PROVIDER MANUAL

In the Colorado Access Provider Manual, you will find information about:

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Search Tip:
You can search quickly and easily by clicking on the binoculars icon on your toolbar, or by using the command Control+Shift+F. This will display a search box for you to enter what you want to find.

If you have any questions, call us at 800-511-5010 (toll free).

Colorado ACCESS

Claims

Providers are required to submit complete claims for all services rendered to our members, whether the services are rendered under capitation or fee-for-service. Electronic submission of claims is preferred. However, we will accept paper claims in current CMS 1500 or UB04/CMS 1450 formats. In order to process claims in a timely, accurate manner, we ask Providers to observe standard billing requirements.

Providers may also reference the following resources when completing claims submissions:

- CMS 1500 Physician's Manual
- UB04 Billing Manual
- ICD-10-CM Code Book
- AMA Current Procedural Terminology (CPT) code sets
- Healthcare Common Procedure Coding System (HCPCS) code sets

CLAIMS SUBMISSION:

Colorado Access Claims:
PO Box 17470
Denver, CO 80217-0470

Provider Carrier Disputes (Claim Appeals):
PO Box 17189
Denver, CO 80217-0189

TIMELY FILING

- Initial claims must be submitted within 120 calendar days from the date of service or the contractual time limit; whichever is shorter.
- Provider carrier disputes (claim appeals) or corrected claims must be submitted within 120 days from the date of service or 60 calendar days from the date of the provider Explanation of Payment (EOP) on which the claim appears.

ELECTRONIC CLAIMS

We accept claims electronically through clearinghouses or through direct batch file submissions in the HIPAA5010 version of the 837 file format. We currently do not accept electronic claims through a web-based application/web portal. If you have questions about electronic claim submissions please email edi_coordinator@coaccess.com.

EDI Clearinghouses

The use of clearinghouses is preferred as they provide quick and efficient submission of electronic/EDI claims that are compliant with current guidelines. We accept electronic/EDI

claims from the clearinghouses listed at coaccess.com/electronic-claims. If you use one of these clearinghouses, please advise the clearinghouse to direct your claims to the appropriate payer ID.

EDI Front-End Validation Process

We have an EDI Front-End Validation Process to ensure that inbound claims are meeting the standard HIPAA validation rules and to increase auto-adjudications rates. The process will be validating WEDI SNIP Level 1-7. Claims that fail the SNIP levels will be rejected and the provider will be notified via the 277.

CLAIM STATUS

Providers can check the status of a claim in two ways; by using our provider portal or calling our customer service department.

Online Provider Portal

To check the status of your claim on our website, you must register for the provider portal and receive your username and password. If you do not have a provider portal account, you can request one by submitting the form located at coaccess.com/frequently-used-forms.

Customer Service

720-744-5100 (Denver metro area)
800-511-5010 (toll free)

Our customer service team can answer questions regarding benefits, claims, claim appeals, claim status, and general questions about our policies. Customer service representatives are available Monday through Friday from 8 a.m. to 5 p.m., Mountain Time.

COLORADO ACCESS RESPONSIBILITIES

We have the following responsibilities with respect to the Provider:

- Provide information about requirements for filing claims
- Notify new Providers of standard forms, instructions or requirements upon acceptance into the plan
- Determine whether sufficient information has been submitted to allow proper consideration of the claim
- Provide appropriate explanation for denied claims
- Approve, deny, or settle all “clean” paper claims within 45 calendar days of receipt, and clean EDI claims within 30 days, or the time period specified in the Provider’s contract
- Approve, deny, or settle all other claims (except fraudulent, abusive, and/or wasteful claims) within 90 calendar days
- Apply interest and/or penalties to clean claims paid outside of these guidelines in accordance with Division of Insurance regulations

Note: we will not interpret claim information from provider statements or superbills.

Note: in case of fire, flood, war, civil disturbance, court order, strike, an act of terrorism, or other cause beyond our control, we may be unable to process claims on a timely basis. No legal action or lawsuit may be taken against Colorado Access due to a delay caused by any of these events.

PROVIDER RESPONSIBILITIES

Providers rendering services to our members have the following responsibilities in relation to billing for these services:

- Except in the case of emergencies, verify the member's eligibility and PCP assignment prior to rendering services
- Ensure that the appropriate authorization requirements have been met
- Bill in compliance with any/all applicable HCPF billing/coding manuals
- Verify place of service codes are correct
- Verify that diagnosis and/or procedure codes match the service provided
- Complete all required data elements
- Leave non-required data fields blank (do not enter N/A)
- Use only black or dark red ink on any handwritten paper claims
- Use only good quality toner, typewriter or printer ribbons/cartridges for paper claims
- Do not use highlighters to mark claims or attachments
- Bill original claims within 120 days or as specified by the contract
- Bill third party prior to submitting claims to Colorado Access
- Attach all required documentation to the claim
- If several claims require the same attachment, a photocopy of the attachment must be submitted with each claim
- Do not submit "continuation" claims
- We will allow interim billing only if the claim pays a per diem rate per contract. If the claim will pay a DRG rate, we cannot accept an interim claim.
- Submit paper claims to the appropriate address
- Provider shall comply with the Colorado Access fraud and abuse program identified in this Manual and shall bill in compliance therewith

CMS 1500 CLAIMS SPECIFICATIONS

Providers must file all claims for professional services, including laboratory services performed by an independent laboratory, on the current CMS 1500 or appropriate electronic claim format. Please reference Health First Colorado (Colorado's Medicaid Program) provider billing manuals.

UB04/CMS 1450 CLAIMS SPECIFICATIONS

Providers must submit all hospital and facility claims, including those for laboratory services performed by a hospital, on the UB04/CMS 1450 or appropriate electronic format. Please reference Health First Colorado (Colorado's Medicaid Program) provider billing manuals.

PRESENT ON ADMISSION (POA) INDICATOR

We require a Present on Admission (POA) indicator on all inpatient claims.

Note: inpatient claims will be denied if the POA indicator is not submitted on the claim.

According to state and federal guidelines, all inpatient facility claims should include POA indicators. The Centers for Medicare & Medicaid Services (CMS) defines present on admission as:

> "…present at the time the order for inpatient admission occurs – conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission."

A POA indicator should be assigned to the principal and secondary diagnoses. According to coding guidelines, the correct POA indicators are:

- Y – Yes
- N – No
- U – Unknown
- W – Clinically undetermined unreported/not used (exempt from POA reporting)

In the event of improper reporting, DRG assignment and reimbursement will be adjusted accordingly.

In some cases, retrospective claim review may occur. We reserve the right to collect any overpayments that are the result of the retrospective review.

DIAGNOSIS CODING

We require Providers to enter the appropriate diagnosis code on each claim submitted. We only accept those codes published in the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10 codes). The Provider must enter ICD-10 codes clearly on the claim form and include all digits and characters.

- Some procedures are appropriate only when specific conditions are present.
- We require Providers to ensure the diagnosis entered is appropriate for the services provided and is supported by the patient's medical record.

- We require Providers to submit ICD-10 codes to the highest specificity with all of the required digits (three, four, or five) to completely and accurately describe the disorder or illness, including behavioral health services.

Confidential Diagnosis Coding

Please enter AIDS or AIDS-related diagnosis codes on the claim form as with any other diagnosis or condition. While federal and state statutes provide stringent penalties for failure to keep AIDS-related information confidential, these statutes are not intended to prevent accurate and appropriate submission of claims.

Federal and state statutes prohibit disclosure of information regarding application for or receipt of public assistance. However, this information may be disclosed for purposes of administering a public assistance program. Claims submitted for serviced rendered to our members include information necessary to process claims, calculate costs, and project future funding. In sharing information for these purposes, we do not jeopardize the privacy of the recipient.

PROCEDURE CODING

We use the Centers for Medicare & Medicaid Services' Healthcare Common Procedure Coding System (HCPCS) to identify services provided to eligible recipients. HCPCS codes (Level 1) include CPT codes. In order to ensure that claims are processed promptly and accurately, please follow these guidelines:

- Use the most current CPT/HCPCS code revision, based on date of service.
- Be aware that not all codes are covered benefits under Colorado Access member benefits.
- When we receive billed codes that are considered obsolete, the claim line(s) will be denied and written notification will be sent on a claim voucher.
- Our claims transaction system utilizes the CMS-mandated Correct Coding Initiative (CCI) edits and American Medical Association's (AMA) Current Procedural Terminology (CPT) guidelines to evaluate coding accuracy.

ANESTHESIA BILLING

Anesthesia service codes (procedure codes 00100-01999) must appear in field 24-D. Time units must be entered in field 24-G (1 unit equals 15 minutes). When calculating reimbursement on anesthesia claims, we do pay for time and units. However, we pay for the actual time administered. Please see the example below:

Step 1: Actual time divided by 15 equals X.

Step 2: The Base Factor is added to the X. This total equals Y.

Step 3: The Relative Value is multiplied by Y. This total is the payment amount.

IMMUNIZATIONS

- Please report all immunizations given to Colorado Access members on the CMS 1500 claim form with the vaccine procedure code.
- A separate vaccine code should be listed for each vaccine administered.
- Providers should bill the appropriate vaccine administration code(s) per CPT guidelines. When billing immunization administration fees submit on a single claim line with the appropriate number of units. This will avoid denials for duplicate charges.
- Immunization information may be used for tracking and reporting purposes.

MULTIPLE OCCURRENCES

Report multiple occurrences of the same procedure on the same date on one billing line, using multiple units of service. The charges reported should equal the unit procedure price multiplied by the number of units provided.

- Providers may refer to the CPT or HCPCS Bulletin for more information about unit definitions.
- DME Providers should use the units outlined in the CPT coding manual.

NON-CLEAN CLAIMS PROCESS

In accordance with CRS 10-16-106.5, if a submitted claim required additional information in order to be paid, denied, or settled, the claim will not be considered a clean claim. Such claims will be paid, denied, or settled according to the following:

- Within 30 calendar days of receiving the claim, we will pend the claim and send a Missing Information Notice requesting the missing information.
- If, within 30 calendar days of our request, a Provider fails to submit the additional information, the claim will be denied.
- When all additional information necessary to resolve the outstanding claim has been provided, during the 30 calendar day period, the claim will be processed, absent fraud, within 90 calendar days after the date that we first received the claim.

LOCUM TENENS

Locum Tenens physicians (MD or DO only) who provide services under a locum tenens agreement must enroll in Health First Colorado (Colorado's Medicaid Program). Claims for services by a locum tenens physician must identify the enrolled locum tenens physician as the rendering provider. Hospitals may enter the member's regular physician's Medical Assistance Program provider ID in the Attending ID field if the locum tenens physician is not enrolled in Medicaid.

A member's regular Provider may submit a claim and receive payment for covered visit services (including emergency visits and related services) which the regular physician arranges to be provided by a substitute physician if:

- The regular physician is unable to provide the visit services;

- The member has arranged or seeks to receive the services from the regular physician;
- The regular physician pays the locum tenens for his or her services on a per diem or similar fee-for-time basis;
- The substitute physician does not provide the visit services to members over a continuous period of longer than 14 days for a reciprocal billing arrangement, or a continuous period of longer than 90 days for a locum tenens arrangement; and
- The regular physician identifies the patient visit as services provided by a substitute physician meeting the requirements of this section by entering modifier Q5 (service furnished by a locum tenens practitioner) in box 24d of CMS 1500, after the procedure code. Until further notice, the regular physician must keep on file a record of each service provided by the substitute physician, associated with the substitute physician's UPIN, and make this record available to Colorado Access upon request.

A continuous period of covered visit services begins with the first day on which the substitute physician provides covered services to the patients of the regular physician, and it ends with the last day on which the substitute physician provides these services to these patients before the regular physician returns to work. This period continues without interruption on days on which no covered visit services are provided to patients on behalf of the regular physician. A new period of covered visit services can begin after the regular physician has returned to work.

Example: The regular physician goes on vacation on June 30, 2009 and returns to work on September 4, 2009. A substitute physician provides services to patients of the regular physician on July 2, 2009, and at various times thereafter, including August 30, 2009 and September 2, 2009. The continuous period of covered visit services begins on July 2, 2009 and runs through September 2, 2009, a period of 63 days. Since the September 2nd services are furnished after the expiration of 60 days of the period, the regular physician is not entitled to bill and receive payment for them. The regular physician may, however, bill and receive the payment for the services that the substitute physician provides on his or her behalf in the period of July 2, 2009 through August 30, 2009.

Note: A physician who has left a group, and for whom the group has engaged a locum tenens physician as a temporary replacement, may be still be considered a member of the group until a permanent replacement is obtained.

OUT-OF-AREA SERVICES

We are financially responsible for all emergency services and certain urgent care services provided by out-of-area medical and hospital facilities. Please refer any out-of-area provider contacts regarding a Colorado Access member to us at 800-511-5010 (toll free). Out-of-area providers should submit claims to our claims address for processing.

CORRECTED CLAIMS

Providers may resubmit claims for reprocessing within 120 days of the date of service or the timeframes outlined in the Provider's contract or 60 days from the date of the last denial recorded on a voucher.

Corrected Claim Process

- Corrected electronic claims should be submitted following the guidelines in the HIPAA standard TR3 Implementation Guide, using the frequency code of "7" in Loop 2300, Segment CLM05-3 and the original claim number in Loop 2300, Ref*F8.
- Corrected paper claims should be clearly marked "Corrected" on the face of the newly completed claim form.
  - The resubmission must be newly dated and signed with an authorized signature.
  - Correct the appropriate information clearly and accurately.
  - Adjust total charges to reflect the amount being resubmitted.
  - For a UB04 claim form, change the fourth digit of the bill type to a "7," the original claim number in Box 64. For example, an initial inpatient claim would be submitted with a bill type of 0111 and a corrected claim would be submitted with a bill type of 0117.
  - For a CMS 1500 claim form, enter a "7" in Box 22 with the original claim number of the corrected claim.
  - Mail all resubmitted claims to our claims address (see our addresses located in this section).

LATE OR ADDITIONAL CHARGES

Providers billing late or additional charges for previously submitted claims must resubmit the entire claim. Do not submit the missing lines or additional lines separately. For example, if an inpatient claim was submitted without the laboratory fees, the new/corrected claim must include the laboratory fees AND the original claim lines.

MEMBER BILLING OR BALANCE BILLING

Hold Harmless Clause for Covered Services

According to your contract with Colorado Access and CRS § 25.5-4-301(1)(a)(I),

> Provider agrees that, in no event, including nonpayment by Colorado Access, the insolvency of Colorado Access, or breach of this Agreement by any party, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against members or persons other than Colorado Access. This provision shall not prohibit collection of copayments on Colorado Access' or Payer's behalf in accordance with the terms of the applicable Benefit Program. Provider further agrees that this provision: (a) shall survive the termination of this Agreement regardless of the cause giving rise to termination; (b) shall be construed for the benefit of members; and (c) supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and members or persons acting on their behalf.

This includes charging members for missed appointment and for failing to follow appointment cancellation policies.

Medicaid members may NOT be changed for Medicaid-covered items or services regardless of whether Colorado Access has actually reimbursed the Provider and regardless of whether the Provider is enrolled in the Colorado medical assistance program.

Circumstances in Which a Member can be Billed for Services

- Any deductible, copayment or coinsurance that is the member's cost share
- A CHP+ member sees a non-participating provider in a non-emergent, non-urgent, outpatient setting without prior authorization (applies to in-state and out-of-state providers).
- A member does not follow the pharmacy rules (member may have to pay for the medication).
- A member receives non-emergent health care services outside of the United States.

MISSED APPOINTMENTS

Per state requirements, members are not subject to missed appointment fees, even if the cancellation occurred within 24 hours of the scheduled appointment time.

OVERPAYMENTS

You should routinely review claims and payments in an effort to determine if you have received any overpayments. Overpayments requiring recoupment from a provider routinely occur in a number of ways, including, but not limited to:

- Claims paid in error;
- Claims allowed/paid greater than billed;
- Duplicate payments;
- Payments made for individuals who are not eligible;
- Payments made for services in excess of applicable benefit limitations; or
- Payments made in excess of amounts due in instances of third party liability and/or coordination of benefits.

These types of errors are typically discovered through self-disclosure by the Provider or through our claims review and/or audit processes. These are considered overpayments discovered during the normal course of business, and do not include auditing performed or repayments required specific to fraud, waste, and abuse efforts.

When an overpayment is discovered during the normal course of business, you may be directed to either submit a revised claim on a Non-Clinical Adjustment/Appeal Process Request form available at www.coaccess.com/fequently-used-forms, or submit a check for the overpayment,

at our discretion. Any revised claim adjustments will be reflected as a credit balance and are set off against future claims submitted by the Provider.

Repayments for non-participating Providers will be made by check.

In the event that there is an outstanding negative balance as a result of claims adjustments or nonpayment after a reasonable period of time, we may issue a demand for repayment to you, subject to applicable laws and regulations. If you fail to respond and/or provide the amounts demanded within a reasonable period of time, such failure to respond is deemed approval and agreement with the demand for repayment, and we may pursue all available remedies. If you disagree with demand for repayment of an overpayment, you may request in writing that such demand for repayment be reviewed, provided that such review is submitted prior to the due date of the repayment.