Outpatient Substance Abuse Treatment Program

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Outpatient Substance Abuse Treatment Program

Program Overview

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

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

The Colorado Medical Assistance Program reimburses providers for medically necessary medical and surgical services furnished to eligible clients.

Beginning July 1, 2006, Outpatient Substance Abuse Treatment Services became available to all Medical Assistance Program clients. Approved services must be provided by a practitioner or facility with a substance abuse provider specialty type. Qualified providers are:

- Facilities licensed by the Alcohol and Drug Abuse Division (ADAD) of the Department of Human Services
- Licensed physicians
- Licensed non-physician practitioners as follows:
  - Psychologist, PhD.
  - Nurse Practitioner.
  - Licensed Clinical Social Worker (LCSW).
  - Marriage and Family Therapist.
  - Licensed Professional Counselor (LPC).

and

- The above licensed physician and non-physician practitioners shall also be certified or licensed addiction counselors with the following credentials:
  - Certified or Licensed Addiction Counselors (CAC II, CAC III or LAC) by Department of Regulatory Agencies (DORA).

    or

  - Certified by the National Association of Alcohol and Drug Abuse Counselors (NAADAC) as an NCAC II or MAC.

    or

  - Licensed physicians who are also certified in Addiction Medicine by the American Society of Addiction Medicine (ASAM).

Effective February 1, 2007, the Primary Care Provider (PCP) referral requirement for Outpatient Substance Abuse Treatment Services has been eliminated. When filing a claim, in either electronic or paper form, please do not enter a *Referring* Provider number. Approved services must still be provided by a practitioner or facility with a substance abuse provider specialty type.

Providers should refer to the Code of Colorado Regulations, Program Rules (10 C.C.R. 2505-10), for specific information when providing substance abuse services.

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 for paper claim submission may be sent to the fiscal agent, 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 ensure 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 of the Department's Web site.

Batch Electronic Claims 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 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 the Provider Services EDI Support section of the Department's Web site.

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 will be forwarded along with the data 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 system 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.

Substance Abuse Covered Services

Substance Abuse Assessment: An evaluation designed to determine the level of drug/alcohol abuse or dependence and the comprehensive treatment needs of a client with a drug/alcohol diagnosis. Assessment is limited to three sessions per State fiscal year (July 1-June 30).

Individual and Family Therapy: Therapeutic substance abuse counseling and treatment services with one client per session. Family therapy will be directly related to the client's treatment for substance abuse and/or dependence. Individual/family therapy is limited to 25 sessions at 15 minutes per unit, up to four units (one hour) per session per State fiscal year.

Group Therapy: Therapeutic substance abuse counseling and treatment services with more than one client of up to and including three hours per session. Group therapy is limited to 36 sessions per State fiscal year.

Alcohol/Drug Screening: The collection of urine to test for the presence of alcohol and/or drugs. Substance abuse counseling services are provided along with screening to discuss results with client. Alcohol/ drug screening is limited to 36 specimen collections per State fiscal year.

Targeted Case Management: Medically necessary coordination and planning services provided with or on behalf of a client with a substance abuse diagnosis.

Services may include service planning, advocacy and linkage to other medical services related to substance abuse diagnosis, monitoring and care coordination. Substance abuse case management services are limited to 36 contacts per State fiscal year.

Social/Ambulatory Detoxification: Services are provided on a residential basis, excluding room and board, by a facility that has passed ADAD certification and licensure based on ASAM criteria. Includes supervision, observation and support for individuals whose intoxication/ withdrawal signs and symptoms are severe enough to require a 24 hour structured program but do not require hospitalization. Social/ambulatory detoxification is limited to seven days per State fiscal year.

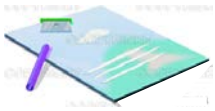
Substance Abuse Diagnosis Codes

Please refer to the coding reference guide below for the diagnosis codes available for billing Outpatient Substance Abuse Treatment services.

Diagnosis Code (ICD-9)	Diagnosis Description
Alcohol Use Disorders	
303.90	Alcohol Dependence
305.00	Alcohol Abuse
Alcohol-Induced Disorders	
303.00	Alcohol Intoxication
291.80	Alcohol Withdrawal
291.00	Alcohol Intoxication Delirium
291.00	Alcohol Withdrawal Delirium
291.20	Alcohol Induced Persisting Dementia
291.10	Alcohol Induced Persisting Amnesic Disorder
291.50	Alcohol Induced Psychotic Disorder With Delusions
291.30	Alcohol Induced Psychotic Disorder With Hallucinations
291.80	Alcohol Induced Mood Disorder
291.80	Alcohol Induced Anxiety Disorder
291.80	Alcohol Induced Sexual Dysfunction
291.80	Alcohol Induced Sleep Disorder
291.90	Alcohol-Related Disorder Not Otherwise Specified
Amphetamine Use Disorders	
304.40	Amphetamine Dependence
305.70	Amphetamine Abuse

Diagnosis Code (ICD-9)	Diagnosis Description
Amphetamine Induced Disorders	
292.89	Amphetamine Intoxication
**	Amphetamine Intoxication With Perceptual Disturbances
292.00	Amphetamine Withdrawal
292.81	Amphetamine Intoxication Delirium
292.11	Amphetamine Induced Psychotic Disorder With Delusions

Diagnosis Code (ICD-9)	Diagnosis Description
Amphetamine Induced Disorders	
292.12	Amphetamine Induced Psychotic Disorder With Hallucinations
292.84	Amphetamine Induced Mood Disorder
292.89	**Amphetamine Induced Anxiety Disorder**
292.89	Amphetamine Induced Sexual Dysfunction
292.89	Amphetamine Induced Sleep Disorder
292.90	Amphetamine Related Disorders Not Otherwise Specified
Cannabis Use Disorders	
304.30	Cannabis Dependence
305.20	Cannabis Abuse
Cannabis Induced Disorders	
292.89	Cannabis Intoxication
**	Cannabis Intoxication With Perceptual Disturbances
292.81	Cannabis Intoxication Delirium
292.11	Cannabis Induced Psychotic Disorder With Delusions
292.12	Cannabis Induced Psychotic Disorder With Hallucinations
**	Cannabis Induced Anxiety Disorder
292.89	Cannabis Induced Mood Disorder
292.90	Cannabis Related Disorders Not Otherwise Specified
Cocaine Use Disorders	
304.20	Cocaine Dependence
305.60	Cocaine Abuse
Cocaine Induced Disorders	
292.89	Cocaine Intoxication
**	Cocaine Intoxication With Perceptual Disturbances
292.00	Cocaine Withdrawal
292.81	Cocaine Intoxication Delirium
292.11	Cocaine Induced Psychotic Disorder With Delusions
292.12	Cocaine Induced Psychotic Disorder With Hallucinations
292.84	Cocaine Induced Mood Disorder
292.89	Cocaine Induced Anxiety Disorder
292.89	Cocaine Induced Sexual Dysfunction
292.89	Cocaine Induced Sleep Disorder
292.90	Cocaine Related Disorders Not Otherwise Specified



Diagnosis Code (ICD-9)	Diagnosis Description
Hallucinogen Use Disorders	
304.50	Hallucinogen Dependence
305.30	Hallucinogen Abuse

Diagnosis Code (ICD-9)	Diagnosis Description
Hallucinogen Induced Disorders	
292.89	Hallucinogen Intoxication
292.89	Hallucinogen Persisting Perception Disorder (Flashbacks)
292.81	Hallucinogen Intoxication Delirium
292.11	Hallucinogen Induced Psychotic Disorder With Delusions
292.12	Hallucinogen Induced Psychotic Disorder With Hallucinations
292.84	Hallucinogen Induced Mood Disorder
292.89	Hallucinogen Induced Anxiety Disorder
292.90	Hallucinogen Related Disorders Not Otherwise Specified
Inhalant Use Disorders	
304.60	Inhalant Dependence
305.90	Inhalant Abuse

Diagnosis Code (ICD-9)	Diagnosis Description
Inhalant Induced Disorders	
292.89	Inhalant Intoxication
292.81	Inhalant Intoxication Delirium
292.82	Inhalant Induced Persisting Dementia
292.11	Inhalant Induced Psychotic Disorder With Delusions
292.12	Inhalant Induced Psychotic Disorder With Hallucinations
292.84	Inhalant Induced Mood Disorder
292.89	Inhalant Induced Anxiety Disorder
292.90	Inhalant Related Disorders Not Otherwise Specified
Opioid Use Disorders	
304.00	Opioid Dependence
305.50	Opioid Abuse
Opioid Induced Disorders	
292.89	Opioid Intoxication
**	Opioid Intoxication with Perceptual Disturbances
292.00	Opioid Withdrawal
292.81	Opioid Intoxication Delirium
292.11	Opioid Induced Psychotic Disorder With Delusions
292.12	Opioid Induced Psychotic Disorder With Hallucinations
292.84	Opioid Induced Mood Disorder
292.89	Opioid Induced Sexual Dysfunction
292.89	Opioid Induced Sleep Disorder
292.90	Opioid Related Disorders Not Otherwise Specified

Diagnosis Code (ICD-9)	Diagnosis Description
Phencyclidine Use Disorders	
304.90	Phencyclidine Dependence
305.90	Phencyclidine Abuse
Phencyclidine Induced Disorders	
292.89	Phencyclidine Intoxication
**	Phencyclidine Intoxication With Perceptual Disturbances
292.81	Phencyclidine Intoxication Delirium
292.11	Phencyclidine Induced Psychotic Disorder With Delusions
292.12	Phencyclidine Induced Psychotic Disorder With Hallucinations
292.84	Phencyclidine Induced Mood Disorder
292.89	Phencyclidine Induced Anxiety Disorder
292.90	Phencyclidine Related Disorders Not Otherwise Specified
Sedative-,Hypnotic-,or Anxiolytic Use Disorders	
304.10	Sedative-,Hypnotic-,or Anxiolytic Dependence
305.40	Sedative-,Hypnotic-,or Anxiolytic Abuse

Diagnosis Code (ICD-9)	Diagnosis Description
Sedative-,Hypnotic-,or Anxiolytic-Induced Disorders	
292.89	Sedative-,Hypnotic-,or Anxiolytic Intoxication
292.00	Sedative-,Hypnotic-,or Anxiolytic Withdrawal
292.81	Sedative-,Hypnotic-,or Anxiolytic Intoxication Delirium
292.81	Sedative-,Hypnotic-,or Anxiolytic Withdrawal Delirium
292.82	Sedative-,Hypnotic-,or Anxiolytic Induced Persisting Dementia
292.83	Sedative-,Hypnotic-,or Anxiolytic Induced Persisting Amnestic Disorder
292.11	Sedative-,Hypnotic-,or Anxiolytic Induced Psychotic Disorder With Delusions
292.12	Sedative-,Hypnotic-,or Anxiolytic Induced Psychotic Disorder With Hallucinations
292.84	Sedative-,Hypnotic-,or Anxiolytic Induced Mood Disorder
292.89	Sedative-,Hypnotic-,or Anxiolytic Induced Anxiety Disorder
292.89	Sedative-,Hypnotic-,or Anxiolytic Induced Sexual Dysfunction
292.89	Sedative-,Hypnotic-,or Anxiolytic Induced Sleep Disorder
292.90	Sedative-,Hypnotic-,or Anxiolytic-Related Disorder Not Otherwise Specified
**	Polysubstance Dependence

Diagnosis Code (ICD-9)	Diagnosis Description
Tobacco Use Disorder	
305.10	Tobacco Use Disorder

Substance Abuse Procedure Coding

Please refer to the following procedural codes and modifiers when billing for Outpatient Substance Abuse Treatment Services.

Code + Modifier	Code Description	Comments
H0001 + HF	Alcohol and/or drug assessment	
H0004 + HF	Behavioral health counseling and therapy, per 15 minutes	
H0005 + HF	Alcohol and/or drug services; group counseling by a clinician	
H0014 + HF	Alcohol and /or drug services; ambulatory detoxification	End dated 03/01/07
H0006 + HF	Alcohol and/or drug services; case management (targeted)	
S3005 + HF	Safety assessment including suicide ideation and other behavioral health issues	Effective 03/01/07 Replaces H0014 + HF Does not include R & B
S9445 + HF	Drug screening and monitoring	
T1007 + HF	Physical assessment of detoxification progression including vital signs monitoring	Effective 03/01/07 Replaces H0014 + HF Does not include R & B
T1019 + HF	Provision of daily living needs including hydration, nutrition, cleanliness and toiletry for clients	Effective 03/01/07 Replaces H0014 + HF Does not include R & B
T1023 + HF	Level of motivation assessment for treatment evaluation	Effective 03/01/07 Replaces H0014 + HF Does not include R & B

Provider Specialty Types

To provide and bill Outpatient Substance Abuse Treatment Services, providers are required to apply for a provider number with a Substance Abuse specialty type. Applications are available in the Provider Services Enrollment section of the Department's Web site.

Paper Claim Reference Table

The following paper form reference table shows required, optional, and conditional fields and detailed field completion instructions.

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. Use the birth date given on the eligibility verification response. Example: 07012009 for July 1, 2009.
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 exactly as it appears on the eligibility verification response. 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 ☐ Female ☐	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.

Field Label	Completion Format	Special Instructions
7. Client Relationship to Insured	Check box Self ☐ Spouse ☐ Child ☐ Other ☐	Conditional Complete if the client is covered by a commercial health care insurance policy
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.
10. Was Condition Related To	Check box A. Client Employment Yes ☐ B. Accident Auto ☐ Other ☐ 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 the date of the accident.
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.

Field Label	Completion Format	Special Instructions
12. Pregnancy **HMO** **NF**	Check box ☐	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 ☐ Benefits Exhausted ☐ Non-covered services	Conditional Complete if the client has Medicare coverage and Medicare denied the benefits or does not cover the billed services.
14A. Other Coverage Denied	Check box No ☐ Yes ☐ Pay/Deny Date 6 digits: MMDDYY	Conditional Complete if the client has commercial health care insurance coverage. Enter the date that the other coverage paid or denied the services.
15. Name of Supervising Physician Provider Number	Text 8 digits	Conditional Complete if the individual who performs the service (rendering provider) is a non-physician practitioner who requires on-premises supervision by a licensed physician (see Provider Participation). Enter the eight digit Colorado Medical Assistance Program provider number assigned to the on-premises supervising physician.
16. For services related to hospitalization, give hospitalization dates	N/A	N/A

Field Label	Completion Format	Special Instructions
17. Name and address of facility where services rendered (If other than Home or Office) **Provider Number**	N/A	N/A
17A. Check box if laboratory work was performed outside Physician office	N/A	N/A
18. ICD-9-CM	1 _____ 2 _____ 3 _____ 4 _____ Codes: 3, 4, or 5 characters. 1st character may be a letter.	Required At least one diagnosis code must be entered. Enter up to four ICD-9-CM diagnosis codes starting at the far left side of the coding area. Do not enter the decimal point. Do not enter zeros to fill the spaces when the diagnosis code is fewer than 5 digits. Example: **ICD-9-CM description** / **Code** / **Claim Entry** Alcohol Abuse / 303.90 / 3 0 3 9 0
Diagnosis or nature of illness or injury. In column F, relate diagnosis to procedure by **Reference numbers 1, 2, 3, or 4**	Text	Optional If entered, the written description must match the code(s).
Transportation Certification attached	N/A	N/A
Durable Medical Equipment **Line #** **Make** **Model** **Serial Number**	N/A	N/A
Prior Authorization #:	N/A	N/A

Field Label	Completion Format	Special Instructions
19A. Date of Service	From: 6 digits MMDDYY To: 6 digits MMDDYY	Required Enter two dates: a "beginning" or "from" date of service and an "ending" or "to" date of service. Single date of service From To 07/05/2010 Or From To 07/05/2010 07/05/2010 Span dates of service From To 07/01/2010 07/31/2010 Practitioner claims must be consecutive days. Single Date of Service: Enter the six digit date of service in the "From" field. Completion of the "To" field is not required. Do not spread the date entry across the two fields. Span billing: Span billing is permitted if the same service (same procedure code) is provided on consecutive dates.
19B. Place of Service	2 digits	Required 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. Enter 11 (Office) or 12 (Patient's residence)
19C. Procedure Code (CMS code) **Modifier**	5 digits 2 letters	Required Enter the procedure code that specifically describes the treatment for which payment is requested. Procedure codes are listed in this manual. **HF - Substance Abuse Program** Always use "HF" for OP substance treatment

Field Label	Completion Format	Special Instructions
19D. Rendering Provider Number	8 digits	Required Enter the eight-digit Colorado Medical Assistance Program billing provider number.
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	P S T 1 digit per column	Required From field 18 To field(s) 19F For each billed service, indicate which of the diagnoses in field 18 are Primary, Secondary, or Tertiary. Example: 1 7 8 5 5 9 2 8 2 4 3 2 7 6 5 4 V 2 2 P S T Line 1 1 3 4 Line 2 2 Line 3 4 2

Field Label	Completion Format	Special Instructions
19G. Charges	Up to 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. The base procedure is the procedure with the highest allowable amount. The base code is used to determine the allowable amounts for additional CPT surgical procedures when more than one procedure from the same grouping is performed. Submitted charges cannot be more than charges made to non-Colorado Medical Assistance Program covered individuals for the same service. Do not deduct Colorado Medical Assistance Program co-payment or commercial insurance payments from usual and customary charges.
19H. Days or Units	Up to 4 digits	Required Enter the number of services provided for each procedure code. Enter whole numbers only. Do not enter fractions or decimals. Do not enter a decimal point followed by a 0 for whole numbers.
19I. Co-pay	1 digit	Conditional Complete if co-payment is required of this client for this service. 1-Refused to pay co-payment 2-Paid co-payment 3-Co-payment not requested
19J. Emergency	1 character	Conditional If checked, the service on this detail line is exempt from co-payment and from PCP Program referral requirements.
19K. Family Planning	N/A	N/A
19L. EPSDT	1 character	Conditional

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). ▪ 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.
20. 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
23. Net Charge	7 digits: Currency 99999.99	Required **Colorado Medical Assistance Program claims (Not Medicare Crossover)** Claims without third party payment. Net charge equals the total charge (field 20). Claims with third party payment. Net charge equals the total charge (field 20) minus the third party payment (field 22) amount. **Medicare Crossover claims** 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. 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.
24. Medicare Deductible	7 digits: Currency 99999.99	Conditional Complete for Medicare crossover claims. Enter the Medicare deductible amount shown on the Medicare payment voucher.
25. Medicare Coinsurance	7 digits: Currency 99999.99	Conditional Complete for Medicare crossover claims. Enter the Medicare coinsurance amount shown on the Medicare payment voucher.
26. Medicare Disallowed	7 digits: Currency 99999.99	Conditional Complete for Medicare crossover claims. Enter the amount Medicare disallowed, if any, shown on the Medicare payment voucher.

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

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 of the Department's Web site.

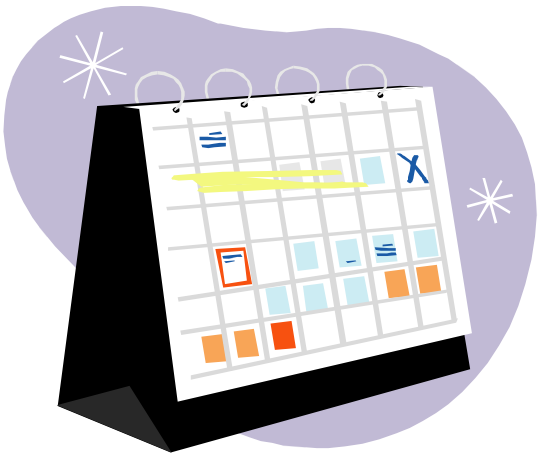
Making false statements about timely filing compliance is a misrepresentation and falsification that, upon conviction, makes the individual who prepares the claim and the enrolled provider subject to fine and imprisonment under state and/or federal law.

Billing Instruction Detail	Instructions
LBOD Completion Requirements	• 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. ➢ *UB-04*: Occurrence code 53 and the date are required in FL 31-34. ➢ *Colorado 1500*: Indicate "LBOD" and the date in box 30 -Remarks. ➢ *2006 ADA Dental*: Indicate "LBOD" and the date in box 35 - Remarks.
Adjusting Paid Claims	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. **Adjust the claim within 60 days** of the claim payment. Retain all documents that prove compliance with timely filing requirements. *Note: There is no time limit for providers to adjust paid claims that would result in repayment to the Colorado Medical Assistance Program.* **LBOD** = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the payment.

Billing Instruction Detail	Instructions
Denied Paper Claims	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: **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. **LBOD** = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the denial.
Returned Paper Claims	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. **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. **LBOD** = the stamped fiscal agent date on the returned claim.
Rejected Electronic Claims	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. **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. **LBOD** = the date shown on the claim rejection report.
Denied/Rejected Due to Client Eligibility	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. **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. **LBOD** = the date shown on the eligibility rejection report.
Retroactive Client Eligibility	The claim is for services provided to an individual whose Colorado Medical Assistance Program eligibility was backdated or made retroactive. 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: • Identifies the patient by name • States that eligibility was backdated or retroactive • Identifies the date that eligibility was added to the state eligibility system. **LBOD** = the date shown on the county letter that eligibility was added to or first appeared on the state eligibility system.

Billing Instruction Detail	Instructions
Delayed Notification of Eligibility	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. • 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. **LBOD** = the date the provider was advised the individual had Colorado Medical Assistance Program benefits.
Electronic Medicare Crossover Claims	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.) **File the claim within 120 days** of the Medicare processing/ payment date shown on the Standard Paper Remit (SPR) or Electronic Remittance Advice (ERA). Maintain a copy of the SPR/ERA on file. **LBOD** = the Medicare processing date shown on the SPR /ERA.
Medicare Denied Services	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. *Note: This becomes a regular Colorado Medical Assistance Program claim, not a Medicare crossover claim.* **File the claim within 60 days** of the Medicare processing date shown on the Standard Paper Remit (SPR) or Electronic Remittance Advice (ERA). Attach a copy of the SPR/ERA if submitting a paper claim and maintain the original SPR/ERA on file. **LBOD** = the Medicare processing date shown on the SPR/ERA.
Commercial Insurance Processing	The claim has been paid or denied by commercial insurance. **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.

Billing Instruction Detail	Instructions
Commercial Insurance Processing	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. **LBOD** = the date commercial insurance paid or denied.
Correspondence LBOD Authorization	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. **File the claim within 60 days** of the date on the authorization letter. Retain the authorization letter. **LBOD** = the date on the authorization letter.
Client Changes Providers during Obstetrical Care	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. **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. **LBOD** = the last date of OB care by the billing provider.



Outpatient Substance Abuse 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: 08/05/1995
3. MEDICAID ID NUMBER (CLIENT ID NUMBER): D333333
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NUMBER
5. CLIENT SEX: MALE ☐ ☒ FEMALE
6. MEDICARE ID NUMBER (HIC OR SSN)
7. CLIENT RELATIONSHIP TO INSURED: SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐
8. ☐ CLIENT IS COVERED BY EMPLOYER HEALTH PLAN AS EMPLOYEE OR DEPENDENT
EMPLOYER NAME:
POLICYHOLDER NAME:
GROUP :
9. OTHER HEALTH INSURANCE COVERAGE — INSURANCE COMPANY NAME, ADDRESS, PLAN NAME, AND POLICY NUMBER(S)
TELEPHONE NUMBER
10. WAS CONDITION RELATED TO:
A. CLIENT EMPLOYMENT YES ☐
B. ACCIDENT AUTO ☐ OTHER ☐
C. DATE OF ACCIDENT
11. CHAMPUS SPONSORS SERVICE/SSN
9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NUMBER
12. PREGNANCY ☐ HMO ☐ NURSING FACILITY ☐

PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF: 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) ☐ BENEFITS EXHAUSTED ☐ NON-COVERED SERVICES
14A. OTHER COVERAGE DENIED ☐ NO ☐ 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 ☐ 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
1.
2.
3.
4.
TRANSPORTATION CERTIFICATION ATTACHED ☐ YES
DURABLE MEDICAL EQUIPMENT
Line # Make Model Serial Number
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 P	S	T	G. CHARGES	H. DAYS OR UNITS	I. COPAY	J. EMERGENCY	K. FAMILY PLANNING	L. EPSDT
07/05/2010	07/05/2010	11	H0001		01234567		1			$102.00	1		☐	☐	☐
													☐	☐	☐
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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.

20. TOTALCHARGES $102.00
LESS
MEDICARE SPR DATE

27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE
Authorized Signature 07/05/2010
28. BILLING PROVIDER NAME
OP Clinic
29. BILLING PROVIDER NUMBER
04444444
30. REMARKS

21. MEDICARE PAID
22. THIRD PARTY PAID $.00
23. NET CHARGE $102.00
24. MEDICARE DEDUCTIBLE $.00
25. MEDICARE COINSURANCE $.00
26. MEDICARE DISALLOWED

COL-101
FORM NO. 94320 (REV. 02/99)
ELETRONIC APPLICATION

COLORADO 1500

Outpatient Substance Abuse Revisions Log

Creation Date	Additions/Changes	Pages	Made by
04/06/2010	*Drafted manual*	*All*	*vr*
07/09/2010	*Updated date examples for field 19A* *Updated claim example*	*15* *25*	*jg*
07/14/2010	*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.*	*18* *23*	*Jg*
12/06/2011	*Replaced 997 with 999* *Replaced http://www.wpc-edi.com/hipaa with http://www.wpc-edi.com/* *Replaced Implementation Guide with Technical Report 3 (TR3)*	*5* *3* *3*	*Ss*
06/14/12	*Field 19D, added* " billing" to provider number and removed "Cannot be assigned to a group or clinic."	*16*	*cc*

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.*