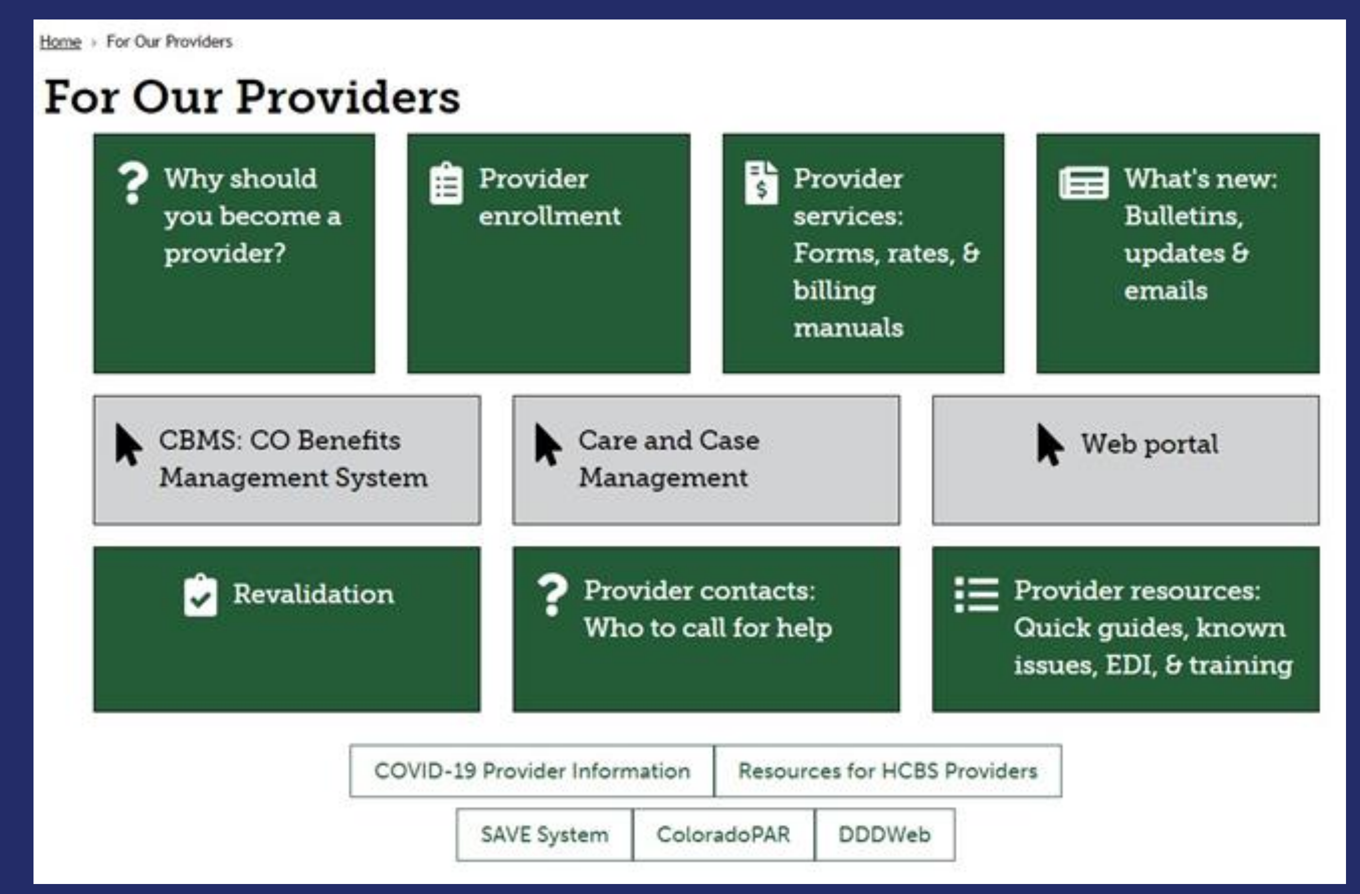
Health First COLORADO
Colorado's Medicaid Program

We can #KeepCOCovered

For Our Providers Home Page

Access to billing manuals, fee schedules, enrollment, revalidation, the Provider Web Portal, contacts and resources like Quick Guides

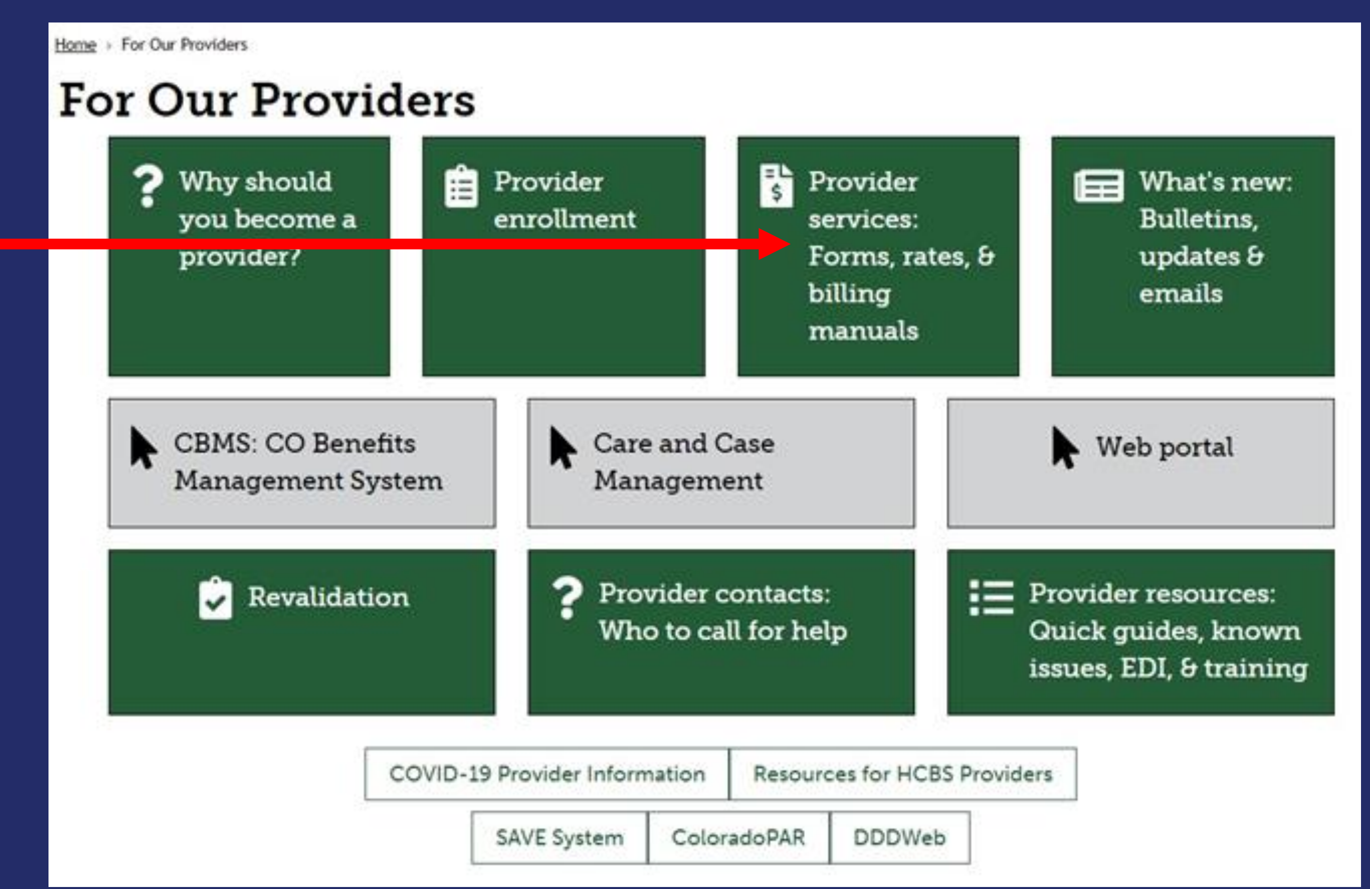
Contains important information regarding Health First Colorado (Colorado's Medicaid program) & other topics of interest to providers and billing professionals



Provider Services

Forms, fee schedules and billing manuals can be found on the Provider Services web page

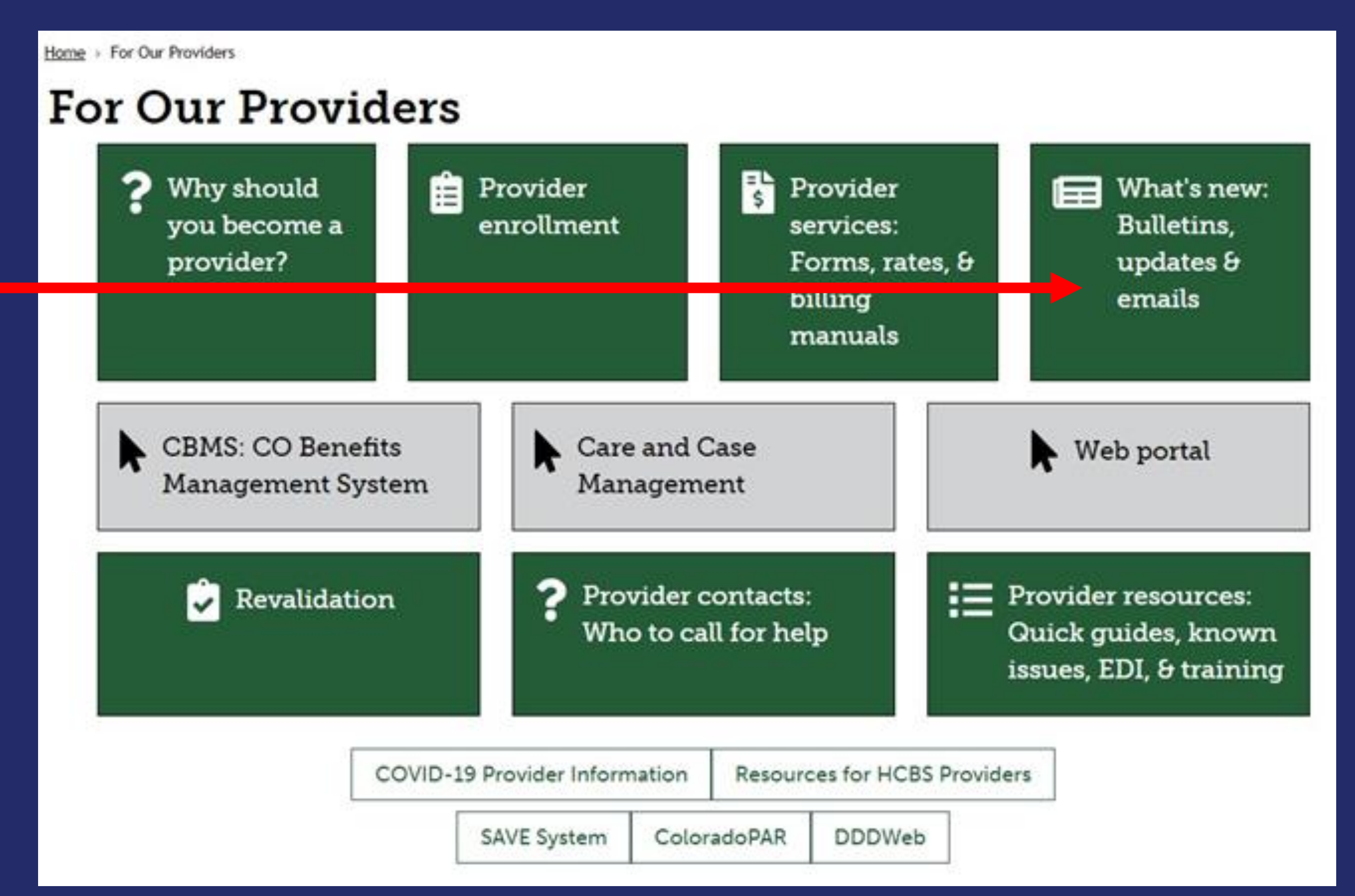
The General Provider Information manual is an overview of the program, including billing and policy information



What’s New: Bulletins, Updates & Emails

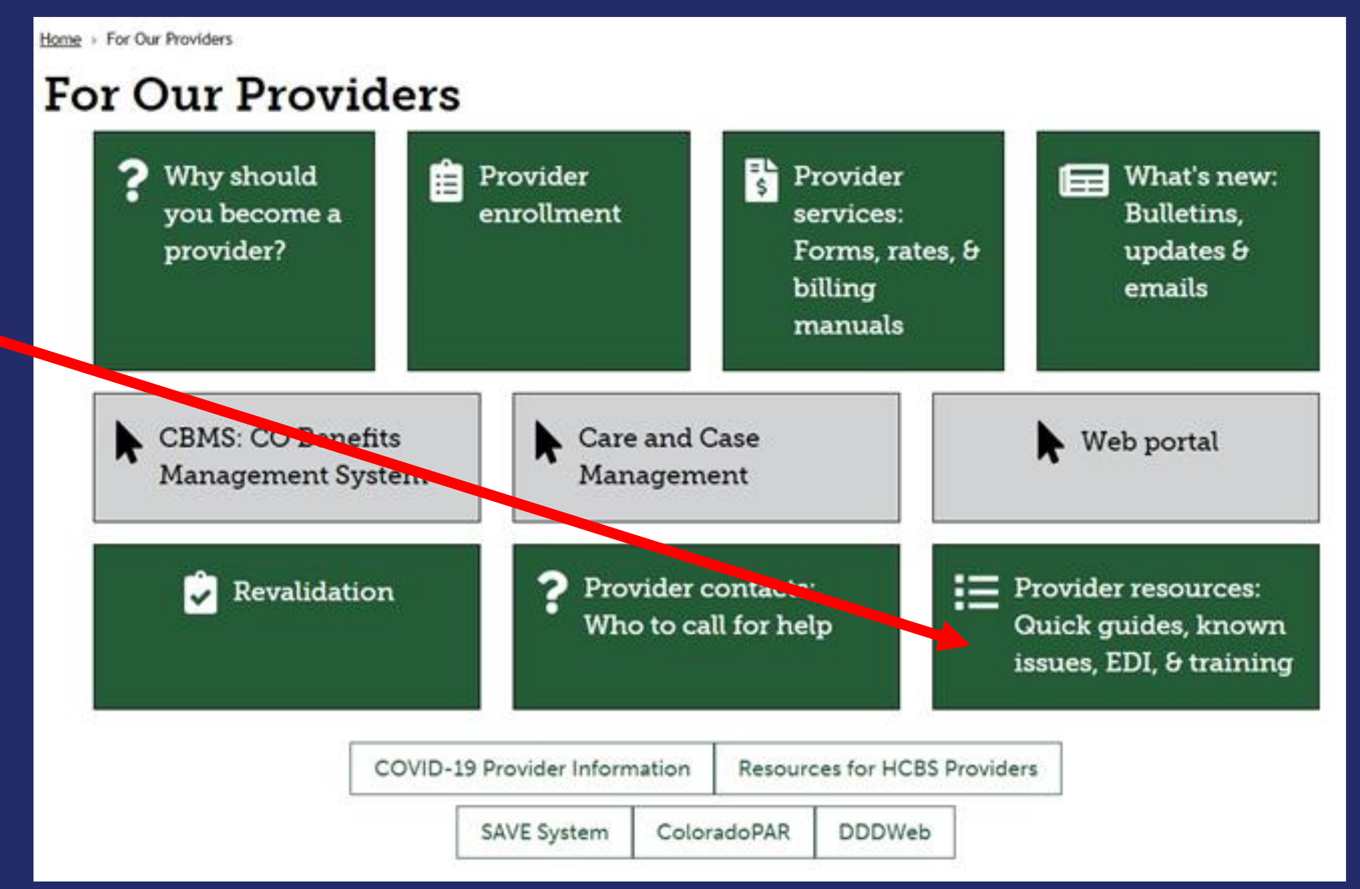
Sign up for publications

Weekly newsletters and monthly bulletins



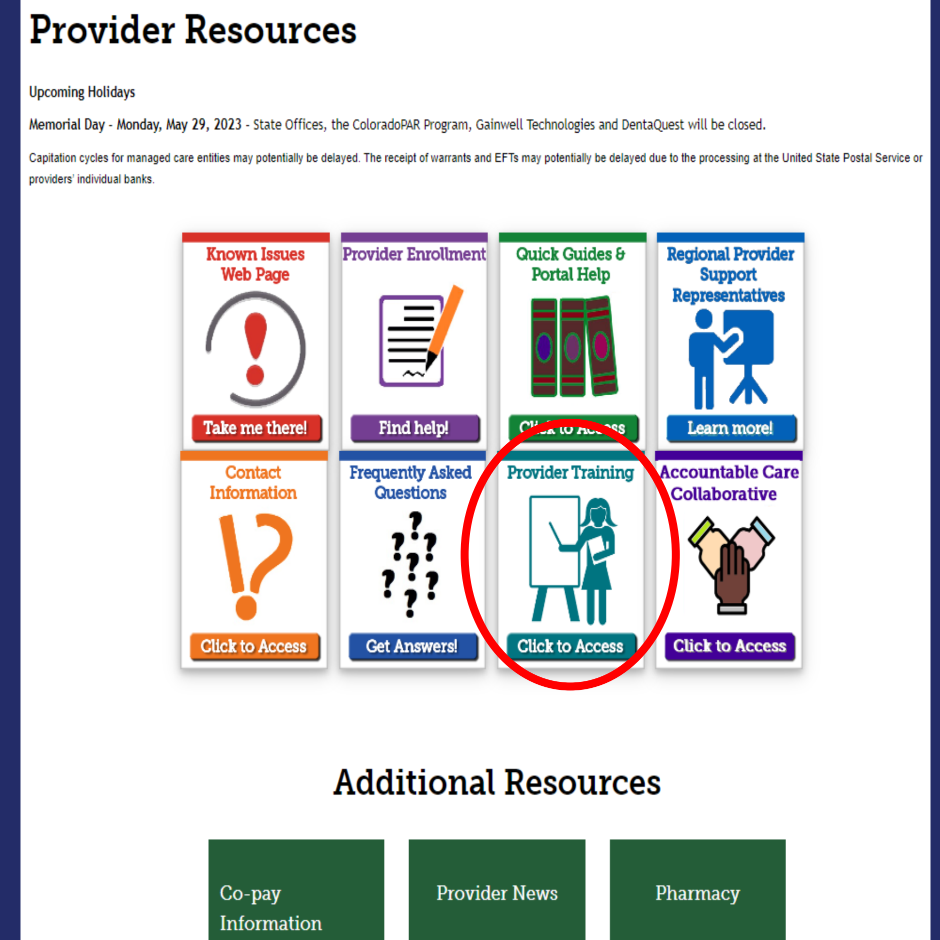
Provider Resources

Provider Web Portal Quick Guides, Electronic Data Information (EDI) for batch billing information, training presentations, field representatives and more



COLORADO
Department of Health Care Policy & Financing

Provider Training



Billing Training - Schedule and Signup

Sign up for live webinar training sessions below.

Note: Trainings may end prior to 11:30 a.m. MT. Time has been allotted for questions at the end of each session.

November 2023 Training Schedule						
Sunday	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
			1	2 Beginner Billing Training: Professional Claims (CMS 1500) - Thursday, November 2, 2023, 9:00 a.m.-11:30 a.m. MT	3	4
5	6	7	8	9 Beginner Billing Training: Institutional Claims (UB-04) - Thursday, November 9, 2023, 9:00 a.m.-11:30 a.m. MT	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

December 2023 Training Schedule						
Sunday	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
					1	2
3	4	5	6	7 Beginner Billing Training: Professional Claims (CMS 1500) - Thursday, December 7, 2023, 9:00 a.m. - 11:30 a.m. MT	8	9
10	11	12	13	14 Beginner Billing Training: Institutional Claims (UB-04) - Thursday, December 14, 2023, 9:00 a.m. - 11:30 a.m. MT	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

Billing Training - Resources

Provider Enrollment

Provider Enrollment

Website

Question:

Who enrolls providers?

Answer:

Gainwell Technologies enrolls providers, not members, for Health First Colorado.

** Some applications require final state approval.*

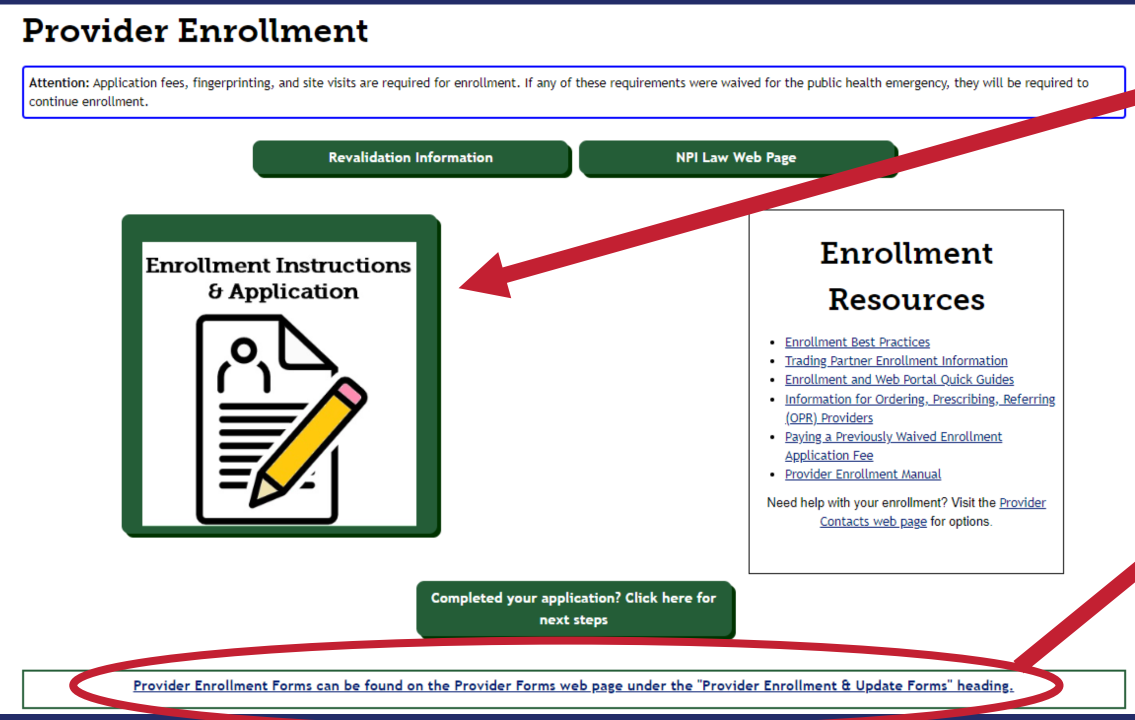
Question:

Who needs to enroll?

Answer:

Everyone who provides services for Health First Colorado members, including Ordering, Prescribing and Referring (OPR) providers

Provider Enrollment



- To prepare for enrollment as a new provider, go to the Provider Enrollment web page and click the Enrollment Instructions & Application button.
- There is a list of resources, as well as forms, for enrolling providers.

Provider Enrollment & Update Forms

- Affidavit of Lawful Presence
- Attestation Form for Facilities Enrolling with Health First Colorado - RCCF/QRTP
- Backdate Enrollment Form - **Do not** submit any attachment with this form (such as a claim form). **Note:** The backdate form is only for fee-for-service billing. CHP+ and behavioral health providers need to contact their MCO/RAE to determine rules as they may have different restrictions.
- Behavioral Therapy Provider Attestation Form
- Change of Ownership (CHOW) Form
- Disclosure Instructions EIN
- Disclosure Instructions SSN
- Electronic Visit Verification Attestation Form
- Legal Name Change Form - **Do not** mail to Gainwell Technologies. Follow instructions on the form to submit via the Provider Web Portal.
- National Provider Identifier (NPI) Backdate Form - **Do not** mail to Gainwell Technologies. Follow instructions on the form to submit via the Provider Web Portal.
- Network Participation Verification Form - Instead of uploading a copy of the entire contract, providers can complete and upload this form to the *Attachments and Fees* page of the Online Provider Enrollment tool.
- Provider Application Fee Refund Request Form
- Provider Participation Agreement - Can only be signed from within the Online Provider Enrollment tool.
- Provider Participation Agreement - Effective March 1, 2023 - Can only be signed from within the Online Provider Enrollment tool.
- EFT Exemption Instructions - Used only for Case Managers, Out of State providers, and Colorado State Government Entities.
- RN Supervision Form
- W9 - Required for Taxpayer Identification Number (TIN) verification.

Visit the Provider Enrollment web page for more provider enrollment instructions and information.

Provider Types

- Enrollees will need to pick the appropriate provider type based on the services rendered before starting the application.
  - A provider type is a two-digit number that indicates what type of provider is billing
  - Provider types can be found on the Find Your Provider Type web page
  - Providers can be individuals, organizations and vendors

- Providers will be assigned an 8- to 10-digit Health First Colorado Provider ID when the enrollment is approved.

Licensure

- Some providers must obtain licensing through the Colorado Department of Public Health and Environment (CDPHE).
- All providers, including those who obtain licensure through CDPHE, must enroll with Health First Colorado in order to provide and bill for services. CDPHE and the Colorado interChange system do not share information so any changes a provider makes with one entity must be made with the other.
- The Colorado interChange does take in information from the Department of Regulatory Agencies (DORA) to update licenses. Providers are encouraged to ensure the name and all demographic information matches so the licenses can be automatically updated.

CDPHE
COLORADO
Department of Public Health & Environment

Dora
Department of Regulatory Agencies
Division of Insurance

Enrolled Providers

- Enrolled providers are encouraged to review the Provider Enrollment web page often as there are updates, frequently asked questions and information on revalidation.

Provider Enrollment

ATTENTION: The state has imposed a moratorium on new enrollments for Non-Emergent Medical Transportation (NEMT) due to a significant potential for fraud, waste, or abuse to the Medicaid program. The moratorium will be in place for a minimum of 6 months and may extend beyond that. Additional information will be announced as it becomes available.

ATTENTION: Providers that do not complete the revalidation process by their revalidation due date will be subject to claim denials or disenrollment. Providers can locate their new revalidation date on the revalidation spreadsheet located on the Revalidation web page under the Revalidation Resources section.

ATTENTION: Application fees, fingerprinting, and site visits are required for enrollment. If any of these requirements were waived for the public health emergency, they will be required to continue enrollment.

Revalidation Information

NPI Law Web Page

Revalidation

- All Health First Colorado and Child Health Plan *Plus* (CHP+) providers must revalidate in the program at least every five (5) years to continue as a provider.
- **Providers who do not complete the revalidation process by their revalidation due date will be subject to claim denials and disenrollment.**
- A spreadsheet with providers' revalidation dates can be found on the Department's Revalidation web page.
- Each provider will be notified via email six (6) months in advance of their revalidation deadline. The deadline is based on the date the enrollment application was approved.

Revalidation Resources

- Provider Revalidation Manual
- Revalidation/NPI Law Fact Sheet
- Revalidation Quick Guide
- Provider Revalidation Dates Spreadsheet (updated 10/02/2023)
- Revalidation Information by Provider Type
- Revalidation Information for HCBS Providers

Revalidation Newsletters

- Provider News & Resources - Revalidation Special Newsletter - 09-29-2023

National Provider Identifier (NPI)

- A National Provider Identifier (NPI) is a unique 10-digit identification number issued to U.S. health care providers by the Centers for Medicare and Medicaid Services (CMS).
  - All providers except for some Home and Community-Based Services (HCBS) require an NPI for billing transactions. If you are unsure, please check the Find Your Provider Type web page. If an organization is not required to have an NPI, it will use its Health First Colorado Provider ID in all billing transactions.
  - Providers who bill Medicare need to ensure each NPI for Health First Colorado is also enrolled with Medicare.

Individual Providers (Individuals within a Group, Billing Individuals or Ordering/Prescribing/Referring)	**Organizational Providers** (Groups, Facilities)
• NPI is permanent regardless of rendering provider location or affiliation • Only one NPI and one Health First Colorado ID is needed	• Need to use a unique NPI for each service location and provider type enrolled in the Colorado interChange

National Provider Identifier (NPI)

- How to obtain and learn additional information
  - Centers for Medicare and Medicaid Services (CMS) web page
  - National Plan and Provider Enumeration System (NPPES) website
    - 1-800-456-3203
    - 1-800-692-2326 TTY

Member Eligibility

Member Eligibility

[Verifying Member Eligibility]

[Viewing Member Information]

[Health First Colorado Member ID Cards]

[Eligibility Types]

[Managed Care]

[Medicare]

[Third Party Liability]

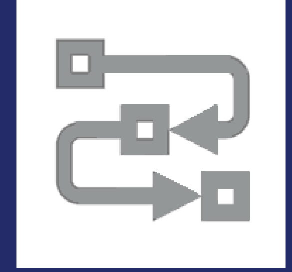
[Co-Pay]

Verifying Member Eligibility

- Member's eligibility must be checked on each date of service.
  - Facilities that bill monthly: Eligibility extends through end of the month. It is recommended that providers check eligibility on the first of each month.
- Ways to verify eligibility:

Provider Web Portal

Virtual Agent
1-844-235-2387



Batch 270

Log In to View Member Information

Provider Web Portal

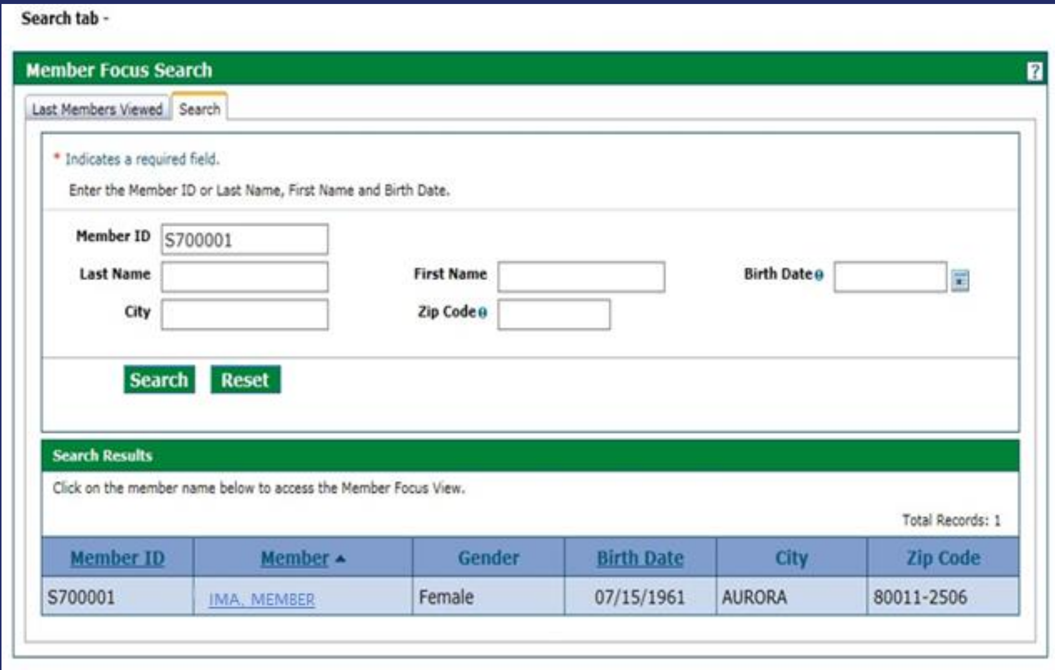
Providers with multiple locations should ensure that the correct location is being used. Having the incorrect location can impact whether a claim will adjudicate—or process a decision—correctly.

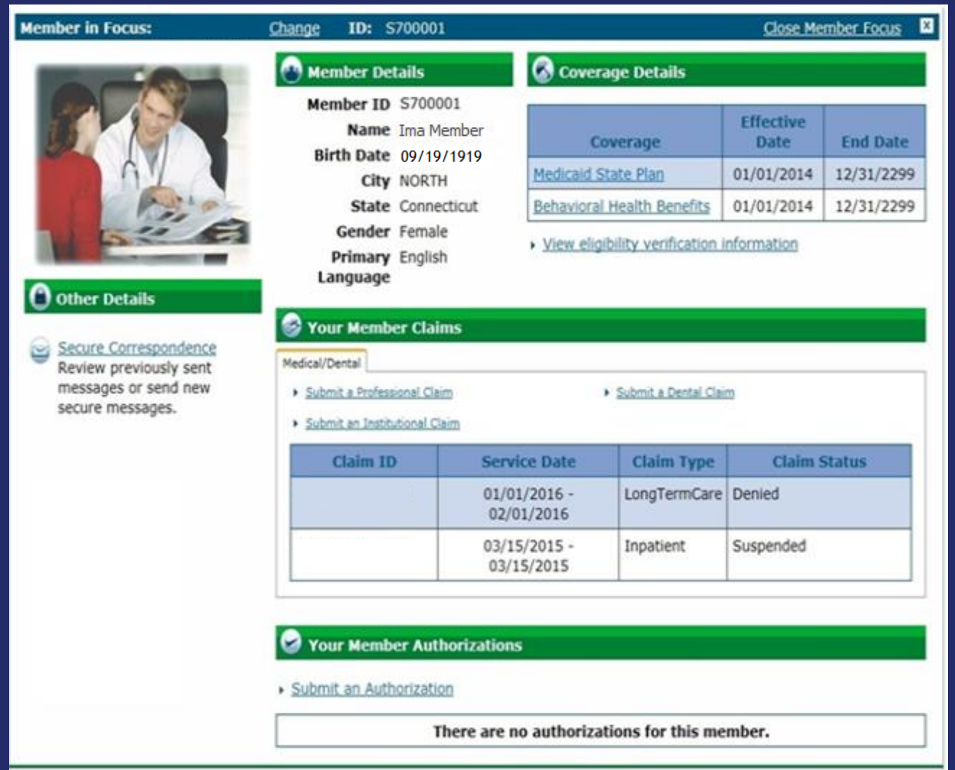
Providers with separate National Provider Identification (NPI) numbers are encouraged to verify their NPI before moving past this home page screen.

Viewing Member Information

Provider Web Portal

"CAPTCHA" verification is required to ensure the provider is not a robot. On the Search tab, enter the Member ID or Last Name, First Name and Birthdate.





This search will display the Member in Focus page which provides Member Details, Coverage Details and Member Claims and Authorizations.

Health First Colorado Identification Cards

- This page shows two older branded cards that are still valid.
- Identification card does not guarantee eligibility.
- Only the front is shown below.

Sample A Sample
A123456

Department of Health Care
Policy and Financing

Present this card every time you receive medical services.

Questions?

- Call Customer Service at 303-866-3513 within Metro Denver or 1-800-221-3943 outside Metro Denver, Monday - Friday, 8 - 5, excluding holidays.
- Call 1-800-QUIT.NOW (1-800-784-8669) for help to quit smoking.
- **Call 1-800-283-3221 (24 Hour Nurse Advice Line) for help deciding what to do when you are sick and cannot call your doctor or other health provider.**

In a life threatening emergency, dial 911 or go to the nearest emergency room.
This card does not guarantee eligibility or payment for services

Providers:

- Verify the identity and eligibility of the cardholder.
- Request prior authorization when pre-approval of services is required.

Member name: FirstName LastName
Member ID #: ########

- Talk to a nurse anytime at 1-800-283-3221. Dial 911 or go to the ER in a life threatening emergency.
- View coverage and co-payment info or find a provider:
  - Colorado.gov/HCPF
  - PEAK*Health* mobile app
  - Call 1-800-221-3943 or State Replay 711, M-F, 7:30am-5:15pm
- Keep your coverage and info current:
  - Colorado.gov/PEAK
  - PEAK*Health* mobile app
- Bring a photo ID when you go to your provider or pharmacy.

Providers: This card does not guarantee eligibility or payment for services. You must verify identity and eligibility before providing services.

Health First Colorado Identification Cards

- This page depicts newer branded cards in English and Spanish.
- Identification card does not guarantee eligibility.
- Only the front is shown below.

Member ID: Z999999

Name: Ima Member

Your PCP is available to help.

Primary Care Provider (PCP): (303) 555-1212

HEALTH COLORADO, INC. RAE 4

Emergencies or medical advice

If you aren't sure if it's an emergency, call your PCP or the Nurse Advice Line. If it's an emergency, call 911 or go to the emergency room.

24/7 Nurse Advice Line: 800-283-3221

24/7 Mental health crisis: 844-493-TALK (8255)

ColoradoCrisisServices.org text TALK to 38255

If you need help getting an appointment call 1-888-502-4185.

See if you're active on the PEAK*Health* App

ID de miembro: Z999999

Nombre: Ima Member

Su PCP está a su disposición para ayudarle.

Médico de cabecera (Proveedor de atención primaria o PCP): 303-555-1212

DENTAQUEST USA

Emergencias o asesoramiento médico

Si no está seguro de si se trata de una emergencia, llame a su PCP o a la Línea de asesoramiento de enfermería. Si es una emergencia, llame al 911 o vaya al servicio de emergencias.

Línea de asesoramiento de enfermería las 24 horas del día, los siete días de la semana: 800-283-3221

Crisis de salud mental las 24 horas del día, los siete días de la semana: 844-493-TALK (8255)

ColoradoCrisisServices.org envíe TALK al 38255

Si necesita ayuda para hacer una cita, llame al 1-855-384-7926.

Consulte si está activo en la aplicación PEAK*Health*

COLORADO
Department of Health Care Policy & Financing

Eligibility Types

- Most members: Health First Colorado benefits (Title XIX)
- Some members have different eligibility types:
  - Old Age Pension, state only
  - Non-Citizens (individuals without documentation)
  - Presumptive Eligibility
  - Managed Care
- Some members have additional benefits:
  - Medicare
  - Third-party commercial insurance

Eligibility Types

Old Age Pension (OAP) - State Only

- Members are not eligible for Title XIX due to income.
- Claims will have reduced reimbursement amounts since the program only gets state funds and no federal match.
- Providers cannot bill the member for the difference between the billed amount and the reimbursement amount.
- Does not cover:
  - Home and Community-Based Services (HCBS)
  - Inpatient, psychiatric or nursing facility services

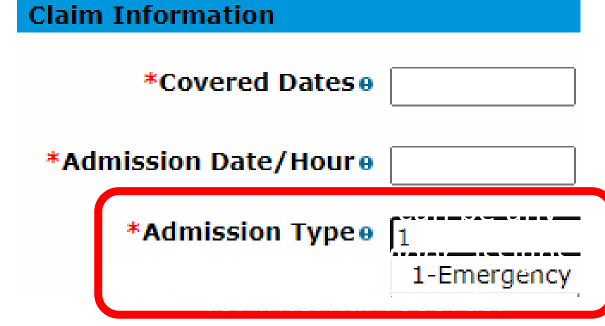
Eligibility Types

Family Planning and Non-Citizens

- Family Planning Expansion
  - Applies to individuals with a higher income than the standard Medicaid limit (between 133%-260% of the federal poverty level [FPL])
  - Covers up to a 12-month supply of contraceptives
  - Family planning coverage for non-citizens available from July 1, 2022
- Non-Citizen Emergency Medicaid Services (EMS)
  - Eligibility type only covers emergency services, including labor and delivery
  - Claim must indicate emergency
  - Emergency services must be certified in writing by the provider and kept on file, but does not need to be submitted with the claim

Who Defines an Emergency?

- The provider determines whether the service is considered an emergency and marks the claim appropriately by writing a “1” in box 14 for Admission Type on the UB-04 paper claim or typing “1” for the Admission Type on the first screen in the Provider Web Portal.
- Health First Colorado does not determine emergency status based on diagnosis or procedure codes used on the claim. The box must be checked to indicate emergency.
- Examples of an emergency are:
  - Active labor and delivery
  - Sudden, urgent occurrences requiring immediate action
  - Acute symptoms of sufficient severity and severe pain in which the absence of medical attention might result in serious impairment to bodily functions and/or dysfunction of any bodily organ or part



Eligibility Types

Child Health Plan *Plus* (CHP+)

- Members that are determined to be eligible are later assigned to one of the four CHP+ Managed Care Organizations (MCOs): Colorado Access, Denver Health, Kaiser Permanente or Rocky Mountain Health Plans.
  - Services must be billed as fee-for-service to the Fiscal Agent, Gainwell Technologies, or Magellan for pharmacy services if there is an interim period between the eligibility determination and the MCO assignment
  - Services provided after MCO assignment must be submitted to the MCO
- Providers should contact the MCO for further benefit details once a member is assigned. Benefits through CHP+ may vary from the Title 19 (Medicaid) benefit plan.
  - Applied Behavior Analysis (ABA) therapy is not covered by CHP+
  - Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is not covered by CHP+
  - CHP+ does not divide behavioral health from other services

Eligibility Types

Presumptive Eligibility

- Temporary coverage of Health First Colorado or Child Health Plan *Plus* (CHP+) services until eligibility is determined
- Presumptive Eligibility (PE) is only available to:

Population	Eligibility	Covered Benefits
Child or pregnant person that meets Health First Colorado PE requirements	Health First Colorado Eligibility Criteria	All Health First Colorado benefits: includes labor and delivery, excludes inpatient (hospital) care
Child or pregnant person that meets CHP+ PE requirements	CHP+ Eligibility Criteria	All CHP+ benefits excluding dental services
Family Planning Limited (FAMPL) Benefit	FAMPL Eligibility Criteria	Birth control, STI testing and treatment, Cervical cancer screening and prevention, Related counseling and preventative services
Breast and Cervical Cancer Program (BCCP)	BCCP Eligibility Criteria	All Health First Colorado benefits

Managed Care

Program of All-Inclusive Care for the Elderly (PACE)

Managed Care Organizations (MCOs)

- Rocky Mountain Health Plans
- Denver Health

Managed Care Options

Regional Accountable Entity (RAE)

Managed Care

Managed Care Organizations (MCOs)

- Some services are not included in the managed care contract for Rocky Mountain Health Plans or Denver Health.
  - Those fee-for-service claims can be billed directly to the Fiscal Agent (Gainwell Technologies)

Example:

  - Denver Health does not pay for hospice. Hospice claims for a member with Denver Health enrollment would be billed directly to Gainwell Technologies.

Managed Care

Regional Accountable Entity (RAE)

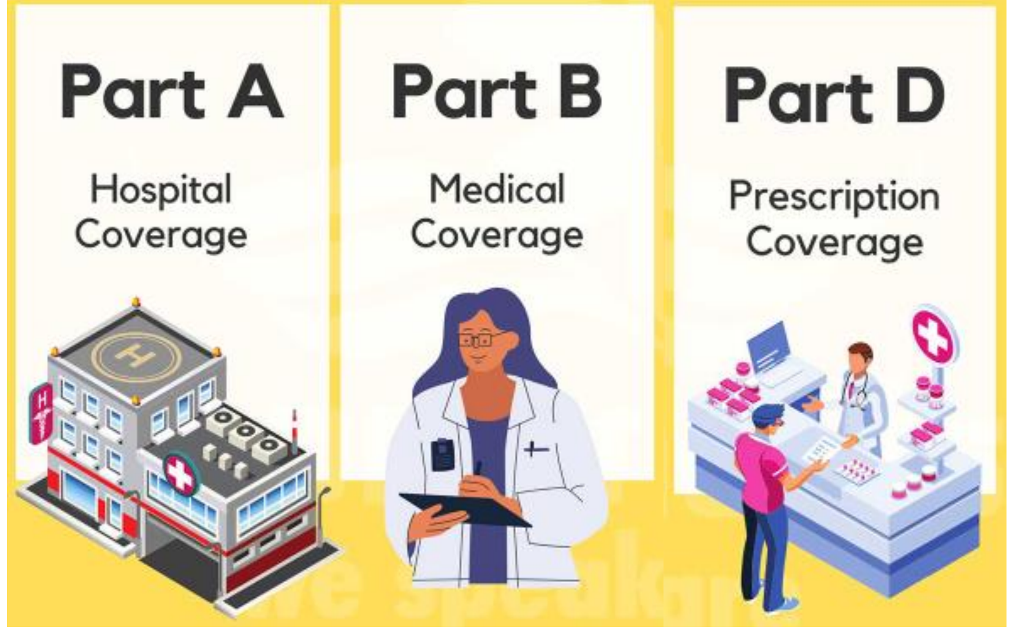
- Members are assigned to the Regional Accountable Entity (RAE) for their geographic area.
  - The RAE administers behavioral health services to members

Dual Eligibility

- Members may be eligible for both Medicare and Health First Colorado.
- Health First Colorado is always the payer of last resort.
  - Bill Medicare first for members with Medicare and Health First Colorado
- Retain proof of:
  - Submission to Medicare prior to Health First Colorado
  - Medicare denials(s) for seven (7) years
- Medicare Explanation of Benefits does not need to be attached to claim submission.

Medicare

- Medicare members may have:
  - Part A only covers institutional services
    - Hospital insurance
  - Part B only covers professional services
    - Medical insurance
  - Part A and B covers both services
  - Part D covers prescription drugs



https://boomerbenefits.com/wp-content/uploads/2021/04/parts-of-medicare-1.png

Medicare

Qualified Medicare Beneficiary (QMB)

- QMB programs cover any service covered by Medicare.
  - QMB Plus Medicaid (QMB+): Members also receive Health First Colorado benefits (Title XIX)
  - QMB Only: Members do not receive Health First Colorado benefits. Health First Colorado will only pay if Medicare pays primary.
- Members are only responsible for Health First Colorado co-pay.
- Health First Colorado uses "lower of pricing" logic - either coinsurance and deductible or difference between Medicare paid amount and Health First Colorado allowed amount, whichever is lower.

Coinsurance
+ Deductible
=

What Medicare paid
- Health First Colorado allowable
=

Which side is lower? That's what is paid by Medicaid.

Third Party Liability
(Commercial Insurance)

- Health First Colorado is always the payer of last resort.
- Indicate the date the Third-Party Liability (Commercial Insurance) paid or denied on each claim.
- The Explanation of Benefits (EOB) does not need to be attached to the claim.
- When a provider agrees to render service to a member, they agree to work with all the member's forms of insurance. Providers working with Health First Colorado members cannot:
  - Bill the member the difference between the amount billed and the amount reimbursed
  - Bill the member for the co-pay or deductible assessed by the Third-Party Liability (commercial insurance)

Third Party Liability
(Commercial Insurance)

- Health First Colorado pays the difference between Third-Party Liability payment and Program Allowable.

Example 1:

Charge = $500

Program allowable = $400

TPL payment = $300

Program allowable – TPL payment =

Reimbursement

$400.00 - $300.00 = $100.00

Example 2:

Charge = $500

Program allowable = $400

TPL payment = $400

Program allowable – TPL payment =

Reimbursement

$400.00 - $400.00 = $0.00

Co-Pay

Website

- Effective July 1, 2023, most member co-pays were reduced to $0.
    - Change effective for members eligible for Title XIX (Medicaid), the Alternative Benefits Plan and the Old Age Pension
    - Exceptions to this change are special programs administered by the Department, such as Child Health Plan *Plus* (CHP+)
- **Outpatient hospital non-emergent emergency room visits continue to carry an $8 co-pay per visit.**
- Providers can check co-pay amounts when verifying member eligibility on the Provider Web Portal.
- A provider may not deny services to individuals when such members are unable to immediately pay the co-pay amount. However, the member remains liable for the co-pay at a later date (8.754.6.B rule in 10 CCR 2505 volume 8.700).

Co-Pay

- The co-pay maximum is 5% of the household monthly income.
  - The head of household will receive a letter showing the household has reached the monthly limit
- The Provider Web Portal tracks co-pays only when claims have been submitted.
  - Providers are encouraged to submit claims as soon as possible to ensure a co-pay does not need to be refunded to the member

Co-Pay Exempt Members

Full List

Nursing Facility Residents

Pregnant Women

Children and Former Foster Care Eligible

Prior Authorizations

Prior Authorization Requests (PARs)

- The ColoradoPAR Program reviews Prior Authorization Requests (PARs) for the following services or supplies:
  - Audiology
  - Diagnostic imaging
  - Durable medical equipment
  - Some inpatient admissions (including out of state)
  - Medical services (including transplant, back and bariatric surgery)
  - Physical, occupational and speech therapy
  - Physician Administered Drugs (PADs) from January 1, 2022
  - Pediatric behavioral therapy
  - Pediatric home health care
  - Pediatric personal care
  - Synagis (seasonal)

Prior Authorization Requests (PARs)

- PAR and PAR revisions processed by the ColoradoPAR Program must be submitted via the vendor utilization management portal managed by Acentra Health (formerly Kepro).
- Final Prior Authorization Request (PAR) determination letters are mailed to members. Letter inquiries should be directed to ColoradoPAR.
- Providers can review PARs via the Provider Web Portal.

Website:	Phone:
ColoradoPAR website	Phone: 1-888-801-9355 FAX: 1-866-940-4288

Prior Authorization Requests (PARs)

- All PARs for members ages 20 and under are reviewed according to Early Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. Even if it is not a covered service for an adult, it may be covered under EPSDT if deemed medically necessary for a child/youth.
- ColoradoPAR does not process Prior Authorization Requests (PARs) for adult home health, dental, pharmacy, transportation or behavioral health services covered by the Regional Accountable Entities (RAEs).

Billing and Payment

Billing and Payment

Record Retention

Payment Processing and Remittance

Timely Filing

Extensions for Timely Filing

Record Retention

- Electronic record keeping is allowed and encouraged.
- Providers must:
  - Maintain records for at least seven (7) years (or longer if required by specific contract between provider and Health First Colorado)
  - Furnish information upon request about payments claimed for Health First Colorado services
- Medical records must:
  - Substantiate submitted claim information
  - Be signed and dated by person(s) ordering and providing the service

Payment Processing Schedule

Mon.	Tue.	Wed.	Thur.	Fri.	Sat.

Providers bill claims

Weekly claim submission cutoff

Mon.	Tue.	Wed.	Thur.	Fri.	Sat.

Remittance Advices (RAs) and 835s are posted to the Provider Web Portal

Electronic Fund Transfer (EFT) payments are deposited to provider accounts

Remittance

Retrieval of Remittance Advice or 835

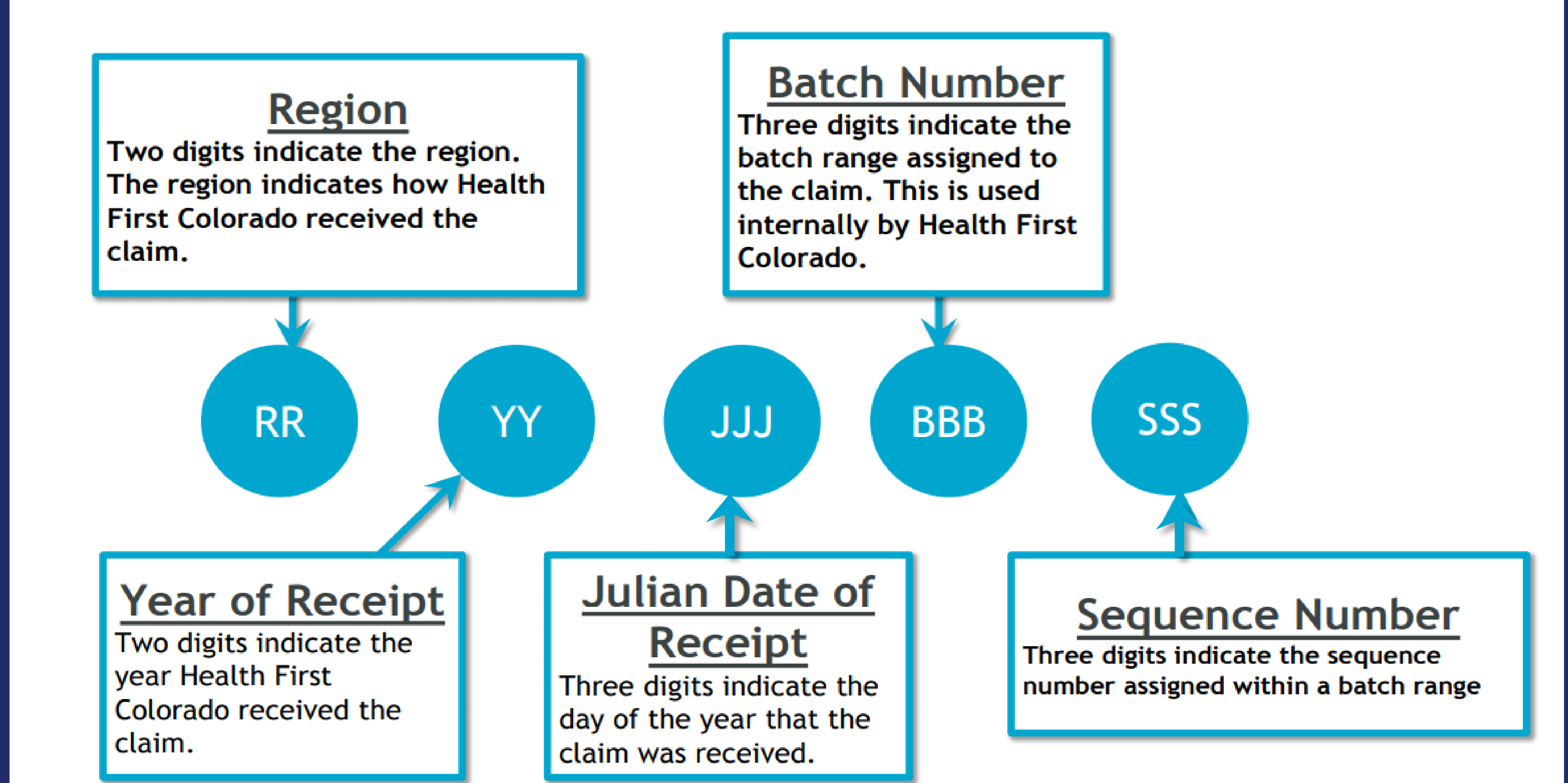
- To pull a Remittance Advice (RA), log into the Provider Web Portal and click on Resources and then Report Download.

- To pull an Electronic Remittance Advice (ERA) X12 835, click on File Exchange and then Download Reports.

- Resources:
  - Provider Web Portal Quick Guide – Pulling Remittance Advice (RA)
  - Provider Web Portal Quick Guide – Linking the TPID and Pulling an 835

Remittance

Internal Control Number (ICN)



Remittance

Region Codes

The Region Code, the first two digits of the claim Internal Control Number (ICN), indicates how Health First Colorado received the claim.

10 – Paper Claims with No Attachments
11 – Paper Claim with Attachments
20, 21 – Batch Claim
22 – Web Portal Claim with No Attachments
23 – Web Portal Claim with Attachments
25 – PBM Pharmacy Claims
30, 31, 40 – Claims Converted from Old MMIS
50 – Provider Initiated Adjustment (via paper)
51, 52, 53, 55, 58 – System Initiated Adjustments
54 – Mass Void
56 – Mass Void Request or Single Claim Void
57 - Cash Void
59 – Provider Initiated Electronic Adjustment
67 - Cash Adjustments
80 – Claim Resubmission by Gainwell
92 – Batch Reconsideration Claims with Attachments
93 – Provider Initiated Batch Reconsideration Adjustment with Attachments
94 – Web Portal Reconsideration Claims with Attachments
95 – Provider Initiated Web Portal Reconsideration Adjustment with Attachments

Remittance

Internal Control Number (ICN) Example

Region
Two digits indicate the region. The region indicates how Health First Colorado received the claim.

Batch Number
Three digits indicate the batch range assigned to the claim. This is used internally by Health First Colorado.

22 | 19 | 001 | BBB | SSS

Year of Receipt
Two digits indicate the year Health First Colorado received the claim.

Julian Date of Receipt
Three digits indicate the day of the year that the claim was received.

Sequence Number
Three digits indicate the sequence number assigned within a batch range

Timely Filing

- 365 days from Date of Service (DOS) determined by date of receipt of the claim
  - Certified mail is not proof of timely filing
  - Prior Authorization Requests (PARs) are not proof of timely filing
  - Contacting the Fiscal Agent (Gainwell Technologies) or waiting for response to a verbal inquiry is not proof of timely filing
  - Claims must be submitted to keep them within timely filing guidelines, even if the result is a denial

Timely Filing

Dates of Service

Type of Service	Timely Filing Calculation
Nursing Facility; Home Health, Inpatient, Outpatient; all services filed on the UB-04	From the “through” (last) date of service
Dental; EPSDT; Supply; Pharmacy; All services filed on the CMS 1500	From the date of each service (line item)

Timely Filing Extensions

Rebilled Claims

- Providers always have the initial timely filing period of 365 days from the date of service to submit claims. If a claim is denied within the initial 365-day period, providers can resubmit without referencing the Internal Control Number (ICN).
- **If a claim is denied after the 365-day period has expired, providers have an additional 60 days from the date of the last Remittance Advice (RA) or returned paper claim to resubmit.**
    - Reference the last Internal Control Number (ICN)
    - Do not attach copy of Remittance Advice (RA) with claim
    - Keep supporting documentation

Timely Filing Extensions

Primary Payers

- Members who have commercial insurance (Third Party Liability [TPL])
  - Claim cannot be paid if over 365 days from date of service per federal statute.
    - Per state and federal regulation (42 C.F.R. § 447.45(d), 10 CCR 2505-10 8.043.01 and .02A), all claims which include commercial insurance (third-party liability) information that are received more than 365 days from the date of service must be denied. The provider is responsible for pursuing available third-party resources in a timely manner.
- Members who are enrolled with both Medicare and Health First Colorado
  - Providers have an additional 120 days from Medicare Explanation of Benefit (EOB) date.

Timely Filing Extensions

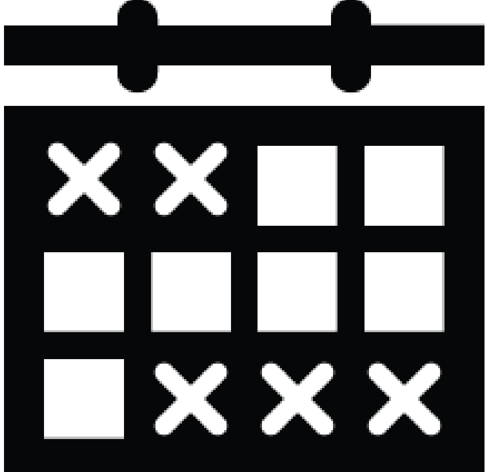
Delayed Notification & Backdated Eligibility

- Delayed Notification
  - Providers are responsible for determining member eligibility within 365 days of date of service even if the member does not notify them of Health First Colorado eligibility. **No further extensions are given for delayed notification of eligibility.**
- Backdated Eligibility
  - Providers can request load letters when a county backdates member eligibility farther than 365 days from date of service. Once a load letter is received, a **provider has 60 days from the load letter date to submit claims.**
    - Submit claims with copy of the load letter via the Provider Web Portal

Timely Filing Extensions

Provider Enrollment

- Backdated Approval
  - Claims do not need to be submitted while waiting for provider enrollment to be approved.
  - If the date of service is beyond the initial timely filing period of 365 days, providers have 60 days from the date of the enrollment letter to submit a claim.
    - The enrollment letter showing backdated approval must be attached to the claim via the Provider Web Portal



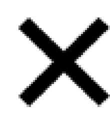
Timely Filing

Is the claim within 365 days of the (final) date of service?

Health First Colorado: Check member's eligibility and submit claim

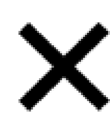
Health First Colorado + Third-Party (Commercial Insurance): Bill commercial insurance as soon as possible

Health First Colorado + Medicare: Bill Medicare first



Just found out that patient is a Health First Colorado member? Provider can not submit claims to Health First Colorado if it is after 365 days from the date of service.

County backdated member's eligibility farther than 365 days from date of service? Request load letter and attach to claim submitted within 60 days of letter.



Just received Explanation of Benefits (EOB) from Third-Party (Commercial Insurance)? Provider can not submit claims to Health First Colorado if it is after 365 days from the date of service.

Just received Explanation of Benefits (EOB) from Medicare? Providers have 120 days from Medicare Explanation of Benefits (EOB) to submit claims to Health First Colorado

Claim Submission

Claim Submission

Claim Submission Methods

Claim Submission Information

UB-04 Paper Claim Form & Example

Claim Status & Common Terms

Common Denial Reasons

Claim Adjustments, Voids and Refunds

Claim Submission Methods

- Electronically through the Fiscal Agent's (Gainwell Technologies) Provider Web Portal (free of charge)
    - Interactive, one claim at a time, immediate response with claim status
- Electronically using a batch vendor, clearinghouse or software
    - Submitters must test batch transactions before approval to submit
- Paper
    - Only when pre-approved due to consistently submitting less than five (5) per month
    - Request form must be mailed to the Fiscal Agent (Gainwell Technologies) to request paper claim submission approval

Claim Submission Methods

Electronic Data Interchange (EDI)

- Providers do not need to obtain a trading partner ID/submitter ID to access the Provider Web Portal.
- Only a submitter who sends batch transactions or receives batch reports needs to enroll in the Electronic Data Interchange (EDI) for a trading partner ID.
- Visit the EDI Support web page for more information.

Claim Submission Methods

Medicare Crossovers

- **Automatic** Medicare Crossover Process:

- Claims not automatically crossed over must be submitted directly by the provider.
- Crossovers may not be processed by Health First Colorado if:
  - NPI used on Medicare claim does not match NPI enrollment with Health First Colorado
  - Member is a retired railroad employee
  - Member has incorrect or missing Medicare information on file

Claim Submission Information

Attending Provider (Individual Within a Group)

Individual that provides services to a Health First Colorado member

Billing Provider

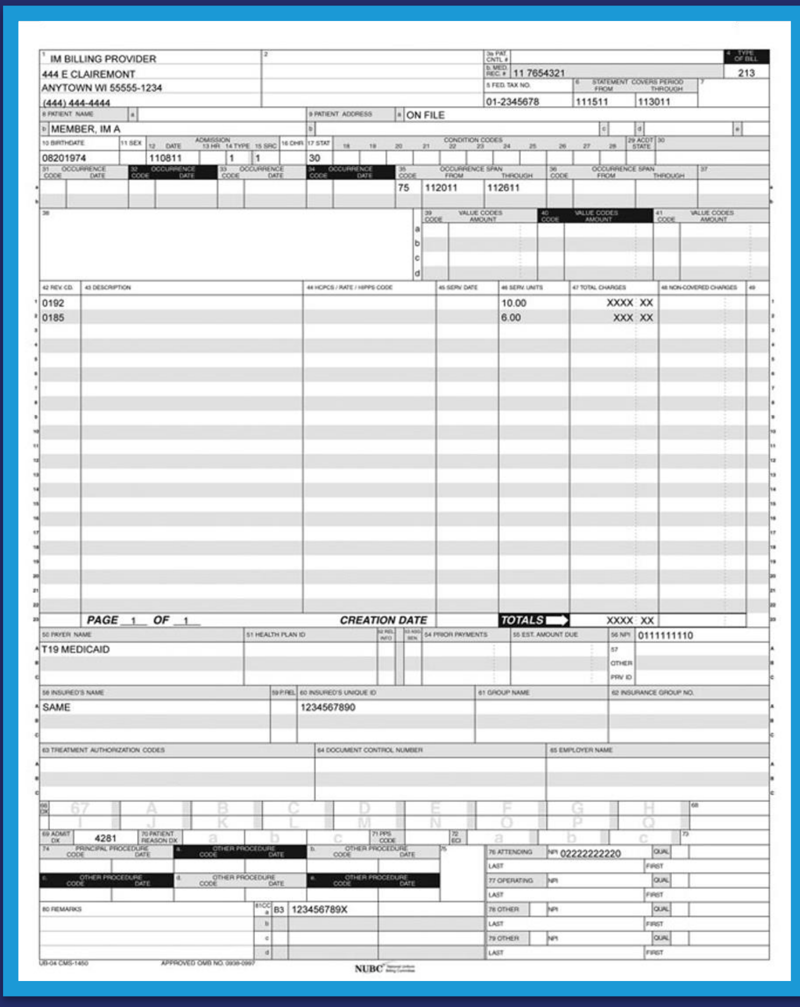
Entity being reimbursed for service

UB-04 (Paper Claim)

UB-04 is the standard institutional claim form used by Health First Colorado and Medicare programs

Where can a provider get the UB-04?

Information available on the Centers for Medicare and Medicaid Services website



1 IM BILLING PROVIDER
444 E CLAIREMONT
ANYTOWN WI 55555-1234
(444) 444-4444

2

3a PAT. CNTL #
b. MED. REC. # 11 7654321

4 TYPE OF BILL 213

5 FED. TAX NO. 01-2345678

6 STATEMENT COVERS PERIOD FROM 111511 THROUGH 113011

7

8 PATIENT NAME a
b MEMBER, IM A

9 PATIENT ADDRESS a ON FILE
b c d e

10 BIRTHDATE 08201974
11 SEX
ADMISSION 12 DATE 110811 13 HR 14 TYPE 1 15 SRC 1
16 DHR
17 STAT 30
CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28
29 ACDT STATE
30

31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE 75 FROM 112011 THROUGH 112611
36 OCCURRENCE SPAN CODE FROM THROUGH
37

38

39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0192				10.00	XXXX XX		
0185				6.00	XXX XX		
	PAGE 1 OF 1	CREATION DATE		TOTALS	XXXX XX		

50 PAYER NAME A T19 MEDICAID
51 HEALTH PLAN ID
52 REL. INFO
53 ASG. BEN.
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI 0111111110
57 OTHER PRV ID

58 INSURED'S NAME A SAME
59 P.REL
60 INSURED'S UNIQUE ID 1234567890
61 GROUP NAME
62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX 67 A B C D E F G H I J K L M N O P Q
68

69 ADMIT DX 4281
70 PATIENT REASON DX a b c
71 PPS CODE
72 ECI a b c
73

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE
75

76 ATTENDING NPI 02222222220 QUAL
LAST FIRST
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

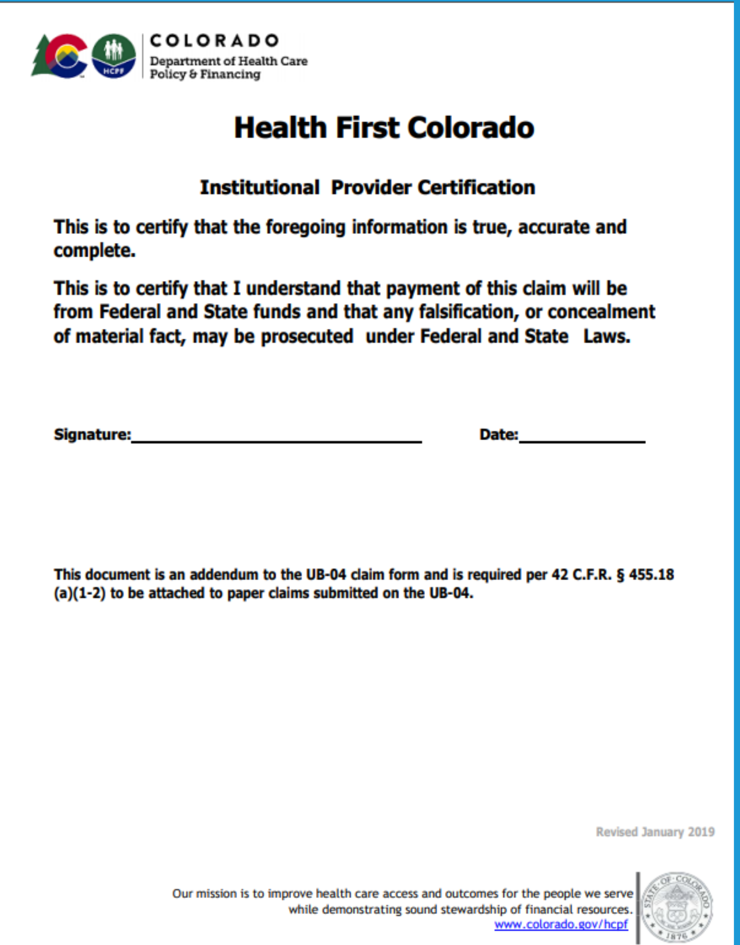
80 REMARKS
81CC a B3 123456789X
b
c
d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC

UB-04 (Paper Claim)

UB-04 certification must be completed and attached to all claims submitted on the paper UB-04

Visit the Provider Forms web page to print a copy of the certification



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. § 455.18 (a)(1-2) to be attached to paper claims submitted on the UB-04.

Revised January 2019

Our mission is to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.
www.colorado.gov/hcpf

Paper Claim - Example 1

- REQUIRED FIELDS
- CONDITIONAL FIELDS
- OPTIONAL FIELDS

Field 1 - **Optional.** If sharing a billing NPI, the Zip+4 of the location address must be used.

Field 4 - **Required.** (Type of facility, Bill classification, and Frequency). 8--special facility-hospice. 1--inpatient-non hospital based. 3--interim-continuous claim.

Field 18 - **Required.** Z4 necessary for paper claims.

Field 31-34 - **Required.** Enter the appropriate code and the date on which it occurred. Enter the date using MMDDYY format.

Field 15 & 17 - **Required.** For field 15 enter source of admission. For field 17 enter client status as ongoing patient (code 30) or as of discharge date.

Field 39-41 - **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. If a value code is entered, a dollar amount or numeric value related to the code must always be entered.

Field 48 - **Conditional.** Enter incurred charges that are not payable by the Health First Colorado.

1 ABC Hospice
1234 Alphabet Lane
Anytown, CO 33333-9999
Phone: 999-999-9999

2

3a PAT. CNTL # 11111-000
b. MED. REC. # 123

4 TYPE OF BILL 813

5 FED. TAX NO. 999999999

6 STATEMENT COVERS PERIOD FROM 07012018 THROUGH 07312018

7

8 PATIENT NAME a
b Doe, John

9 PATIENT ADDRESS a Greentown Nursing and Rehabilitation 123 Southern Rd, Room 555
b Greentown c CO d 11111-4444 e

10 BIRTHDATE	11 SEX	12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
02121950	M	02132018	12	3	5		30	Z4												

ADMISSION (13–14); CONDITION CODES (18–28)

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
27	051418													

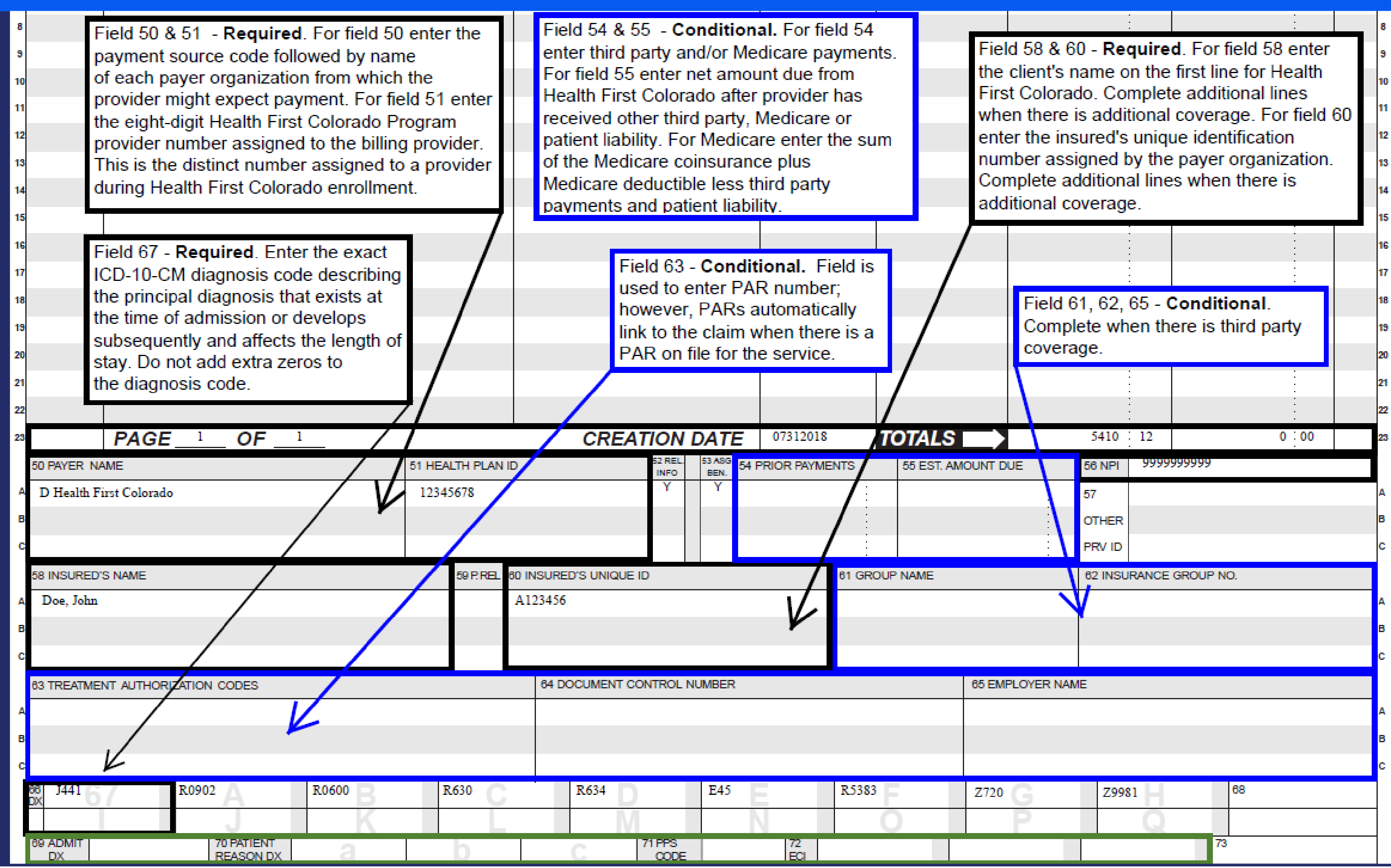
38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a						
b						
c						
d						

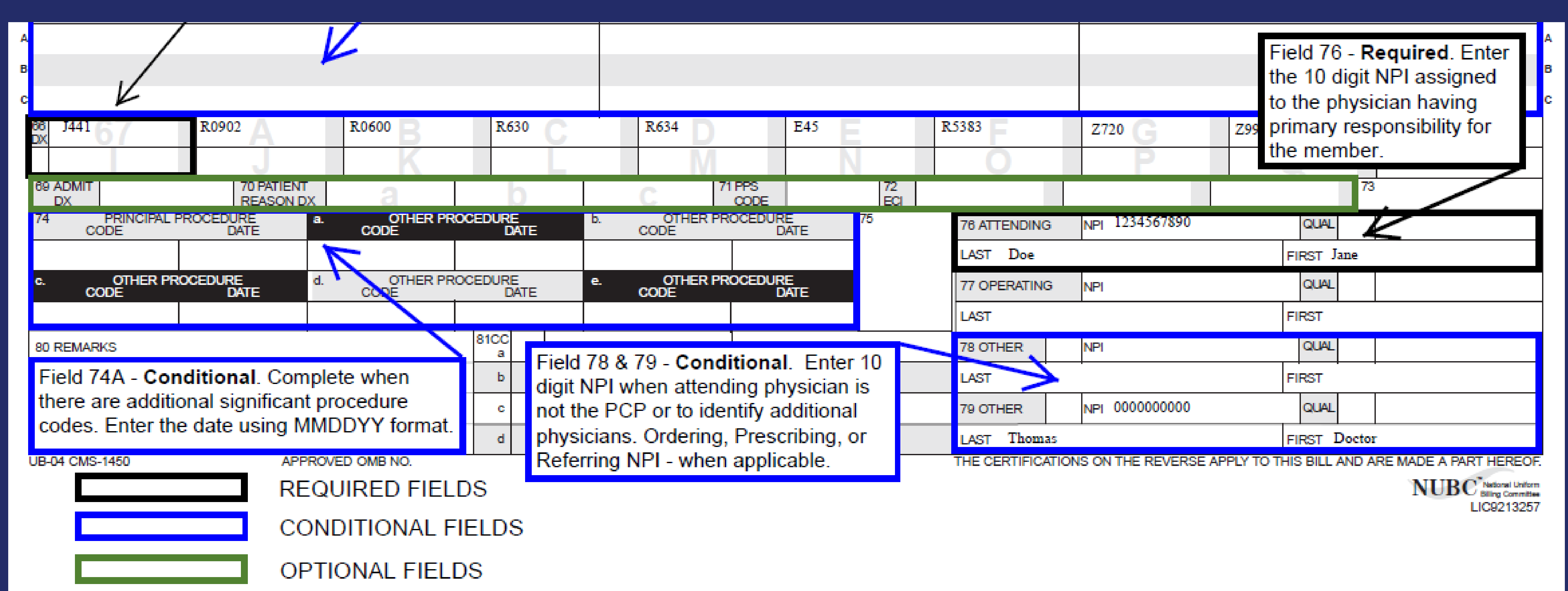
	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0651	Routine Low Days		07012018	31	5410 12	0 00	
2								
3								
4								
5								

COLORADO
Department of Health Care Policy & Financing

Paper Claim - Example 2

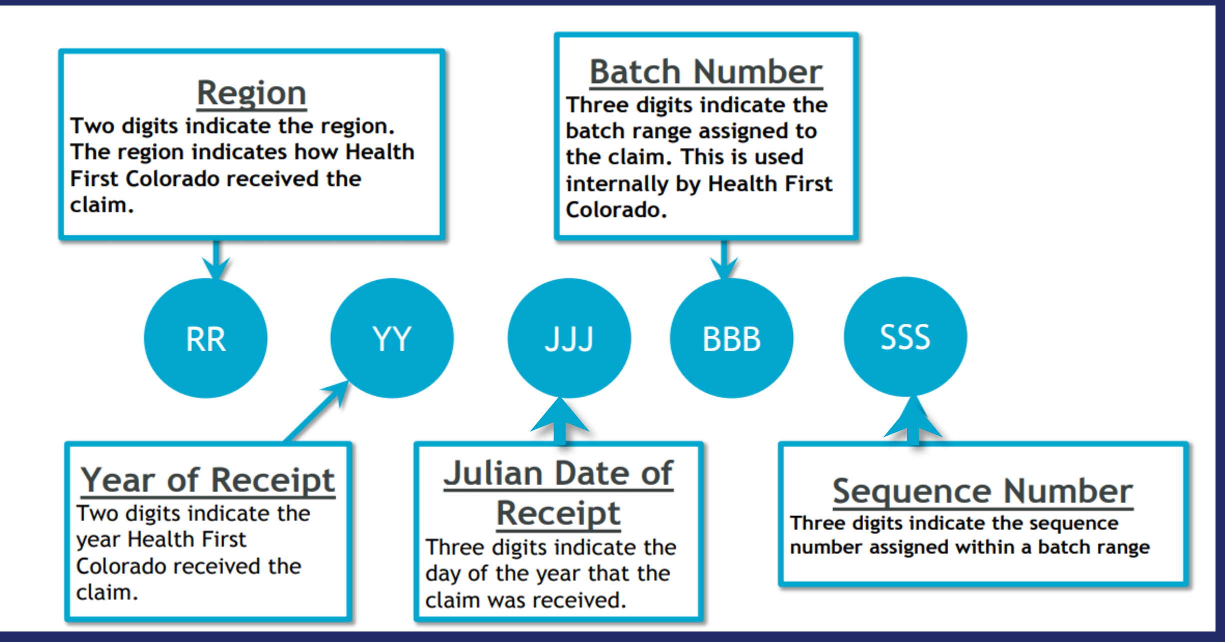


Paper Claim - Example 3



Claim Status

Internal Control Number (ICN) & Region Codes



The Region Code, the first two digits of the claim Internal Control Number (ICN), indicates how Health First Colorado received the claim.

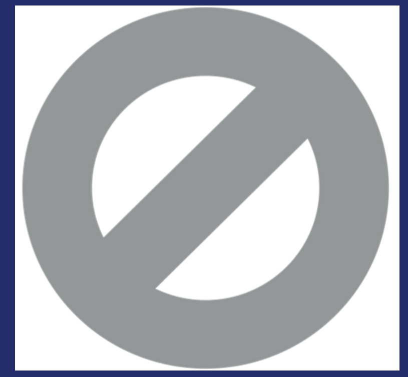
10 - Paper Claims with No Attachments
11 - Paper Claim with Attachments
20, 21 - Batch Claim
22 - Web Portal Claim with No Attachments
23 - Web Portal Claim with Attachments
25 - PBM Pharmacy Claims
30, 31, 40 - Claims Converted from Old MMIS
50 - Provider Initiated Adjustment (via paper)
51, 52, 53, 55, 58 - System Initiated Adjustments
54 - Mass Void
56 - Mass Void Request or Single Claim Void
57 - Cash Void
59 - Provider Initiated Electronic Adjustment
67 - Cash Adjustments
80 - Claim Resubmission by Gainwell
92 - Batch Reconsideration Claims with Attachments
93 - Provider Initiated Batch Reconsideration Adjustment with Attachments
94 - Web Portal Reconsideration Claims with Attachments
95 - Provider Initiated Web Portal Reconsideration Adjustment with Attachments

Claim Status

Common Terms

Paid

Claim processed & paid by claims processing system. Claims paid at zero due to lower of pricing are still considered paid.



Denied

Claim processed & denied by claims processing system. Denied claims may not be adjusted but may be resubmitted after corrections have been made.

Common Denial Reasons

Timely Filing	Claim was submitted more than 365 days without reference to a previous Internal Control Number (ICN)
Duplicate Claim	A subsequent claim was submitted after a claim for the same service had already been paid
Bill Medicare or Other Insurance	Health First Colorado is always the payer of last resort. Provider should enroll with and bill all other appropriate carriers first. Primary information must be reported on the claim form.

Common Denial Reasons

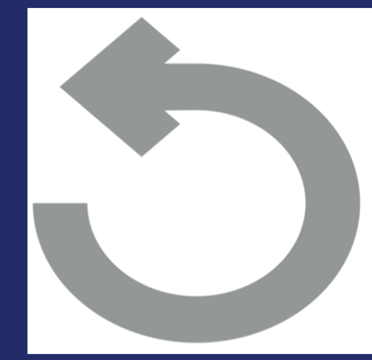
Prior Authorization (PAR) Not on File	No approved prior authorization on file for services that are being submitted, or modifiers, units or PAR type may not match
Total Charges Invalid	Line-item charges do not match the claim total
Type of Bill	Claim was submitted with an incorrect or invalid type of bill. Verify appropriate type of bill in billing manual.

Claim Status

Common Terms

Adjustment

Correct a paid claim



Resubmit

Rebill a previously denied claim

Suspend

Claim must be manually reviewed before final decision

Void

Cancel a paid claim

Providers should only void claims if accidentally submitted OR there is an incorrect Member ID or Provider ID

Claim - Resubmissions

- Providers may resubmit, also known as rebill, claims that have been denied
  - If the resubmitted claim is outside of timely filing, the original Internal Control Number (ICN), or Claim ID, must be referenced

Resubmit a claim when	Do not resubmit a claim when
• Claim was denied	• Claim was paid • Claim is suspended

Claim - Resubmissions

Date of Service Within 365 Days

- Copy original claim and make corrections
- Do not reference original Internal Control Number (ICN)

Paper

- Submit new claim with corrections
- Do not reference original Internal Control Number (ICN)

Claim - Resubmissions

Date of Service Past 365 Days

If the original timely filing period (365 days from date of service) has expired, the next submission must be received within 60 days of the last action (i.e., Remittance Advice, load letter, returned paper claim)

Provider Web Portal	Batch	Paper
• Copy original claim and make corrections • Reference original Internal Control Number (ICN) in the "Previous Claim ICN" field in the Claim Information section	• Qualify claim loop with F8 and use the previous Internal Control Number (ICN) as the Payer Claim Control Number along with the 1 code in the 2300/CLM segment	• Indicate resubmission by using code 1 as the third digit in box 4 (Type of Bill) and the original Internal Control Number (ICN) in box 64

Claim - Adjustments

- What is an adjustment?
  - Adjustments create a replacement claim
  - Two step process: Credit & Repayment

Adjust a claim when	Do not adjust a claim when
• Provider billed incorrect services or charges • Claim paid incorrectly	• Claim was denied • Claim is suspended

Claim - Adjustments

If the original timely filing period (365 days from date of service) has expired, the next submission must be received within 60 days of the last action (i.e., Remittance Advice, load letter, returned paper claim)

Provider Web Portal	Batch	Paper
• Search for original claim and click "Adjust" at the bottom	• Qualify claim loop with F8 and use the previous Internal Control Number (ICN) as the Payer Claim Control Number along with the 7 code in the 2300/CLM segment	• Indicate adjustment by using code 7 as the third digit in box 4 (Type of Bill) and the original Internal Control Number (ICN) in box 64

Claim - Voids and Refunds

- Providers should void claims only if there is an incorrect Member ID or Provider ID or if accidentally submitted
- Refund recoupment will appear on Remittance Advice

<u>Provider Web Portal</u>	Batch	Paper
• Search for original claim and click “Void” at the bottom	• Qualify claim loop with F8 and use the previous Internal Control Number (ICN) as the Payer Claim Control Number along with the 8 code in the 2300/CLM segment	• Indicate void by using code 8 as the third digit in box 4 (Type of Bill) and the original Internal Control Number (ICN) in box 64

Resubmission, Adjustment & Void Codes

	Provider Web Portal	Batch	Paper
	Search for original claim and	Qualify claim loop with F8 and use the previous Internal Control Number (ICN) as the Payer Claim Control Number along with	Use code listed below as the third digit in box 4 (Type of Bill) and the original Internal Control Number (ICN) in box 64
Resubmission (Date of Service Past 365 Days)	Click "Copy" at the bottom; include original ICN in "Previous Claim ICN" field	1 code in the 2300/CLM segment	Code 1 as third digit in box 4 and ICN in box 64
Adjustment	Click "Adjust" at the bottom	7 code in the 2300/CLM segment	Code 7 as third digit in box 4 and ICN in box 64
Void	Click "Void" at the bottom	8 code in the 2300/CLM segment	Code 8 as third digit in box 4 and ICN in box 64

Claim Submission: Resubmit or Adjust?

Was the claim denied?

Yes

Is it within 365 days of the (final) date of service?

- **Yes**: Make corrections and **submit new claim** without referencing the Internal Control Number (ICN)
- **No**: Is it within 60 days of the last Remittance Advice (RA), returned paper claim or load letter?
  - **Yes**: Make corrections and **rebill/ resubmit claim**. Be sure to reference the original Internal Control Number (ICN)
  - **No**: Contact Provider Services Call Center at 1-844-235-2387

No, it paid

Is it within 365 days of the (final) date of service?

- **Yes**: Make corrections and **adjust claim** by:
  1) Using adjustment indicator on third (3rd) digit of type of bill on paper claim form UB-04
  2) Click "Adjust" at the bottom of the screen after searching for claim on the Provider Web Portal
- **No**: Contact Provider Services Call Center at 1-844-235-2387

Quick Guides

- Copy, Adjust or Void a Claim
- Pulling Remittance Advice (RA)
- Reading the Remittance Advice (RA)
- Submitting an Institutional Claim

- All Provider Web Portal Quick Guides can be found on the Department's Quick Guides web page.

Resources

Billing Manuals web page

- General Provider Billing Manual
- Appendix R (for a detailed list of Explanation of Benefits [EOB] codes)

Provider Web Portal Quick Guides

Provider Training web page

Provider & Care and Case Manager Contacts web page

Provider Services Call Center
1-844-235-2387

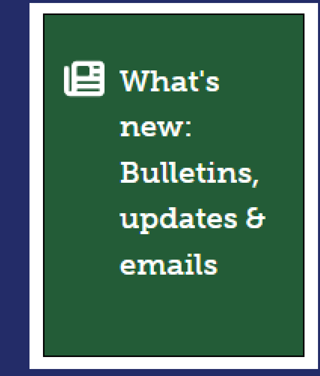
Regional Field Representatives web page

Reminders

- A post-training survey is now linked in the chat. Please take a few moments now or later to complete it. Your feedback is valued.

- Remember to sign up for Department of Health Care Policy & Financing communications by visiting the website and clicking "For Our Providers" and then "What's new: Bulletins, updates & emails."

- Interested in more training? Sign up by visiting the website and clicking "Provider Resources" and then "Provider Training." The next Institutional Claims training is on **Thursday, December 14th**.



Provider Web Portal Demo

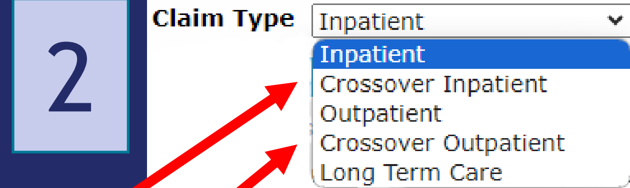
Step 1: Member and Claim Information

1

Home | Eligibility | Claims | Care Management | Resources

Search Claims | Submit Claim Dental | Submit Claim Inst | Submit Claim Prof | Search Payment History

2



The Crossover Inpatient and Crossover Outpatient institutional claim is used when Medicare is the primary payer.

3

Patient number can be any number the provider assigns for internal records.

Reference the original Internal Control Number (ICN) if you are resubmitting a claim after it has been denied.

Claim Information

*Covered Dates - *

*Admission Date/Hour - (hh:mm) Discharge Hour (hh:mm)

*Admission Type

*Admission Source

*Admitting Diagnosis Type ICD-10-CM

*Admitting Diagnosis

*Patient Status

*Facility Type Code

*Patient Number

Previous Claim ICN

Note

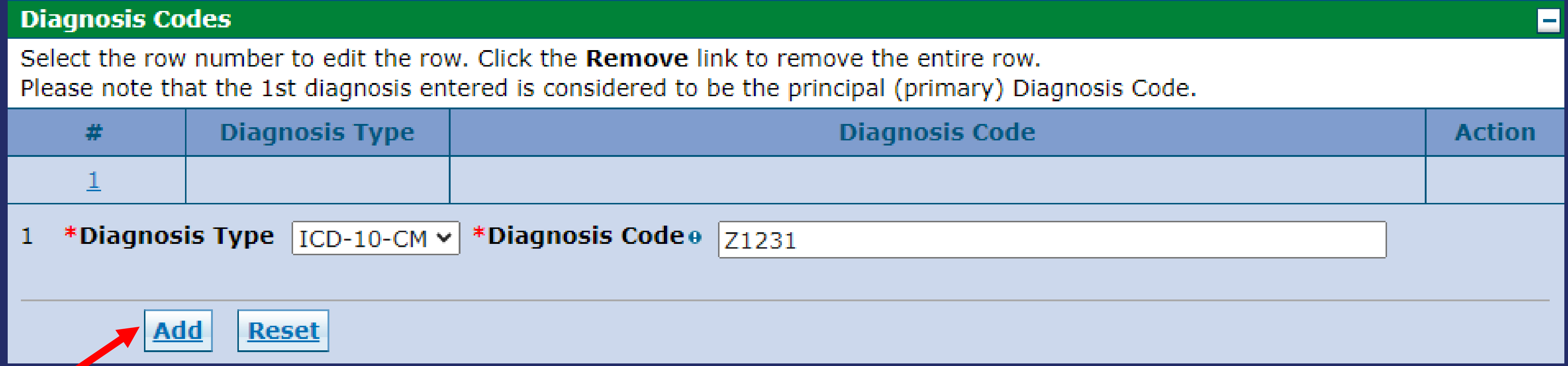
Include Other Insurance

Total Charged Amount $0.00

Check "Include Other Insurance" if there is a third-party liability (commercial insurance) that is the primary payer. This is NOT used for Medicare.

Provider Web Portal Demo

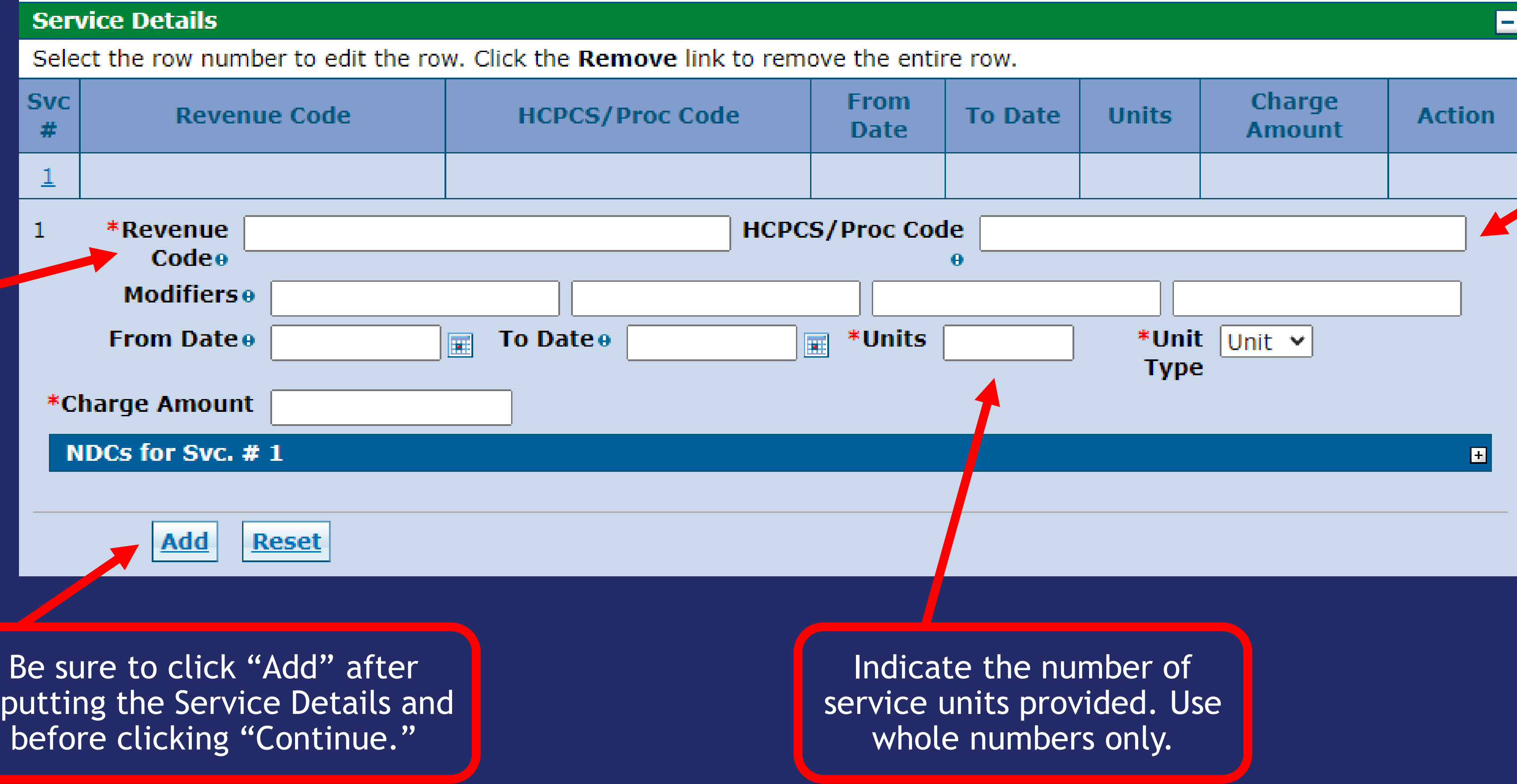
Step 2: Diagnosis Panel



Be sure to click "Add" after inputting the Diagnosis Code and before clicking "Continue."

Provider Web Portal Demo

Step 3: Service Details Panel



Provider Web Portal Demo

Step 4: Correcting a Denied Claim

1

Adjudication Errors

Header / Detail	EOB	Description
Service # 1	3314	Denied. Detail Dates Are Not Within Statement Covered Period.

Check the "Adjudication Errors" for information on why a claim denied.

2

Copy Outpatient Claim

Select the information you would like to have copied to the new claim. Press Copy to initiate the claim and continue entering claim information.

- **Member Information**: Member ID, Last Name, First Name, Birth Date, Address, Condition Codes(s)
- **Service Information**: Admission Source, Admission Type, Admitting Diagnosis, Facility Type Code, Diagnosis Code(s), Revenue Code(s), HCPCS/Proc Code(s), Modifier(s), Detail Charge Amount(s), Units, Unit Type(s), NDC Code Type(s), NDC Code(s), NDC Quantity(s), NDC Unit of Measure(s)
- **Member and Service Information**: Copies data listed in previous 2 columns.
- **Entire Claim**: Copies data listed in columns 1 and 2 PLUS: All Providers, Admission Date/Hour, Discharge Hour, Patient Status, Occurrence Code(s), Value Code(s), Surgical Procedure Code(s), Other Insurance, All Dates, All Amounts

Copy | Cancel

Copy the entire claim to make necessary changes.

3

Click on blue numbers to expand and change information within that panel.

Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Svc #	Revenue Code	HCPCS/Proc Code	From Date	To Date	Units	Charge Amount	Action
1	0329-RADIOLOGY - DIAGNOSTIC OTHER RADIOLOGY - DIAGNOSTIC DX X-RAY/OTHER	77066-DX MAMMO INCL CAD BI	10/02/2023	10/02/2023	1.000 Unit	$1,000.00	Remove

1 *Revenue Code: 0329-RADIOLOGY - DIAGNOSTIC OTHER F | HCPCS/Proc Code: 77066-DX MAMMO INCL CAD BI

Modifiers:

From Date: 10/02/2023 | To Date: 10/02/2023 | *Units: 1.000 | *Unit Type: Unit

*Charge Amount: 1,000.00

NDCs for Svc. # 1

Save | Reset | Cancel

After copying the entire claim and making necessary changes, be sure to click "Save" before clicking "Continue."

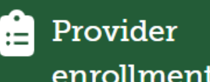
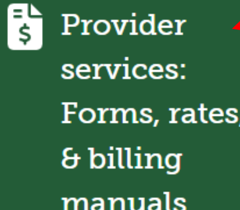
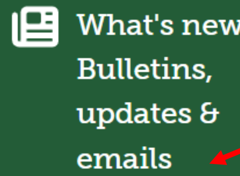
hcpf.colorado.gov/our-providers

Where can I find…?

For Our Providers

- Enrollment forms
- Revalidation dates spreadsheet
- National Provider Identifier (NPI) information
- Provider types

- Fee schedules
- General Provider Information manual
- Billing manuals & appendices
- Forms
  - Prior Authorization Requests (PARs)
  - Load letters
  - Request to use paper claims form

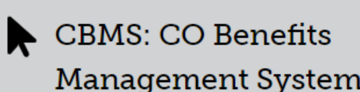
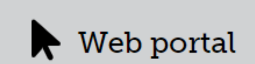
Why should you become a provider?

Provider enrollment

Provider services: Forms, rates, & billing manuals

What's new: Bulletins, updates & emails

- Newsletters
- What’s New?

CBMS: CO Benefits Management System

Care and Case Management

Web portal

- Check member eligibility
- Submit claims
- Review Prior Authorization Requests (PARs)
- Receive Remittance Advices (RAs)
- Complete provider maintenance requests

Revalidation

Provider contacts: Who to call for help

Provider resources: Quick guides, known issues, EDI, & training

- Quick Guides for Web Portal
- Known issues
- EDI Support
- Training registration
- Information about
  - Accountable Care Collaborative & RAEs
  - Co-Pays
  - EVV

COVID-19 Provider Information | Resources for HCBS Providers

SAVE System | ColoradoPAR | DDDWeb | Value Based Payments

Thank you for the services you provide to Health First Colorado!