

Audiology

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Audiology

Providers must be enrolled as a Colorado Medical Assistance Program provider in order to:

- Treat a Colorado Medical Assistance Program client
- Submit claims for payment to the Colorado Medical Assistance Program

Providers should refer to the Code of Colorado Regulations, [Program Rules](#) (10 CCR 2505-10), for specific information when providing audiology care.



Billing Information

National Provider Identifier (NPI)

The Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities (i.e., health plans, health care clearinghouses, and those health care providers who transmit any health information electronically in connection with a transaction for which the Secretary of Health and Human Services has adopted a standard) use NPIs in standard transactions.

Paper Claims



Electronic claims format shall be required unless hard copy claims submittals are specifically prior authorized by the Department of Health Care Policy and Financing (the Department). Requests may be sent to Affiliated Computer Services (ACS), P.O. Box 90, Denver, CO 80201-0090. The following claims can be submitted on paper and processed for payment:

- Claims from providers who consistently submit 5 claims or fewer per month (requires prior approval)
- Claims that, by policy, require attachments
- Reconsideration claims

Paper claims do not require an NPI, but do require the Colorado Medical Assistance Program provider number. Electronically mandated claims submitted on paper are processed, denied, and marked with the message "Electronic Filing Required".

Electronic Claims

Instructions for completing and submitting electronic claims are available through the following:

- X12N Technical Report 3 (TR3) for the 837P, 837I, or 837D (<http://www.wpc-edi.com/>)
- Companion Guides for the 837P, 837I, or 837D in the Provider Services [Specifications](#) section of the Department's Web site.
- Web Portal User Guide (via within the Web Portal)

The Colorado Medical Assistance Program collects electronic claim information interactively through the Colorado Medical Assistance Program Secure Web Portal (Web Portal) or via batch submission through a host system.

Interactive Claim Submission and Processing

Interactive claim submission through the Web Portal is a real-time exchange of information between the provider and the Colorado Medical Assistance Program.



Colorado Medical Assistance Program providers may create and transmit HIPAA compliant 837P (Professional), 837I (Institutional), and 837D (Dental) claims electronically one at a time.

These claims are transmitted through the Colorado Medical Assistance Program OnLine Transaction Processor (OLTP).

The Colorado Medical Assistance Program OLTP reviews the claim information for compliance with Colorado Medical Assistance Program billing policy and returns a response to the provider's personal computer about that single transaction. If the claim is rejected, the OLTP sends a rejection response that identifies the rejection reason.

If the claim is accepted, the provider receives an acceptance message and the OLTP passes accepted claim information to the Colorado Medical Assistance Program claim processing system for final adjudication and reporting on the Colorado Medical Assistance Program Provider Claim Report (PCR).



The Web Portal contains online training, user guides and help that describe claim completion requirements, a mechanism that allows the user to create and maintain a data base of frequently used information, edits that verify the format and validity of the entered information, and edits that assure that required fields are completed.

Because a claim submitter connects to the Web Portal through the Internet, there is no delay for “dialing up” when submitting claims. The Web Portal provides immediate feedback directly to the submitter. All claims are processed to provide a weekly Health Care Claim Payment/Advice (Accredited Standards Committee [ASC] X12N 835) transaction and/or Provider Claim Report to providers. The Web Portal also provides access to reports and transactions generated from claims submitted via paper and through electronic data submission methods other than the Web Portal. The reports and transactions include:

- Accept/Reject Report
- Provider Claim Report
- Health Care Claim Payment/Advice (ASC X12N 835)
- Managed Care Reports such as Primary Care Physician Rosters
- Eligibility Inquiry (interactive and batch)
- Claim Status Inquiry

Claims may be adjusted, edited and resubmitted, and voided in real time through the Web Portal. Access the Web Portal at colorado.gov/hcpf ➔ [Secured Site](#). For help with claim submission via the Web Portal, please choose the *User Guide* option available for each Web Portal transaction. For additional electronic billing information, please refer to the appropriate Companion Guide located in the Provider Services [Specifications](#) section.

Batch Electronic Claim Submission

Batch billing refers to the electronic creation and transmission of several claims in a group. Batch billing systems usually extract information from an automated accounting or patient billing system to create a group of claim transactions. Claims may be transmitted from the provider's office or sent through a billing vendor or clearinghouse.



All batch claim submission software must be tested and approved by the Colorado Medical Assistance Program fiscal agent.

Any entity sending electronic claims to ACS Electronic Data Interchange (EDI) Gateway for processing where reports and responses will be delivered must complete an EDI enrollment package. This provides ACS EDI Gateway the information necessary to assign a Logon Name, Logon ID, and a Trading Partner ID, which are required to submit electronic claims.

You may obtain an EDI enrollment package by contacting the Medical Assistance Program fiscal agent or by downloading it from Provider Services [EDI Support](#) section.

The X12N 837 Professional, Institutional, or Dental transaction data will be submitted to the EDI Gateway, which validates submission of American National Standards Institute (ANSI) X12N format(s). The TA1 Interchange Acknowledgement reports the syntactical analysis of the interchange header and trailer. If the data is corrupt or the trading partner relationship does not exist within the Medicaid Management Information System (MMIS), the interchange will reject and a TA1 along with the data will be forwarded to the ACS State Healthcare Clearinghouse (SHCH) Technical Support for review and follow-up with the sender. An X12N 999 Functional Acknowledgement is generated when a file that has passed the header and trailer check passes through the ACS SHCH.

If the file contains syntactical error(s), the segment(s) and element(s) where the error(s) occurred will be reported. After validation, the ACS SHCH will then return the X12N 835 Remittance Advice containing information related to payees, payers, dollar amount, and payments. These X12N transactions will be returned to the Web Portal for retrieval by the trading partner, following the standard claims processing cycle.

Testing and Vendor Certification

Completion of the testing process must occur prior to submission of electronic batch claims to ACS EDI Gateway. Assistance from ACS EDI business analysts is available throughout this process. Each test transmission is inspected thoroughly to ensure no formatting errors are present. Testing is conducted to verify the integrity of the format, not the integrity of the data; however, in order to simulate a production environment, EDI requests that providers send real transmission data.



The number of required test transmissions depends on the number of format errors on a transmission and the relative severity of these errors. Additional testing may be required in the future to verify any changes made to the MMIS have not affected provider submissions. Also, changes to the ANSI formats may require additional testing.

In order to expedite testing, ACS EDI Gateway requires providers to submit all X12N test transactions to Edifecs prior to submitting them to ACS EDI Gateway. The Edifecs service is free to providers to certify X12N readiness. Edifecs offers submission and rapid result turnaround 24 hours a day, 7 days a week. For more information, go to <http://www.edifecs.com>.

Benefits

Hearing benefits are limited to the minimum services required to meet the client's medical needs. As stated in Volume 8.280.06, medically necessary, or medical necessity, shall be defined as a Medical Assistance Program service that will, or is reasonably expected to prevent, diagnose, cure, correct, reduce or ameliorate the pain and suffering, or the physical, mental, cognitive or developmental effects of an illness, injury, or disability; and for which there is no other equally effective or substantially less costly course of treatment suitable for the child's needs. Hearing exams, speech therapy, diagnostic testing, surgeries, and related hospitalizations are regular benefits of the Medical Assistance Program. Claims must meet all requirements outlined in this manual.



Newborn Hearing Screening

The Colorado legislature passed House Bill 97-1095, which establishes hearing screenings for newborn infants [25-4-1004.7(VI)(b)]. Appropriate testing and identification of newborn infants with hearing loss makes early intervention and treatment possible and promotes the healthy development of children.

HCP Audiology Regional Coordinators provide consultation information, technical assistance, and referral services to families of children with special health care needs.

Cochlear Implants

Cochlear Implants are benefits of the Medical Assistance Program for clients ages 20 and under who meet the appropriate criteria. Replacement of an existing cochlear implant for all ages is a benefit when the currently used component is no longer functional and cannot be repaired.

Trial Rental Period

The Trial Rental Period is included in the purchase reimbursement for the hearing aid(s). Use the last day of the rental period as the date of service.



Hearing Aid Replacement

Hearing aids are expected to last 3 – 5 years. Hearing aids may be replaced when they no longer fit, have been lost or stolen, or the current hearing aid is no longer medically appropriate for the child.

Non-Benefit Services

- Hearing aid insurance
- Hearing aids for adults (Hearing exams and evaluations are a benefit for adults only when a concurrent medical condition exists.)
- Ear molds for the purpose of noise reduction or swimming

Eligible Providers

Physicians are responsible for contacting the fiscal agent to confirm their enrollment with an otolaryngology specialty. Certified audiologists are eligible to become Medical Assistance Program providers. Audiologists must be registered with the Department of Regulatory Agencies in order to dispense hearing aids. Colorado Home Intervention Program (CHIP) facilitators must be credentialed by Health Care Programs for Children with Special Needs (HCP). CHIP facilitators are eligible to become Medical Assistance Program providers and need to enroll in the Colorado Medical Assistance Program.

Prior Authorization Requests (PARs)

For services requiring prior authorization, only an audiologist may submit a PAR for Hearing Aids. The audiologist submitting the PAR must have a provider specialty of HCP or Children’s Hearing Aid Program (CHAP).

Dental Care, Medical Care, and Supply PARs may be submitted through the Web Portal. All PAR responses and inquiries can be made through the Web Portal.

PARs submitted to the authorizing agency must be submitted on the correct PAR form using the national Centers for Medicare and Medicaid Services (CMS) and Current Procedural Terminology (CPT) codes described in this manual. PARs submitted without utilizing the Healthcare Common Procedural Coding System (HCPCS) codes or on the incorrect form will not be accepted. Instructions for completing the required PAR form are included in this manual. Prior authorization forms and instructions are also available in the Provider Services [Forms](#) section.



Approval of a PAR does not guarantee Colorado Medical Assistance Program payment and does not serve as a timely filing waiver. Prior authorization only assures that the service is considered a benefit of the Colorado Medical Assistance Program. All claims, including those for prior authorized services, must meet eligibility and claim submission requirements (e.g. timely filing, Primary Care Physician (PCP) information completed appropriately, third party resources payments pursued, required attachments included, etc.) before payment can be made.



After a PAR has been reviewed, a PAR letter is sent to the provider and the client. For approved services, allow sufficient time for the fiscal agent to enter the PAR data into the Colorado Medical Assistance Program processing system before submitting a claim for the authorized service.

PAR Revisions

Please print "REVISION" in bold letters at the top and enter the PAR number being revised in box # 7. Do not enter the PAR number being revised anywhere else on the PAR.

Paper PAR Instructional Reference

Field Label	Completion Format	Instructions
The upper margin of the PAR form must be left blank. This area is for authorizing agent's use only.		
Invoice/Pat Account Number	Text	Optional Enter up to 12 characters (numbers, letters, hyphens) to identify the claim or client.
1. Client Name	Text	Required Enter the client's last name, first name and middle initial. Example: Adams, Mary A.
2. Client Identification Number	7 characters, a letter prefix followed by six numbers	Required Enter the client's state identification number. This number consists of a letter prefix followed by six numbers. Example: A123456.
3. Sex	Check box <input type="checkbox"/> M <input type="checkbox"/> F	Required Enter an "X" in the appropriate box.
4. Date of Birth	6 numbers (MMDDYY)	Required Enter the client's birth date using MMDDYY format. Example: January 1, 2009 = 010109.
5. Client Address	Characters: numbers and letters	Required Enter the client's full address: Street, city, state, and zip code.
6. Client Telephone Number	10 numbers ###-###-####	Optional Enter the client's telephone number.
7. Prior Authorization Number	None	System assigned Do not write in this area. The authorizing agent reviews the PAR, and approves or denies the services. Enter the assigned PAR number in the appropriate field on the claim form when billing for prior authorized services.

Field Label	Completion Format	Instructions
8. Dates Covered by This Request	6 numbers for from date and 6 numbers for through date (MMDDYY)	Required Enter the date(s) for the requested service(s). If left blank, dates are entered by the authorizing agency. Authorized services must be provided within these dates. If retroactive authorization is requested, enter the date(s) of service and provide justification in field 11 (Diagnosis).
9. Does Client Reside in a Nursing Home?	Check box <input type="checkbox"/> Yes <input type="checkbox"/> No	Required Enter an "X" in the appropriate box.
10. Group Home Name if Patient Resides in a Group Home	Text	Conditional Enter the name of the Group Home if the client lives in a group home.
11. Diagnosis	Text	Required Enter the diagnosis and sufficient relevant diagnostic information to justify the request and include the prognosis. Provide relevant clinical information, other drugs or alternative therapies tried in treating the condition, results of tests, etc., to justify a Colorado Medical Assistance Program determination of medical necessity. If diagnosis codes are used, the narrative is also required. Approval of the PAR is based on documented medical necessity. Attach documents as required.
12. Requesting Authorization for Repairs	None	Not required
13. Indicate Length of Necessity	None	Not required
14. Estimated Cost of Equipment	None	Not required
15. Services to be Authorized Line Number	None	Preprinted Do not alter preprinted line numbers. No more than five services or items can be requested on one form.

Field Label	Completion Format	Instructions
16. Describe Procedure, Supply, or Drug to be Provided	Text	Required Enter a description of the service(s) that will be provided.
17. Procedure, Supply or Drug Code	Revenue codes - 3 numbers CMS codes - 5 Characters	Required Enter the revenue and/or CMS code(s) for each service that will be billed on the claim form. The code(s) indicated on the PAR form must be used for billing.
18. Requested Number of Services	3 numbers	Required Enter the number of visits, services, procedures requested. If this field is blank, the authorizing agency will complete it.
19. Authorized No. Of Services	None	Leave Blank The authorizing agency indicates the number of services authorized. This number may or may not equal the number requested in field 18 (Number of Services).
20. Approved Denied	None	Leave Blank No longer used. Refer to the PAR letter or check the PAR online.
21. Primary Care Physician (PCP) Name Telephone Number	Text	Conditional If the client has a primary care physician, enter the name of the primary care physician in this field. Optional Enter the primary care physician's phone number.
22. Primary Care Physician Address	Text	Optional Enter the address of the primary care physician.
23. PCP Provider Number	8 numbers	Conditional If the client has a primary care physician, enter the primary care physician's provider number in this field.

Field Label	Completion Format	Instructions
29. Service Provider Number	8 numbers	Required If the clinic is requesting a PAR, enter the clinic's eight-digit Colorado Medical Assistance Program provider number. If an independent audiologist is requesting a PAR, enter the audiologist's eight-digit Colorado Medical Assistance Program provider number. The rendering provider must be enrolled with the Colorado Medical Assistance Program.
30. Comments	Text	This field is completed by the authorizing agency. Refer to the PAR response for comments submitted by the authorizing agency.
31. PA Number Being Revised	Text	This field is completed by the authorizing agency

The authorizing agent reviews all completed PARs. The authorizing agency approves or denies, by individual line item, each requested service or supply listed on the PAR. The results of the PAR review are available through the Web Portal and included in PAR letters. **Read the response carefully as some line items may be approved and others denied.**

Do not render or bill for services until the PAR has been processed. The claim **must** contain the PAR number for payment.

If the PAR is denied, direct inquiries to the authorizing agency listed in Appendix D of the Appendices section in Provider Services [Billing Manuals](#).



Prior Authorization Request (PAR) Form

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND FINANCING

INVOICE/PAT. ACCOUNT NUMBER

MEDICAID PRIOR AUTHORIZATION REQUEST (PAR)

To avoid delay, please answer all questions completely.

1. CLIENT NAME (Last, First, Middle Initial)		2. CLIENT IDENTIFICATION NUMBER		3. SEX <input type="checkbox"/> M <input type="checkbox"/> F		4. DATE OF BIRTH (MMDDYY)	
5. CLIENT ADDRESS (Street, City, State, ZIP Code)						6. CLIENT TELEPHONE NUMBER ()	
7. PRIOR AUTHORIZATION NUMBER * SYSTEM ASSIGNED		8. DATES COVERED BY THIS REQUEST FROM (MMDDYY) THROUGH (MMDDYY)		9. DOES CLIENT RESIDE IN A NURSING FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		10. GROUP HOME NAME - IF PATIENT RESIDES IN A GROUP HOME	
11. ICD-9-CM DIAGNOSIS CODE and DESCRIPTION (Must include Diagnosis Code and Description, Prognosis, Clinical Information and Other Medications presently prescribed)						12. REQUESTING AUTHORIZATION FOR REPAIRS. EQUIPMENT MUST BE OWNED BY THE CLIENT - THE SERIAL NUMBER MUST BE ENTERED	
						13. INDICATE LENGTH OF NECESSITY (IN MONTHS AND YEARS) I.E. HOW LONG WILL THIS EQUIPMENT BE NEEDED?	
						14. ESTIMATED COST OF EQUIPMENT	

SERVICES TO BE AUTHORIZED

15. LINE NO.	16. DESCRIBE THE PROCEDURE OR SUPPLY TO BE PROVIDED — INCLUDE MODEL NUMBER FOR DME PURCHASE OR SERIAL NUMBER FOR REPAIR	17. PROCEDURE OR SUPPLY CODE	18. REQUESTED NUMBER OF SERVICES	19. AUTHORIZED NO. OF SERVICES (LEAVE BLANK **)	20. APPROVED/DENIED (LEAVE BLANK **)
01					
02					
03					
04					
05					

21. PRIMARY CARE PHYSICIAN (PCP) NAME		22. PRIMARY CARE PHYSICIAN ADDRESS (Street, City, State, ZIP code)			
TELEPHONE NUMBER ()		23. PCP PROVIDER NUMBER			
24. NAME AND ADDRESS OF PHYSICIAN REQUESTING PRIOR AUTHORIZATION			25. NAME AND ADDRESS OF PROVIDER WHO WILL RENDER SERVICE		
26. REQUESTING PHYSICIAN SIGNATURE		27. DATE SIGNED			
TELEPHONE NUMBER ()		28. REQUESTING PHYSICIAN PROVIDER NUMBER		TELEPHONE NUMBER ()	
		29. SERVICE PROVIDER NUMBER			

If services are provided according to the manner prescribed by State of Colorado Laws and Regulations, reimbursement will be provided for authorized services following submission of an appropriately completed Medicaid claim.

30. COMMENTS **

ATTACH COPY OF THIS PAR TO CLAIM(S) **

SIGNATURE OF STATE AGENCY REPRESENTATIVE **		DATE **		31. PA NUMBER BEING REVISED **	
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* THE ASSIGNED PAR NUMBER APPEARS ON THE PAR LETTER. ENTER THE PAR NUMBER FROM THE LETTER ON THE CLAIM WHEN BILLING FOR THE SERVICES. ** THESE FIELDS ARE COMPLETED BY THE AUTHORIZING AGENT

Procedure/HCPCS Codes Overview

The codes used for submitting claims for services provided to Colorado Medical Assistance Program clients represent services that are approved by the Centers for Medicare and Medicaid Services (CMS) and services that may be provided by an enrolled Colorado Medical Assistance Program provider.

The Healthcare Common Procedural Coding System (HCPCS) is divided into two principal subsystems, referred to as level I and level II of the HCPCS. Level I of the HCPCS is comprised of Current Procedural Terminology (CPT), a numeric coding system maintained by the American Medical Association (AMA). The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter followed by 4 numeric digits, while CPT codes are identified using 5 numeric digits.

HIPAA requires providers to comply with the coding guidelines of the AMA CPT Procedure Codes and the International Classification of Disease, Clinical Modification Diagnosis Codes. If there is no time designated in the official descriptor, the code represents one unit or session. Providers should regularly consult monthly bulletins in the Provider Services [Bulletins](#) section. To receive electronic provider bulletin notifications, an email address can be entered into the Web Portal in the (MMIS) *Provider Data Maintenance* area or by filling out a publication preference form. Bulletins include updates on approved procedure codes as well as the maximum allowable units billed per procedure.

Paper Claim Reference Table

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



Field Label	Completion Format	Special Instructions
Invoice/Pat Acct Number	Up to 12 characters: letters, numbers or hyphens	Optional Enter information that identifies the patient or claim in the provider's billing system. Submitted information appears on the Provider Claim Report.
Special Program Code	N/A	N/A
1. Client Name	Up to 25 characters: letters & spaces	Required Enter the client's last name, first name, and middle initial.
2. Client Date of Birth	Date of Birth 8 digits (MMDDCCYY)	Required Enter the patient's birth date using two digits for the month, two digits for the date, two digits for the century, and two digits for the year. Example: 07012009 for July 1, 2009.

Field Label	Completion Format	Special Instructions
3. Medicaid ID Number (Client ID Number)	7 characters: a letter prefix followed by six numbers	Required Enter the client's Colorado Medical Assistance Program ID number. Each person has his/her own unique Colorado Medical Assistance Program ID number. Example: A123456
4. Client Address	Not required	Submitted information is not entered into the claim processing system.
5. Client Sex	Check box Male <input type="checkbox"/> Female <input type="checkbox"/>	Required Enter a check mark or an "x" in the correct box to indicate the client's sex
6. Medicare ID Number (HIC or SSN)	Up to 11 characters: numbers and letters	Conditional Complete if the client is eligible for Medicare benefits. Enter the individual's Medicare health insurance claim number. The term "dually eligible" refers to a person who is eligible for both Colorado Medical Assistance Program and Medicare benefits.
7. Client Relationship to Insured	Check box Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	Conditional Complete if the client is covered by a commercial health care insurance policy. Enter a check mark or an "x" in the box that identifies the person's relationship to the policyholder.
8. Client Is Covered By Employer Health Plan	Text	Conditional Complete if the client is covered by an employer health plan as policyholder or as a dependent. Enter the employer name policyholder's name and group number. Also complete fields 9 and 9A.
9. Other Health Insurance Coverage	Text	Conditional Complete if the client has commercial health insurance coverage. Enter the name, address, policy number, and telephone numbers, if known, of the commercial health care insurer.
9A. Policyholder Name and Address	Text	Conditional Complete if the client has commercial health insurance coverage. Enter the name, address, and telephone number, if known, of the policyholder.

Field Label	Completion Format	Special Instructions
10. Was Condition Related To	Check box A. Client Employment Yes <input type="checkbox"/> B. Accident Auto <input type="checkbox"/> Other <input type="checkbox"/> C. Date of accident 6 digits: MMDDYY	Conditional Complete if the condition being treated is the result of employment, an automobile accident, or other accident. Enter a check mark or an "x" in the appropriate box. Enter the date of the accident in the marked boxes.
11. CHAMPUS Sponsors Service/SSN	Up to 10 characters	Conditional Complete if the client is covered under the Civilian Health And Medical Plan of the Uniformed Services (CHAMPUS). Enter the sponsor's service number or SSN.
Durable Medical Equipment Model/serial number (unlabeled field)	N/A	N/A
12. Pregnancy HMO NF	Check box <input type="checkbox"/>	Conditional Complete if the client is in the maternity cycle (i.e., pregnant or within 6 weeks postpartum). Conditional Complete if the client is enrolled in a Colorado Medical Assistance HMO. Conditional Complete if the client is a nursing facility resident.
13. Date of illness or injury or pregnancy	6 digits: MMDDYY	Optional Complete if information is known. Enter the following information as appropriate to the client's condition: Illness Date of first symptoms Injury Date of accident Pregnancy Date of Last Menstrual Period (LMP)
14. Medicare Denial	Check box <input type="checkbox"/> Benefits Exhausted <input type="checkbox"/> Non-covered services	Conditional Complete if the client has Medicare coverage and Medicare denied the benefits or does not cover the billed services.

Field Label	Completion Format	Special Instructions
<p>19A. Date of Service</p>	<p>From: 6 digits MMDDYY</p> <p>To: 6 digits MMDDYY</p>	<p>Required</p> <p>Enter two dates: a “beginning” or “from” date of service and an “ending” or “to” date of service.</p> <p>Single date of service</p> <p>From To</p> <p> 08/05/2011</p> <p>Or</p> <p>From To</p> <p> 08/05/2011 08/05/2011</p> <p>Span dates of service</p> <p>From To</p> <p> 08/05/2011 08/12/2011</p> <p>Practitioner claims must be consecutive days.</p> <p>Single Date of Service: Enter the six digit date of service in the “From” field. Completion of the “To” field is not required. Do not spread the date entry across the two fields.</p> <p>Span billing: Span billing is permitted if the same service (same procedure code) is provided on consecutive dates.</p>
<p>19B. Place of Service</p>	<p>2 digits</p>	<p>Required</p> <p>Enter the Place Of Service (POS) code that describes the location where services were rendered. The Colorado Medical Assistance Program accepts the CMS place of service codes.</p> <p>Enter 11 (Office)</p>
<p>19C. Procedure Code (HCPCS)</p>	<p>5 digits</p>	<p>Required</p> <p>Enter the procedure code that specifically describes the service for which payment is requested.</p>
<p>Modifier</p>	<p>N/A</p>	<p>N/A</p>
<p>19D. Rendering Provider Number</p>	<p>8 digits</p>	<p>Required</p> <p>Enter the eight-digit Colorado Medical Assistance Program provider number assigned to the <u>individual</u> who actually performed or rendered the billed service. This number cannot be assigned to a group or clinic.</p>

Field Label	Completion Format	Special Instructions																														
19E. Referring Provider Number	8 digits	Conditional Complete for clients enrolled in the Primary Care Physician (PCP) program if: The rendering or billing provider is not the primary care provider and the billed service requires PCP referral. Enter the PCP's eight-digit Colorado Medical Assistance Program provider number. Entry of the PCP's provider number represents the provider's declaration that he/she has a referral from the PCP.																														
19F. Diagnosis	<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px; height: 20px; text-align: center;">P</td> <td style="width: 20px; height: 20px; text-align: center;">S</td> <td style="width: 20px; height: 20px; text-align: center;">T</td> </tr> </table> 1 digit per column	P	S	T	Required From field 18 To field(s) 19F For each billed service, indicate which of the diagnoses in field 18 are <u>P</u> rimary, <u>S</u> econdary, or <u>T</u> ertiary. Example (May require 4 th or 5 th digits): <div style="text-align: right; margin-right: 50px;"> ↓ <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px; height: 20px; text-align: center;">P</td> <td style="width: 20px; height: 20px; text-align: center;">S</td> <td style="width: 20px; height: 20px; text-align: center;">T</td> </tr> </table> </div> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%;">1</td> <td style="width: 60%;">78559</td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> </tr> <tr> <td>2</td> <td>824X</td> <td>Line 1</td> <td style="border: 1px solid black; text-align: center;">1</td> <td style="border: 1px solid black; text-align: center;">3</td> <td style="border: 1px solid black; text-align: center;">4</td> </tr> <tr> <td>3</td> <td>276.5X</td> <td>Line 2</td> <td style="border: 1px solid black; text-align: center;">2</td> <td style="border: 1px solid black; text-align: center;"> </td> <td style="border: 1px solid black; text-align: center;"> </td> </tr> <tr> <td>4</td> <td>V22</td> <td>Line 3</td> <td style="border: 1px solid black; text-align: center;">4</td> <td style="border: 1px solid black; text-align: center;">2</td> <td style="border: 1px solid black; text-align: center;"> </td> </tr> </table>	P	S	T	1	78559					2	824X	Line 1	1	3	4	3	276.5X	Line 2	2			4	V22	Line 3	4	2	
P	S	T																														
P	S	T																														
1	78559																															
2	824X	Line 1	1	3	4																											
3	276.5X	Line 2	2																													
4	V22	Line 3	4	2																												
19G. Charges	7 digits: Currency 99999.99	Required Enter the usual and customary charge for the service represented by the procedure code on the detail line. Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one procedure from the same group is billed, special multiple pricing rules apply.																														

Field Label	Completion Format	Special Instructions
<p>19G. Charges (continued)</p>	<p>7 digits: Currency 99999.99</p>	<p>The base procedure is the procedure with the highest allowable amount. The base code is used to determine the allowable amounts for additional CPT surgical procedures when more than one procedure from the same grouping is performed.</p> <p>Submitted charges cannot be more than charges made to non-Colorado Medical Assistance Program covered individuals for the same service.</p> <p>Do not deduct Colorado Medical Assistance Program co-payment or commercial insurance payments from usual and customary charges.</p>
<p>19H. Days or Units</p>	<p>4 digits</p>	<p>Required</p> <p>Enter the number of services provided for each procedure code.</p> <p>Enter whole numbers only.</p> <p>Do not enter fractions or decimals.</p> <p>Do not enter a decimal point followed by a 0 for whole numbers.</p>
<p>19I. Co-pay</p>	<p>1 digit</p>	<p>Conditional</p> <p>Complete if co-payment is required of this client for this service.</p> <p>1-Refused to pay co-payment 2-Paid co-payment 3-Co-payment not requested</p>
<p>19J. Emergency</p>	<p>1 character</p>	<p>Conditional</p> <p>Enter a check mark or an “x” in the column to indicate the service is rendered for a life-threatening condition or one that requires immediate medical intervention.</p> <p>If checked, the service on this detail line is exempt from co-payment and from PCP Program referral requirements.</p>
<p>19K. Family Planning</p>	<p>N/A</p>	<p>N/A</p>
<p>19L. EPSDT</p>	<p>1 character</p>	<p>Conditional</p> <p>Enter a check mark or an “x” in the column to indicate the service is provided as a follow-up to or referral from an EPSDT screening examination.</p>

Field Label	Completion Format	Special Instructions
Medicare SPR Date (unlabeled field)	6 digits: MMDDYY	Conditional Complete for Medicare crossover claims. Enter the date of the Medicare Standard Paper Remit (SPR) or Electronic Remittance Advice (ERA). <ul style="list-style-type: none"> ▪ Do not complete this field if Medicare denied all benefits. ▪ Do not combine items from several SPRs/ERAs on a single claim form. ▪ Bill for as many crossover items as appear on a single SPR/ERA up to a maximum of 6 lines. Complete separate claim forms for additional lines on the SPR/ERA. ▪ Providers must submit a copy of the SPR/ERA with paper claims. Be sure to retain the original SPR/ERA for audit purposes.
23. Total Charges	7 digits: Currency 99999.99	Required Enter the sum of all charges listed in field 19G (Charges). Each claim form must be completed as a full document. Do not use the claim form as a continuation billing (e.g., Page 1 or 2, etc.).
21. Medicare Paid	7 digits: Currency 99999.99	Conditional Complete for Medicare crossover claims. Enter the Medicare payment amount shown on the Medicare payment voucher.
22. Third Party Paid	7 digits: Currency 99999.99	Conditional Complete if the client has commercial health insurance and the third party resource has made payment on the billed services. Enter the amount of the third party payment shown on the third party payment voucher. Do not enter Colorado Medical Assistance Program co-payment in this field or anywhere else on the claim form.

Field Label	Completion Format	Special Instructions
<p>23. Net Charge</p>	<p>7 digits: Currency 99999.99</p>	<p>Required</p> <p>Colorado Medical Assistance Program claims (Not Medicare Crossover)</p> <p>Claims without third party payment. Net charge equals the total charge (field 20).</p> <p>Claims with third party payment. Net charge equals the total charge (field 20) minus the third party payment (field 22) amount.</p> <p>Medicare Crossover claims</p> <p>Crossover claims without third party payment. Net charge equals the sum of the Medicare deductible amount (field 24) plus the Medicare coinsurance (field 25) amount.</p> <p>Crossover claims with third party payment. Net charge equals the sum of the Medicare deductible amount (field 24) plus the Medicare coinsurance (field 25) amount minus the third party payment (field 22) amount.</p>
<p>24. Medicare Deductible</p>	<p>7 digits: Currency 99999.99</p>	<p>Conditional</p> <p>Complete for Medicare crossover claims.</p> <p>Enter the Medicare deductible amount shown on the Medicare payment voucher.</p>
<p>25. Medicare Coinsurance</p>	<p>7 digits: Currency 99999.99</p>	<p>Conditional</p> <p>Complete for Medicare crossover claims.</p> <p>Enter the Medicare coinsurance amount shown on the Medicare payment voucher.</p>
<p>26. Medicare Disallowed</p>	<p>7 digits: Currency 99999.99</p>	<p>Conditional</p> <p>Complete for Medicare crossover claims.</p> <p>Enter the amount Medicare disallowed, if any, shown on the Medicare payment voucher.</p>

Field Label	Completion Format	Special Instructions
<p>27. Signature (Subject to Certification on Reverse) and Date</p>	<p>Text</p>	<p>Required</p> <p>Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent.</p> <p>A holographic signature stamp may be used <u>if</u> authorization for the stamp is on file with the fiscal agent.</p> <p>An authorized agent or representative may sign the claim for the enrolled provider <u>if</u> the name and signature of the agent is on file with the fiscal agent</p> <p>Unacceptable signature alternatives:</p> <p>Claim preparation personnel may not sign the enrolled provider’s name.</p> <p>Initials are not acceptable as a signature.</p> <p>Typed or computer printed names are not acceptable as a signature.</p> <p>“Signature on file” notation is not acceptable in place of an authorized signature.</p>
<p>28. Billing Provider Name</p>	<p>Text</p>	<p>Required</p> <p>Enter the name of the individual or organization that will receive payment for the billed services.</p>
<p>29. Billing Provider Number</p>	<p>8 digits</p>	<p>Required</p> <p>Enter the eight-digit Colorado Medical Assistance Program provider number assigned to the individual or organization that will receive payment for the billed services.</p>
<p>30. Remarks</p>	<p>Text</p>	<p>Conditional</p> <p>Use to document the Late Bill Override Date for timely filing.</p>

Late Bill Override Date

For electronic claims, a delay reason code must be selected and a date must be noted in the “Claim Notes/LBOD” field.

Valid Delay Reason Codes

- 1 Proof of Eligibility Unknown or Unavailable
- 3 Authorization Delays
- 7 Third Party Processing Delay
- 8 Delay in Eligibility Determination
- 9 Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules
- 11 Other



The Late Bill Override Date (LBOD) allows providers to document compliance with timely filing requirements when the initial timely filing period has expired. Colorado Medical Assistance Program providers have 120 days from the date of service to submit their claim. For information on the 60-day resubmission rule for denied/rejected claims, please see the General Provider Information manual in the Provider Services [Billing Manuals](#) section.

Making false statements about timely filing compliance is a misrepresentation and falsification that, upon conviction, makes the individual who prepares the claim and the enrolled provider subject to fine and imprisonment under state and/or federal law.

Billing Instruction Detail	Instructions
LBOD Completion Requirements	<ul style="list-style-type: none"> • Electronic claim formats provide specific fields for documenting the LBOD. • Supporting documentation must be kept on file for 6 years. • For paper claims, follow the instructions appropriate for the claim form you are using. <ul style="list-style-type: none"> ➤ <i>UB-04</i>: Occurrence code 53 and the date are required in FL 31-34. ➤ <i>Colorado 1500</i>: Indicate “LBOD” and the date in box 30 - Remarks. ➤ <i>2006 ADA Dental</i>: Indicate “LBOD” and the date in box 35 - Remarks.
Adjusting Paid Claims	<p>If the initial timely filing period has expired and a previously submitted claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was paid and now needs to be adjusted, resulting in additional payment to the provider.</p> <p>Adjust the claim within 60 days of the claim payment. Retain all documents that prove compliance with timely filing requirements.</p> <p><i>Note: There is no time limit for providers to adjust paid claims that would result in repayment to the Colorado Medical Assistance Program.</i></p> <p>LBOD = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the payment.</p>
Denied Paper Claims	<p>If the initial timely filing period has expired and a previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was denied.</p>

Billing Instruction Detail	Instructions
	<p>Correct the claim errors and refile within 60 days of the claim denial or rejection. Retain all documents that prove compliance with timely filing requirements.</p> <p>LBOD = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the denial.</p>
<p>Returned Paper Claims</p>	<p>A previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was returned for additional information.</p> <p>Correct the claim errors and re-file within 60 days of the date stamped on the returned claim. Retain a copy of the returned claim that shows the receipt or return date stamped by the fiscal agent.</p> <p>LBOD = the stamped fiscal agent date on the returned claim.</p>
<p>Rejected Electronic Claims</p>	<p>An electronic claim that was previously entered within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was rejected and information needed to submit the claim was not available to refile at the time of the rejection.</p> <p>Correct claim errors and refile within 60 days of the rejection. Maintain a printed copy of the rejection notice that identifies the claim and date of rejection.</p> <p>LBOD = the date shown on the claim rejection report.</p>
<p>Denied/Rejected Due to Client Eligibility</p>	<p>An electronic eligibility verification response processed during the original Colorado Medical Assistance Program timely filing period states that the individual was not eligible but you were subsequently able to verify eligibility. Read also instructions for retroactive eligibility.</p> <p>File the claim within 60 days of the date of the rejected eligibility verification response. Retain a printed copy of the rejection notice that identifies the client and date of eligibility rejection.</p> <p>LBOD = the date shown on the eligibility rejection report.</p>
<p>Retroactive Client Eligibility</p>	<p>The claim is for services provided to an individual whose Colorado Medical Assistance Program eligibility was backdated or made retroactive.</p> <p>File the claim within 120 days of the date that the individual's eligibility information appeared on state eligibility files. Obtain and maintain a letter or form from the county departments of social services that:</p> <ul style="list-style-type: none"> • Identifies the patient by name • States that eligibility was backdated or retroactive • Identifies the date that eligibility was added to the state eligibility system. <p>LBOD = the date shown on the county letter that eligibility was added to or first appeared on the state eligibility system.</p>

Billing Instruction Detail	Instructions
<p>Delayed Notification of Eligibility</p>	<p>The provider was unable to determine that the patient had Colorado Medical Assistance Program coverage until after the timely filing period expired. File the claim within 60 days of the date of notification that the individual had Colorado Medical Assistance Program coverage. Retain correspondence, phone logs, or a signed Delayed Eligibility Certification form (see Appendix H) that identifies the client, indicates the effort made to identify eligibility, and shows the date of eligibility notification.</p> <ul style="list-style-type: none"> • Claims must be filed within 365 days of the date of service. No exceptions are allowed. • This extension is available only if the provider had no way of knowing that the individual had Colorado Medical Assistance Program coverage. • Providers who render services in a hospital or nursing facility are expected to get benefit coverage information from the institution. • The extension does not give additional time to obtain Colorado Medical Assistance Program billing information. • If the provider has previously submitted claims for the client, it is improper to claim that eligibility notification was delayed. <p>LBOD = the date the provider was advised the individual had Colorado Medical Assistance Program benefits.</p>
<p>Electronic Medicare Crossover Claims</p>	<p>An electronic claim is being submitted for Medicare crossover benefits within 120 days of the date of Medicare processing/ payment. (Note: On the paper claim form (only), the Medicare SPR/ERA date field documents crossover timely filing and completion of the LBOD is not required.)</p> <p>File the claim within 120 days of the Medicare processing/ payment date shown on the SPR/ERA. Maintain the original SPR/ERA on file.</p> <p>LBOD = the Medicare processing date shown on the SPR /ERA.</p>
<p>Medicare Denied Services</p>	<p>The claim is for Medicare denied services (Medicare non-benefit services, benefits exhausted services, or the client does not have Medicare coverage) being submitted within 60 days of the date of Medicare processing/denial.</p> <p><i>Note: This becomes a regular Colorado Medical Assistance Program claim, not a Medicare crossover claim.</i></p> <p>File the claim within 60 days of the Medicare processing date shown on the SPR or ERA. Attach a copy of the SPR/ERA if submitting a paper claim and maintain the original SPR/ERA on file.</p> <p>LBOD = the Medicare processing date shown on the SPR/ERA.</p>
<p>Commercial Insurance Processing</p>	<p>The claim has been paid or denied by commercial insurance.</p> <p>File the claim within 60 days of the insurance payment or denial. Retain the commercial insurance payment or denial notice that identifies the patient, rendered services, and shows the payment or denial date.</p>
	<p>Claims must be filed within 365 days of the date of service. No exceptions are allowed. If the claim is nearing the 365-day limit and the commercial insurance company has not completed processing, file the claim, receive a denial or rejection, and continue filing in compliance with the 60-day rule until insurance processing information is available.</p> <p>LBOD = the date commercial insurance paid or denied.</p>

Billing Instruction Detail	Instructions
<p>Correspondence LBOD Authorization</p>	<p>The claim is being submitted in accordance with instructions (authorization) from the Colorado Medical Assistance Program for a 60 day filing extension for a specific client, claim, services, or circumstances.</p> <p>File the claim within 60 days of the date on the authorization letter. Retain the authorization letter.</p> <p>LBOD = the date on the authorization letter.</p>
<p>Client Changes Providers during Obstetrical Care</p>	<p>The claim is for obstetrical care where the patient transferred to another provider for continuation of OB care. The prenatal visits must be billed using individual visit codes but the service dates are outside the initial timely filing period.</p> <p>File the claim within 60 days of the last OB visit. Maintain information in the medical record showing the date of the last prenatal visit and a notation that the patient transferred to another provider for continuation of OB care.</p> <p>LBOD = the last date of OB care by the billing provider.</p>



Audiology Claim Example

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND
FINANCING

INVOICE/PAT ACCT NUMBER
SPECIAL PROGRAM CODE

HEALTH INSURANCE CLAIM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL) Client, Ima A	2. CLIENT DATE OF BIRTH 08/05/1946	3. MEDICAID ID NUMBER (CLIENT ID NUMBER) D444444
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. CLIENT SEX MALE <input type="checkbox"/> FEMALE <input checked="" type="checkbox"/>	6. MEDICARE ID NUMBER (HIC OR SSN)
TELEPHONE NUMBER	7. CLIENT RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. <input type="checkbox"/> CLIENT IS COVERED BY EMPLOYER HEALTH PLAN AS EMPLOYEE OR DEPENDENT EMPLOYER NAME: _____
9. OTHER HEALTH INSURANCE COVERAGE — INSURANCE COMPANY NAME, ADDRESS, PLAN NAME, AND POLICY NUMBER(S)	10. WAS CONDITION RELATED TO: A. CLIENT EMPLOYMENT YES <input type="checkbox"/> B. ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/> C. DATE OF ACCIDENT <input style="width: 50px;" type="text"/>	POLICYHOLDER NAME: _____ GROUP: _____ 11. CHAMPUS SPONSORS SERVICE/SSN
TELEPHONE NUMBER	12. PREGNANCY <input type="checkbox"/> HMO <input type="checkbox"/> NURSING FACILITY <input type="checkbox"/>	

PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF: <input type="checkbox"/> ILLNESS (FIRST SYMPTON) OR INJURY (ACCIDENT) OR FIRST PREGNANCY (LMP)	14. MEDICARE DENIAL (ATTACH THE MEDICARE STANDARD PAPER REMITTANCE (SPR) IF EITHER BOX IS CHECKED) <input type="checkbox"/> BENEFITS EXHAUSTED <input type="checkbox"/> NON-COVERED SERVICES	14A. OTHER COVERAGE DENIED <input type="checkbox"/> NO <input type="checkbox"/> YES PAY/DENY DATE: _____
15. NAME OF SUPERVISING PHYSICIAN	PROVIDER NUMBER	16. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES ADMITTED: _____ DISCHARGED: _____
17. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (IF OTHER THAN HOME OR OFFICE)	PROVIDER NUMBER	17A. CHECK BOX IF LABORATORY WORK WAS PERFORMED OUTSIDE THE PHYSICIANS OFFICE <input type="checkbox"/> YES

18. ICD-9-CM DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. IN COLUMN F, RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE NUMBERS 1, 2, 3, OR 4	TRANSPORTATION CERTIFICATION ATTACHED <input type="checkbox"/> YES
1. 6850	DURABLE MEDICAL EQUIPMENT Line # Make Model Serial Number
2. _____	
3. _____	
4. _____	PRIOR AUTHORIZATION #:

19A. DATE OF SERVICE FROM TO	B. PLACE OF SERVICE	C. PROCEDURE CODE (HCPCS)	MODIFIERS	D. RENDERING PROVIDER NUMBER	E. REFERRING PROVIDER NUMBER	F. DIAGNOSIS			G. CHARGES	H. DAYS OR UNITS	I. COPAY	J. EMERG ENCY	K. FAMILY PLANNING	L. EPSDT
						P	S	T						
08/05/2011 08/05/2011	24	11770		01234567	09876543	1			\$517.00			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
												<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
												<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
												<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
												<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<p style="font-size: small;">THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE, AND COMPLETE. I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS.</p> <p>27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE <i>Authorized Signature 08/06/2011</i></p> <p>28. BILLING PROVIDER NAME ABC Surgery Center</p> <p>29. BILLING PROVIDER NUMBER 04564891</p>	<p>20. TOTAL CHARGES → \$517.00</p> <p>21. MEDICARE PAID <input style="width: 50px;" type="text"/></p> <p>22. THIRD PARTY PAID <input style="width: 50px;" type="text"/> \$0.00</p> <p>23. NET CHARGE <input style="width: 50px;" type="text"/> \$517.00</p> <p>24. MEDICARE DEDUCTIBLE <input style="width: 50px;" type="text"/> \$0.00</p> <p>25. MEDICARE COINSURANCE <input style="width: 50px;" type="text"/> \$0.00</p> <p>26. MEDICARE DISALLOWED <input style="width: 50px;" type="text"/></p>
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Audiology Revisions Log

Revision Date	Additions/Changes	Pages	Made by
01/05/2009	<i>Drafted Manual</i>	<i>All</i>	<i>jg</i>
05/11/2009	<i>Web site addresses updated</i>	<i>Throughout</i>	<i>jg</i>
07/06/2009	<i>Accepted changes and verified TOC</i>	<i>Throughout</i>	<i>jg</i>
10/08/2009	<i>Deleted allowable amount column</i>	<i>11-13</i>	<i>vr</i>
10/19/2009	<i>Updated PAR instructions</i>	<i>6-9</i>	<i>jg</i>
10/19/2009	<i>LBOD</i>	<i>25</i>	<i>jg</i>
01/12/2010	<i>Updated Web site links</i>	<i>Throughout</i>	<i>jg</i>
02/10/2010	<i>Changed EOMB to SPR</i>	<i>22 & 27</i>	<i>jg</i>
03/04/2010	<i>Added link to Program Rules</i>	<i>2</i>	<i>jg</i>
03/11/2010	<i>Changed No to Yes in PAR column for code V5090</i>	<i>12</i>	<i>jg</i>
03/11/2010	<i>Added SPR to Special Instructions for Medicare SPR Date field</i>	<i>21</i>	<i>jg</i>
07/09/2010	<i>Updated date examples for field 19A</i>	<i>18</i>	<i>jg</i>
	<i>Updated claim example</i>	<i>28</i>	
07/14/2010	<i>Added Electronic Remittance Advice (ERA) to Special Instructions for Medicare SPR Date field and to Electronic Medicare Crossover Claims & to Medicare Denied Services in Late Bill Override Date section.</i>	<i>21 26</i>	<i>jg</i>
08/03/2011	<i>Procedure Code Table</i>	<i>11-13</i>	<i>vr</i>
	<i>Update Benefits statement</i>	<i>4</i>	
	<i>Updated Cochlear Implants statement</i>	<i>5</i>	
	<i>Updated PAR Reference Table</i>	<i>6-10</i>	
	<i>Updated Paper Reference Table</i>	<i>15, 18</i>	
08/03/2011	<i>Updated TOC</i>	<i>1</i>	<i>Jg</i>
	<i>Reformatted</i>	<i>Throughout</i>	
	<i>Updated claim example</i>	<i>27</i>	
12/06/2011	<i>Replaced 997 with 999</i>	<i>4</i>	
	<i>Replaced http://www.wpc-edi.com/hipaa with http://www.wpc-edi.com/</i>	<i>2</i>	<i>ss</i>
	<i>Replaced Implementation Guide with Technical Report 3 (TR3)</i>	<i>2</i>	
01/27/2012	<i>Changed authorizing agent to authorizing agency</i>	<i>Throughout</i>	<i>jg</i>

Revision Date	Additions/Changes	Pages	Made by
01/27/2012	<i>Removed:</i> "Hearing services for children have been a Medical Assistance Program benefit since 1979. The Colorado Department of Public Health and Environment, Health Care Program..."	2	jg

Note: *In many instances when specific pages are updated, the page numbers change for the entire section. Page numbers listed above are the page numbers on which the updates/changes occur.*