

Claims Submission and Processing

In order to comply with Federal requirements, HCPF standards, and to fulfill the contracts of NBH, claims must be processed in a timely and accurate manner, and standard filing procedures must be observed. Providers are to submit complete claims for all covered mental health services rendered to NBH Members in the form and manner required by NBH as specified below, and/or in accordance with the terms of their contract with NBH.

Claims may be submitted via diskette, standard mail, or dial-up telephone connection. Every attempt is made to accommodate each Provider's unique needs. NBH uses an administrative services organization (ASO), InNET, Inc., to process claims. All original claims must be submitted to InNET, Inc. at the following address:

InNET, Inc.
Attention: NBH Claims Department
155 Inverness Drive West, Suite 203
Centennial, Colorado 80112-1411

Reference Manuals

When processing claims, Providers should reference:

- › The NBH Medicaid Provider Manual,
- › HCFA-1500 Billing Instructions,
- › UB-92 Billing Instructions,
- › The NBH Referral Authorization Letter,
- › International Classification of Diseases. Ninth Revision. Clinical Modification (ICD9- CM) Codes,
- › Current Procedural Terminology (CPT™) Codes, and
- › Healthcare Common Procedure Coding System (HCPCS) Codes.

Claim Forms

Paper claims submitted to NBH are filed using the following uniform claim forms as applicable to the covered mental health services provided:

- › HCFA-1500 (CMS-1500) (Appendix A)
- › UB-92 (HCFA-1450) (Appendix B)

Any claims received by InNET, Inc. that are not correct or are incomplete will be returned to the Provider with a request for correction or more information, which may delay claim processing and payment.

InNET staff determines if sufficient information has been submitted to allow processing of the claim. If the information is not sufficient, the claim will be denied with an appropriate explanation. Additional information or clinical documentation may also be requested from the Provider to consider the claim; if so, the Provider has forty-five (45) days from the date of request to submit the additional information and/or clinical documentation. This additional information or clinical

documentation should be submitted directly to:

NBH
Attention: Claims & Appeals Review
1300 North 17th Avenue
Greeley, CO 80631

Electronic Claim Submission

Providers may choose to file claims electronically, and are in fact encouraged to do so. Submitting claims electronically improves accuracy, hastens claim processing and payment, and reduces administrative office costs. InNET, Inc. has software available for Providers to use for entry, pre-submission editing, and transmission. The software is tested after it is installed and training is provided. These services are provided at no cost to Providers. Please contact the InNET, Inc. Management Information Systems (MIS) Department at (303) 617-2679 for the software, protocols, additional information, and/or instructions for submitting electronic claims.

Electronically submitted claims are screened by the InCare System for appropriate security and pre-audit of the data prior to being accepted into the system for processing. Electronic claims that do not include appropriate security and audit controls are rejected and returned to the Provider. Electronic claims that are accepted are processed to generate facsimile claims for auditing purposes. Electronically submitted claims that are "clean" are typically adjudicated and paid within one (1) week and not more than thirty (30) days.

Claims Submission Tips

- A separate claim form must be submitted for each Member for whom the Provider bills and it must contain all of the required data elements.
- Limit each billing line to one (1) date of service and one (1) procedure code, unless care is consecutive. Charges for the service should equal the unit procedure price multiplied by the number of units of service provided.
- All pertinent information is necessary to process a claim promptly and accurately. Include the following elements when submitting a claim:
 - List date of service individually on HCFA claim forms. (No date spans.) UB-92 will have date spans.
 - Valid ICD-9 diagnosis codes.
 - Rendering Provider and Provider billing information, including tax identification number.
 - Appropriate and valid place of service codes with correlating appropriate and valid CPT codes.
 - Accurate Consumer information including Member identification number, name, and date of birth (No nicknames.)
- The services billed must correspond to those authorized. In order for payment to occur, the procedure/revenue codes and DOS must match those authorized.
- Use black or dark ink to complete the claim form.

- Do not use highlighters to mark claims or attachments. Use a dark ink pen to circle or underline information that requires special attention.
- Attach all required documentation behind the claim.
- If several claims require the same attachment(s), a photocopy of the attachment(s) must be submitted with each claim.
- Use the original red claim forms, rather than photocopies.
- Print claim data within the defined boxes on the claim form.
- Use white out or correction tape for corrections.
- Submit any notes on 8 1/2" x 11" paper.
- Use an 8-digit date format (e.g., 10212000).
- Use a fixed width font (Courier, for example).
- Verify the Member's Medicaid eligibility prior to submitting the claim.
- Complete all required data elements.
- Leave non-required data fields blank. (Do not enter "N/A.")
- Use only good quality toner, typewriter or printer ribbons/cartridges, or a laser printer, for paper claims.
- Bill original claims within ninety (90) days.
- Bill third party or Medicare prior to submitting claims to NBH.
- Do not submit "continuation" claims.
- Submit claims at least weekly to ensure timely payment for services.
- Submit EPSDT claims information.
- Submit claims to the appropriate address

Incomplete Claims

All claims received with incomplete or invalid information are returned to the Provider with an EOB advising the Provider of the incorrect or invalid information. "Corrected" claims providing the updated information for reconsideration should be sent to:

InNET, Inc.
Attention: NBH Claims Department
155 Inverness Drive West, Suite 203
Centennial, Colorado 80112-1411

Corrected claims received more than thirty (30) days from the date on the EOB will not be considered for payment.

Claims Status Inquiries

Providers who have questions about a specific claim or EOB should call NBH at 970-347-2366 Monday through Friday, 8:00 a.m.-5:00 p.m.

Claims Status Questions

NBH strives to have 100% of all claims processed within 30 days of receipt. If notification is not received within 30 days, please take the following steps *prior* to submitting a duplicate claim:

- If the original claim was submitted as paper, wait 30 days from the date you submitted the claim before contacting InNET, Inc. Provider

- Services to verify receipt and determine the next steps.
- If the original claim was submitted as electronic, access the claim status inquiry through InNET, Inc. on-line services to verify that the claim was accepted.

Timely Filing Requirements

The following is a summary of timely filing requirements for various types of claim submissions:

Type of Claim Submission	Timely Filing Requirement
Initial Claim Submission	Submitted within 90 calendar days from the date the services were provided, or 90 calendar days from the date of discharge from an inpatient, ATU, or residential facility, regardless of service authorization status.
Claim Resubmission	Submitted within 30 calendar days from the date of the last denial.
Claim Adjustment	Submitted within calendar 30 days of the EOB date.
Claim Reconsideration	Submitted within 30 calendar days of the additional information request from NBH.
Third Party Resources	Submitted within 60 calendar days of the third party payment or denial or within 365 days of the date of service or discharge from an inpatient, ATU, or residential facility, <u>whichever occurs first</u> .
Delayed/Retroactive Client Eligibility	Submitted within 120 calendar days of the date that the client appears on State eligibility files. Each claim must have an attached <u>dated</u> State-authorized form from the County Department of Human Services that verifies the eligibility determination delay or backdating.
Delayed notification of eligibility	Submitted within 60 calendar days of the date that the provider was notified of eligibility or 365 days from the date of the service, <u>whichever occurs first</u> . A Delayed Eligibility Notification form (Appendix E) must be completed and attached to each claim.
Circumstance beyond the provider's control	Reviewed during an appeal of a denied payment of a claim. Exceptions are granted only where the provider is able to document that appropriate action to meet filing requirements was taken and that the provider was prevented from filing as the results of exceptional circumstances that could not have been foreseen or controlled. Employee negligence, employer failure to provide sufficient, well-trained employees, or failure to properly monitor the

	activities of employees and agents (billing services) are not beyond the provider's control.
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Claims submitted after the filing deadline will be denied and neither NBH nor the Member will have further payment liability for such claims. Claims that are not submitted timely will not be considered for reimbursement. The claim must also match the service authorization for the claim to be paid correctly.

Claims Resubmission

Providers may resubmit denied claims for reprocessing within thirty (30) days from the date of the last denial recorded on an EOB. Claims may be resubmitted if denied for additional information needed or information missing from the original submission. Claims may also be resubmitted for the following reasons by attaching proof:

- Denials for no authorization where the Provider has proof of prior service authorization from NBH.
- Denials for Member ineligible on the date of service (DOS) where the Provider has a copy of the State Web Portal print out verifying Member eligibility on the DOS.

To resubmit a claim:

- A resubmission should be submitted on a newly completed claim form marked "Resubmission" or "Re-bill". The resubmission must be dated and signed with an authorized signature.
- Do not include items that were paid on the prior claim.
- Do not add new services that were not included on the original claim; these should be submitted separately.
- Attach a copy of the EOB listing the originally submitted claim as denied.
- Attach the additional information needed or information missing from the original claim submission.
- Please do not resubmit a denied claim more than one (1) time. If a Provider does not understand the EOB reason for the denial, he/she should contact NBH Claims Department or the UM Department for clarification. Repeatedly resubmitting denied claims, without additional new information that was not included with the original claim, only serves to hinder overall claims processing procedures.

Mail the claim resubmission to:

InNET, Inc.
Attention: NBH Claims Department
155 Inverness Drive West, Suite 203
Centennial, Colorado 80112-1411

NBH researches the claim resubmission and adjudicates the claim according to the newly resubmitted information. Once adjudicated, an EOB is sent to the Provider with an explanation of the reason for payment or denial.

Claims Adjustment

On occasion, after a payment has been issued, either NBH Claims staff or the provider may detect an error in the amount that was paid. The adjustment process deals with the correction of those claims that have been through the adjudication cycle and been paid. If a claim has been rejected and not paid, it is not subject to an "adjustment". Only those claims that have already been paid can be adjusted. Claims adjustments generally occur for the following reasons:

- Claim was submitted and paid twice.
- Claim was paid at wrong rate.
- Claim was paid for the wrong number of days (inpatient, ATU, residential services only).
- A Compliance audit was conducted.

NBH will review request for an adjustment on paid claims, if the request is received within thirty (30) days of the EOB date and includes all of the following items:

- A Claims Adjustment Form (Appendix C),
- A copy of the EOB corresponding to the claim that is to be adjusted, and
- A copy of the original claim and any supporting documentation.

Adjustment requests that do not include the necessary documentation are denied. Paid claims that are not submitted as adjustments, but are resubmitted without the documentation described above, will be denied as duplicate claims. Denied claims cannot be adjusted but must be submitted for reconsideration/appeal.

Adjustment requests should be mailed to:

NBH
Attention: Claims Department
1300 North 17th Avenue
Greeley, CO 80631

Claims Payment

- Providers are reimbursed at the contracted or negotiated rate for covered services.
- Providers are not be reimbursed for account-specific exclusions.
- A Member can only be charged for the applicable account-specific co-payment, co-insurance, or deductible portion of such rate for covered services.
- Members may not be charged for any fees above the contracted rates.
- Providers are not allowed to "balance-bill" Members. This includes any balance billing because a claim was denied for failure to obtain a required prior service authorization, or for timely filing. (Refer to the "Balance Billing Prohibition" Section.)
- The signature in Block 31 of the HCFA-1500 Form certifies that services were

actually rendered by the Provider signing the claim form.

Clean Claims

A "clean claim" is a claim for payment of covered mental health services that is submitted to InNET, Inc. on the appropriate uniform claim form with the required fields completed with correct and complete information, including all required documents. A claim requiring additional information is not considered a clean.

Clean claims are to be received by InNET, Inc. within ninety (90) days from the date of service. In addition, the claims must be free from defect or impropriety (including lack of required substantiating documentation) or circumstance requiring special treatment that prevents timely payment. If additional information is required, the Provider agrees to cooperate by providing any information reasonably requested for the purpose of consideration and in obtaining necessary information relating to coordination of benefits, subrogation, and verification of coverage and health status. All billings by the Provider are considered final unless adjustments or an appeal request is received within thirty (30) days from the date indicated on the Explanation of Benefits (EOB) form sent by NBH. Reimbursement is based upon authorization for services covered under the Member's benefit plan and the Member's eligibility at the time of service.

Claim Processing:

Claims are entered into the computer system and adjudicated as follows:

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|-----------------------|---|
| Authorization: | A claim will be denied if there is no matching authorization found in the system. A match is based on date range, treatment, chart and provider. |
| Eligibility: | A claim will be denied if there is no eligibility record found based on claim begin and ending dates. |
| Diagnosis: | A claim will be denied if the selected diagnosis is not eligible. Refer to page 9 of this section for further information. |
| Expired: | If timely filing requirements were not met, a claim will be denied. |
| Duplicate: | If a matching claim was found, claim will be denied as <i>possible duplicate claim—claim number</i> . The match is based on date range, treatment, chart and provider. |
| Service: | A claim will be denied if the CPT (procedure) code billed was not an authorized service. A matching authorization may have been found based on date range, chart and provider but the authorized CPT code is not correct. |
| Invalid Dates: | If an authorization is not found with matching date range, a claim will be denied. |

- Date Range:** If the service date range falls outside of authorization date range, the claim may be denied. However, payment will be made on the service falling within the date range.
- Provider:** A claim will be denied if the provider listed does not match authorization.
- TPL:** The claim will be denied if the client has other insurance and there is no evidence of primary insurance payment.
- Visits*:** If more visits were claimed than authorized, only the authorized visits will be paid.
- Maximum Units*:** If more units per visit were claimed than authorized, only the authorized units per visit will be paid.
- Maximum Amount*:** If the claim amount exceeds the authorization amount, only the *contracted rate* will be paid.

*These items are only checked if all other criteria are met.

If there is no reason for denial or change of payment amount, the claim is considered a “clean” claim and sent for payment processing. All other claims are sent for manual processing which includes time-consuming research. Therefore, it is important that all claims should be accurate. Refer to the Referral Authorization for billing information and requirements.

Explanation of Benefits (EOB)

NBH encloses an EOB or remittance advice with each check for payment of submitted claims to assist Providers in determining the reason for payment. Any adjustments or denials made by NBH to the claim payment are also accompanied by an EOB. A sample of an EOB is on the following page.

Northeast Behavioral Health, LLC
1300 North 17th Avenue
Greeley, CO 80631

EXPLANATION OF BENEFITS

Dr. A. Therapist, PhD
1234 Pine Street
Any Town, CO 80000

<u>Client</u>		<u>Provider</u>	
Name:	JOHN DOE	Medicaid:	05001003
Medicaid:	H000000	Account:	46914602
Auth No.:			
Claim No.:	110699	Batch:	6383
EOB Date:	6/2/2004		

From	To	Code	Service	Billed	Allowed	Paid	Explanation
1/2/2004	1/2/2004	90806	Individual Psychotherapy 45-50 minutes	80.00	0.00	60.00	Paid at contracted rate

Claim Item Totals	80.00	0.00	60.00
Third Party Payment:			0.00
Other Discount:			0.00
Total Paid:			60.00

Reconsideration / Appeal Process:

Requests for reconsideration or appeal of the above claim denial may be made in writing to Northeast Behavioral Health by the Medicaid provider within thirty (30) calendar days of the Explanation of Benefits (EOB) date. The provider must provide documentation essential to review the request for reconsideration or appeal, including new information not provided with the original claim. This documentation includes but is not limited to: copies of the clinical record, copies of all EOBs – including those from other payers – and other written notification of denial documenting initial and subsequent timely filing, a sign copy of the original claim (including original attachments), and a brief explanation of the nature of the reconsideration or appeal. If the claim was denied for lack of ‘timely filing’, the provider should attach a copy of an EOB from the primary payer explaining the delay in filing.

The request for reconsideration or appeal must be clearly identified by attaching a designated ‘Request for Reconsideration / Appeal’ form to the claim, OR by identifying the word ‘reconsideration’ or ‘Appeal’ on the face of the claim form. Requests for reconsideration or appeal that do not include a completed claim form will be returned to the provider. Requests for reconsideration or appeal are reviewed and the result of the review reported to the Medicaid provider in writing within thirty (30) calendar days of receipt.

Please send written request for reconsideration or appeal to:

Northeast Behavioral Health, LLC
Attention: Reconsideration / Appeals
1300 North 17th Avenue
Greeley, CO 80631

Claims Reconsideration/Appeal

All denials are subject to appeal and reconsideration. However, all appeal requests must include new information that was not provided at the time of the initial claim, including the reason for appeal. Appeals submitted without additional information including the reason for appeal will be returned to the provider.

These procedures do not in any way prohibit the provider from accessing the full array of regulatory appeal mechanisms available under various rules and regulations. However, denials of claims can occur due to error or misunderstanding and providers are encouraged to utilize the NBH appeal process as a means of resolving these issues at the lowest level.

All appeals related to clinical issues such as medical necessity will be reviewed by the NBH Medical Director or designee. These appeals should include information not previously provided and should support the clinical rationale for treatment rendered. Such support should include specific references to the medical record documenting the symptoms and behaviors that support the patient's treatment.

Informal appeals: Questions regarding why a claim was not paid, may be referred to the Claims Department for further clarification at 970-347-2366 or toll free at 888-296-5827.

Formal appeals: For a review of a denied claim, the following steps must be taken:

In order to provide the information needed to evaluate the appeal, the Request for Reconsideration/Appeal form (Appendix D) should be used. Documentation to be included with the request is:

- A copy of the EOB which is being appealed;
- Copies of EOB from other payers, if applicable;
- Copy of the clinical record;
- A signed copy of the original claim including original attachments;
- Other information in support of the request for reconsideration /appeal; and
- A completed claim form. (Required) Request will be returned to provider if not attached.

Level 1 The appeal must be in writing and sent within 30 calendar days of receipt of the denial. First level appeals are processed within 30 days of the receipt of the appeal by the Director of Utilization Management. If the denial is upheld, an EOB and/or letter will be sent to the provider with an explanation. If the appeal is overturned, an EOB will accompany the check for payment to the provider.

Level 2 Second level appeals must be in writing and sent within 30 days of receipt of the Level 1 denial. All appeal requests must include new information that was not provided at the time of the first level appeal, including the reason for appeal.

It is reviewed by the Medical Director and a decision is made within 30 days of receipt of the Level 2 appeal. If the denial is reversed, the

claim is paid. If the denial is upheld, you have the right to take the appeal to Level 3.

- Level 3** Third level appeals must be in writing and sent within 30 days of receipt of the Level 2 denial. It is reviewed by the Executive Director, and a decision is made within 30 days of receipt of the Level 3 appeal. This is the final level of appeal and decisions made at this level are upheld.

Diagnosis Codes

NBH accepts only those diagnoses codes covered by the Medicaid Community Mental Health Services Program. Providers must ensure that the diagnosis billed matches the diagnosis on the request for service authorization, supports the validity and appropriateness of the services provided, and is supported by the Member's medical record. NBH utilizes ICD-9-CM diagnosis coding. Providers must enter ICD-9-CM codes clearly on the claim form and include all digits and characters. NBH is responsible for psychiatric services only, and prior authorizes and pays for covered mental health services for covered psychiatric diagnoses only.

Procedure Codes

NBH uses the HCPCS to identify services provided to Members. HCPCS codes include CPT™ codes. To ensure claims are processed promptly and accurately, Providers should use the most current CPT™ revision. Providers should also be aware that not all codes listed in the annual Medicaid HCPCS publication are regular benefits under NBH.

Transaction and Code Requirements

Under HIPAA, all covered entities are required to use the transaction and code standards effective October 16, 2003. In using this system, NBH and Providers must not:

- Change any definition, data condition or use of a data element or segment as proscribed in the Health and Human Services Transaction Standard Regulation (45 CFR 162.915(a)).
- Add any data elements or segments to the maximum defined data set as defined in the HHS Transaction Standard Regulation (45 CFR 162.915 (b)).
- Use any code or data elements that are either marked "not used" in the HHS Transaction Standard's implementation specifications, or are not in the HHS Transaction Standard's implementation specifications (45 CFR 162.915 l).
- Change the meaning or intent of any of the HHS Transaction Standard's implementation specifications (45 CFR 162.915 (d)).

There is the possibility that NBH or others may request an exception from the uses of a standard in the HHS Transaction Standards. If this occurs, Providers participate in such test modifications. From time-to-time, HHS may modify and set compliance dates for HHS Transaction Standards. Providers must

comply with any such modifications or changes. NBH and its Providers agree to keep open code sets being processed or used for at least the current billing period or any appeal period, which ever is longer.

Medicare and Third Party Resources

Payer of Last Resort

Under Federal law, the Medicaid Community Mental Health Services Program is the "payer of last resort." Any available insurance, including Medicare, must be used before Medicaid pays for covered mental health services. NBH and the Provider are both responsible for identifying Members who have health care insurance and making full disclosure of this information to the other party. Providers are to bill those insurance carriers for the cost of covered mental health services, prior to billing NBH.

Coordination of Benefits

When a Member has insurance, in addition to Medicaid, payment by NBH is coordinated with the third party plan(s). The order of payment is determined in accordance with the Colorado Division of Insurance (DOI) Coordination of Benefits Regulations as applicable law. In no case is the total payment to the Provider more than the NBH allowable amount, unless the third party's payment is greater. When NBH is the secondary payer and the covered mental health services requested are not covered by the Member's insurance, NBH prior authorization rules apply. (Refer to the "Service Authorization Policy and Procedures.")

Providers cooperate with NBH in providing any information reasonably requested in connection with claims and in obtaining necessary information relating to the coordination of benefits. Providers make reasonable efforts to determine whether Members have insurance or health care coverage other than NBH, and promptly report such coverage to NBH. Coordination of benefit rules determine payment made to the Provider. In no event is NBH obligated to pay the Provider any portion of a secondary payment whereby the sum of the primary payment plus the secondary payment exceeds the compensation specified in the reimbursement schedule. Other requirements include:

- ▶ The Provider must exhaust all avenues of other insurance coverage and payment prior to billing for covered mental health services.
- ▶ When the insurance carrier has made a decision regarding reimbursement, a copy of the disposition (i.e., EOB) must accompany the HCFA-1500 or UB-92 claim submission to NBH through InNET, Inc., to ensure accurate coordination of benefits payment.
- ▶ Coordination of Benefits claims must be received by InNET, Inc. within sixty (60) days from the date of the insurance carrier's disposition.
- ▶ Outstanding Coordination of Benefits balances between the billed amount and the total amount paid are not to be billed to the Member.

Coordination of Benefits Claim Tips

One of the primary reasons for delays in claims processing is the lack of information necessary to coordinate benefits across multiple payers. The following tips are designed to assist Providers in reducing payment delays attributed to coordination of benefits related issues:

- Ask Members if they have coverage through multiple payers or other resources.
- If the Member does not have other coverage and the services are being submitted on a HCFA-1500, please make sure that 11 (d) indicate "NO". If other coverage is available, the other insured information in box 9 (a-d) needs to be completed.
- Determine the primary and secondary payers.
- Attach the EOB from the insurance carrier when submitting the claim as secondary to NBH through InNET, Inc.

Third Party Resources

Federal and State regulations require all available third party resources to be pursued prior to reimbursement by NBH. NBH pays all applicable co-payments, coinsurance and deductibles for authorized covered mental health services for the Member from the third party resource using the lower-of pricing methodology except that, in any event, the payments are limited to the amount that Medicaid would have paid under NBH contracted rates.

- The sum of reported third party coinsurance and/or deductible or
- The NBH contracted rates minus the amount paid by the third party, whichever is lower.

If a Member has third party insurance coverage and is also enrolled in Medicaid, NBH takes the following steps to help the Member access mental health services:

1. When the Member calls NBH or a Network MHC, the triage clinician does a brief screening with the Member to determine his/her level of need. The clinician also obtains the Member's insurance information for both the third party insurance and Medicaid.
2. If the Member needs mental health services which are covered under the Member's third party insurance, the Member is assisted to access his/her benefits under the that coverage.
 - a. If NBH has an appropriate Provider who is also in-network with the third party insurance, the Member may be referred in that manner.
 - b. NBH will pay any co-pay on the primary insurance for covered, medically necessary mental health services up to the Medicaid benefit limit if one exists (e.g., individual therapy). This co-pay is covered regardless of whether or not the Provider is part of NBH's Network.
3. If the Member needs medically necessary mental health services which

- are not covered under the third party insurance, NBH arranges for those services under the Member's Medicaid eligibility.
4. NBH continues to arrange for medically necessary mental health services not covered under the Member's third party insurance.
 5. If the Member's third party insurance mental health benefit limits are reached and there is medical necessity for additional covered mental health services, NBH attempts to maintain the continuity of care with the Provider.

Victim's Compensation/Medicaid

While Medicaid is the "payer of last resort" when eligible Members have insurance benefits, this is not the case with Victim's Compensation. If a Provider is rendering covered mental health services under Victim's Compensation to a Consumer with Medicaid, the Provider must request prior service authorization from NBH. If the Provider's claim is denied (e.g., a non-covered diagnosis), the Provider then submits a claim to Victim's Compensation with a copy of the EOB from the BHO.

Dual Medicare/Medicaid Eligibility

For Members who have both Medicare and Medicaid, the Medicaid number should be included on the Medicare claim form. Medicare crosses these claims over and the co-pay is paid directly from Medicaid funds; the Provider does not need to submit a claim to NBH. Medicaid is the "payer of last resort." Therefore, the Provider bills NBH for prior authorized services only when Medicare benefits are exhausted, or when services are not covered by Medicare. NBH is not responsible for Medicare co-payments, coinsurance, and deductibles for approved Medicare Part B services processed by Medicare Part A.

If the Provider is aware that the Member's Medicare benefits will be exhausted during the episode of care and wishes NBH to cover subsequent services, prior service authorization must be obtained before the loss of Medicare benefits. Providers may call NBH Utilization Department to request prior service authorization of inpatient mental health services and for prior authorization of outpatient mental health services.

All dual Medicare/Medicaid eligible Members who need mental health services beyond what is covered by Medicare are provided the same amount and type of services as any other Member. Dual Medicare/Medicaid eligible Members who are solely in need of Medicare-covered mental health services are assisted in obtaining services from qualified Medicare Providers. If the Member is unable to find a qualified Medicare Provider, NBH ensures that the Member receives all medically necessary covered mental health services.

Dual Medicare/Medicaid eligible Members who are in need of mental health services beyond what is covered by Medicare are provided all medically necessary covered mental health services through NBH's Network. If the Member is considered at high risk, he/she is provided medically necessary

mental health services through NBH's Network without a community Medicare Provider search by the Member.

Filing Claims When Medicaid is the Secondary Payer Source

To file a claim for a Member who has third party resources:

- Attach documentation to the HCFA-1500 or UB-92 claim form showing claims processing results from the third party, including all remark codes with corresponding wording.
- Attach a copy of the EOB, denial notice (including all denial reason wording), benefits exhausted statement, or a copy of the check or voucher used for claim payment from the third party.
- Letters or notices from third party resources refusing payment because of claim preparation errors or failure to provide sufficient processing information are not acceptable as proof of denial.
- If an EOB applies to more than one (1) claim, a copy of the EOB must be attached to each claim submitted.
- Complete the appropriate third party data fields on the claim form submitted to InNET, Inc. Claim third party data fields are specific to third party insurance or Medicare; they cannot be used interchangeably.
- Submit the claim within sixty (60) calendar days from the date of denial or processing date from the third party.
- Include only the minimum necessary PHI to accomplish the intended purpose.

Recovery of Third Party Payments

HCPF has set forth its expectations regarding the recovery of third party payments. Those expectations of BHOs, Providers, and Members are as follows:

- All Members are required to assign their rights to any benefits to the HCPF and agree to cooperate with HCPF in identifying third parties who may be liable for all or part of the costs for providing covered services to the Member, as a condition for participation in the Medicaid program.
 - NBH has the same rights as HCPF for all months that the Consumer is a Member of the BHO.
- Members comply with the NBH protocols when a third party is not primarily liable, including using Providers within the NBH Network, prior to receiving non-emergency mental health care.
 - Failure to follow the NBH protocols may result in a Member being liable for the payment or cost of any care or services that NBH would have been liable to pay.
- When a third party is primarily liable for the payment of the costs of a Member's mental health benefits, the Member complies with the protocols of the third party, including using Providers within the third party's network, prior to receiving non-emergency mental health care.
 - Failure to follow the third party's protocols may result in a

Member being liable for the payment or the cost of any care or any service that the third party would have been liable to pay.

- NBH develops and implements systems and procedures to identify potential third parties that may be liable for payment of all or part of the costs for providing covered services.
- NBH actively pursues and collects from third party resources that have been identified, except when the cost of pursuing recovery reasonably exceeds the amount that may be recovered.
- NBH does not restrict access to covered services due to the existence of possible or actual third party liability.

However, NBH does not require Providers to absorb the cost of services, or to wait an excessive amount of time for payment in cases where NBH believes a third party is financially responsible, but the third party refuses to pay the Provider. NBH will pay the Provider in a timely manner, once the Provider has demonstrated reasonable efforts to obtain third party payment. Reasonable efforts can be demonstrated by:

- Providing copies of claims showing the dates sent into the third party;
- Providing copies of notes (dated) from phone conversations attempting to resolve the issues; and/or
- Providing copies of any documentation (dated) from the third party. If the Provider is paid by NBH and subsequently paid by the third party, the Provider must reimburse NBH for the payment.

"Balance Billing" Prohibition

Providers may not bill Members for services to be paid for by NBH or for non-authorized covered mental health services. Providers who knowingly "balance bill" Members are subject to Provider sanctions. Network Providers also agree that this provision supercedes any oral or written contrary agreement previously entered into between the Provider and Member.

Providers may only collect applicable deductibles, coinsurance, and/or co-payments from the Member at the time of services. NBH reimburses the Provider the balance up to the fee schedule maximum or negotiated rate, or the billed charge (whichever is less) for covered services upon receipt of a clean claim form by InNET, Inc., in compliance with NBH policies and procedures outlined in this section of the Manual.

The following situations are not considered "balance billing":

- When Members contract with a Provider to self-pay for services not covered under their benefit plan.
- Billing Members who continue to have services provided after their annual benefit limits have been knowingly reached.

Non-Authorized Services

If a Provider fails to secure the required prior service authorization from NBH for services that are included in the Member's plan, the Member cannot be

held liable for the cost of those services.

In the event that NBH notifies the Provider that the proposed treatment or services for a Member will not be authorized, or treatment or services for a Member which had been will no longer continue to be authorized, the Provider may initiate an appeal of such non-authorization by following NBH's service authorization appeal procedure. The Provider must also inform the Member of the NBH appeal process. At the time of the first denial, the Provider may inform the Member of the denial and seek written consent from the Member to be financially responsible for the non-authorized treatment. However, the Provider must continue and complete the appeals process before directly billing the Member. Please refer to the Grievance System in the NBH Member Handbook

Non-Covered Services

- The Provider may bill the Member for services that are included in the Member's plan but that are not certified as medically necessary, only if the Provider has followed the procedures set forth in the Provider's contract.
- The Provider may bill the Member for services not covered under the Member's plan.
- The Provider may bill the Member who continues to have services provided after their annual benefit limits have been knowingly reached.

Missed Appointments

NBH does not authorize payment to Providers for missed appointments, nor may a Member be billed unless he or she has agreed in writing to pay out-of-pocket for any missed appointments at the start of treatment.

Emergency and Post-Stabilization Care Services

NBH is responsible for the cost of all emergency mental health services provided to Members under the Colorado Medicaid Community Mental Health Services Program, including emergency services rendered by out-of-network Providers, based on the principal diagnosis treated.

Liability for these charges can also depend in part upon whether a Member is hospitalized in the same hospital immediately following an emergency department (ED) encounter. In cases of immediate hospitalization, the ED charges are assumed to be included in "the Medicaid payment for inpatient services." This was the consistent practice under fee-for-service Medicaid and was carried forward as an operating principle under the Colorado Medicaid Community Mental Health Services Program.

If the Member is not hospitalized in the same hospital, then the responsible party is determined solely by the principal diagnosis assigned in the ED. If the principal diagnosis is covered under the Colorado Medicaid Community Mental Health Services Program, then NBH is responsible for all the bundled ED services provided at that encounter. Conversely, if the principal diagnosis

is medical and the Member also receives some mental health treatment, the Member's Health Maintenance Organization (HMO) or the Medicaid fee-for-service program is responsible for all ED charges for the mental health treatment.

Providers of emergency services are required to bill NBH directly for reimbursement. If a claim is submitted directly to the Medicaid Fiscal Agent or to a Member's HMO for reimbursement for emergency mental health services delivered to an Enrollee in the Colorado Medicaid Community Mental Health Services Program, payment will be denied and the requestor will be instructed to bill the BHO.

NBH may challenge claims for payment if the clinical documentation does not support the emergency nature of the services provided. NBH will only deny payment when there is clear clinical evidence that an emergency did not exist or that the Provider rendered services beyond those required treating the emergency and for which the Provider reasonably could have sought prior service authorization without risk to the Member or others. In reviewing claims for emergency services, NBH follows the "prudent layperson criteria" defined in DOI Regulation 4-2-17.

Facilities submitting claims for ED services are encouraged to submit all clinical documentation relating to the charges concurrently. NBH will review the claim and documentation to determine the extent of payment. Charges for Members presenting a non-mental health condition will not be paid. Non-mental health services such as EKG, X-ray, brain imaging studies, medication, etc., are not a benefit of the Colorado Medicaid Community Mental Health Services Program and, consequently, will be denied.

Submit ED claims to:

InNET, Inc.
Attention: NBH Claims Department
155 Inverness Drive West, Suite 203
Centennial, Colorado 80112-1411

Submit supporting ED clinical documentation to:

NBH
Attention: Claims & Appeals Review
1300 North 17th Avenue
Greeley, CO 80631

Emergency Department Physician Services

Physician services and other services in Emergency Departments are frequently billed separately and follow a somewhat different set of rules. In the case of physician services and other services, *both* the principal diagnosis *and* the procedure performed determine the responsible party. If a severely injured person (from a suicide attempt, for example) with a principal ED diagnosis of severe trauma receives consultation from a psychiatrist (perhaps for a medication evaluation or sedation), the physician

charges for the psychiatric consultation is the responsibility of NBH, despite the medical condition being the principal diagnosis. The HMO or fee-for-service program would still be responsible for all of the bundled ED charges because of the principal diagnosis.

Conversely, if the principal diagnosis in the ED is covered under the Colorado Medicaid Community Mental Health Services Program, the physician charges and other separate charges relating to medical procedures are the responsibility of the Member's HMO or Medicaid fee-for-service coverage. For example, someone with a minor cut to the wrist may receive a principal mental health diagnosis but require a physician to treat the cut. In that case, the HMO or Medicaid fee-for-service program would be responsible for the physician services for the treatment of the wound. NBH would still be responsible for all ED services, however, because of the principal diagnosis.

Principal Diagnosis in Emergency Encounters

The *principal diagnosis* should be the one that is the *primary focus* of the ED treatment. An ED encounter caused by a drug overdose or serious injury should have a principal diagnosis related to the treatment of those immediate conditions, not the diagnosis of an underlying or historical mental health condition.

Billing Discrepancies Discovered in Audits

Billing discrepancies include claims billed to NBH for which corresponding adequate documentation was not found, billing Medicaid for services prior to billing Medicare or other third party insurance, submitting claims for sessions when the client no-showed, or submitting claims for service provided by someone other than the contracted provider.

For every claim submitted to NBH, the chart must contain appropriate documentation of service. Upon discovering billing discrepancies, NBH will ask the Provider to submit the missing documentation. If warranted, an action plan will be required to help prevent future billing discrepancies. If the Provider cannot produce the required documentation, revocation of the payment will be requested. The presence of billing discrepancies in a quality assurance audit will automatically lead to an increase in the amount of monitoring of your NBH caseload. This may include more frequent audits or more charts selected at future audits.

Appendix A

PLEASE
DO NOT
STAPLE
IN THIS
AREA



APPROVED OMB-0938-0008

CARRIER

HEALTH INSURANCE CLAIM FORM																																																																																																																																																																																																																															
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)																																																																																																																																																																																																																										
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																																																																																																																																																																																										
5. PATIENT'S ADDRESS (No., Street)					7. INSURED'S ADDRESS (No., Street)																																																																																																																																																																																																																										
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9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					11. INSURED'S POLICY GROUP OR FECA NUMBER																																																																																																																																																																																																																										
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b. OTHER INSURED'S DATE OF BIRTH SEX					b. AUTO ACCIDENT? PLACE (State)																																																																																																																																																																																																																										
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT?																																																																																																																																																																																																																										
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<p>READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.</p> <p>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.</p> <p>SIGNED _____ DATE _____</p>																																																																																																																																																																																																																															
14. DATE OF CURRENT: MM DD YY			ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																																																																																																																																																																																																						
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE			17a. I.D. NUMBER OF REFERRING PHYSICIAN			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			20. OUTSIDE LAB? \$ CHARGES																																																																																																																																																																																																																						
19. RESERVED FOR LOCAL USE			21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)			22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.			23. PRIOR AUTHORIZATION NUMBER																																																																																																																																																																																																																						
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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.)						32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)						33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #																																																																																																																																																																																																																			
SIGNED _____ DATE _____						PIN# _____ GRP# _____																																																																																																																																																																																																																									

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HCFA 1500/CMS 1500 Claims Specifications

Providers must file all claims for professional services; including laboratory services performed by an independent laboratory, on the HCFA 1500/CMS 1500 Universal Billing form.

Box Number	Data Element	Description	Required
1a	Patient's ID Number	Patient's ID number.	Yes
2	Patient's Name	Patient's last name, first name and middle initial exactly as they appear on the MAC	Yes
3	Patient's DOB/Sex	Patient's DOB using MMDDYY format. Patient's sex (M = Male, F = Female).	Yes
4	Insured's Name		No
5	Patient's Address		Yes
6	Patient Relationship to Insured	Relationship between the patient and the policyholder (insured) of the third party insurance.	Required if patient has third party coverage
7	Insured's Address	Address and telephone number of the policyholder (insured) of the insurance. Third party claims refer to subscriber not 3rd party.	Required if patient has third party coverage
8	Patient Status		No
9	Other Insured's Name	Policyholder's last name, first name, and middle initial.	Required if patient has third party coverage
9a	Other Insured's Policy/or Group Number	Policy Number	Required if patient has third party coverage
9b	Other Insured's DOB and Sex	Date of birth, sex of policyholder	Required if patient has third party coverage
9d	Insurance Plan Name or Program Name	Name of insurance company or program providing third party coverage.	Required if patient has third party coverage
10	Is Patient's Condition Related to	Indicate whether patient's condition is related to employment, auto accident, or other accident.	No
10d	Reserved for Local Use	Enter the accident date MMDDYY	Required if applicable
11	Insured's Policy Group or FECA #		Yes
11a	Insured's Date of Birth and Sex		No
11b	Employer's name or school name		No

Box Number	Data Element	Description	Required
11c	Insurance plan name or program name		No
11d	Other Health Benefit Plan?		No
12	Patient's or Authorized Person's Signature	Patient's signature or notation that signature is "on file."	Yes
13	Insured's or Authorized Person's Signature.	Insured's signature or notation that signature is "on file"	Yes
14	Date of Current Illness, Injury or Pregnancy	Date of first symptoms, accident, or last menstrual period using MMDDYY format.	Yes
15	First Date of Similar Illness		No
16	Dates Unable to Work		No
17	Name of Referring Physician or Other Source	Name of Physician	No
17a	I.D. Number of Referring Physician	Provider Tax ID number of the referring physician.	No
19	Local Use		No
20	Outside Lab/\$ Charges	Indicate whether ALL laboratory work was performed outside of the physician's office by an independent lab. If yes, no payment will be made to the physician for laboratory fees. Do not check yes if ANY laboratory work was performed within the physician's office.	No
21	Diagnosis Code	Written description — optional. Enter up to four ICD-9-CM diagnosis codes. Decimal points should not be entered.	Yes
22	Medicaid Resubmission	Code and the original reference number.	No
23	Prior Authorization Number	Prior Authorization number received from NBH or from the PCP.	Required if applicable
24a	Date of Service	Dates that service began and ended using MMDDYY format	Yes
24b	Place of Service	NBH requires providers to use the correct CPT™ code that is appropriate for the place of service listed on the claim form. The following is a list of place of service codes used by NBH. In order for claims to be processed, these codes must be used. Single digit or alpha place of service codes will be considered invalid codes. Code Description 11 Office 12 Patient's home 20 Urgent Care	Yes

		21 Inpatient hospital 22 Outpatient hospital 23 Emergency room-hospital 24 Ambulatory surgical center	
Box Number	Data Element	Description	Required
		25 Birthing center 26 Military treatment facility 31 Skilled nursing facility 32 Nursing facility 33 Custodial care facility 34 Hospice 41 Ambulance — land 42 Air ambulance 51 Inpatient psychiatric 52 Psychiatric facility partial hospital 53 Community mental health center 54 Interim care facility (ICE) 55 Residential substance abuse facility 61 Comp IP rehabilitation facility 62 Comp OP rehabilitation facility 65 End stage renal treatment facility 71 ST/Local disease treatment facility 72 Rural health clinic 81 Independent laboratory	
24c	Type of Service		No
24d	Procedures, Services or Supplies (including modifiers)	CPT-4 or HCPCS code	Yes – including EPSDT modifiers 1X and 2X
24e	Diagnosis code	Number 1, 2, 3, or 4 from field 21 to indicate which diagnosis is related to the procedure on each billing line. Do not enter the ICD-9-CM code.	Yes
24f	Charges	Usual and customary charge for each service.	Yes
24g	Days or units	Number of service units for each procedure. Days or units must be whole numbers.	Yes
24h	EPSDT Family Plan		No
24i	EMG	Enter an "X" if the service provided is emergency related. An emergency is defined as care for any condition which is life threatening or which requires immediate medical intervention.	Yes
24j	COB		No
24k	Local Use		No

25	Federal Tax ID Number	Enter the nine-digit Provider Tax ID number of the provider or agency that will receive payment for these services.	Yes
26	Patient's Account Number	Will appear on the voucher if completed.	Yes
Box Number	Data Element	Description	Required
27	Accept Assignment	All NBH claims are reimbursed to the provider.	No
28	Total Charge	Sum of all charges listed in field 24f	Yes
29	Amount Paid	All amounts paid by a third party. If not applicable, input \$0.	No
30	Balance Due	The net amounts of line 28 and line 29.	No
31	Signature of Physician	Authorized signature or printed name and date of the physician.	Yes
32	Name and address of facility where services were rendered.	Name and address of facility if other than home or office.	Yes
33	Physician's, Supplier's Billing Name, Address, Zip Code and Phone Number	Name, address, and telephone number of physician's billing service. (PIN # and Group # not required)	Yes

Appendix B

APPROVED OMB NO. 0938-0279

1		2		3 PATIENT CONTROL NO.			4 TYPE OF BILL																																				
		5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM THROUGH		7 COV. D.	8 N-C.D.	9 C-I.D.	10 L-R.D.	11																																	
12 PATIENT NAME				13 PATIENT ADDRESS																																							
14 BIRTHDATE		15 SEX		16 MS		17 DATE		18 HR		19 TYPE I		20 SRC		21 D HR		22 STAT		23 MEDICAL RECORD NO.		24		25		26		27		28		29		30		31									
32 OCCURRENCE CODE		33 OCCURRENCE DATE		34 OCCURRENCE CODE		35 OCCURRENCE DATE		36 OCCURRENCE CODE		37 OCCURRENCE SPAN FROM THROUGH		38		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT		42		43		44		45		46		47		48		49									
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42 REV. CD.		43 DESCRIPTION				44 HCPCS / RATES		45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49		50		51		52		53		54		55		56		57											
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57		58 INSURED'S NAME		59 P. REL.		60 CERT. - SSN - HIC - ID NO.		61 GROUP NAME		62 INSURANCE GROUP NO.		63		64		65		66		67		68		69		70		71		72		73		74		75		76		77		78	
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63 TREATMENT AUTHORIZATION CODES		64 ESC		65 EMPLOYER NAME		66 EMPLOYER LOCATION		67		68		69		70		71		72		73		74		75		76		77		78		79		80		81		82					
A		B		C		D		E		F		G		H		I		J		K		L		M		N		O		P		Q		R		S		T					
67 PRIN. DIAG. CD.		68 CODE		69 CODE		70 CODE		71 CODE		72 CODE		73 CODE		74 CODE		75 CODE		76 ADM. DIAG. CD.		77 E-CODE		78		79		80		81		82		83		84		85		86					
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84 REMARKS		85 PROVIDER REPRESENTATIVE		86 DATE		87		88		89		90		91		92		93		94		95		96		97		98		99		100		101		102							
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UB-92 HCFA-1450

OCR ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-92/CMS 1450 Claims Specifications

Providers must use the UB-92 billing form to submit all hospital and facility claims, including those for laboratory services performed by a hospital...

Box Number	Data Element	Description	Required
1	Provider Data	Provider's name, address and telephone number.	Yes
2			N/A
3	Patient Control Number	Account or bill control number assigned by the provider	Yes
4	Type of Bill	Type of facility (1 st digit), bill classification (2 nd digit), and frequency (3 rd digit). Refer to the AHA UB-92 (3rd digit). Uniform Billing Manual for a list of codes.	Yes
5	Federal TIN		Yes
6	Statement Covers Period	Beginning and ending service dates of the period included on the bill	Yes
7	Covered Days	The number of days covered by the primary payer as qualified by the payer organization.	No
8	Non-Covered Days	Days of care not covered by the primary payer.	No
9	Co-insurance days	Number of regular Medicare co-insurance days used during this billing period	No
10	Lifetime Reserve Days		No
11	Lab CLIA Number		No
12	Patient's Name	Patient's last name, first name, and middle initial as they appear on the patient's Medicaid Authorization Card (MAC)	Yes
13	Address of the Patient		Yes
14	Birth Date	Patient's birth date in MMDDYY format.	Yes
15	Sex	Patient's sex (M = Male, F = Female)	No
16	Marital status		No
17	Admission Date	Admission date or start date of care in MMDDYY format.	Yes
18	Admission hour	Admission hour code that best indicates the patient's time of admission.	Yes – for emergency room or lab services completed more than once within the same day.

Box Number	Data Element	Description	Required
19	Admission type	Admission type code that best fits the reason for admission. <ol style="list-style-type: none"> 1. <i>Emergency</i>— Patient requires medical intervention for severe, life-threatening, or potentially disabling conditions. Documentation must be attached 2. <i>Urgent</i>— Patient requires immediate attention. 3. <i>Elective</i> — Patient's condition permits time to schedule services. 4. <i>Newborn</i> — Patient is a newborn. 	No
20	Admission Source	Code that best describes the source of admission: <i>Adults and Pediatrics:</i> <ol style="list-style-type: none"> 1. Physician Referral 2. Clinical Referral 3. HMO Plan Referral 4. Transfer from Hospital 5. Transfer from Skilled Nursing Home 6. Transfer from other Health Care Facility 7. Emergency Room 8. Court/Law Enforcement 9. Information not available. <i>Newborns (Refer to Field 19)</i> <ol style="list-style-type: none"> 1. Normal Birth 2. Premature Birth 3. Sick Newborn 4. Extramural Birth 	No
21	Discharge Hour	Code to indicate the hour the recipient was discharged from inpatient care	No
22	Patient Status	Patient's status for this billing period. <ol style="list-style-type: none"> 1. Discharged to Home or Self Care 2. Transferred to Another short-term general hospital 3. Transferred to a Skilled Nursing Facility 4. Transferred to an Intermediate Care Facility 5. Transferred to Another Type of Institution 6. Discharged to Home Under Care of an Organized Home Health Services Organization 7. Left Against Medical Advice 8. Discharged/Transferred to Home Under Care of Home IV Provider 	No

Box Number	Data Element	Description	Required
		20.Expired	
		30.Still a Patient 40.Expired at Home 41.Expired in Hospital, SNF, ICF or Hospice 42.Expired, Place Unknown	
23	Provider Medical Record Number	Number assigned to the patient's medical/health record by the provider. (Do not enter the patient control number).	No
24-30		Codes used to identify conditions related to the claim that may affect processing.	No
31	DRG Code		No
32-36	Occurrence Codes and Dates	The code and associated date defining a significant event relating to the claim that may affect processing.	No
37	Control number	Internal Control Number Assigned by Payer	No
38	Name & Address of Responsible Party		No
39-41	Value Codes and Amount	Codes used to identify payment variations	No
42	Revenue Codes	Codes that identify a specific accommodation, ancillary service, or billing calculation. Accommodation days should not be billed on outpatient bill types. Revenue codes are to be billed in the following sequence: chronologically for accommodation dates; in descending order for non- accommodation revenue codes	Yes
43	Revenue Codes Description	Description of related revenue codes.	No
44	HCPCS/Rates	Accommodation rate for inpatient bills and the HCPCS code for all ancillary services and outpatient bills.	Yes
45	Service Date	Date of outpatient service in MMDDYY format	Yes
46	Service Units	Services units provided. If accommodation days are billed, the number of units billed must be consistent with the Statement Covers Period (Box 6). Service units should be billed in whole numbers. Round any fractions to the nearest whole number.	Yes
47	Total Charges	Total Charges for Field 47 are obtained by multiplying the units of service (Box 46) by the value of the revenue code (Box 42).	Yes
48	Non-covered charges		No
49	Not used.		No

Box Number	Data Element	Description	Required
50	Payer	Name and identification number, if available, of each payer who may have full or partial responsibility for the charges incurred by the patient and from which the provider might expect some reimbursement. NBH should be the last entry.	No
51	Provider ID Number	Number assigned to the provider by the payer indicated in Box 50 A, B, C.	No
52	Release of Information	Enter "Y" if the provider has signed written consent from the patient to release medical/billing information. Otherwise, enter ""R" for restricted or modified release or "N" for no release.	No
53	Assignment of Benefits Certification Indicator	A code showing whether the provider has a signed form authorizing the party payer to pay the provider.	No
54	Prior Payments	Amount received toward payment from any payer, including the patient. If no payment was received as a result of billing, enter "0." The "0" indicates that a reasonable attempt was made to determine available coverage for the services provided.	No
55-57	Estimated Amount Due		No
58	Insured's Name	Name of the insured who is covered by the payer listed in Box 50.	No
59a-c	Patient's Relationship to Insured	Code indicating relationship of the insured to the patient. For Medicaid, code will be 01	No
60	Patient Identifier	Patient's ID Number	Yes
61	Group Name	Insured's group name. .	No
62	Insurance Group Number		Yes
63	Treatment Authorization Codes		No
64	Employment status code		No
65	Employer name		No
66	Employer location		No
67	Principal diagnosis code	Principal diagnosis, determined after study, using ICD-9-CM codes. The codes should match those on the NBH prior authorization letter if an authorization has been obtained.	Yes
68-75	Other diagnosis codes	Other applicable ICD-9-CM diagnosis codes. These should include codes for other conditions that existed during the episode of care being billed, but were not primarily responsible for admission.	Required if applicable
76	Admitting diagnosis code	ICD-9-CM diagnosis code that represents	Required

		the significant admitting diagnosis.	for inpatient
77	E-code	External cause of injury	No
Box Number	Data Element	Description	Required
78	DRG Code		Required, if applicable
79	Procedure coding method	"4" if using CPT™ "9" if using ICD-9-CM	No
80	Principal Procedure	Principal procedure code and date the principal procedure was performed during this hospital stay. ICD-9-CM procedure codes are required. If more than one procedure is performed, the principal procedure should be the one related to the principal diagnosis, which was performed for definitive treatment of that condition and requires the highest skill level.	Yes
81	Other procedure code	Other procedure codes performed during the hospital stay. Enter the codes in descending order of importance.	If applicable
82	Attending Physician ID number	The provider's 8 digit Medicaid ID number.	No
84	Remarks	Information when applicable.	No
85	Provider Representative	An authorized hospital or facility representative must sign each claim form, verifying the certifications on the reverse of the claim. Rubber stamp or facsimile signatures are acceptable but must be initialed by a provider representative.	No
86	Date	Enter date (MMDDYY) bill submitted to NBH	No

Appendix C

NORTHEAST BEHAVIORAL HEALTH, LLC

1300 North 17th Avenue, Greeley, CO 80631
970-347-2366 ▪ Fax 970-392-1354
northeastbho@northeastbho.org

CLAIMS ADJUSTMENT

Client's Full Name:	_____
Medicaid ID:	_____
Date(s) of Service:	_____

Explanation for claims adjustment or additional information not included with original claim:	_____

Documentation attached:
<input type="checkbox"/> Completed claim form. <i>(Required for additional payment. Will be returned to provider if not attached.)</i>
<input type="checkbox"/> Copy of the EOB which is being appealed.
<input type="checkbox"/> Copies of EOB from other payers, if applicable.
<input type="checkbox"/> A signed copy of the original claim including original attachments.
<input type="checkbox"/> Other information in support of the request for adjustment.

Full name of person requesting appeal:	_____
Title:	_____
Company name:	_____
Address	_____
City, State Zip:	_____
Telephone number:	_____

Signature	_____	Date	_____
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Appendix D

NORTHEAST BEHAVIORAL HEALTH, LLC

1300 North 17th Avenue, Greeley, CO 80631
970-347-2366 ▪ Fax 970-392-1354
northeastbho@northeastbho.org

REQUEST FOR RECONSIDERATION / APPEAL

Client's Full Name:	_____
Medicaid ID:	_____
Date(s) of Service:	_____

Explanation for Reconsideration or additional information not included with original claim:	_____

Documentation attached:
<input type="checkbox"/> Completed claim form. (<i>Required.</i> Will be returned to provider if not attached.)
<input type="checkbox"/> Copy of the EOB which is being appealed.
<input type="checkbox"/> Copies of EOB from other payers.
<input type="checkbox"/> Copies of the clinical record.
<input type="checkbox"/> A signed copy of the original claim including original attachments.
<input type="checkbox"/> Other information in support of the request for reconsideration / appeal.

Full name of person requesting appeal:	_____
Title:	_____
Company name:	_____
Address	_____
City, State Zip:	_____
Telephone number:	_____

Signature	_____	Date	_____
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