DENVER HEALTH MEDICAL PLAN INC.™

CLAIMS GUIDE

Last Updated: September 2023

CONTENTS

SECTION I: WELCOME!

Denver Health Medical Plan, Inc. (DHMP) is a local, nonprofit health insurance company established in 1997 to provide quality, accessible and affordable health insurance.

We provide health insurance coverage to over 100,000 members in select Colorado counties. We offer employer group, Medicare, Child Health Plan Plus (CHP+), health care exchange and Medicaid products.

The DHMP Claims Guide is meant to provide guidance on how to submit claims for payment at DHMP. The guide is not meant to advise providers on how to bill, what procedure codes to use or what diagnosis to use. Providers are expected to bill for services that are medically necessary and are in accordance with generally accepted billing practices.

When providing services to DHMP members we encourage you to review the "For Providers" section at denverhealthmedicalplan.org/providers to become familiar with your patients medical plan requirements and ensure claims are paid correctly. Providers can also call 303-602-2100 Monday through Friday, 8 a.m. – 5 p.m.

SECTION II: BILLING & CLAIM PROCESSING

DHMP requires all providers to bill for the medically necessary services provided to its members in order to receive payment. DHMP uses the QNXT claims processing system and makes every effort to adhere to federal and state timely claims processing requirements. DHMP processes reimbursements checks once per week. Providers receive payment either via EFT or regular mail. In either case a remittance advice or electronic version of this is provided along with the reimbursement and details that explain how each claim processed for that provider.

SECTION III: MEMBER ELIGIBILITY

Payment for services rendered is subject to verification that the member was enrolled in a DHMP plan on the date the service was provided. Providers are responsible to meet any and all compliance requierments for DHMP's prior authorizations policies at time of services.

Providers must verify member eligibility at the time of service to ensure the member is enrolled in DHMP. Failure to do so may affect claims payment. Members may retroactively lose their eligibility with DHMP after the date of service. Therefore, verification of eligibility is not a guarantee of payment by DHMP.

Claims submitted for services rendered without proper authorization will be denied for "failure to obtain authorization." No payment will be made.

In certain cases, a managed care plan member, including DHMP members, may change health plans during the course of a hospital stay. When this occurs, providers should bill the health plan to which the member belonged at the time of admission to the hospital.

GRACE PERIOD IMPACT TO ELEVATE EXCHANGE & CO. OPTION PROVIDERS

Provider payment is subject to member's insurance coverage status. Members who receive advance premium tax credit (APTC) subsidies are entitled to a 90-day premium payment grace period. Claims submitted during days 31–90 of the member's grace period will not be subject to prompt-pay provisions until the member pays their premium in full. Providers are not permitted to balance-bill members during days 31–90 of their grace period. If the member's premium is paid in full by the end of the grace period, any pended claims will be processed in accordance with the terms of the contract. If the member premium is not paid in full by the end of the grace period, claims incurred during days 31–90 of the grace period will be denied. (The Grace Period model is now "pay and pursue").

SECTION IV: GENERAL BILLING AND CLAIM SUBMISSION REQUIREMENTS

SUBMITTING CLAIMS ELECTRONICALLY

For all electronic claims, DHMP utilizes Change Healthcare and Smart Data Solutions. Claims submitted electronically receive a status report indicating whether the claims accepted, rejected, and/or are pending. The amount paid on each claim is shown when the claim has finalized. Claims submitted electronically must include:

• DHMP Payer ID Number on each claim. (See Payer ID product list below)
• Complete DHMP Member ID Numbers (see member ID card or monthly enrollment roster)

A National Provider Identifier (NPI) should reside in:
• 837 Professional (HCFA) - Loop 2310B Rendering Provider Identifier, Segment/Element NM109. NM108 must qualify with an XX (NPI);
• 837 Institutional (UB04) - Loop 2010AA Billing Provider, Segment/Element NM109. NM108 must qualify with an XX (NPI).

Payer ID Product List:

Denver Health Medical Plan, Inc. Medical Care/
Point of Service/ Highpoint HMO (DHHA)
Electronic Payer ID: 84-135

Elevate Medicaid Choice
Electronic Payer ID: 84-133

Elevate Child Health Plan Plus (CHP+)
Electronic Payer ID: 84-135

Elevate Health Plans & Colorado Option
Electronic Payer ID: 84-135

Elevate Medicare Choice/Select
Electronic Payer ID: 84-131

First Health
Electronic Payer ID: 65-456

To sign up for electronic billing with Change Healthcare, providers must contact their software vendor and request that their DHMP claims be submitted through Change Healthcare. Providers can also direct their current clearinghouse to forward claims to Change Healthcare. Please call DHMP at 303-602-2100 to set up electronic billing.

Providers who sign up for electronic billing may also sign up for electronic fund transfer/electric remittance advice (EFT/ERA). Please find more information in the provider section of the DHMP website or at the following link: https://www.denverhealthmedicalplan.org/835-and-electronic-fund-transfer-eft-enrollment-request-form

Reports are available through billing software vendors to review electronic submission of claims and rejection errors. Although this may be an optional feature, providers are encouraged to obtain this reporting tool to better manage their submissions.

PAPER CLAIMS
All paper claims should be submitted to:

DHHA
P.O. Box 6300
Columbia, MD 21045
Electronic Payer ID: 84-135

Elevate Medicaid Choice
P.O. Box 6300
Columbia, MD 21045
Electronic Payer ID: 84-133

Elevate Child Health Plan *Plus* (CHP+)
P.O. Box 6300
Columbia, MD 21045
Electronic Payer ID: 84-135

Elevate Health Plans & Colorado Option
P.O. Box 6300
Columbia, MD 21045
Electronic Payer ID: 84-135

Elevate Medicare Advantage
P.O. Box 6300
Columbia, MD 21045
Electronic Payer ID: 84-131

First Health Network
P.O. Box 21524
Eagan, MN 55121
Electronic Payer ID: 65-456

All paper claims include the National Provider Identifier (NPI) and well as the DHMP assigned Provider ID Number (the latter is not required for electronic claims).

WHAT IS A CLEAN CLAIM?

At DHMP, our goal is to process all claims at initial submission. Before we can process a claim, it must be a "clean" or complete claim submission, which includes the following information, when applicable:

1. Primary carrier explanation of benefits (EOB) when DHMP is the secondary payer
2. Authorization for physical therapy
3. Listing individual service dates for physical therapy when billing on form UB04
4. Durable Medical Equipment or prosthesis invoice
5. Trip notes for ambulance transport
6. Standard Diagnostic Related Groupings (DRG) and Revenue codes (inpatient facility)
7. Standard Health Care Procedure Coding System (HCPCS) code sets and modifiers
8. Standard Current Procedural Terminology (CPT®) code sets and modifiers
9. Standard International Classification of Diseases (ICD-10) codes, tenth revision
10. Accurate entries for all the fields of information contained in the UB04 or CMS-1500 forms as listed below

UB-04 Billing Manual (If using CMS-1500 form, instructions below may vary)

Providers must submit all hospital and facility claims, including those for laboratory services performed by a hospital, on the UB-04. Please see below for a list of required fields. Providers must include the information as required.

Box 1 – Billing Provider Name, Address, Phone Number Inpatient – Required

Outpatient – Required

Enter the Provider or agency name and complete mailing address of the Provider billing for the services: Street/post office box, city, state, zip code. Abbreviate the state using standard post office abbreviations. Enter the telephone number.

Box 2 – Pay-to Name, Address, City, State Inpatient – Required if different from Box 1 Outpatient - Required if different from Box 1

Enter the Provider or agency name and complete mailing address of the Provider who will receive payment for the services: Street/post office box, city, state, and zip code. Abbreviate the state using standard post office abbreviations. Enter the telephone number.

Box 3a – Patient Control Number Inpatient – Required

Outpatient – Required

Up to 20 characters: Letters, numbers or hyphens

Enter information that identifies the Client or claim in the Provider's billing system. Submitted information appears on the Provider Claim Report.

Box 3b – Medical Record Number Inpatient - Required Outpatient - Required

Enter the 17-digit number assigned to the Patient to assist in retrieval of medical records.

Box 4 – Type of Bill Inpatient - Required Outpatient - Required

Enter the three-digit number indicating the specific type of bill. The three-digit code requires one digit each in the following sequences (Type of facility, Bill classification, and Frequency):

Digit 1 Type of Facility:
1. Hospital
2. Skilled Nursing Facility
3. Home Health
4. Religious Non-Medical Health Care Institution, Hospital, Inpatient
5. Religious Non-Medical Health Care Institution, Post-hospital extended care services
6. Intermediate Care
7. Clinic-(Rural Health/FQHC/Dialysis Center)
8. Special Facility (Hospice, RTCs)

Digit 2 Bill Classification (except clinics and special facilities):
1. Inpatient (Including Medicare Part A)
2. Inpatient (Medicare Part B only)
3. Outpatient
4. Other (for hospital referenced diagnostic services or home health not under a plan of treatment)
5. Intermediate Care Level I
6. Intermediate Care Level II
7. Intermediate Care Level III Sub-acute Inpatient (revenue code 19X required with this bill type)
8. Swing Beds
9. Other

Digit 2 Bill Classification (Clinics only):
1. Rural Health/FQHC
2. Hospital-based or Independent Renal Dialysis Center
3. Free-standing
4. Outpatient Rehabilitation Facility (ORF)
5. Comprehensive Outpatient Rehabilitation Facilities (COFRs
6. Community Mental Health Center
7. National Assignment
8. National Assignment
9. Other

Digit 2 Bill Classification (Special Facilities Only):
1. Hospice (Non-hospital based)
2. Hospice (Hospital based)
3. Ambulatory Surgical Center
4. Free Standing Birthing Center

Digit 3 Bill Classification
1. Admit through discharge claim
2. Interim –first claim
3. Interim – continuing claims
4. Interim – last claim
5. Late charge only
6. Adjustment of prior claims
7. Replacement of prior claim (Corrected Claims)

8. Void/ Cancel of prior claim

Box 5 – Federal Tax Number Inpatient – Required Outpatient – Required

Box 6 – Statement Covers Period – From/Through Inpatient – Required

Outpatient– Required

Enter the "From" (beginning) date and "Through" (ending) date of service covered by this bill using MM/DD/YY format From MM/DD/YY – Through MM/DD/YY
For Example: January 1, 2008 = 010108
(Note: OP claims cannot span over a month's end)

Inpatient

"From" date is the actual admission date, or first date of an interim bill. "From" date cannot be prior to the date reported in Box 12 (Admission Date). "Through" date is the actual discharge date, or final date of an interim bill. If Patient is admitted and discharged on the same date, that date must appear in both form locators. Interim bills may be submitted for Prospective Payment System (PPS)-DRG claims, but must meet specific billing requirements.

Outpatient

This form locator must reflect the beginning and ending dates of service. When span billing for multiple dates of service and multiple procedures, complete Box 45 (Service Date). Providers not wishing to span bill following these guidelines must submit one claim per date of service. "From" and "Through" dates must be the same. All line item entries must represent the same date of service.

Box 8a – Patient Identifier

Submitted information is not entered into the claim processing system.

Box 8b – Patient Name Inpatient - Required Outpatient - Required

Enter the Client's last name, first name and middle initial from the medical card

Box 9a – Patient Address-Street Inpatient - Required

Outpatient - Required

Enter the Client's street/post office box exactly as it appears on the eligibility verification or as determined at the time of admission.

Box 9b – Patient Address-City Inpatient - Required Outpatient - Required

Enter the Client's city exactly as it appears on the eligibility verification or as determined at the time of admission.

Box 9c – Patient Address-State Inpatient - Required Outpatient - Required

Enter the Client's state exactly as it appears on the eligibility verification or as determined at the time of admission.

Box 9d – Patient Address-Zip Inpatient – Required Outpatient – Required

Enter the Client's zip code exactly as it appears on the eligibility verification or as determined at the time of admission.

Box 9e – Patient Address-County Code Inpatient – Optional

Outpatient – Optional

Box 10 – Birth date Inpatient - Required Outpatient - Required

Enter the Client's birth date, using two digits for the month, two digits for the date, and four digits for the year (MM/DD/CC/YY format)
Example: 01012008 for January 1, 2008
Use the birth date that appears on the eligibility verification or at the time of admission.

Box 11 – Patient Sex Inpatient - Required Outpatient - Required Enter an M (male) or F (female) to indicate the Client's sex

Box 12 – Admission Date Inpatient – Required

Enter the date client was admitted to the hospital. Use MM/DD/YY format for inpatient hospital claims.

Outpatient – Conditional

Required for observation holding beds only

Box 13 – Admission Hour Inpatient - Required

Enter the hour the Client was admitted for inpatient care.

Code Time
00   12:00 – 12:59
01   1:00 – 1:59
02   2:00 – 2:59
03   3:00 – 3:59
04   4:00 – 4:59
05   5:00 – 5:59
06   6:00 – 6:59
07   7:00 – 7:59
08   8:00 – 8:59
09   9:00 – 9:59
10   10:00 – 10:59
11   11:00 – 11:59
12   12:00 – 12:59

13   1:00 – 1:59
14   2:00 – 2:59
15   3:00 – 3:59
16   4:00 – 4:59
17   5:00 – 5:59
18   6:00 – 6:59
19   7:00 – 7:59
20   8:00 – 8:59
21   9:00 – 9:59
22   10:00 – 10:59
23   11:00 – 11:59
99   Unknown

Outpatient – Optional

Required for observation holding beds only

Box 14 – Admission Type Inpatient - Required Outpatient - Optional Enter the following to identify the admission priority:

1. Emergency
    • Client requires immediate intervention as a result of severe, life-threatening or potentially disabling conditions. Exempts inpatient hospital & clinic claims from copayment and PCP referral.

Exempts outpatient hospital claims from copayment and PCP only if revenue code 450 or 459 is present. This is the only benefit service for an undocumented alien. If span billing, emergency services cannot be included in the span bill and must be billed separately from other outpatient services.

2. Urgent
    • The Client requires immediate attention for the care and treatment of a physical or mental disorder.
    • Elective
    • The Client's condition permits adequate time to schedule the availability of accommodations.
    • Newborn
    • Required for inpatient and outpatient hospital.
    • Trauma Center

Visit to a trauma center/hospital as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons and involving trauma activation.

Box 15 – Source of Admission
1. Inpatient - Required
2. Outpatient - Required

Enter the appropriate code for copayment exceptions on claims submitted for outpatient services (to be used in conjunction with Box 14, Type of Admission).
1. Physician referral
2. Clinic referral
3. Referred from HMO
4. Transfer from a hospital

5. Transfer from a skilled nursing facility (SNF)
6. Transfer from another health care facility
7. Emergency Room
8. Court/law enforcement
9. Information not available
10. Transfer from a Critical Access Hospital
11. Transfer from another Home Health Agency C
12. Readmission to same Home Health Agency

Newborns
1. Normal Delivery
2. Premature Delivery
3. Sick Baby
4. Extramural Birth (birth in a non-sterile environment)

Box 16 – Discharge Hour Inpatient - Required

Enter the hour the client was discharged from inpatient hospital care. Use the same coding used in Box 13 (Admission Hour).

Box 17 – Patient Discharge Status Inpatient – Required

Outpatient – Conditional

Enter Patient status as of discharge date.
• 01 Discharged to home or self-care (dialysis is limited to code 01)
• 02 Discharged/transferred to another short-term hospital
• 03 Discharged/transferred to a Skilled Nursing Facility (SNF)
• 04 Discharged/transferred to an Intermediate Care Facility (ICF)
• 05 Discharged/transferred to another type institution
• 06 Discharged/transferred to home under care of organized Home and Community-Based Services Program (HCBS)
• 07 Left against medical advice or discontinued care
• 08 Discharged/transferred to home under care of a Home Health Provider
• 09 Admitted as an inpatient to this hospital
• 20 Expired
• 30 Still a Patient or expected to return for outpatient services
• 31 Still a Patient - Awaiting transfer to long-term psychiatric hospital
• 32 Still a Patient - Awaiting placement by Colorado Medical Assistance Program
• 50 Hospice – Home
• 51 Hospice – Medical Facility discharged/transferred within this institution to hospital-based
• 61 Medicare-approved swing bed
• 62 Discharged/transferred to an inpatient rehabilitation hospital
• 63 Discharged/transferred to a Medicare-certified long-term care hospital
• 71 Discharged/transferred/referred to another institution for outpatient services
• 72 Discharged/transferred/referred to this institution for outpatient services

Box 18 - 28 – Condition Codes Inpatient – Conditional Outpatient - Conditional

Complete with as many codes necessary to identify conditions related to this bill that may affect payer processing.

Condition Codes:
- 01 Military service-related
- 02 Employment-related
- 04 HMO enrollees
- 05 Lien has been filed
- 06 SRD Patients - first 18 months entitlement
- 07 Treatment of non-terminal condition/hospice
- 17 Patient is homeless
- 25 Patient is a non-U.S. resident
- 39 Private room(s) medically necessary
- 60 DRG (day outlier)

Renal dialysis settings:
- 71 Full-care unit
- 72 Self-care unit
- 73 Self-care training
- 74 Home care
- 75 Home care - 100 percent reimbursement
- 76 Backup facility

Special Program Indicator Codes:
- A1 EPSDT/CHAP
- A2 Physically Handicapped Children's Program A4 Family Planning
- A6 PPV/Medicare
- A7 Induced abortion - Danger to Life
- A8 Induced abortion - Victim Rape/Incest A9 Second Opinion Surgery
- B3 Pregnancy indicator

PRO Approval Codes:
- C1 Approved as billed
- C2 Automatic approval as billed – based on focused review C3 Partial approval
- C4 Admission / services denied
- C5 Post-payment review applicable
- C6 Admission pre-authorization
- C7 Extended authorization

Box 29 – Accident State Inpatient

Optional Outpatient – Optional

Box 31 - 34 – Occurrence Code/Date Inpatient – Conditional

Outpatient – Conditional

Complete both the code and date of occurrence.

Enter the appropriate code and the date on which it occurred. Enter the date using MMDDYY format.

Occurrence Codes:
- 01 Accident/Medical Coverage
- 02 Auto Accident - No Fault Liability
- 03 Accident/Tort Liability
- 04 Accident/Employment Related
- 05 Other Accident/No Medical Coverage or Liability Coverage
- 06 Crime Victim
- 20 Date Guarantee of Payment Began
- 24 Date Insurance Denied
- 25 Date Benefits Terminated by Primary Payer
- 26 Dates SNF Bed Available
- 27 Date of Hospice Certification or Recertification
- 40 Scheduled Date of Admission (RTD)
- 50 Medicare Pay Date
- 51 Medicare Denial Date
- 53 Late Bill Override Date
- 55 Insurance Pay Date

A3 Benefits Exhausted – Indicate the last date of service that benefits are available and after which payment can be made to payer A.

B3 Benefits Exhausted – Indicate the last date of service that benefits are available and after which payment can be made to payer B.

C3 Benefits Exhausted – Indicate the last date of service that benefits are available and after which payment can be made to payer C.

NOTE: Other Payer Occurrence codes 24 and 25 must be used when applicable. The claim must be submitted with the third-party information.

Box 35 - 36 – Occurrence Span Code From/Through Inpatient – If applicable

Outpatient – If applicable

Box 38 – Responsible Party Name/Address Submitted information is not entered into the claim processing system.

Box 39 - 41 – Value Code-Code Value Code - Amount Inpatient – Conditional Outpatient - Conditional

If a value code is entered, a dollar amount or related numeric value must be entered.

Enter the appropriate codes and related dollar amounts to identify monetary data or number of days using whole numbers which are necessary for the processing of this claim. Never enter negative amounts. If a value code is entered, a dollar amount or numeric value related to the code must always be entered.

- 01 Most common semi-private rate (Accommodation Rate)
- 06 Medicare blood deductible

- 14 No fault including auto/other
- 15 Workers Compensation
- 31 Patient Liability Amount
- 32 Multiple Patient Ambulance Transport
- 37 Pints of Blood Furnished
- 38 Blood Deductible Pints
- 40 New Coverage Not Implemented by HMO
- 45 Accident Hour - Enter the hour when the accident occurred that necessitated medical treatment. Use the same coding used in Box 18 (Admission Hour)
- 49 Hematocrit Reading - EPO-related
- 58 Arterial Blood Gas (PO2/PA2)
- 68 EPO-Drug
- 80 Covered Days
- 81 Non-covered Days

Enter the deductible amount applied by indicated payer. A1 Deductible Payer A

B1 Deductible Payer B C1 Deductible Payer C

Enter the amount applied to client's co-insurance by indicated payer. A2 Coinsurance Payer A

B2 Coinsurance Payer B C2 Coinsurance Payer C

Enter the amount paid by indicated payer:
A3 Estimated Responsibility Payer A B3 Estimated Responsibility Payer B C3 Estimated Responsibility Payer C

Box 42 – Revenue Code Inpatient - Required Outpatient - Required

Enter the revenue code which identifies the specific accommodation or ancillary service provided.

List revenue codes in ascending order:
A revenue code must appear only once per date of service. If more than one of the same services is provided on the same day, combine the units and charges on one line accordingly. When billing outpatient hospital radiology, the radiology revenue code may be repeated, but the corresponding HCPCS/CPT code cannot be repeated for the same date of service. Refer to instructions under Box 44 (HCPCS/CPT/Rates).

Box 43 – Revenue Code Description Inpatient – Required

Outpatient – Required

Enter the revenue code description or abbreviated description.

When reporting an NDC:
Enter the NDC qualifier of "N4" in the first two positions on the left side of the field
Enter the 11-digit NDC numeric code
Enter the NDC unit of measure qualifier (examples include):
- F2 – International Unit
- GR – Gram
- ML – Milliliter

- UN – Units

Enter the NDC unit of measure quantity

Box 44 – HCPCS/Rates/HIPPS Rate Codes Inpatient – Optional

Outpatient – Conditional

Enter only the HCPCS/CPT code for each detail line. Use approved modifiers listed in this section for hospital-based transportation services. Complete for laboratory, radiology, physical therapy, occupational therapy, and hospital-based transportation. When billing HCPCS codes, the appropriate revenue code must also be billed.

Services Requiring HCPCS/CPT:
- Anatomical Laboratory: Bill with TC modifier
- Hospital-Based Transportation
- Outpatient Laboratory: Use only HCPCS 80000s – 89000s
- Outpatient Radiology Services

Enter HCPCS/CPT and revenue codes for each radiology

With the exception of outpatient lab and hospital-based transportation, outpatient radiology services can be billed with other outpatient services.

HCPCS/CPT codes must be identified for the following revenue codes:
- 32X Radiology – Diagnostic
- 33X Radiology – Therapeutic
- 34X Nuclear Medicine
- 35X CT Scan
- 40X Other Imaging Services
- 61X MRI

NOTE: HCPCS/CPT codes cannot be repeated for the same date of service.

Combine the units in Box 46 (Service Units) to report multiple services. When CPT/HCPC is repeated more than once per day and billed on separate lines, use modifier 76 to indicate this is a repeat procedure and not a duplicate.

- 251 Generic Drugs
- 252 Non-Generic Drugs
- 253 Take-Home Drugs
- 255 Drugs Incident to Radiology
- 257 Non-prescription
- 258 IV Solutions
- 259 Other Pharmacy
- 260 IV Therapy General Classification
- 261 Infusion Pump
- 262 IV Therapy/Pharmacy Services
- 263 IV Therapy/Drug/Supply Delivery
- 264 IV Therapy/Supplies
- 269 Other IV Therapy

- 631 Single-source Drug
- 632 Multiple-source Drug
- 633 Restrictive Prescription
- 634 Erythropoietin (EPO) <10,000
- 635 Erythropoietin (EPO) >10,000
- 636 Drugs Requiring Detailed Coding

Box 45 – Service Date Inpatient - Leave blank Outpatient - Required For span bills only.
Enter the date of service using MM/DD/YY format for each detail line completed.
Each date of service must fall within the date span entered in the Statement Covers Period. Not required for single date of service claims.

Box 46 – Service Units Inpatient - Required Outpatient - Required
Enter a unit value on each line completed. Use whole numbers only. Do not enter fractions or decimals and do not show a decimal point followed by a 0 to designate whole numbers (e.g., do not enter 1.0 to signify one unit). The grand total line (Line 23) does not require a unit value.

For span bills, the units of service reflect only those visits, miles or treatments provided on dates of service in Box 45.

Box 47 – Total Charges Inpatient - Required Outpatient - Required

Enter the total charge for each line item. Calculate the total charge as the number of units multiplied by the unit charge. Do not subtract Medicare or third-party payments from line charge entries. Do not enter negative amounts. A grand total in line 23 is required for all charges.

Box 48 – Non-covered Charges Inpatient – Conditional Outpatient – Conditional

Incurred charges that are not payable by the Company's non-covered charges must be entered in both Box 47 (Total Charges) and Box 48 (Non-Covered Charges). Each column requires a grand total. Non-covered charges cannot be billed for outpatient hospital laboratory or hospital based transportation services.

Box 50 – Payer Name Inpatient - Required Outpatient - Required

Enter the payment source code followed by name of each payer organization from which the Provider might expect payment.

Source Payment Codes
- B - Workers Compensation
- C - Medicare
- D - Colorado Medical Assistance Program
- E - Other Federal Program
- F - Insurance Company
- G - Blue Cross, including Federal Employee Program
- H - Other - Inpatient (Part B Only)
- I - Other
- Line A - Primary Payer
- Line B - Secondary Payer
- Line C - Tertiary Payer

Enter the Provider's Health Plan ID for each payer name. Enter Health Plan ID.

Box 52 – Release of Information
Submitted information is not entered into the claim processing system.

Box 53 – Assignment of Benefits
Submitted information is not entered into the claim processing system.

Box 54 – Prior Payments Inpatient - Conditional Outpatient - Conditional Complete when there are third-party payments.

Box 55 – Estimated Amount Due Inpatient – Conditional Outpatient – Conditional

Complete this box when there are third-party payments.

Beginning May 23, 2008, all identifiers submitted on the Form UB-04 requires National Provider Identifiers (NPI) on all claims.

Box 56 – National Provider Identifier (NPI) Inpatient – Required

Outpatient – Required

Enter the billing Provider's 10-digit National Provider Identifier (NPI) Box 57 – Other Provider ID Inpatient - Required Outpatient - Required

Box 58 – Insured's Name Inpatient - Required Outpatient - Required Enter the Client's name from medical card. Other Insurance

Complete additional lines when there is third-party coverage. Enter the policyholder's last name, first name, and middle initial exactly as it appears on the eligibility verification or on the health insurance card.

Box 60 – Insured's Unique Member ID Inpatient – Required

Outpatient – Required

Enter the insured's unique identification number assigned by the payer organization exactly as it appears on the eligibility verification or on the health insurance card. Include letter prefixes or suffixes shown on the card.

Box 61 – Insurance Group Name Inpatient – Conditional Outpatient – Conditional

Complete when there is third-party coverage. Enter the name of the group or plan providing the insurance to the insured exactly as it appears on the health insurance card.

Box 62 – Insurance Group Number Inpatient – Conditional

Outpatient – Conditional

Complete when there is third party coverage. Enter the identification number, control number, or code assigned by the carrier or fund administrator identifying the group under which the individual is carried.

Box 63 – Treatment Authorization Code Inpatient – Conditional

Outpatient – Conditional

Complete when the service requires authorization. Enter the authorization number in this box when Patient has been approved for the services.

Box 64 – Document Control Number Inpatient – If applicable

Outpatient – If applicable

Box 65 – Employer Name Inpatient - Conditional Outpatient - Conditional

Complete when there is third-party coverage. Enter the policyholder's last name, first name, and middle initial exactly as it appears on the eligibility verification or on the health insurance card.

Box 66 – Diagnosis Version Qualifier

Submitted information is not entered into the claim.

Box 67 – Principal Diagnosis Code Inpatient – Required

Outpatient – Required

Enter the exact ICD-10-CM diagnosis code describing the principal diagnosis that exists at the time of admission or develops subsequently and affects the length of stay. Do not add extra zeros to the diagnosis code.

Box 67a - 67q – Other Diagnosis Inpatient – Required Outpatient – Required

Enter the exact ICD-10-CM diagnosis code corresponding to additional conditions that co-exist at the time of admission or develop subsequently and which effect the treatment received or the length of stay.
Do not add extra zeros to the diagnosis code.

Box 69 – Admitting Diagnosis Code Inpatient – Required

Outpatient – Optional

Enter the ICD-10-CM diagnosis code as stated by the Physician at the time of admission.

Box 70 – Patient Reason Diagnosis Inpatient – If applicable Outpatient – If applicable

Box 71 – PPS Code

Submitted information is not entered into the claim.

Box 72 – External Cause of Injury Code (E-code) Inpatient – Required

Outpatient – Required

Enter the ICD-10-CM diagnosis code for the external cause of an injury, such as poisoning, or adverse effect. This code must begin with an "E".

Box 74 – Principal Procedure Code/Date Inpatient – Conditional

Outpatient – Conditional

Enter the ICD-10-CM procedure code for the principal procedure performed during this billing period and the date on which the procedure was performed. Enter the date using MM/DD/YY format.

Apply the following criteria to determine the principle procedure:
The principal procedure is not performed for diagnostic or exploratory purposes. This code is related to definitive treatment.
The principal procedure is most related to the primary diagnosis.

Box 74a – Other Procedure Code/Date Inpatient – Conditional

Outpatient – Conditional

Complete when there are additional significant procedure codes.

Enter the ICD-10-CM procedure codes identifying all significant procedures other than the principle procedure and the dates on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principle diagnosis. Enter the date using MM/DD/YY format.

Box 76 – Attending NPI Inpatient - Required Outpatient - Required Enter the 10-digit NPI.

Box 77 – Operating - NPI/QUAL/ID Inpatient – Required

Outpatient – Required Enter the 10-digit NPI.

Box 78 - 79 – Other NPI Inpatient - Required Outpatient - Required Enter the 10-digit NPI.

Box 78 - 79 – Other ID Last/First Name (Continued) Inpatient – Required

Outpatient – Required

Enter the attending Physician's last and first name.

Box 80 – Remarks

Enter specific additional information necessary to process the claim or fulfill reporting requirements.

Box 81 – Code-Code QUAL/CODE/VALUE (a-d) Submitted information is not entered into the claim.

1500 Claims Processing Manual CMS-1500 form.

Providers must file all claims for professional services, including laboratory services performed by independent

laboratory, on the current CMS HCFA 1500 form. Please see below for a list of required fields. Providers must include the information marked "Required".

Box 1 – Medicare, Medicaid, Group Health Plan or other insurance Information
Show the type of health insurance coverage applicable to this claim by checking the appropriate box. This is a required field.

Box 1a – Insured's ID Number
Enter the Patient's Health Insurance ID Number. This is a required field.

Box 2 – Patient's Name (Last Name, First Name, Middle Initial) Enter the Patient's last name, first name, and middle initial, if any, as shown on the Patient's card.
This is a required field.

Box 3 – Patient Birth Date
Enter the Patient's 8-digit birth date (MM/DD//CCYY) and sex. This is required field.

Box 4 – Insured's Name (Last Name, First Name, Middle Initial) List the name of the insured here. When the insured and the Patient are the same, enter the word "SAME".
This is required field.

Box 5 – Patient's Address (Number, Street)
Enter the Patient's mailing address and telephone number. On the first line enter the street address; the second line, the city and state; the third line, the zip code and phone number.

Box 6 – Patient Relationship to Insured
Check the appropriate box for Patient's relationship to insured when Box 4 is completed. This is a required field.

Box 7 – Insured's Address (Number, Street)
Enter the insured's address and telephone number. When the address is the same as the Patient's, enter the word "SAME". Complete this item only when Boxes 4, 6 and 11 are completed.

Box 8 – Patient Status
Check the appropriate box for the Patient's marital status and whether Single or Married and Employed or Student.
This is a required field.

Box 9 – Other Insured's name (Last Name, First Name, Middle Initial)
Enter the last name, first name, and middle initial of the enrollee if policy is different. This field may be used in the future for supplemental insurance plans.

Box 9a – Other Insured's Policy or Group Number
Enter the other policy and/or group number of the other insurance. This box must be completed if applicable.

Box 9b – Other Insured's Date of Birth
Enter the other insured's 8-digit birth date (MM/DD/CCYY) and sex. This box must be completed if applicable.

Box 9c –Employer's Name or School Name Enter employer's name or school name.
This box must be completed if applicable.

Box 9d – Insurance Plan Name or Program Name
This box must be completed if applicable.

Boxes 10a - 10c – Is Patient's condition related to:
Check "YES" or "NO" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in Box 24.
This is a required field.

Box 10d – Reserved for local use

Box 11 – Insured's Policy Group Number This box must be completed if applicable.

NOTE: Enter the appropriate information in item 11c if insurance primary to the Company is indicated in Box 11. If there is insurance primary to the Company, enter the insured's policy or group number and proceed to Boxes 11a - 11c. Boxes 4, 6 and 7 must be completed. If there is no insurance primary to the Company, enter the word "NONE" and proceed to Box 12.
If the insured reports a terminating event with regard to insurance which had been primary to the Company (e.g., insured retired), enter the word "NONE" and proceed to Box 11b.

If a lab has collected previously and retained MSP information for a beneficiary, the lab may use that information for billing purposes of the non-face-to-face lab service. If the lab has no MSP information for the beneficiary, the lab will enter the word "NONE" in Block 11 of Form CMS-1500, when submitting a claim for payment of a reference lab service. Where there has been no face-to-face encounter with the beneficiary, the claim will then follow the normal claims process. When a lab has a face-to-face encounter with a beneficiary, the lab is expected to collect the MSP information and bill accordingly.

Insurance Primary to the Company
Circumstances under which the Company payment may be secondary to other insurance:
• Group Health Plan Coverage through spouse working aged
• Disability (large group health plan)
• End-stage renal disease
• No fault and/or other liability
• Work-related illness/injury
• Workers compensation
• Black lung
• Veterans' Benefits

NOTE: For a paper claim to be considered for the Company's secondary payer benefits, a copy of the primary payer's EOB notice must be forwarded along with the claim form.

Box 11a – Insured's Date of Birth
Enter the insured's 8-digit birth date (MM/DD/CCYY) and sex if different from Box 3.

Box 11b – Employer's Name or School Name
Enter employer's name, if applicable. If there is a change in the insurance status, such as retired, enter a 6-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY) retirement date preceded by the word "RETIRED."

Box 11c – Insurance Plan Name or Program name
Enter the 9-digit Payer ID number of the primary insurer. If no Payer ID number exists, then enter the complete primary payer's program or plan name. If the primary payer's EOB does not contain the claims processing address, record the primary payer's claims processing address directly on the EOB. This is required if there is insurance primary to the Company which is indicated in Box 11.

Box 11d – Is there another Health Benefit Plan? This box must be completed if applicable.

Box 12 – Patient's or Authorized Person's Signature
The Patient or authorized representative must sign and enter either a 6-digit date (MM/DD/YY), 8-digit date (MM/DD/CCYY), or an alpha-numeric date (e.g., January 1, 2008) unless the signature is on file.
NOTE: This can be "Signature on File" and/or a computer-generated signature.
The Patient's signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the Provider of service or supplier when the Provider of service or supplier accepts assignment on the claim.
Signature by Mark (X) - When an illiterate or physically handicapped enrollee signs by mark, a witness must enter their name and address next to the mark.
This is a required field.

Box 13 – Insured's or Authorized Person's Signature
The Patient's signature or the statement "Signature on File" in this box authorizes payments of medical benefits to the Physician or supplier.
The Patient or their authorized representative signs this item or the signature must be on file separately with the Provider as an authorization. However, note that when payment under the Act can only be made on an assignment-related basis or when payment is for services furnished by a participating Physician or supplier, a Patient's signature or a "Signature on File" is not required in order for the Company payment to be made directly to the Physician or supplier.
NOTE: This can be "Signature on File" signature and/or a computer generated signature. This is a required field.

Box 14 – Date of Current
Enter either an 8-digit (MM/DD/CCYY) or 6-digit (MM/DD/YY) date of current illness, injury, or pregnancy. This is a required field.

Box 15 –If Patient has had the same or similar Illness. This box must be completed if applicable.

Box 16 – Dates Patient unable to work in current occupation
If the Patient is employed and is unable to work in their current occupation, enter an 8-digit (MM/DD/CCYY) or 6-digit (MM/DD/YY) date when Patient is unable to work. An entry in this field may indicate employment-related insurance coverage.

Box 17 – Name of Referring Provider or Other Source
Enter the name of the referring or ordering Physician if the service or item was ordered or referred by a Physician.

Box 17a – Leave blank
NOTE: Effective May 23, 2008, 17a is not to be reported, but 17b must be reported when a service was ordered or referred by a Physician.

Box 17b Form CMS-1500 – NPI
Enter the NPI of the referring/ordering Physician listed in Box 17.
All Physicians who order services or refer the Company's beneficiaries must report this data. This is a required field.

Box 18 – Hospitalization Dates Related to Current Services
Enter either an 8-digit (MM/DD/CCYY) or a 6-digit (MM/DD/YY) date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

Box 19 – Reserved for Local Use
This box must be completed if applicable.
Enter all applicable modifiers when modifier -99 (multiple modifiers) is entered in item. If modifier -99 is entered on multiple line items of a single claim form, all applicable modifiers for each line item containing a -99 modifier should be listed as follows: 1=(mod), where the number 1 represents the line item and "mod" represents all modifiers applicable to the referenced line item.

Box 20 – Outside Lab
Complete this item when billing for diagnostic tests subject to purchase price limitations. Enter the purchase price under charges if the "YES" block is checked. A "YES" check indicates that an entity other than the entity billing for the service performed the diagnostic test. A "NO" check indicates "no purchased tests are included on the claim." When "YES" is annotated, item 32 shall be completed. When billing for multiple purchased diagnostic tests, each test shall be submitted on a separate claim Form CMS-1500. Multiple purchased tests may be submitted on the ASC X12 837 electronic format as long as appropriate line level information is submitted when services are rendered at different service facility locations.
NOTE: This is a required field when billing for diagnostic tests subject to purchase price limitations.

Box 21 – Diagnosis or Nature of Illness Injury
Enter the Patient's diagnosis/condition. With the exception of claims submitted by ambulance suppliers (specialty type 59), all Physician and non-Physician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-10-CM code number and code to the highest level of specificity for the date of service. Enter up to four diagnoses in priority order.
This is a required field.

Box 22 – Medicaid Resubmission Code Not applicable.

Box 23 – Prior Authorization Number
Enter the Company Prior Authorization number for those procedures that require the Company's prior approval.

Box 24a – Date(s) of Service
Enter a 6-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY) date for each procedure, service or supply. This is a required field.

Box 24b – Place of Service
Enter the appropriate place of service code(s) from the list provided.
Identify the location, using a place of service code, for each item used or service performed:
•   11 - Clinic
•   12 - Home
•   21 - Inpatient Hospital

- 22 - Outpatient Hospital
- 23 - Emergency Room
- 24 - Ambulatory Surgery
- 41 - Ambulance
- 50 - FQHC
- 65 - End-stage renal disease treatment.

This is a required field.

Box 24c – EMG
This box must be completed if applicable.

Box 24d – Procedures, Services, or Supplies - CPT/HCPCS Modifiers
Enter the procedures, services, or supplies using the Healthcare Current Procedural Terminology (CPT) or Common Procedure Coding System (HCPCS). When applicable, show CPT/ HCPCS modifiers with CPT/HCPCS code. The Form CMS-1500 has the ability to capture up to four modifiers. Enter the specific CPT/HCPCS procedure code without a narrative description.
However, when reporting an "unlisted procedure code" or "not otherwise classified" (NOS), include a narrative description in Box 19, if a coherent description can be given, within the confines of that box. Otherwise, an attachment should be submitted with the claim.
This is a required field.

Box 24e – Diagnosis Pointer
Enter the diagnosis code reference number as shown in Box 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line item. When multiple services are performed, enter the primary reference number for each service (i.e., a 1, or a 2, or a 3 or a 4).
If a situation arises where two or more diagnoses are required for a procedure code (e.g., pap smears), the Provider shall reference only one of the diagnoses in Box 21.
This is a required field.

Box 24f – $ Charges
Enter the charge for each listed service. This is a required field.

Box 24g – Days or Units
Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume. If only one service is performed, the numeral "1" must be entered. Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple ostomy or urinary supplies, medication dosages, or allergy testing procedures). When multiple services are provided, enter the actual number provided. For anesthesia, show the elapsed time (minutes) in Box 24g. Convert hours into minutes and enter the total minutes required for this procedure.
This is a required field.
NOTE: This field should contain at least 1 day or unit. The carrier should program their system to automatically default to "1" unit when the information in this field is missing to avoid returning claims as unprocessable.

Box 24h – EPSDT Family Plan Not applicable.

Box 24j – Rendering Provider NPI
Enter the rendering Provider's NPI number in the lower unshaded portion. This is a required field.
NOTE: Effective May 23, 2008, the shaded portion of 24j is not to be reported. Box 25 – Federal Tax ID Number
Enter the service Provider's or supplier's Federal Tax ID (Employer Identification Number or Social Security

Number) and check the appropriate check box. Providers are required to complete this box for crossover purposes. Tax identification information is used in the determination of accurate NPI reimbursement. Reimbursement of claims submitted without tax identification information will/may be delayed. This is a required field.

Box 26 – Patient's Account Number
Enter the Patient's account number assigned by the service Provider's or supplier's accounting system. This is a required field to assist the Provider in Patient identification.

Box 27 – Accept Assignment? Yes or No?
Check the appropriate block to indicate whether the service Provider or supplier accepts assignment of the Company benefits. The service Provider or supplier shall also be a participating service Provider or supplier with the Company and accept assignment of the Company benefits for all covered charges for all Patients. This is a required field.

Box 28 – Total Charge
Enter total charges for the services (i.e., total of all charges in Box 24F). This is a required field.

Box 29 – Amount Paid
Enter the total amount the Patient paid on the covered services only. This box must be completed if applicable.

Box 30 – Balance Due
This box must be completed if applicable.

Box 31 – Signature of Physician or Supplier
Enter the signature of service Provider or supplier, or their representative, and one of the following: the 6-digit date (MM/DD/YY), 8-digit date (MM/DD/CCYY), or alphanumeric date (e.g., January 1, 1998) the form was signed on.
NOTE: This is a required field. However, the claim can be processed if the following occurs: if a Physician, supplier, or authorized person's signature is missing, but the signature is on file; or if any authorization is attached to the claim or if the signature field has "Signature on File" and/or a computer generated signature.

Box 32 – Service Facility Location Information
Enter the name, address and zip code of the facility if the services were furnished in a hospital, clinic, laboratory or facility other than the Patient's home or Physician's office.

For durable medical, orthotic, and prosthetic claims, the name and address of the location where the order was accepted must be entered (DMERC only). When more than one supplier is used, a separate Form CMS-1500 shall be used to bill for each supplier. This item is completed whether the supplier's personnel performs the work at the Physician's office or at another location.
Complete this box for all laboratory work performed outside a Physician's office. If an independent laboratory is billing, enter the place where the test was performed.
This is a required field.

Box 32a – Service Facility Location Information
Required by the Company for claims processing policy. Enter the NPI of the service facility if applicable. Box

32b – Effective May 23, 2008, Box 32b is not to be reported.

Box 33 – Billing Provider Info & PH Number
Enter the service Provider's or supplier's billing name, address, zip code and telephone number. This is a required field.

Box 33a – Billing Provider Info & PH Number Enter the NPI of the billing Provider or group. This is a required field.

Box 33b - Effective May 23, 2008, Box 33b is not to be reported.

Present on Admission (POA)
The POA indicator applies to diagnosis codes for certain healthcare claims. POA indicator reporting is mandatory for claims involving inpatient admissions to general acute care hospitals or other facilities. It clarifies whether a diagnosis was present at the time of admission. DHMP requires POA indicators for all primary and secondary diagnosis codes as well as the external cause of injury codes, regardless of the manner in which claims are submitted (i.e., paper or electronic). Please refer to the instructions provided by CMS regarding identification of the POA for all diagnosis codes for inpatient claims submitted on the UB-04 and ASCX12N 837 Institutional (837I) forms.

Requirements for Billing by Facilities
Facilities, including hospitals, must submit inpatient and outpatient facility claims on the UB-04 or on electronic media:

Report the name, NPI, and DHMP provider ID number of the attending provider in Field 76 (DHMP provider ID number is not required on electronic transactions).

Include the DHMP authorization number on claims submitted for inpatient and outpatient services.

Claims will be matched to prior authorization data in the DHMP system and processed in accordance with applicable DHMP policies and procedures.

Professional services that are not part of the facility claim should be billed on a CMS 1500 form.

Facilities billing on behalf of employed providers must submit claim reporting data on the UB-04 for outpatient services or directly to DHMP via electronic claim submission. Report the name, NPI, and DHMP provider ID number of the attending provider in Field 76 (DHMP provider ID number is not required on electronic transactions).

REQUIRED DATA ELEMENTS AND CLAIM FORMS

If the following information is missing from the claim, the claim is not "clean" and will be rejected:

Data Element	CMS-1500	UB-04
Patient Name	X	X
Patient Date of Birth	X	X
Patient Sex	X	X
Subscriber (Mbr) Name/Address	X	X
DHMP ID Number	X	X
Coordination of Benefits (COB) Other Insurance Information	X	X
Date(s) of service	X	X
ICD-10 Diagnosis(s) Code(s) including 4th,5th,6th, and 7th Digits	X	X
CPT4 Procedure Code(s)	X	X
HCPC Code(s)	X	X
Service Code Modifiers (if applicable)	X	X
Place of Service	X	X
Service Unit(s)	X	X
Charges Per Serice and Total Charges	X	X
Provider NameProvider Address/Phone NumberNational Provider Identifier -NPI	X	X
Tax ID Number	X	X
DHMP Provider Number- For Paper Claims Only	X	X
DHMP Payer ID Number for EDI Claims Only (Refer to section XX)	X	X
Hospital /Facility Name & Address		X
Type of Bill		X
Admission Date and Type		X
Patient Discharge Status Code		X
Condition Code(s)		X
Occurrence Codes and Dates		X
Value Code(s)		X
Revenue Code (s) and corresponding CPT/HCPCs codes when billing outpatient services		X
Present of Admission (POA) indicator - If applicaable		X
DHMP Authorization Number if applicable		X
Referring Physician	X	X
NDC Codes	X	X

SECTION V: CLAIMS CODING

All DHMP claims require diagnosis codes and procedure codes. The appropriate diagnosis code must be entered on all claims. Procedure codes are dependent on the type of service and claim type.

DHMP utilizes National Correct Coding Initiative (NCCI) Methodology. The Center for Medicare & Medicaid Services (CMS) promotes national correct coding methodologies and reduces improper coding which may result in inappropriate payments of Medicare Part B claims and Medicaid claims. Visit https://www.cms.gov for information about, and edits for, the Medicare NCCI program. The Medicaid NCCI program has significant differences from the Medicare NCCI program https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicare.

Diagnosis Coding
DHMP recognizes only diagnosis codes published in the ICD-10-CM by the U.S. Department of Health and Human Services, Public Health Service, and Center for Medicare & Medicaid Services (CMS).

ICD-10-CM codes must be entered properly on the claim form and must relate to the services for which charges are being submitted.

DHMP provides benefits for services that are medically necessary. The diagnosis code must be specific and indicate an appropriate cause for and relationship to the services provided. In general, non-specific codes (e.g., for radiology examinations or gynecology examinations) are not acceptable for DHMP. Common medical practice indicates that some procedures are appropriate only when specific conditions are present. Providers must assure that the diagnosis entered supports the validity and appropriateness of the billed service. DSMIV codes are not accepted.

Procedure Coding – HCPCS
DHMP uses the CMS HCPCS to identify services provided to its members. The HCPCS includes codes identified in the Physician's Current Procedural Terminology (CPT) and codes developed by CMS.

Providers should use the most current CPT version. The CPT manual can be from the American Medical Association at the following address:
> Book & Pamphlet Fulfillment: OP-341/9
> American Medical Association
> PO Box 10946
> Chicago, IL 60610

Always use the current HCPCS publication when submitting the DHMP claims.

HCPCS publications vary in length and are replaced annually. Providers should keep the current HCPCS publication with the Billing Manual or Provider Manual.

Revenue Coding
The appropriate Revenue codes are required to submit a claim to DHMP. Claims submitted with revenue codes that are not valid or appropriate are denied.

Coding Guidelines
DHMP will follow and accept all coding guidelines for Medicaid, CHP, and Medicare as outlined by CMS at cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/coding_billing.

Physician Administered Drugs (PAD)
The NDC of the PAD which was administered to the member must be included with the claim. If no NDC is received or if the NDC received is invalid, the claim will be denied. Claims for all PADs must be billed with the following information:
- Procedure code (HCPCS)
- May include miscellaneous or unlisted J codes, temporary or permanent drug related Q, C, and J codes
- NDC of the drug administered
- NDC must be in 11-digit format with no spaces, hyphens or other characters
- If the NDC on the PAD does not include an 11-digit NDC, provider must add zeros to maintain 5-4-2 formatting
  » XXXX-XXXX-XX = 0XXXX-XXXX-XX = XXXXXXXXXXX
  » XXXXX-XXX-XX = XXXXX-0XXX-XX = XXXXXXXXXXX
  » XXXXX-XXXX-X = XXXXX-XXXX-0X = XXXXXXXXXXX
- HCPCS units
- For miscellaneous J codes, use HCPCS unit of 1
- For all other PADs, refer to Appendix X - HCPCS/NDC Crosswalk for appropriate HCPCS unit billing
- NDC units

- Calculate the number of units administered according to the NDC labeling
- NDC unit of measure qualifier
- Only the following are acceptable
- GR (gram): ointments, creams, inhalers or bulk powders
- This unit of measure will primarily be used in the retail pharmacy setting and not usually for physician-administered drug billing
- ML (milliliter): bill for liquid injectable products in vials/ampules/prefilled syringes, or for certain approved liquid non-injectable products
- EA (each): bill when a drug comes in a vial in powder form and must be reconstituted before administration or with certain, approved tablets, capsules or suppositories

Sterilization, Hysterectomy, and Abortion Benefits
Medicaid Choice:
See the special billing instructions for Abortions, Hysterectomies, and Sterilizations in applicable Specialty Manuals located on the Billing Manuals web page at https://www.colorado.gov/hcpf/billing-manuals

SECTION VI: TIME FRAMES FOR CLAIM SUBMISSION, ADJUDICATION, AND PAYMENT

TIMELY CLAIM SUBMISSION
Providers should submit all claims within 30 (thirty) days of the date of service for prompt adjudication and payment. However, claims for services that are submitted later than the time period set forth in the provider's agreement with DHMP will not be paid except under certain circumstances.

Product	Timely filing
Commercial/Elevate	120 days from Date of Service
Non-contracted providers	365 days/1 year from Date of Service
Medicaid/CHP+	365 days/1 year from Date of Service
Medicare	365 days/1 year from Date of Service

* COB Claims: All COB claims for Commercial/Elevate members must be submitted within 365 days from the paid date of the primary insurance explanation of payment.

SECTION VII: COORDINATION OF BENEFITS (COB)

Coordination of benefits ensures that the proper payers are held responsible for the cost of healthcare services and is one (1) of the factors that can help members and providers understand co-payments and premiums. DHMP follows all standard guidelines for COB. Members are asked to provide information about other insurance plans under which they are covered.

Elevate Medicaid Choice acts as the payer of last resort because Federal regulations require that all available health insurance benefits be used before Elevate Medicaid Choice considers payment. With few exceptions, claims for members with health insurance resources are denied when the claim does not

show insurance payment or denial information. Commercial health insurance coverage often offers greater benefits than Elevate Medicaid Choice, so it is advantageous for providers to pursue commercial health insurance payments. Elevate Medicaid Choice does not automatically pay commercial health insurance co-pays, coinsurance, or deductibles. If the commercial health insurance benefit is the same or more than the Elevate Medicaid Choice benefit allowance, no additional payment will be made.

Providers cannot bill members for the difference between commercial health insurance payments and their billed charges when Elevate Medicaid Choice does not make additional payment. The provider also cannot bill members for co-pay/deductibles assessed by the TPL.

DHMP does not pay for services provided under the following circumstances when there is COB:
- The Department of Veterans Affairs (VA) or other VA facilities (except for certain emergency hospital services)
- When VA-authorized services are provided at a non-VA hospital or by a non-VA provider

The following applies to Elevate Medicare Advantage plans only:
DHMP will use the same guidelines as Medicare for the determination of primary and secondary payer. As a result, DHMP is the secondary payer for all of the cases listed above as well as for the following:
- Most Employer Group Health Plans (EGHP)
- Most EGHPs for disabled members

All benefits payable under an EGHP in the case of individuals who are entitled to benefits solely or partly on the basis of end-stage renal disease (ESRD) during a period of thirty (30) months. (This applies to all services, not just to ESRD. If the individual entitlement changes from ESRD to over sixty-five [65] or disability, the coordination period will continue.)

DHMP is always the secondary payer in the following circumstances:
- Workers' compensation
- Automobile medical
- No-fault or liability auto insurance

SECTION VIII: REMITTANCE ADVICE (RA) /ELECTRONIC FUNDS TRANSFER (EFT)/ELECTRONIC REMITTANCE ADVICE (ERA)

The RA describes how claims for services rendered to DHMP members were reviewed. It details the adjudication of claims, describing the amounts paid or denied and indicating the determinations made on each claim. There are separate Explanation of Payment (EOP) for inpatient facility services and for outpatient services. The outpatient services EOP includes outpatient facility services, Provider Relations, and ancillary services such as DME. The EOP shall include the following elements:
- Name and Address of Payer
- Toll-free Number of Payer
- Subscriber's Name and Address
- Subscriber's Identification (ID) Number
- Member's Name
- Provider's Name
- Provider Tax Identification Number (TIN)
- Claim Date of Service

- Type of Service
- Total Billed Charges
- Allowed Amount
- Discount Amount
- Excluded Charges
- Explanation of Excluded Charges (Denial Codes)
- Amount Applied to Deductible
- Copayment/Coinsurance Amount
- Total Member Responsibility Amount
- Total Payment Made and to Whom

The RA is arranged numerically by member account number. Inpatient facility claims are sorted separately from all other claims. Each claim represented on an EOP may comprise multiple rows of text. The line number indicated below the date of service identifies the beginning and end of a particular claim. Key fields that will indicate payment amounts and denials are as follows:

- *Paid Claim Lines:* If the Paid Amount field reads greater than zero (0), the claim was paid in the amount indicated.
- *Denied Claim Lines:* If the Not Covered field is greater than zero (0) and equal to the allowed amount, the service was denied.
- *Claim Processed as a Capitated Service:* If the amount in the Prepaid Amount field is greater than zero (0), the service was processed as a capitated service.
- *End of Claim:* Each claim is summarized by a claim total. If there are multiple claims for a single member, the EOP also summarizes the total amount paid for that member.

Providers may request a copy of an EOP on our website at denverhealthmedicalplan.org or by calling DHMP Health Plan Services at 303-602-2100.

ELECTRONIC FUNDS TRANSFER/ELECTRONIC REMITTANCE ADVICE (EFT/ERA)

DHMP's Electronic Funds Transfer (EFT)/Electronic Remittance Advice (ERA) program is a convenient service for the automatic reimbursement of DHMP claims.

EFT is the direct electronic deposit of claim reimbursements into your bank account, and ERA is the statement that allows you to reconcile these reimbursements to your member accounts. Advantages of these programs include:

- Prompt payment – no waiting for checks to clear
- Reduced paperwork
- No lost checks or mail delay
- Savings of administrative and overhead costs
- Simplified and organized recordkeeping
- Improved cash flow

You must be able to submit claims electronically to use EFT/ERA. When claims are submitted for payment, the payment is deposited electronically into your bank account. Capitation checks can also be deposited directly into your account. When you enroll in EFT/ERA, you will continue to receive an Explanation of Payment (EOP) for a sixty (60) day grace period. The EOP shows the member's name, dates of service, services rendered, and amounts of DHMP payments. After the grace period, you will receive only the ERA. Bank statements will continue to reflect deposited amounts and dates of deposit. Your clearinghouse/software vendor must be able to accept the ERA file which is in the 835 HIPAA standard format.

Please refer to our website at denverhealthmedicalplan.org for information on how to enroll in EFT/ERA. You can also call DHMP Health Plan Services at 303-602-2100.

SECTION IX: CLAIM INQUIRIES, CORRECTED CLAIMS, CLAIM RECONSIDERATION, AND DISPUTE PROCESS

CLAIM INQUIRIES

Providers can view claims status on our website at denverhealthmedicalplan.org or by calling DHMP Health Plan Services at 303-602-2100 Monday through Friday, 8 a.m. – 5 p.m.

As described below, DHMP provides a two (2)-level process for providers to appeal a claim denial or payment which the provider believes was incorrect or inaccurate. Please note that the provider reconsideration process described in this section does not apply to utilization management determinations concerning medical necessity.

CORRECTED CLAIMS - DEFINITIONS

Rejected Claim: A claim that was received by DHMP and determined to be unclean. The claim is never loaded to the adjudication system. The claim is returned to the provider along with the reason for the rejection.

Re-Submission Claim: Represents a claim that was rejected by DHMP. Once the provider makes the appropriate changes to the claim, the provider must re-submit the claim within timely filing guidelines for new claims. Note: This re-submitted claim is always treated as a new claim.

Accepted Claim: A claim that was received by DHMP and passed all criteria. The claim was successfully loaded to the adjudication system. The system then makes a final determination of paid or denied.

Corrected Claim: Represents a claim that was accepted by DHMP. The corrected claim has changed data elements that will potentially effect the payment of the claim.

EDI Corrected Claims:
When submitting an EDI "Corrected" Professional and/or Institutional claim to DHMP the following requirements must be met:
1. The claim type/frequency (CLM05-03) must be a 7.
   Ex. CLM*8084*96.98***11>B>7*Y*A*W*I*P~
2. The DHMP original claim ID must be sent in the REF*F8 segment in the 2300 loop. The DHMP claim ID is made up of a 2 digit branch code, 6 digit batch date, 3 digit batch sequence, and a 2 digit sequence ID. The DHMP claim ID can be found on the EOP and/or 835.
   Ex. REF*F8*0104141539061~

Paper Corrected Claims:
When submitting a Paper "Corrected" Professional and/or Institutional claim to DHMP, Providers should stamp or handwrite on the claim "CORRECTED" or "CORRECTED CLAIM" and must include the original claim number being corrected.

Note: Corrected Claims submission must follow timely filing guidelines for new claims.

REQUESTS FOR REVIEW AND RECONSIDERATION OF A CLAIM

Providers who are dissatisfied with a claim determination made by DHMP must submit a written request for review and reconsideration with all supporting documentation to DHMP within sixty (60) business days from the paid date on the provider's EOP. Written requests, including attachments should be mailed to the address indicated on the appropriate form located on the DHMP website at denverhealthmedicalplan.org.

NOTE: Medicare claims denials for non-contracted providers follow a separate process than the steps outlined below. Please skip to the section below titled "Medicare Non-Contract Provider Disputes" for instructions.

- You have 60 business days from the date of the original Remittance advice to request a reconsideration.
- DHMP will make every effort to respond to your request within 30 business days.
- Your reconsideration must be submitted with a completed reconsideration form or it will be returned to you. DHMP uses this form to route your request to the appropriate department.
- If you have received a decision on a claim and have an issue with what was approved an authorization, DHMP will uphold its original claim decision. No clinical review is performed on claims after the original pre-service UM decision appeal process has passed. DHMP only conducts utilization review/clinical review through the member appeal process. We do not conduct clinical reviews for provider payment appeals unless there were extenuating circumstances that explain why you were unable to follow plan rules of obtaining authorization prior to rendering services.

What happens next?

DHMP will review your request to ensure that your claim was submitted timely, authorization and documentation guidelines were followed and the proper reimbursement was applied to your claim.
If your request is received outside of the reconsideration timely filing period of 60 business days, your request will not be considered for review.

The following will appear on your remittance advice:

RECONTF: Your request for reconsideration has been denied for timely filing
If the above requirements were met and your claim didn't pay correctly, DHMP will overturn its original decision and reimburse the claim based on your provider agreement with DHMP. The following will appear on your remittance advice:

RCONPAY: We have reviewed and agree with your reconsideration request. Claim has now been reprocessed for payment.
If any of the above requirements were not met. DHMP will maintain its original decision and the following will appear on your remittance advice:

RECON: We have reviewed your reconsideration request and determined the claim has been processed correctly. If you disagree, please see the provider dispute instructions for next steps at www.denverhealthmedicalplan.org.

What can I do if I don't like the response I received from DHMP on my reconsideration request?

- The dispute process is the final step in DHMP's internal review process when a provider is not satisfied with our claims decision.
- You have 30 calendar days from the date on the reconsideration remittance advice to complete and submit a dispute form and the appropriate supporting documents.
- For participating providers, DHMP will review and make a decision on your dispute within 45 calendar days
- For non-participating providers, DHMP will review and make a decision on your dispute within 90 calendar days.

- Your dispute must be submitted with a completed dispute form or it will be returned to you. DHMP uses this form to route your request to the appropriate department.
- No clinical review is performed on claims payment disputes. DHMP only conducts utilization review/clinical review through the member appeal process. We do not conduct clinical reviews for provider payment appeals unless there were extenuating circumstances that explain why you were unable to follow plan rules of obtaining authorization prior to rendering services.

Medicare Non-Contract Provider Disputes for Non-Contracted providers who disagree with a claims payment amount:
- Inquiry- Please first contact our Health Plan Provider services line to discuss your issue and for assistance with routine questions or inquiries.
- Medicare Non-Contract Provider Dispute - If you disagree with your claims payment amount or denial from DHMP, you may submit a request for a claims dispute. Requests for disputes must be submitted in writing on our Provider Dispute form (Attachment 1). Submit the dispute form to the address found on the form. This form must have all required fields completed. Incomplete forms will be returned to the Provider. You must also submit a Waiver of Liability form (Attachment 8) with your dispute request. Include all supporting documentation and evidence to support the dispute. Provider-carrier disputes must be received by DHMP within 60 calendar days of receiving your RA. Only one provider-carrier dispute may be filed per claim. Upon receipt of all required documentation, the Company will provide a written response to your dispute within 60 calendar days. *Please note that if the claim disagreement is for a paid claim and is limited to the amount a non-contract provider could collect if the member were enrolled in Original Medicare, this issue follows our internal payment dispute process as described in the section above.*

The provider "Request for a payment reconsideration form" can be found at the following link: https://www.denverhealthmedicalplan.org/provider-request-payment-reconsideration-form

The provider "Request for a Dispute Resolution form" can be found at the following link: https://www.denverhealthmedicalplan.org/provider-request-dispute-resolution-form

All questions concerning requests for review and reconsideration should be directed to DHMP Health Plan Services at 303-602-2100.

SECTION X: OVERPAYMENTS, DUPLICATE PAYMENTS AND UNDERPAYMENTS

DHMP periodically reviews payments made to providers to ensure claims are paid accurately pursuant to the terms of the provider's contract. If DHMP identifies that it has overpaid a provider for certain services, DHMP will notify the provider and recoup the overpayment amount according to the procedures detailed below, and any applicable requirements under Section 10-16-705(13) the Colorado Department of Health Care Policy & Financing Insurance Law or other applicable law or regulation. Unless a shorter lookback period is specified in the provider's contract, DHMP will not initiate overpayment recovery efforts with respect to any claim more than twenty-four (24) months after the original payment date for the claim; provided, however, that any time limitation shall not apply to overpayments that are: (1) based upon a reasonable belief of fraud, intentional misconduct, or abusive billing, (2) required or initiated by the request of a self-insured plan, or (3) required or authorized by a state or federal government program. In the case of any DHMP plans offered through the Medicaid and/or Child Health Plus programs, DHMP may pursue recovery of any overpayment identified to

provider within six (6) years of provider's receipt of payment; provided however that the six-year limitation will not apply to overpayments in which fraud may be involved or in which the provider or an agent or the provider prevents or obstructs DHMP auditing and overpayment recovery efforts.

We Will Provide Notice of Overpayments before Seeking Recovery
If DHMP determines that an overpayment has occurred, DHMP will provide sixty (60) days advance written notice to the provider of the overpayment before engaging in any overpayment recovery efforts. This notice will include the member's name, service dates, payment amount(s), proposed adjustment, a reasonably specific explanation of the reason for the overpayment, and the proposed adjustment. In response to a notice of overpayment, the provider may either (1) dispute the finding or (2) remit payment to DHMP as outlined below.

If You Agree That We Have Overpaid You
If a provider agrees with DHMP's overpayment determination as detailed in the overpayment notice, providers may voluntarily submit a refund check made payable to the corporate entity named on the demand letter (e.g., DHMP) within sixty (60) days from the date the overpayment notice was mailed by DHMP. Providers should further include a statement in writing regarding the purpose of the refund check (e.g. payment of identified overpayment) and a copy of the overpayment notice to ensure the proper recording and timely processing of the refund. Refund checks should be mailed to:

> Denver Health Medical Plan Finance Department
> Attention: Overpayment Recovery
> 777 Bannock St., MC 6000
> Denver, CO 80204

If You Disagree That We Overpaid You
If a provider disagrees with DHMP's overpayment determination as detailed in the overpayment notice, the provider must submit the following in accordance with the "Claims Reconsideration Process" within sixty (60) days from the date the overpayment notice was mailed: (1) a written request for a reconsideration, and (2) any supporting documentation. Upon making a determination on the provider's reconsideration request and supporting documentation, DHMP will provide written notice of the reconsideration determination. If DHMP upholds the overpayment determination, providers may submit a dispute request.

If DHMP upholds the overpayment determination, providers may initiate arbitration, as provided pursuant to their provider agreement. DHMP will proceed to offset the amount of the overpayment prior to any final determination made pursuant to binding arbitration.

If You Fail to Respond to an Overpayment Notice
If a provider fails to dispute or otherwise respond to an overpayment notice within sixty (60) days from the date the overpayment notice was mailed by DHMP, the provider will be deemed to have acknowledged and accepted the overpayment amount demanded by DHMP and, subject to the provider's right to arbitration pursuant to the provider agreement, DHMP will offset the overpayment amount against current and future claim remittance(s) until the full overpayment amount is recovered by DHMP.

If an Offset Results in a Negative Balance
If an overpayment offset results in a negative balance, the provider will receive a special Negative Balance Letter from DHMP while the offset amount is being recovered, in lieu of the standard Remittance Advice (RA). This letter will contain the current negative offset balance and any claim activity that has taken place since

during the check cycle period to reduce the negative balance. Once the entire negative amount has been recovered, the provider will resume receiving standard RAs.

Duplicate Payments

DHMP may also apply the procedures described in this section to recoup duplicate claims payments. However, DHMP reserves the right to use other available procedures to recoup duplicate claims payments.

Underpayments

After a provider has complied with the Review and Reconsideration Process and/or the Disputes Process, if DHMP agrees with the provider's assertion that DHMP has underpaid any claim(s) to the provider, DHMP may offset such identified underpayments against any overpayments dating as far back as the claimed underpayment that have not yet been recouped. Prior to such offset, however, DHMP shall ensure compliance regarding notice of overpayments to the provider.

SECTION XI: REFUNDS

There may be times when you feel that DHMP made a partial or full payment on a claim in error and you would like to return all or part of the funds. To ensure that the issue is addressed and the funds are received and credited back correctly we ask that you follow the following procedures.

Contact DHMP Health Plan Services and speak with a representative. DHMP will adjust the claim and offset the refund against any future claims payment. You will not receive payment on any claims you submit to DHMP until the offset or balance is satisfied. If the payment can't be recovered via claims submitted by your office within 60 - 90 days, DHMP will send you a demand letter requesting any monies owed. Please follow the remit instructions indicated in the letter.

SECTION XII: REIMBURSEMENT POLICIES

DHMP will develop and utilize reimbursement policies from time to time to ensure quality care is provided to its members. For its Medicaid, Medicare products it will at its discretion adopt the Centers for Medicare & Medicaid Service or its MAC reimbursement policies or reimbursement polices utilized by Colorado Department of Health Care Policy & Financing. These policies can be found on both organization websites below.

CMS
cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929

Colorado Medicaid
colorado.gov/hcpf/billing-manuals

PROVIDER REIMBURSEMENT
Claims payments are based on each provider's individual agreement with DHMP. Questions concerning contract terms should be directed to DHMP Health Plan Services at 303-602-2100.

SECTION XIII: OFF-SETS/ACCOUNTS RECEIVABLE/RECOUPMENTS

There may be a time when DHMP will need to adjust a claim for various reasons at your request, or the plan's. This adjustment may result in DHMP needing to take back a payment that has already been paid to you. DHMP refers to this as a recoupment. In most cases the reason why this recoupment has been performed will be explained on your provider remittance advice or on a separate letter mailed to the address we have on file for your office. When a recoupment occurs, an accounts receivable is set up in our claims system to off-set any future claims payments against this receivable. It may take longer than one payment cycle for the accounts receivable to clear. It is therefore, very important that you retain all remittance advice that shows a negative balance due until you receive a payment. You will then need a remittance advice for all payment cycles where the remittance advice was negative in addition to the most recent positive remittance advice in order to tie out your payment.

What does this mean for your office?
DHMP will not send you a paper check or deposit funds into your account until the balance is satisfied.

How is the accounts receivable satisfied?
The accounts receivable is satisfied through eligible and payable claims that you continue to submit to DHMP on ANY member.

What can I do to quickly resolve the accounts receivable?
- You can submit eligible and payable charges directly after identifying an accounts receivable has been created on your account.
- Contact DHMP Health Plan Services at 303-602-2100 to discuss other options. You may be able to submit a check to DHMP to clear the accounts receivable faster.

DHMP suggests when an offset first appears on your provider remittance that you note the member and amount being recouped and keep a record so that you will know when to expect the balance to be satisfied.

Sequestration
CMS implemented mandatory payment percent reductions for Medicare Advantage Organizations (MAOs), Part D plans, and other programs (including Managed Care Organizations) beginning April 1, 2013, in accordance with the Budget Control Act of 2011.