Medical/Surgical Services Manual

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Benefits Overview

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

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

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

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

Billing Information

Refer to the General Provider Information manual for general billing information.

Anesthesia Services

General Benefits

Anesthesia benefits are provided for medical, surgical and radiological procedures. Anesthesia reimbursement is based on actual anesthesia time. One unit of service equals fifteen minutes of anesthesia time. Anesthesia time begins when the anesthetist starts member preparation for induction in the operating room or an equivalent area and ends when the member may be safely placed under post-operative care. No additional benefits are provided for emergency conditions or the member's physical status.

Reimbursement for anesthesia includes all of the following:

- Preoperative evaluation
- Postoperative visits
- Anesthesia care during the procedure
- Fluid and/or blood administration
- Interpretation of blood gases
- Any necessary non-invasive monitoring procedures (e.g., EKG)

Nerve blocks for anesthetic purposes are processed as general anesthesia. Nerve blocks for diagnostic or therapeutic purposes are processed as surgical procedures.

The following services are considered incidental to the anesthesia service and no separate benefit is allowed:

- Total body hypothermia in combination with or in addition to procedure codes described as "open" or "bypass"
- Endotracheal intubation or extubation

Anesthesia by Surgeon

Local infiltration, digital block, or topical anesthesia administered by the operating surgeon is included in the surgical reimbursement and no additional benefit is available. IV valium or IV pentothal is a benefit when administered by the surgeon. For obstetrical deliveries, local pudendal and paracervical block anesthesia is included in the obstetrical payment and no additional benefits are allowed for the delivering physician.

Obstetrical Anesthesia

Epidural anesthesia by a provider other than the delivering practitioner is a covered benefit. Member contact time must be documented on the claim. Claims for more than 120 minutes (eight or more time units) of direct member contact epidural time require an attached copy of the anesthesia record.

Standby Anesthesia

Standby anesthesia is a benefit in conjunction with obstetrical deliveries, subdural hematomas, femoral or brachial artery embolectomies, members with a physical status of 4 or 5, insertion of a cardiac pacemaker, cataract extraction and/or lens implant, percutaneous transluminal angioplasty, and corneal transplant. Unusual circumstances or exceptions to allow a benefit for standby anesthesia for other procedures must be fully documented. Documentation must be submitted with claim.

Family Planning Services

Family planning services including intrauterine devices, implants, diaphragms, and contraceptive drugs are benefits of the Health First Colorado.

Foot Care Services

Foot care services are benefits of the Health First Colorado whether provided by a physician or licensed podiatrist. Claims for services provided to dually eligible (i.e., Health First Colorado and Medicare eligible) members are submitted directly to the fiscal agent.

If the billed service is routine foot care and is identified by the Medicare program as non-reimbursable, use the GY modifier to identify routine podiatric foot care services that are not covered by Medicare. The Medicare non-covered services field on the claim record must also be completed.

Medical Services

Consultation

Effective April 1, 2010, CPT consultation codes (ranges 99241-99245 for office/outpatient consultations and 99251-99255 for inpatient consultations) will no longer be recognized for payment. This change was implemented to be consistent with Medicare policy.

Please submit claims for consultation services using another Evaluation and Management (E/M) code that most appropriately represents where the visit occurred and that identifies the complexity of the visit performed.

Annual Physical

Adults may receive one physical examination per year. Sports physicals are not covered.

Vaccines/Immunizations

Please refer to the Immunization Benefits Billing Manual on the Department's website.

Medical Care and Surgery on the Same Day

Both medical care and surgery are allowed when performed on the same day by the physician when the surgical procedure is minor in nature. Follow up care requirements are determined by the Department and are related to those assigned by Medicare and other sources.

New Member Services

New member medical care visits are limited to one per member per provider. A medical records administrative fee is included in the Health First Colorado reimbursement.

Nursing Facility Visits

Nursing facility visits are limited to one visit per day per member by the same provider for the same diagnosis or condition.

Office Visits

Office visits are limited to one visit per day per member by the same provider for the same diagnosis or condition.

Supplies Provided by a Physician

Providers may bill for non-routine supplies following the instructions in the current CMS bulletin for practitioners.

Billable non-routine supplies are listed in the CMS publication under separate categories. Providers should always refer to the most current publications when billing the Health First Colorado as some supplies are considered inclusive in the medical or surgical service.

Non-benefit Medical Services

Services for which Health First Colorado assistance is not available include, but are not limited to:

- Cosmetic surgery solely for improvement of physical appearance
- Telephone call charges for prescriptions
- Immunizations for the sole purpose of overseas travel
- Missed appointments
- Telephone consultation
- Medical testimony
- Chiropractic services (except crossover claims for QMB members)
- Homeopathic services
- Report preparation
- Acupuncture

Psychiatric Services

General benefits

Psychiatric services refer to services described in CPT under the heading "Psychiatry". Health First Colorado benefits are available for face to face member contact services only. Benefits are not available for report preparation, telephone consultation, case presentations, or staff consultation.

Non-benefit psychiatric services

Psychotherapy services provided for the following specific primary diagnoses are not benefits of the Health First Colorado.

F03.90	Unspecified dementia without behavioral disturbance
F05	Delirium due to known physiological condition
290.4	Vascular dementia
F01.50	Vascular dementia without behavioral disturbance
F01.51	Vascular dementia with behavioral disturbance

310	Specific nonpsychotic mental disorders due to brain damage
F07.0	Personality change due to known physiological condition
F07.81	Postconcussional syndrome
F48.2	Pseudobulbar affect
310.8	Other specified nonpsychotic mental disorders following organic brain damage
F07.89	Other personality and behavioral disorders due to known physiological condition
F07.9	Unspecified personality and behavioral disorder due to known physiological condition
F09	Unspecified mental disorder due to known physiological condition
F70	Mild intellectual disabilities
318	Other specified mental retardation
F71	Moderate intellectual disabilities
F72	Severe intellectual disabilities
F73	Profound intellectual disabilities
F78	Other intellectual disabilities
F79	Unspecified intellectual disabilities
R41.81	Age-related cognitive decline
R54	Age-related physical debility

The following psychiatric services are not benefits:

- Activity group therapy
- Play therapy
- Family therapy
- Recreational therapy
- Occupational therapy
- Peer relations therapy
- Day care
- Medication check
- Play observation
- Sleep observation
- Music therapy
- Religious counseling
- Group socialization
- Educational activities
- Services directed towards making one's personality more forceful or dynamic
- Consciousness raising
- Vocational counseling
- Primal scream
- Biofeedback
- Marital counseling
- Sex therapy
- Milieu therapy
- Training disability services
- Rolfing or structural integration
- Bioenergetic therapy
- Guided imagery
- Z-therapy
- Obesity control therapy
- Dance therapy
- Tape therapy (recorded psychotherapy)

Unusual circumstances or exceptions to allow benefits for these services must be fully documented, reviewed, and prior authorized.

Regional Accountable Entities (RAEs)

Regional Accountable Entities (RAEs) provide all mental health care to members in their geographical area. Non-network practitioners who render emergency mental health services must bill the RAE for payment. The RAE will not pay for non-emergency services provided without RAE prior authorization.

Members who are dually eligible (i.e., Medicaid and Medicare eligible) may obtain services through the RAE or from a non-RAE provider, and the fiscal agent will process submitted Medicare crossover claims. If the mental health service is covered by the Health First Colorado only, the member must obtain services from the RAE.

Radiology Services

Please refer to the Outpatient Imaging and Radiology Billing Manual on the Department's website.

Surgical Services

General Benefits

Surgical reimbursement includes payment for the operation, local infiltration, digital block or topical anesthesia when used, and normal, uncomplicated follow-up care. Under most circumstances, the immediate preoperative visit necessary to examine the member is included in the surgical procedure whether provided in the hospital or elsewhere.

Cosmetic Surgery

Procedures intended solely to improve the physical appearance of an individual but which do not restore bodily function or correct deformity are not benefits of the Health First Colorado.

Abortion

Therapeutic legally induced abortions are benefits of the Health First Colorado when performed to save the life of the mother. The Health First Colorado also reimburses legally induced abortions for pregnancies that are the result of sexual assault (rape) or incest. Specific instructions for submitting claims for abortions performed for maternal life endangering circumstances, sexual assault or incest are described in the Sterilizations, Hysterectomies, and Abortions Billing Instructions section.

Assistant Surgeon

Assistant surgeon services may be reported by adding the appropriate modifier code 80, 81, or 82 to the surgical procedure code. The source for procedures appropriate for assistant surgery benefit is the Medicare Physician Fee Schedule Database (MPFSDB). Information is entered on the procedure file for those procedures for which Medicare allows assistant surgeon benefits.

Payment allowed is up to 20 percent of the surgeon's maximum allowable reimbursement for the first procedure and 5 percent of the surgeon's maximum allowable reimbursement for second and subsequent procedures. If multiple surgery pricing also applies to services reported with modifier 80, 81 or 82, the assistant surgery pricing will be applied after the multiple surgery discount.

Surgeries performed by the same rendering provider for the same member on the same date of service must be submitted on a single claim. Each rendering provider's procedures should be submitted on a separate claim, even if the claims are submitted by the same billing provider.

- Benefits for assistant surgeons are not allowed for non-physician assistants at surgery.

Hysterectomy

A hysterectomy is a benefit of the Health First Colorado when performed solely for medical reasons. A hysterectomy is **not** a benefit when:

- The procedure is performed solely for the purpose of sterilization.
- There is more than one purpose for the procedure and it would not have been performed except for the purpose of sterilization.

Refer to the Sterilizations, Hysterectomies, and Abortions Billing Instructions section for billing requirements.

Reconstructive surgery

Surgical procedures intended to improve function and appearance of anybody area altered by disease, trauma, congenital or developmental anomalies, or previous surgical processes may be benefits of the program if services are prior authorized. Physician documentation on the PAR form is the basis for determining the benefit for reconstructive surgery.

Sterilization

Voluntary sterilization is a benefit when appropriately documented on the Med-178 form. Refer to the Sterilizations, Hysterectomies, and Abortions Billing Instructions section for sterilization billing requirements.

Transplantation

Organ procurement and transplantation are benefits only when prior authorized. Corneal and kidney transplants are benefits and do not require prior authorization.

Important: Organ transplants are <u>not</u> a covered benefit for non-citizens.

Multiple Surgeries

Health First Colorado utilizes the general surgical guidelines, subsection instructions, and procedure code modifiers found in each year's CPT code book published by the AMA. The following information is in addition to the CPT guidelines, and should be utilized for billing the Health First Colorado and reimbursement purposes.

The Medicare Physician Fee Schedule Data Base (MPFSDB) designates some procedure codes as subject to multiple surgery criteria. When two or more procedures subject to multiple surgery pricing are reported on a claim, the surgery procedure commanding the greatest allowable payment will be reimbursed at 100 percent of the allowed amount, the surgery procedure with the second greatest allowable payment at 50 percent and subsequent surgery procedures at 25 percent.

Services must be billed on the same claim to receive payment for multiple surgical services rendered on the same date of service, for the same member, by the same rendering provider. If a separate claim is billed for the same rendering provider, the subsequent claim will deny. If multiple surgeons provide services to a member on the same date of service, report each rendering provider's procedures on a separate claim.

Bilateral procedures – modifier 50

Unless otherwise identified in the CPT-4 listings, bilateral procedures requiring a separate incision that are performed at the same operative session, should be identified by the appropriate five-digit code describing the procedure with modifier 50 added to the procedure code. Use of this modifier should be limited to procedures for which "bilateral" services are appropriate according to the MPFSDB.

Bilateral procedures indicated using modifier 50 will be reimbursed at 180 percent of the maximum allowable for the procedure. If multiple surgery pricing also applies to services reported with modifier 50, the multiple surgery discount will be applied after the bilateral pricing.

Two surgeons – modifier 62

When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) including add-on procedure(s) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. Note: if a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

Report each rendering provider's procedures on a separate claim, even if the claims are submitted by the same billing provider. Procedures reported with modifier 62 will be priced at 62.5% of the maximum allowed amount. Multiple surgery discounting will be applied to eligible procedures after the 62.5% adjustment.

Endoscopic Procedures

Certain procedure codes are designated as endoscopic and placed into families according to the MPFSDB. A reimbursement reduction is applied to multiple endoscopic procedures within the same family performed by the same physician on the same member on the same day. When a claim contains multiple endoscopy procedures within the same family, the procedure with the highest allowable payment will be reimbursed at 100 percent of that amount, the procedure with the next highest allowable payment will be reimbursed at 80 percent, and subsequent procedures will be reimbursed at 50 percent.

Reimbursement for endoscopic procedures within the same family is calculated independently of discounts that might apply to other lines on the claim, including other families of endoscopic procedures, or multiple surgeries.

Unlisted CPT Codes

Unlisted surgery CPT codes are used when there is no CPT or HCPCS code that accurately identifies the services performed. Unlisted surgery codes with dates of service on or after November 1, 2018, will be priced by a clinical reviewer with the Department's fiscal agent.

Claims with unlisted codes must include as attachments the operating report from the procedure and the Unlisted Surgical Procedure Code Form. The Department will deny claims lacking the required attachments. Claims denied for incomplete information will have to be resubmitted with the correct information for reimbursement.

The following procedure codes must be accompanied by the Unlisted Surgical Procedure Code Form and an operating report:

15999	22999	29799	37501	41599	44238	47399	51999	59897	67599
17999	23929	29999	37799	41899	44799	47579	53899	59898	67999

19499	24999	30999	38129	42299	44899	47999	54699	59899	68399
20999	25999	31299	38589	42699	44979	48999	55559	60659	68899
21089	26989	31599	38999	42999	45399	49329	55899	60699	69399
21299	27299	31899	39499	43289	45499	49659	58578	64999	69799
21499	27599	32999	39599	43499	45999	49999	58579	66999	69949
21899	27899	33999	40799	43659	46999	50549	58679	67299	69979
22899	28899	36299	40899	43999	47379	50949	58999	67399	

Vision Care Services

Please refer to the Vision and Eyewear Billing Manual on the Department's website.

CMS 1500 Paper Claim Reference Table

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

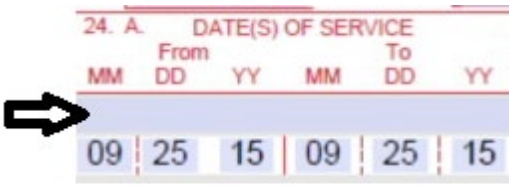
CMS Field #	Field Label	Field is?	Instructions
1	**Insurance Type**	Required	Place an "X" in the box marked as Medicaid.
1a	**Insured's ID Number**	Required	Enter the member's Health First Colorado seven-digit Medicaid ID number as it appears on the Medicaid Identification card. Example: A123456.
2	**Patient's Name**	Required	Enter the member's last name, first name, and middle initial.
3	**Patient's Date of Birth / Sex**	Required	Enter the member's birth date using two digits for the month, two digits for the date, and two digits for the year. Example: 070114 for July 1, 2014. Place an "X" in the appropriate box to indicate the sex of the member.
4	**Insured's Name**	Conditional	Complete if the member is covered by a **Medicare** health insurance policy. Enter the insured's full last name, first name, and middle initial. If the insured used a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name.

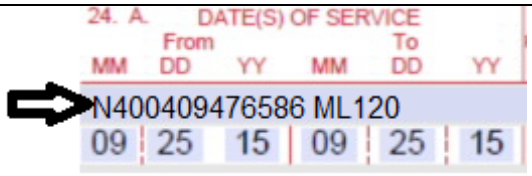
CMS Field #	Field Label	Field is?	Instructions
5	**Patient's Address**	Not Required	
6	**Patient's Relationship to Insured**	Conditional	Complete if the member is covered by a commercial health insurance policy. Place an "X" in the box that identifies the member's relationship to the policyholder.
7	**Insured's Address**	Not Required	
8	**Reserved for NUCC Use**		
9	**Other Insured's Name**	Conditional	If field 11d is marked "yes", enter the insured's last name, first name and middle initial.
9a	**Other Insured's Policy or Group Number**	Conditional	If field 11d is marked "yes", enter the policy or group number.
9b	**Reserved for NUCC Use**		
9c	**Reserved for NUCC Use**		
9d	**Insurance Plan or Program Name**	Conditional	If field 11d is marked "yes", enter the insurance plan or program name.
10a-c	**Is Patient's Condition Related to?**	Conditional	When appropriate, place an "X" in the correct box to indicate whether one or more of the services described in field 24 are for a condition or injury that occurred on the job, as a result of an auto accident or other.
10d	**Reserved for Local Use**		

CMS Field #	Field Label	Field is?	Instructions
11	**Insured's Policy, Group or FECA Number**	Conditional	Complete if the member is covered by a **Medicare** health insurance policy. Enter the insured's policy number as it appears on the ID card. Only complete if field 4 is completed.
11a	**Insured's Date of Birth, Sex**	Conditional	Complete if the member is covered by a **Medicare** health insurance policy. Enter the insured's birth date using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. Place an "X" in the appropriate box to indicate the sex of the insured.
11b	**Other Claim ID**	Not Required	
11c	**Insurance Plan Name or Program Name**	Not Required	
11d	**Is there another Health Benefit Plan?**	Conditional	When appropriate, place an "X" in the correct box. If marked YES, complete 9, 9a and 9d.
12	**Patient's or Authorized Person's signature**	Required	Enter "Signature on File", "SOF", or legal signature. If there is no signature on file, leave blank or enter "No Signature on File". Enter the date the claim form was signed.
13	**Insured's or Authorized Person's Signature**	Not Required	
14	**Date of Current Illness Injury or Pregnancy**	Conditional	Complete if information is known. Enter the date of illness, injury or pregnancy, (date of the last menstrual period) using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. Enter the applicable qualifier to identify which date is being reported 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period

CMS Field #	Field Label	Field is?	Instructions
15	**Other Date**	Not Required	
16	**Date Patient Unable to Work in Current Occupation**	Not Required	
17	**Name of Referring Physician**	Conditional	
18	**Hospitalization Dates Related to Current Service**	Conditional	Complete for services provided in an inpatient hospital setting. Enter the date of hospital admission and the date of discharge using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. If the member is still hospitalized, the discharge date may be omitted. This information is not edited.
19	**Additional Claim Information**	Conditional	
20	**Outside Lab?** **$ Charges**	Conditional	Complete if <u>all</u> laboratory work was referred to and performed by an outside laboratory. If this box is checked, no payment will be made to the physician for lab services. Do not complete this field if <u>any</u> laboratory work was performed in the office. Practitioners may not request payment for services performed by an independent or hospital laboratory.
21	**Diagnosis or Nature of Illness or Injury**	Required	Enter at least one but no more than twelve diagnosis codes based on the member's diagnosis/condition. Enter applicable ICD indicator to identify which version of ICD codes is being reported. 0 ICD-10-CM (DOS 10/1/15 and after) 9 ICD-9-CM (DOS 9/30/15 and before)
22	**Medicaid Resubmission Code**	Conditional	List the original reference number for adjusted claims.

CMS Field #	Field Label	Field is?	Instructions
			When resubmitting a claim as a replacement or a void, enter the appropriate bill frequency code in the left-hand side of the field. 7 Replacement of prior claim 8 Void/Cancel of prior claim This field is not intended for use for original claim submissions.
23	**Prior Authorization**	Conditional	**CLIA** When applicable, enter the word "CLIA" followed by the number. **Prior Authorization** Enter the six-character prior authorization number from the approved Prior Authorization Request (PAR). Do not combine services from more than one approved PAR on a single claim form. Do not attach a copy of the approved PAR unless advised to do so by the authorizing agent or the fiscal agent.
24	**Claim Line Detail**	Information	The paper claim form allows entry of up to six detailed billing lines. Fields 24A through 24J apply to each billed line. **Do not enter more than six lines of information** on the paper claim. If more than six lines of information are entered, the additional lines will not be entered for processing. Each claim form must be fully completed (totaled). **Do not file continuation claims** (e.g., Page 1 of 2).
24A	**Dates of Service**	Required	The field accommodates the entry of two dates: a "From" date of services and a "To" date of service. Enter the date of service using two digits for the month, two digits for the date and two digits for the year. Example: 010114 for January 1, 2014 From To **01 01 14** | | | Or From To **01 01 14 01 01 14**

CMS Field #	Field Label	Field is?	Instructions
			Span dates of service From To **01 01 14 01 31 14** Practitioner claims must be consecutive days. Single Date of Service: Enter the six-digit date of service in the "From" field. Completion of the "To field is not required. Do not spread the date entry across the two fields. Span billing: permissible if the same service (same procedure code) is provided on consecutive dates. **Supplemental Qualifier** To enter supplemental information, begin at 24A by entering the qualifier and then the information.  ZZ code Narrative description of unspecified N4 National Drug Codes ▪ Enter NDC qualifier N4 (left-justified), immediately followed by the 11-digit NDC numeric code. ▪ Enter one space for separation. ▪ Enter the appropriate qualifier for the correct dispensing NDC unit of measure (UN – Units, ML – Milliliter, GR – Gram, or F2 – International Unit), immediately followed by the quantity (number of NDC units). Example:

CMS Field #	Field Label	Field is?	Instructions
			 VP Vendor Product Number OZ Product Number CTR Contract Rate JP Universal/National Tooth Designation JO Dentistry Designation System for Tooth & Areas of Oral Cavity
24B	**Place of Service**	Required	Enter the Place of Service (POS) code that describes the location where services were rendered. The Health First Colorado accepts the CMS place of service codes. 04 Homeless Shelter 11 Office 12 Home 15 Mobile Unit 20 Urgent Care Facility 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room Hospital 25 Birthing Center 26 Military Treatment Center 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Transportation – Land 51 Inpatient Psychiatric Facility 52 Psychiatric Facility Partial Hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility – MR 60 Mass Immunization Center 61 Comprehensive IP Rehab Facility 62 Comprehensive OP Rehab Facility 65 End Stage Renal Dialysis Trtmt Facility

CMS Field #	Field Label	Field is?	Instructions
			71 State-Local Public Health Clinic 99 Other Unlisted
24C	**EMG**	Conditional	Enter a "Y" for YES or leave blank for NO in the bottom, unshaded area of the field to indicate the service is rendered for a life-threatening condition or one that requires immediate medical intervention. If a "Y" for YES is entered, the service on this detail line is exempt from co-payment requirements.
24D	**Procedures, Services, or Supplies**	Required	Enter the HCPCS procedure code that specifically describes the service for which payment is requested. All procedures must be identified with codes in the current edition of Physicians Current Procedural Terminology (CPT). CPT is updated annually. HCPCS Level II Codes The current Medicare coding publication (for Medicare crossover claims only). Only approved codes from the current CPT or HCPCS publications will be accepted.
24D	**Modifier**	Conditional	Enter the appropriate procedure-related modifier that applies to the billed service. Up to four modifiers may be entered when using the paper claim form. **Mod** **Description** 24 **Unrelated Evaluation/Management (E/M) service by the same physician during a postoperative period** Use with E/M codes to report unrelated services by the same physician during the postoperative period. Claim diagnosis code(s) must identify a condition unrelated to the surgical procedure. 25 **Significant, separately identifiable Evaluation/Management (E/M) service by the same physician on the day of a procedure**

CMS Field #	Field Label	Field is?	Instructions
			Use with E/M code to report significant, separately identifiable E/M service above and beyond the primary service provided. Primary service must be a minor surgery (0 or 10 day global period). 26 **Professional component** Use with diagnostic codes to report professional component services (reading and interpretation) billed separately from technical component services. Report separate professional and technical component services only if different providers perform the professional and technical portions of the procedure. Read CPT descriptors carefully. Do not use modifiers if the descriptor specifies professional or technical components. 47 **Anesthesia by surgeon** Use with surgical procedure codes to report general or regional anesthesia by the surgeon. Local anesthesia is included in the surgical reimbursement. 50 **Bilateral procedures** Use to identify bilateral surgical procedures performed at the same operative session. Read CPT descriptions carefully. Do not use modifier 50 if the procedure descriptor states "Unilateral or bilateral" services. 51 **Multiple procedures** Use to identify additional procedures that are performed on the same day or at the same session by the same provider. Do not use to designate "add-on" codes. 55 **Postoperative Management only** Use with eyewear codes (lenses, lens dispensing, frames, etc.) to identify eyewear provided after eye surgery.

CMS Field #	Field Label	Field is?	Instructions
			Benefit for eyewear, including contact lenses, for members over age 20 must be related to surgery. Modifier 55 takes the place of the required claim comment that identifies the type and date of eye surgery. The provider must retain and, upon request, furnish records that identify the type and date of surgery. 57 **Decision for Surgery** Use with Evaluation/Management (E/M) code to report services on the day before or on the day of major surgery (90 day global period) which resulted in the initial decision to perform the surgery. 59 **Distinct Procedural Service** Use to indicate a service that is distinct or independent from other services that are performed on the same day. These services are not usually reported together but are appropriate under the circumstances. This may represent a different session or member encounter, different procedure or surgery, different site or organ system or separate lesion or injury. 62 **Two surgeons** Use when two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. 76 **Repeat procedure or service by <u>same</u> physician/provider/other qualified health care professional**

CMS Field #	Field Label	Field is?	Instructions
			Use to identify subsequent occurrences of the same service on the same day by the same provider. Not valid with E/M codes. 77 **Repeat procedure by <u>another</u> physician/provider/other qualified health care professional** Use to identify subsequent occurrences of the same service on the same day by different rendering providers. 79 **Unrelated procedure or service by the same surgeon during the postoperative period** Unrelated procedures or services (other than E/M services) by the surgeon during the postoperative period. Use to identify unrelated services by the operating surgeon during the postoperative period. Claim diagnosis code(s) must identify a condition unrelated to the surgical procedure. 80 **Assistant surgeon** Use with surgical procedure codes to identify assistant surgeon services. Note: Assistant surgeon services by non-physician practitioners, physician assistants, percussionists, etc. are not reimbursable. 81 **Minimum assistant surgeon** Use with surgical procedure codes to identify minimum surgical assistant services. 82 **Assistant surgeon (when qualified resident surgeon not available)** Use with surgical procedure codes to identify assistant surgeon services. The unavailability of a qualified

CMS Field #	Field Label	Field is?	Instructions
			resident surgeon is a prerequisite for use of modifier 82. GY **Item or services statutorily excluded or does not meet the Medicare benefit.** Use with podiatric procedure codes to identify routine, non-Medicare covered podiatric foot care. Modifier - GY takes the place of the required provider certification that the services are not covered by Medicare. The Medicare non-covered services field on the claim record must also be completed. KX **Specific required documentation on file** Use with laboratory codes to certify that the laboratory's equipment is not functioning or the laboratory is not certified to perform the ordered test. The -KX modifier takes the place of the provider's certification, "I certify that the necessary laboratory equipment was not functioning to perform the requested test ", or "I certify that this laboratory is not certified to perform the requested test." TC **Technical component** Use with diagnostic codes to report technical component services or procedures and includes the cost of equipment and supplies to perform that service or procedure. This modifier corresponds to the equipment/facility part of a given service or procedure. Report separate professional and technical component services only if different providers perform the professional and technical portions of the procedure. Read CPT descriptors carefully. Do not use modifiers if the descriptor specifies professional or technical components.

CMS Field #	Field Label	Field is?	Instructions
24E	**Diagnosis Pointer**	Required	Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis. At least one diagnosis code reference letter must be entered. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. This field allows for the entry of 4 characters in the unshaded area.
24F	**$ Charges**	Required	Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number. Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one procedure from the same group is billed, special multiple pricing rules apply. The base procedure is the procedure with the highest allowable amount. The base code is used to determine the allowable amounts for additional CPT surgical procedures when more than one procedure from the same grouping is performed. Submitted charges cannot be more than charges made to non-Health First Colorado covered individuals for the same service. Do not deduct Health First Colorado co-payment or commercial insurance payments from the usual and customary charges.
24G	**Days or Units**	Required	Enter the number of services provided for each procedure code. Enter whole numbers only- do not enter fractions or decimals.
24G	**Days or Units**	General Instructions	A unit represents the number of times the described procedure or service was rendered. Except as instructed in this manual or in Health First Colorado bulletins, the billed unit must correspond to procedure code descriptions. The following examples show the

CMS Field #	Field Label	Field is?	Instructions
			relationship between the procedure description and the entry of units.

Anesthesia Services

Anesthesia time begins when the anesthetist begins member preparation for induction in the operating room or an equivalent area and ends when the anesthetist is no longer in constant attendance.

Anesthesia time must be reported in minutes. Units may only be reported for CPT 01996: Daily hospital management of epidural or subarachnoid continuous drug administration.

For claims with dates of service prior to June 1, 2018, minutes of service should be billed in fifteen-minute increments, rounded up to the nearest 15-minute increment. For example: 52 minutes of anesthesia time should be billed as 60 minutes.

For claims with dates of service on or after June 1, 2018, providers should bill the exact number of minutes during which services were provided.

Psychiatric Services

The following information applies only to codes identified under the Psychiatry heading in the CPT code book. These instructions do not apply to any other procedure code (hospital services, consultations, etc.) that might be billed by a psychiatric or psychological services provider.

Except for electroconvulsive therapy (ECT), one unit of service for psychiatric or mental health services represents fifteen minutes of face-to-face member contact. A fractional unit of services gets rounded up to the next fifteen-minute unit.

Examples:

15 minutes = 1 unit
16 minutes = 2 units
30 minutes = 2 units
31 minutes = 3 units

Psychiatric providers may not bill for:

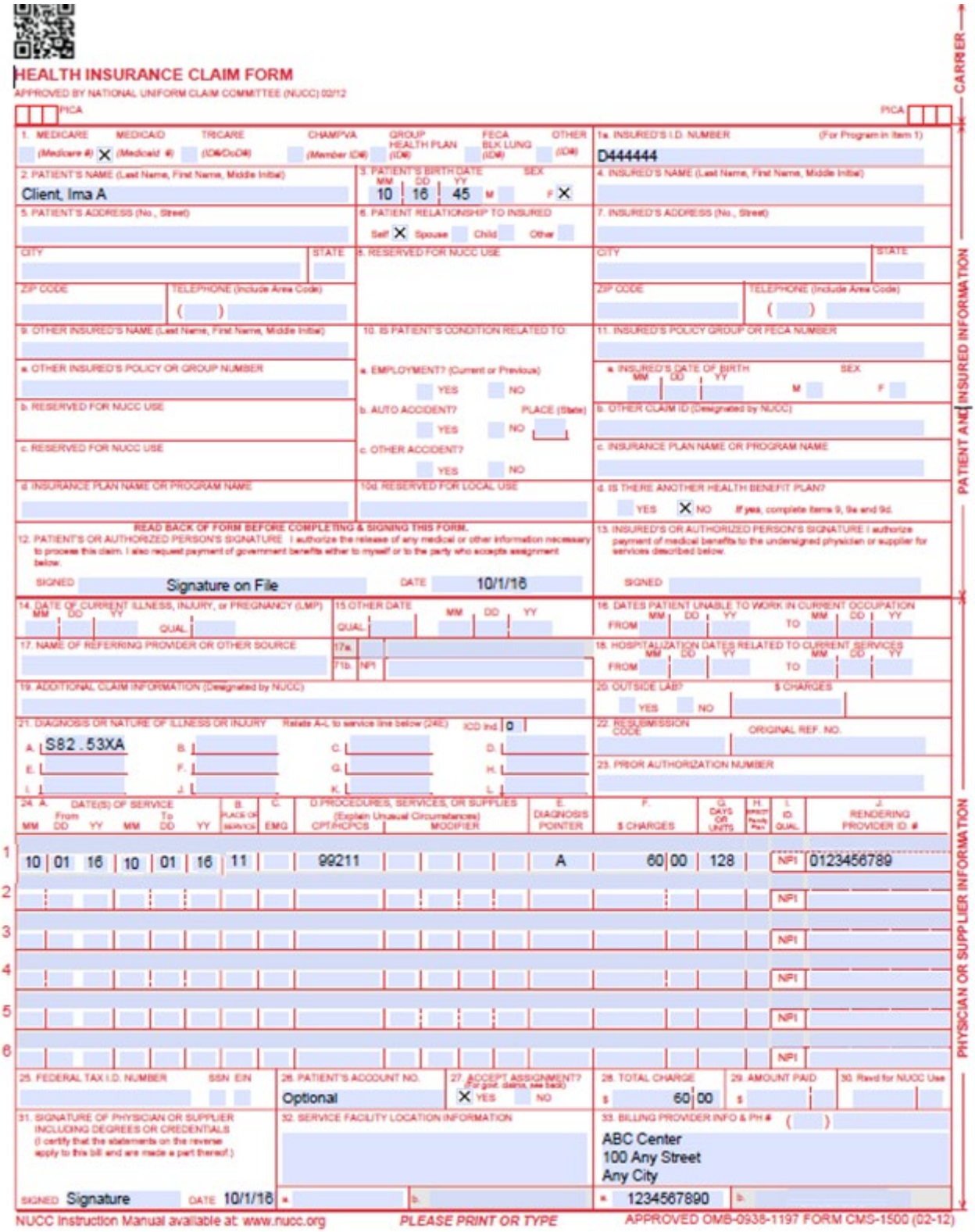
- Test scoring or evaluation time unless the member is present
- Conferences with the member, family members, or other health care providers unless the member is present
- Telephone calls
- Prescription refill calls
- Missed appointments

24H	**EPSDT/Family Plan**	Conditional	**EPSDT** (shaded area) For Early & Periodic Screening, Diagnosis, and Treatment related services, enter the response in the shaded portion of the field as follows: AV Available- Not Used S2 Under Treatment

CMS Field #	Field Label	Field is?	Instructions
			ST New Service Requested NU Not Used **Family Planning** (unshaded area) If the service is Family Planning, enter "Y" for YES or "N" for NO in the bottom, unshaded area of the field**.**
24I	**ID Qualifier**	Not Required	
24J	**Rendering Provider ID #**	Required	In the shaded portion of the field, enter the NPI of the Health First Colorado provider assigned to the individual who actually performed or rendered the billed service. This number cannot be assigned to a group or clinic.
25	**Federal Tax ID Number**	Not Required	
26	**Patient's Account Number**	Optional	Enter information that identifies the member or claim in the provider's billing system. Submitted information appears on the Remittance Advice (RA).
27	**Accept Assignment?**	Required	The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.
28	**Total Charge**	Required	Enter the sum of all charges listed in field 24F. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
29	**Amount Paid**	Conditional	Enter the total amount paid by Medicare or any other commercial health insurance that has made payment on the billed services. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
30	**Rsvd for NUCC Use**		
31	**Signature of Physician or Supplier Including**	Required	Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent.

CMS Field #	Field Label	Field is?	Instructions
	Degrees or Credentials		Each claim must have the date the enrolled provider or registered authorized agent signed the claim form. Enter the date the claim was signed using two digits for the month, two digits for the date and two digits for the year. Example: 070116 for July 1, 2016.
32	**32- Service Facility Location Information** **32a- NPI Number** **32b- Other ID #**	Conditional	Complete for services provided in a hospital or nursing facility in the following format: 1st Line Facility Name 2nd Line Address 3rd Line City, State and ZIP Code 32a- NPI Number Enter the NPI of the service facility (if known).
33	**33- Billing Provider Info & Ph #** **33a- NPI Number** **33b- Other ID #**	Required	Enter the name of the individual or organization that will receive payment for the billed services in the following format: 1st Line Name 2nd Line Address 3rd Line City, State and ZIP Code 33a- NPI Number Enter the NPI of the billing provider

CMS 1500 Medical Claim Example



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

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

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

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

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

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

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

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

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: Signature on File DATE: 10/1/16

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

SIGNED

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

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES | NO $ CHARGES

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

A. S82.53XA B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 01 16	10 01 16	11		99211		A	60 00	128		NPI 0123456789
2											NPI
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. Optional

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES | NO

28. TOTAL CHARGE $ 60 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Signature DATE 10/1/16

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

ABC Center
100 Any Street
Any City

a. 1234567890 b.

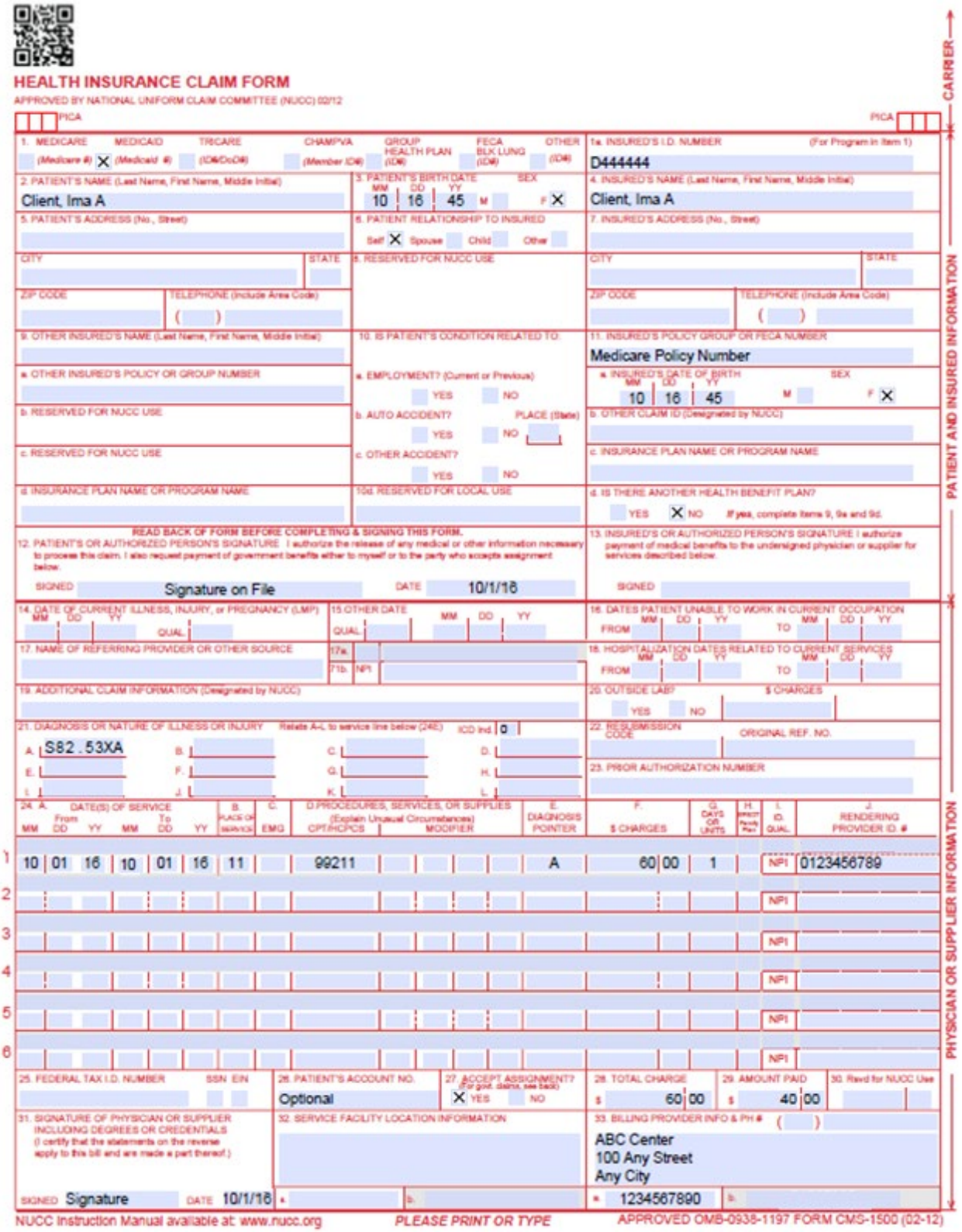
CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

CMS 1500 Medical Crossover Claim Example



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

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

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

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

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

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

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: Medicare Policy Number

a. OTHER INSURED'S POLICY OR GROUP NUMBER

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

a. INSURED'S DATE OF BIRTH: 10 16 45 SEX: M | F X

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: Signature on File DATE: 10/1/16

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

SIGNED

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

15. OTHER DATE QUAL | MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. | 17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES | NO $ CHARGES

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

A. S82.53XA B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 01 16 | 10 01 16	11		99211		A	60 00	1		NPI	0123456789
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: Optional

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE: $ 60 00

29. AMOUNT PAID: $ 40 00

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Signature DATE 10/1/16

32. SERVICE FACILITY LOCATION INFORMATION

a. | b.

33. BILLING PROVIDER INFO & PH # ( )

ABC Center
100 Any Street
Any City

a. 1234567890 b.

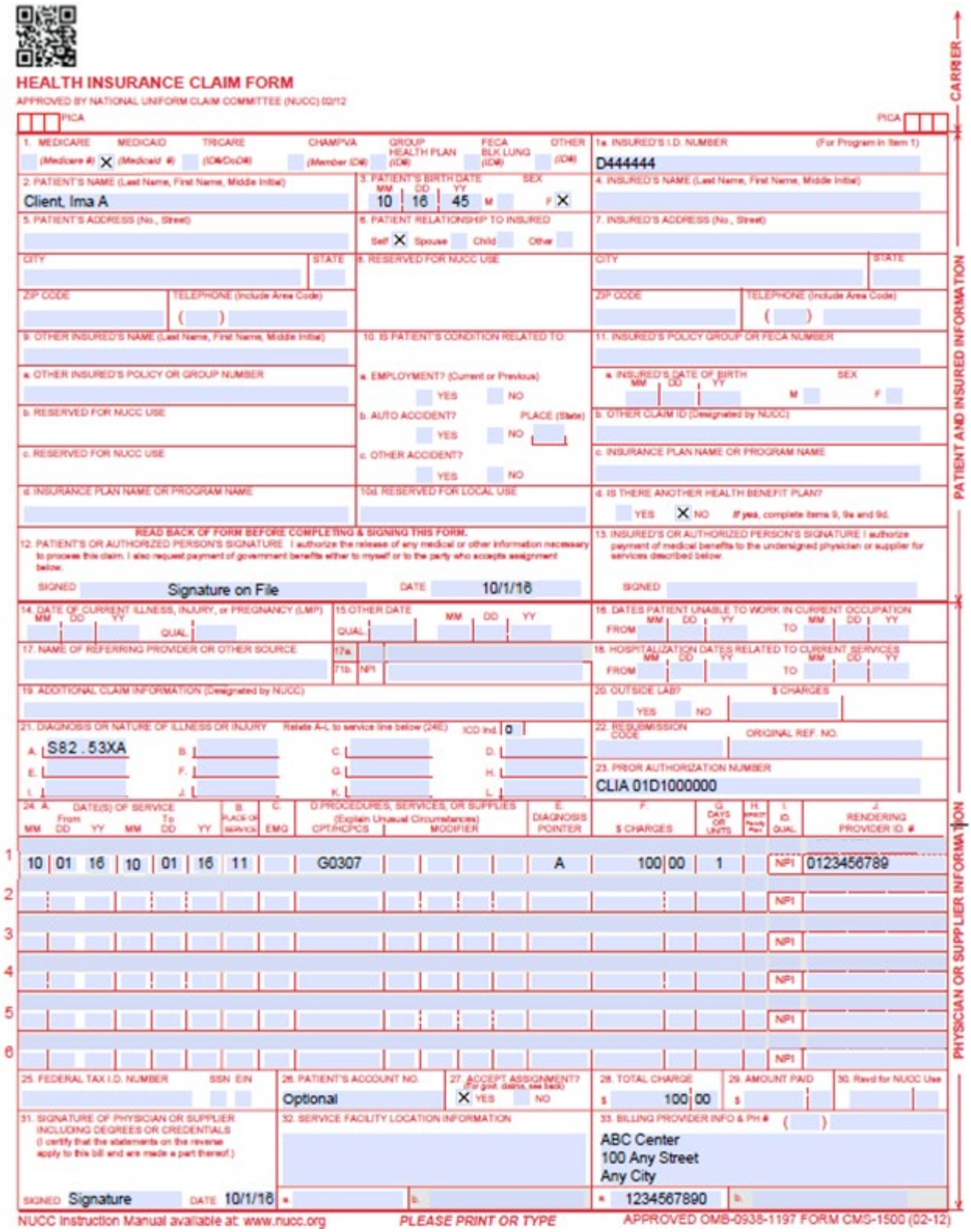
CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

CMS 1500 Medical Claim with CLIA Number Example



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

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

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

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

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

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

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED Signature on File DATE 10/1/16

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

SIGNED

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

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

A. S82.53XA B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: CLIA 01D1000000

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	10	01	16	10	01	16	11		G0307			A	100 00	1		NPI	0123456789
2																NPI	
3																NPI	
4																NPI	
5																NPI	
6																NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. Optional

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE $ 100 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Signature DATE 10/1/16

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

ABC Center
100 Any Street
Any City

a. 1234567890 b.

CARRIER

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Sterilizations, Hysterectomies and Abortions

For more information on Sterilization, Hysterectomies, and Abortions, please see the Obstetrical Care Billing Manual on the Billing Manuals web page under CMS 1500 drop-down menu.

Timely Filing

For more information on timely filing policy, including the resubmission rules for denied claims, please see the General Provider Information manual.

Medical Surgical Services Revisions Log

Revision Date	*Additions/Changes*	*Pages*	*Made by*
12/01/2016	*Manual revised for interChange implementation. For manual revisions prior to 12/01/2016 Please refer to Archive.*	*All*	*HPE (now DXC)*
12/27/2016	*Updates based on Colorado iC Stage II Provider Billing Manual Comment Log v0_2.xlsx*	*Multiple*	*HPE (now DXC)*
1/10/2017	*Updates based on Colorado iC Stage II Provider Billing Manual Comment Log v0_3.xlsx*	*Multiple*	*HPE (now DXC)*
1/19/2017	*Updates based on Colorado iC Stage II Provider Billing Manual Comment Log v0_4xlsx*	*Multiple*	*HPE (now DXC)*
1/26/2017	*Updates based on Department 1/20/2017 approval email*	*Accepted tracked changes throughout*	*HPE (now DXC)*
5/22/2017	*Updates based on Fiscal Agent name change from HPE to DXC*	*1, 13*	*DXC*
8/31/2017	*Updates based on DXC Management comments.*	*15*	*DXC*
1/2/2018	*Supplemental Qualifier addition - instructions for reporting an NDC*	*25, 26*	*DXC*
5/3/2018	*Updated Anesthesia payment policy and billing instructions*	*11, 12, 32, 33*	*RH*
6/26/2018	*Removed entire Laboratory section; updated timely*	*Multiple*	*HCPF*
11/20/2018	*Clarified Multiple Surgery, added Endoscopic and Unlisted sections*	*Multiple*	*RH/CL*
12/21/2018	*Clarification to signature requirements*	*25*	*HCPF*
2/6/2019	*Updated billing instructions for multiple surgery, bilateral, assistant surgeon, and two surgeon sections*	*Multiple*	*CL*
3/18/2019	*Clarification to signature requirement*	*25*	*HCPF*
7/11/2019	*Updated Appendices' links and verbiage*	*34*	*DXC*
10/16/2019	*Added modifier 25 and 57 descriptions, removed vaccine, vision, and radiology sections*	*Multiple*	*CL*

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.