Speech Therapy
Outpatient – Fee-For-Service

SPEECH THERAPY OUTPATIENT – FEE-FOR-SERVICE 1

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Speech Therapy
Outpatient – Fee-For-Service

Provider Qualifications

Eligible Providers

Eligible providers may be individual practitioners or may be employed by home care agencies, children's developmental service agencies, health departments, federally qualified health centers (FQHC), clinics, or hospital outpatient facilities. The provider agency or the individual provider must verify that rendering providers meet the below qualifications.

Speech Language Pathologists (SLPs) must have a current certification by the American Speech-Language-Hearing Association (ASHA).

Speech-Language Pathology Assistants are support personnel who, following academic and/or on-the-job training, perform tasks prescribed, directed, and supervised by ASHA-certified speech-language pathologists. Supervisors must follow the ASHA guidelines on the training, use, and supervision of assistants. (Assistants cannot render services under the Home Health benefit of the Medical Assistance Program.) **Speech therapy assistants** must practice under the general supervision of a Colorado registered therapist.

Clinical Fellows, practicing under the general supervision of an ASHA certified speech-language pathologist may provide speech therapy services.

Provider Participation

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

All speech therapists must submit a completed provider enrollment packet to become a Colorado Medical Assistance Program provider. Providers will find enrollment information in the Provider Services Enrollment section of the Department's Web site (colorado.gov/hcpf). Enrollment documents may be downloaded and mailed to:

Xerox State Healthcare
Colorado Medical Assistance Program Provider Enrollment
PO Box 1100
Denver, CO 80201-1100

Speech therapists not employed by an agency, clinic, hospital, or physician may bill the Colorado Medical Assistance Program directly. Providers should refer to the Code of Colorado Regulations, Qualified Non-Physician Practitioners Eligible to Provide Physician's Services (10 CCR 2505-10, Section 8.2003.C), for specific information when providing speech therapy.

All speech services must be medically necessary and prescribed by an M.D. or D.O., nurse practitioner or physician's assistant. Educational, personal need, and comfort therapies are not covered speech therapy benefits for any client regardless of age.

For detailed coverage and service limitations, please refer to the Speech and Hearing Policy Statement posted on the Department's Web site.

Daily Unit Limits

Speech therapy services do not need to be pre-authorized; however, there is a daily limit of five units of therapy services allowed for speech therapy. Some specific daily limits per procedure code do apply. Please see the August 2011 Provider Bulletin (B1100304) for specific allowable procedure code information.

While a maximum of five units of service is allowed per date of service, providers are required to consult the American Medical Association's (AMA) Current Procedural Terminology (CPT) manual for each coded service. Some codes represent a treatment session without regard to its length of time (1 unit maximum) while other codes may be billed incrementally as "timed" units.

Clients determined to need a speech generating device (HCPCS codes E2500, E2502, E2504,E2510, E2211, E2512 and E2599) should be referred to a Medicaid participating medical supplier to be pre-authorized.

All claims must meet eligibility and claim submission requirements (e.g. timely filing, third party resources payment pursued, required attachments included, etc.) before payment can be made.

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.

The Department of Health Care Policy and Financing (the Department) periodically modifies billing information. Therefore, the information in this manual is subject to change, and the manual is updated as new billing information is implemented.

Paper Claims

Electronic claims format shall be required unless hard copy claims submittals are specifically authorized by the Department. Requests may be sent to the Department's fiscal agent, Xerox State Healthcare, 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 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 (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)

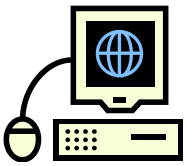
The Colorado Medical Assistance Program collects electronic claim information interactively through the Colorado Medical Assistance Program Secure Web Portal (Web Portal) or via batch submission through a host system.

Interactive Claim Submission and Processing

Interactive claim submission through the Web Portal is a real-time exchange of information between the submitter and the Colorado Medicaid Management Information System (MMIS). 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 OLTP reviews the claim information for compliance with Colorado Medical Assistance Program billing policy and returns a response to the submitter'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 submitter receives an acceptance message and the OLTP passes accepted claim information to the Colorado MMIS 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 a PCR containing information related to submitted claims. The Web Portal provides access to the following reports through the File and Report Service (FRS):

- Accept/Reject Report
- Provider Claim Report
- Health Care Claim Payment/Advice (ASC X12N 835)
- Managed Care Reports such as Primary Care Physician Rosters
- Prior Authorization Letters

Users may also inquire about information generated from claims submitted via paper and through electronic data submission methods other than the Web Portal. Other inquiry options include:

- Eligibility Inquiry (interactive and batch)
- Claim Status Inquiry
- PAR 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 Department's fiscal agent.

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

An enrollment package may be obtained by contacting the Department's fiscal agent or by downloading it from the Provider Services EDI Support section.

The X12N 837 Professional (837P), Institutional (837I), or Dental (837D) 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 MMIS, the interchange will reject and a TA1 along with the data will be forwarded to the 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 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 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's FRS 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 EDI Gateway. Assistance from EDI Gateway 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 Gateway requests that submitters 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, EDI Gateway requires submitters to submit all X12N test transactions to EDIFECS prior to submitting them to 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 edifecs.com.

Procedure/HCPCS Code 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 CPT, a numeric coding system maintained by the 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 located 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.

Colorado 1500 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.

Instructions for completing and submitting electronic claims are available through the X12N Technical Report 3 (TR3) for the 837P (wpc-edi.com), 837P Companion Guide (in the Provider Services Specifications section of the Department's Web site), and in the Web Portal User Guide (via within the portal).

Field Label	Completion format	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	2 digits	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:* 070110 = July 1, 2010
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 Telephone Number	Characters: numbers and letters	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.

Field Label	Completion format	Instructions
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 ☐ Spouse ☐ Child ☐ Other ☐	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.
10. Was condition related to	Check box A. ☐ Client employment Check box B. ☐ Accident 6 digits: MMDDYY 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.

Field Label	Completion format	Instructions
11. CHAMPUS Sponsors Service/SSN	10 digits	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	
12. Pregnancy **HMO** **Nursing Facility**	Check box ☐ Check box ☐ Check box ☐	N/A
13. Date of illness or injury or pregnancy	6 digits: MMDDYY	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 benefits or does not cover the billed services. Enter a check mark or an "**x**" in the Benefits Exhausted box if a Medicare payment voucher shows that Medicare has denied payment because a limited benefit is exhausted. A copy of the Medicare denial notice must be provided upon request. Enter a check mark or an "**x**" in the Non-covered Services box if a Medicare publication or denial notice shows the billed service(s) is/are not a Medicare covered benefit. A copy of the Medicare denial or Medicare publication showing that the service is not covered must be provided upon request. Bill claims for Medicare denied services and Medicare crossover claims separately.

Field Label	Completion format	Instructions
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 a check mark or an "**x**" in the "No" box if the other coverage has paid a portion of the billed charges. If the other coverage payment amount is the same or more than the Colorado Medical Assistance Program benefit, the Colorado Medical Assistance Program will not make additional payment. Enter a check mark or an "**x**" in the "Yes" box if the other coverage carrier has denied payment or has applied all of the allowed benefit to a deductible. Enter the date of the other coverage payment or denial.
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	6 digits: MMDDYY	Admitted | MM | DD | YY | Discharged | MM | DD | YY Conditional Complete for services provided in an inpatient hospital setting. Enter the date of hospital admission and the date of discharge, if known. If the client is still hospitalized, the discharge date may be omitted. This information is not edited.
17. Name and address of facility where services rendered **Provider Number**	Text (address is optional) 8 digits	Conditional Complete for services provided in a hospital or nursing facility. Enter the name of the hospital or nursing facility. This information is not edited. Complete for services provided in a hospital or nursing facility. Enter the Colorado Medical Assistance Program provider number of hospital or nursing facility, if known. This information is not edited.

Field Label	Completion format	Instructions
17A. Check box if laboratory work performed outside physician's office	Check box ☐	Conditional Complete if all laboratory work was referred to and performed by an outside laboratory. If this box is checked, no payment will be made to the physician for lab services. Do not complete this field if any laboratory work was performed in the office. Practitioners may not request payment for services performed by an independent or hospital laboratory.
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 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 (May require 4th or 5th digit): ICD-9-CM description — Code Cerebral Palsy — 434.9 — 4 3 4 9
Diagnosis or nature of illness or injury	Text	Optional Written description is not required. If entered, the written description must match the code(s).
Transportation Certification attached	Check box ☐	N/A
Prior Authorization No.	6 characters: Letter plus 5 digits	Conditional If the procedure requires prior authorization, enter the prior authorization from the approved Prior Authorization Request (PAR). Do not combine services from more than one approved PAR on a single claim form. Do not attach a copy of the approved PAR unless advised to do so by the authorizing agency or the fiscal agent.

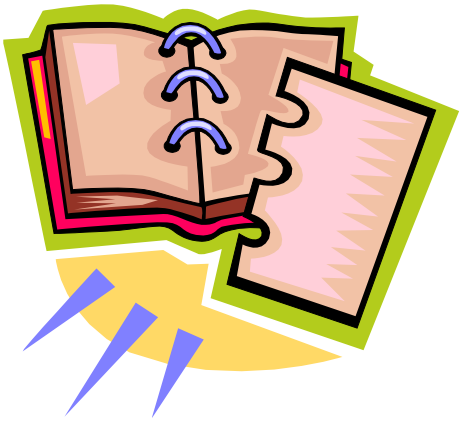
Field Label	Completion format	Instructions
19A. Date of Service	From: 6 digits MMDDYY To: 6 digits MMDDYY	Required The field accommodates the entry of two dates: a “beginning” or “from” date of service and an “ending” or “to” date of service. Single date of service From To 01 01 2012 | | | Or From To 01 01 2012 01 01 2012 Span dates of service 01 01 2012 01 31 2012 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 permissible 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. 04 Homeless Shelter 11 Office 12 Home 15 Mobile Unit 20 Urgent Care Facility 21 Inpatient hospital 22 Outpatient hospital 23 Emergency room hospital 25 Birthing Center 26 Military Treatment Center 31 Skilled Nursing Facility 32 Nursing facility 33 Custodial Care Facility

Field Label	Completion format	Instructions
19B. Place of Service (continued)	2 digits	34 Hospice 41 Transportation Land 51 Inpatient Psychiatric Facility 52 Psychiatric Facility Partial Hospitalization 53 Community mental health center 54 Intermediate Care Facility - MR 60 Mass Immunization Center 61 Comprehensive IP Rehab Facility 62 Comprehensive OP Rehab Facility 65 End Stage Renal Dialysis Trtmt Facility 71 State-Local Public Hlth Clinic 99 Other Unlisted
19C. Procedure Code (HCPCS)	5 characters: 5 digits or 1 letter plus 4 digits or 2 letters plus 3 digits	Required Enter the HCPCS procedure code that specifically describes the service for which payment is requested. All procedures must be identified with codes in the current edition of the AMA CPT. CPT is updated annually. HCPCS Level II Codes The current Medicare coding publication (for Medicare crossover claims only). Only approved codes from the current CPT or HCPCS publications will be accepted.
Modifiers	2 characters: Letters or digits May enter up to two 2 character modifiers	Enter the appropriate procedure-related modifier that applies to the billed service. Enter two (2) characters in each field. Modifier for Speech = GN

Field Label	Completion format	Instructions
19D. Rendering Provider No.	8 digits	Required Enter the eight-digit Colorado Medical Assistance Program provider number assigned to the individual who actually performed or rendered the billed service. This number cannot be assigned to a group or clinic.
19E. Referring Provider No.	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.

Field Label	Completion format	Instructions
19F. Diagnosis	P S T 1 digit per column	Required Each billed line must have at least one primary diagnosis referenced. At least one diagnosis code must be entered. Enter up to four 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. From field 18 To field(s) 19F Example: (May require 4th or 5th digit) 1 7 8 5 5 9 2 8 2 4 X 3 2 7 6 5 X 4 V 2 2 X P S T Line 1 1 2 3 Line 2 2 Line 3 4 2 For each billed service, indicate which of the diagnoses in field 18 are Primary, Secondary, or Tertiary. In the example above, for services reported on line 1, the primary reason for the service (diagnosis) was diagnosis 785.59, the secondary reason was 276.5, and the tertiary reason was V22. For the services reported on line 2, the primary (and only reason) was 824. On line 3, there were two reasons for the services, V22. primary and 824 secondary.

Field Label	Completion format	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	4 digits	Required Enter the number of services provided for each procedure code. Enter whole numbers only. Do not enter fractions or decimals.



Field Label	Completion format	Instructions
19I. COPAY	1 digit	Conditional Complete if co-payment is required of this client for this service. Enter one of the following codes: 1-Refused to pay co-payment 2-Paid co-payment 3-Co-payment not requested
19J. Emergency	Check box ☐	Conditional 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. If checked, the service on this detail line is exempt from co-payment and from PCP Program referral requirements.
19K. Family Planning	Check box ☐	Conditional Enter a check mark or an "**x**" in the column to indicate the service is rendered for family planning. If checked, the service on this detail line is exempt from co-payment and from PCP Program referral requirements.
19L. EPSDT	Check box ☐	Conditional 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.
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.

Field Label	Completion format	Instructions
20. Total Charges	Up to 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 of 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.
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.

Field Label	Completion format	Instructions
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.
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. When applicable, enter the word "CLIA" followed by the number.

UB-04 Paper Claim Reference Table

Speech therapy outpatient hospital paper claims must be submitted on the UB-04 claim form.

The information in the following table provides instructions for completing Form Locators (FL) as they appear on the UB-04 paper claim form. Instructions for completing the UB-04 claim form are based on the current *National Uniform Billing Committee (NUBC) UB-04 Reference Manual*. Unless otherwise noted, all data FLs on the UB-04 have the same attributes (specifications) for the Colorado Medical Assistance Program as those indicated in the *NUBC UB-04 Reference Manual*.

All code values listed in the *NUBC UB-04 Reference Manual* for each FL **may not** be used for submitting paper claims to the Colorado Medical Assistance Program. The appropriate code values listed in this manual must be used when billing the Colorado Medical Assistance Program.

The UB-04 certification must be completed and attached to all claims submitted on the UB-04. A copy of the certification form is included with this manual. Completed UB-04 paper Colorado Medical Assistance Program claims, including hardcopy Medicare claims, should be mailed to the correct fiscal agent address located in Appendix A of the Appendices section in Provider Services Billing Manuals.

Do not submit "continuation" claims. Each claim form has a set number of billing lines available for completion. Do not crowd more lines on the form. Billing lines in excess of the designated number are not processed or acknowledged. Claims with more than one page may be submitted electronically.

The Paper Claim Reference Table below lists the required, optional and/or conditional form locators for submitting the UB-04 paper claim form to the Colorado Medical Assistance Program for speech therapy services.

Instructions for completing and submitting electronic claims are available through the X12N Technical Report 3 (TR3) for the 837I (wpc-edi.com), 837I Companion Guide (in the Provider Services Specifications section of the Department's Web site), and in the Web Portal 837I User Guide (via within the portal).

Form Locator and Label	Completion Format	Instructions
1. Billing Provider Name, Address, Telephone Number	Text	Required Enter the provider or agency name and complete mailing address of the provider who is billing for the services: Street/Post Office box City State Zip Code Abbreviate the state using standard post office abbreviations. Enter the telephone number.

Form Locator and Label	Completion Format	Instructions
2. Pay-to Name, Address, City, State	Text	Required if different from FL 1. Enter the provider or agency name and complete mailing address of the provider who will receive payment for the services: Street/Post Office box City State Zip Code Abbreviate the state using standard post office abbreviations. Enter the telephone number.
3a. Patient Control Number	Up to 20 characters: Letters, numbers or hyphens	Optional Enter information that identifies the client or claim in the provider's billing system. Submitted information appears on the Provider Claim Report.
3b. Medical Record Number	17 digits	Optional Enter the number assigned to the patient to assist in retrieval of medical records.
4. Type of Bill	3 digits	Required Enter the three digit number indicating the specific type of bill. The three digit code requires one digit each in the following sequences (Type of facility, Bill classification, and Frequency): **Digit 1 — Type of Facility** 1 — Hospital 2 — Skilled Nursing Facility 3 — Home Health 4 — Religious Non-Medical Health Care Institution Hospital Inpatient 5 — Religious Non-Medical Health Care Institution Post-Hospital Extended Care Services 6 — Intermediate Care 7 — Clinic (Rural Health/FQHC/Dialysis Center) 8 — Special Facility (Hospice, RTCs)

Form Locator and Label	Completion Format	Instructions
4. Type of Bill (continued)	3 digits	Required Enter the three digit number indicating the specific type of bill. The three digit code requires one digit each in the following sequences (Type of facility, Bill classification, and Frequency): **Digit 2 — Bill Classification (Except clinics & special facilities):** 1 — Inpatient (Including Medicare Part A) 2 — Inpatient (Medicare Part B only) 3 — Outpatient 4 — Other (for hospital referenced diagnostic services or home health not under a plan of treatment) 5 — Intermediate Care Level I 6 — Intermediate Care Level II 7 — Sub-Acute Inpatient (revenue code 19X required with this bill type) 8 — Swing Beds 9 — Other **Digit 2 — Bill Classification (Clinics Only):** 1 — Rural Health/FQHC 2 — Hospital Based or Independent Renal Dialysis Center 3 — Freestanding 4 — Outpatient Rehabilitation Facility (ORF) 5 — Comprehensive Outpatient Rehabilitation Facilities (CORFs) 6 — Community Mental Health Center **Digit 2 — Bill Classification (Special Facilities Only):** 1 — Hospice (Non-Hospital Based) 2 — Hospice (Hospital Based) 3 — Ambulatory Surgery Center 4 — Freestanding Birthing Center 5 — Critical Access Hospital 6 — Residential Facility

Form Locator and Label	Completion Format	Instructions
4. Type of Bill (continued)	3 digits	Required Enter the three digit number indicating the specific type of bill. The three digit code requires one digit each in the following sequences (Type of facility, Bill classification, and Frequency): **Digit 3 Frequency:** 0 Non-Payment/Zero Claim 1 Admit through discharge claim 2 Interim - First claim 3 Interim - Continuous claim 4 Interim - Last claim 7 Replacement of prior claim 8 Void of prior claim
5. Federal Tax Number	None	Not required Submitted information is not entered into the claim processing system.
6. Statement Covers Period – From/Through	From: 6 digits MMDDYY Through: 6 digits MMDDYY	Required (Note: OP claims cannot span over a month's end) Enter the From (beginning) date and Through (ending) date of service covered by this bill. *Example:* 01012011 = January 1, 2011 This form locator must reflect the beginning and ending dates of service. When span billing for multiple dates of service and multiple procedures, complete FL 45 (Service Date). Providers not wishing to span bill following these guidelines, must submit one claim per date of service. "From" and "Through" dates must be the same. All line item entries must represent the same date of service.
8a. Patient Identifier		Not required Submitted information is not entered into the claim processing system.
8b. Patient Name	Up to 25 characters: Letters & spaces	Required Enter the client's last name, first name and middle initial.
9a. Patient Address – Street	Characters Letters & numbers	Required Enter the client's street/post office box as determined at the time of admission.

Form Locator and Label	Completion Format	Instructions
9b. Patient Address – City	Text	Required Enter the client's city as determined at the time of admission.
9c. Patient Address – State	Text	Required Enter the client's state as determined at the time of admission.
9d. Patient Address – Zip	Digits	Required Enter the client's zip code as determined at the time of admission.
9e. Patient Address – Country Code	Digits	Optional
10. Birthdate	8 digits (MMDDCCYY)	Required Enter the client's birthdate using two digits for the month, two digits for the date, and four digits for the year. *Example*: 01012010 = January 1, 2010
11. Patient Sex	1 letter	Required Enter an M (male) or F (female) to indicate the client's sex.
12. Admission Date	6 digits	Conditional Required for observation holding beds only
13. Admission Hour	6 digits	Conditional Required for observation holding beds only

Form Locator and Label	Completion Format	Instructions
14. Admission Type	1 digit	Required Enter the following to identify the admission priority: **1 – Emergency** Client requires immediate intervention as a result of severe, life threatening or potentially disabling conditions. Exempts inpatient hospital & clinic claims from co-payment and PCP referral. Exempts outpatient hospital claims from co-payment and PCP only if revenue code 450 or 459 is present. This is the only benefit service for an undocumented alien. If span billing, emergency services cannot be included in the span bill and must be billed separately from other outpatient services. **2 - Urgent** The client requires immediate attention for the care and treatment of a physical or mental disorder. **3 - Elective** The client's condition permits adequate time to schedule the availability of accommodations. **4 - Newborn** Required for inpatient and outpatient hospital. **5 - Trauma Center** Visit to a trauma center/hospital as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons and involving trauma activation. **Clinics** Required only for emergency visit.

Form Locator and Label	Completion Format	Instructions
15. Source of Admission	1 digit	Required Enter the appropriate code for co-payment exceptions on claims submitted for outpatient services. (To be used in conjunction with FL 14, Type of Admission). 1 Physician referral 2 Clinic referral 3 Referred from HMO 4 Transfer from a hospital 5 Transfer from a skilled nursing facility (SNF) 6 Transfer from another health care facility 7 Emergency Room 8 Court/Law Enforcement 9 Information not available A Transfer from a Critical Access Hospital B Transfer from another Home Health Agency C Readmission to Same Home Health Agency **Newborns** 1 Normal Delivery 2 Premature Delivery 3 Sick Baby 4 Extramural Birth (Birth in a non-sterile environment)
16. Discharge Hour	2 digits	Not Required Enter the hour the client was discharged from inpatient hospital care. Use the same coding used in FL 13 (Admission Hr.)

Form Locator and Label	Completion Format	Instructions
17. Patient Discharge Status	2 digits	Conditional Enter patient status as of discharge date. 01 Discharged to Home or Self Care (Dialysis is limited to code 01) 02 Discharged/transferred to another short term hospital 03 Discharged/transferred to a Skilled Nursing Facility (SNF) 04 Discharged/transferred to an Intermediate Care Facility (ICF) 05 Discharged/transferred to another type institution 06 Discharged/transferred to home under care of organized Home and Community Based Services Program (HCBS) 07 Left against medical advice or discontinued care 08 Discharged/transferred to home under care of a Home Health provider 09 Admitted as an inpatient to this hospital 20 Expired 30** Still a patient or expected to return for outpatient services 31** Still a patient - Awaiting transfer to long term psychiatric hospital 32** Still a Patient - Awaiting placement by Colorado Medical Assistance Program 50 Hospice – Home 51 Hospice - Medical Facility 61 Discharged/transferred within this institution to hospital based Medicare approved swing bed 62 Discharged/transferred to an inpatient rehabilitation hospital. 63 Discharged/transferred to a Medicare certified long term care hospital. 71 Discharged/transferred/referred to another institution for outpatient services 72 Discharged/transferred/referred to this institution for outpatient services

Form Locator and Label	Completion Format	Instructions
17. Patient Discharge Status (continued)	2 digits	Use code 02 for a PPS hospital transferring a patient to another PPS hospital. Code 05, Discharged to Another Type Institution, is the most appropriate code to use for a PPS hospital transferring a patient to an exempt hospital. **A PPS hospital cannot use Patient Status codes 30, 31 or 32 on any claim submitted for DRG reimbursement. The code(s) are valid for use on exempt hospital claims only. Interim bills may be submitted for Prospective Payment System (PPS) -DRG claims, but must meet specific billing requirements. For exempt hospitals use the appropriate code from the codes listed. Note: Refer to the "Interim" billing instruction in this section of the manual.
18-28. Condition Codes	2 Digits	Conditional Complete with as many codes necessary to identify conditions related to this bill that may affect payer processing. **Condition Codes** 01 Military service related 02 Employment related 04 HMO enrollee 05 Lien has been filed 06 ESRD patient - First 18 months entitlement 07 Treatment of non-terminal condition/hospice patient 17 Patient is homeless 25 Patient is a non-US resident 39 Private room medically necessary 60 DRG (Day outlier) **Renal dialysis settings** 71 Full care unit 72 Self care unit 73 Self care training 74 Home care 75 Home care - 100 percent reimbursement 76 Back-up facility

Form Locator and Label	Completion Format	Instructions
18-28. Condition Codes (continued)	2 Digits	**Special Program Indicator Codes** A1 EPSDT/CHAP A2 Physically Handicapped Children's Program A4 Family Planning A6 PPV/Medicare A7 Induced Abortion - Danger to Life A8 Induced Abortion - Victim Rape/Incest A9 Second Opinion Surgery B3 Pregnancy Indicator B4 Admission Unrelated to Discharge **PRO Approval Codes** C1 Approved as billed C2 Automatic approval as billed - Based on focused review C3 Partial approval C4 Admission/Services denied C5 Post payment review applicable C6 Admission preauthorization C7 Extended authorization
29. Accident State		Optional

Form Locator and Label	Completion Format	Instructions
31-34. Occurrence Code/Date	2 digits and 6 digits	Conditional Complete both the code and date of occurrence. Enter the appropriate code and the date on which it occurred. Enter the date using MMDDYY format. **Occurrence Codes:** 01 Accident/Medical Coverage 02 Auto Accident - No Fault Liability 03 Accident/Tort Liability 04 Accident/Employment Related 05 Other Accident/No Medical Coverage or Liability Coverage 06 Crime Victim 20 Date Guarantee of Payment Began 24* Date Insurance Denied 25* Date Benefits Terminated by Primary Payer 26 Date Skilled Nursing Facility Bed Available 27 Date of Hospice Certification or Re-certification 40 Scheduled Date of Admission (RTD) 50 Medicare Pay Date 51 Medicare Denial Date 53 Late Bill Override Date 55 Insurance Pay Date A3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer A indicated in FL 50 B3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer B indicated in FL 50 C3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer C indicated in FL 50 *Other Payer occurrence codes 24 and 25 must be used when applicable. The claim must be submitted with the third party information.

Form Locator and Label	Completion Format	Instructions
35-36. Occurrence Span Code From/ Through	2 digits and 6 digits	Leave blank
38. Responsible Party Name/ Address	None	Not required Submitted information is not entered into the claim processing system.
39-41. Value Code-Code Value Code-Amount	2 characters and 9 digits	Conditional Enter appropriate codes and related dollar amounts to identify monetary data or number of days using whole numbers, necessary for the processing of this claim. Never enter negative amounts. If a value code is entered, a dollar amount or numeric value related to the code <u>must</u> always be entered. 01 Most common semiprivate rate (Accommodation Rate) 06 Medicare blood deductible 14 No fault including auto/other 15 Worker's Compensation 31 Patient Liability Amount 32 Multiple Patient Ambulance Transport 37 Pints of Blood Furnished 38 Blood Deductible Pints 40 New Coverage Not Implemented by HMO 45 Accident Hour Enter the hour when the accident occurred that necessitated medical treatment. Use the same coding used in FL 18 (Admission Hour). 49 Hematocrit Reading - EPO Related 58 Arterial Blood Gas (PO2/PA2) 68 EPO-Drug 80 Covered Days 81 Non-Covered Days

Form Locator and Label	Completion Format	Instructions
39-41. Value Code-Code **Value Code-Amount** (continued)	2 characters and 9 digits	Enter the deductible amount applied by indicated payer: A1 Deductible Payer A B1 Deductible Payer B C1 Deductible Payer C Enter the amount applied to client's co-insurance by indicated payer: A2 Coinsurance Payer A B2 Coinsurance Payer B C2 Coinsurance Payer C Enter the amount paid by indicated payer: A3 Estimated Responsibility Payer A B3 Estimated Responsibility Payer B C3 Estimated Responsibility Payer C For Rancho Coma Score bill with appropriate diagnosis for head injury. Medicare & TPL - See A1-A3, B1-B3, & C1-C3 above
42. Revenue Code	3 digits	Required Enter the revenue code which identifies the specific accommodation or ancillary service provided. List revenue codes in ascending order. A revenue code must appear only once per date of service. If more than one of the same service is provided on the same day, combine the units and charges on one line accordingly. When billing outpatient hospital radiology, the radiology revenue code may be repeated, but the corresponding HCPCS code cannot be repeated for the same date of service. Refer to instructions under FL 44 (HCPCS/Rates). Psychiatric step down Use the following revenue codes: 114 Psychiatric Step Down 1 124 Psychiatric Step Down 2 134 Psychiatric Step Down 3

Form Locator and Label	Completion Format	Instructions
43. Revenue Code Description	Text	Required Enter the revenue code description or abbreviated description. When reporting an NDC Enter the NDC qualifier of “N4” in the first two positions on the left side of the field. Enter the 11-digit NDC numeric code Enter the NDC unit of measure qualifier (examples include): F2 – International Unit GR – Gram ML – Milliliter UN – Units Enter the NDC unit of measure quantity

Form Locator and Label	Completion Format	Instructions
44. HCPCS/Rates /HIPPS Rate Codes	5 digits	Conditional Enter only the HCPCS code for each detail line. Use approved modifiers listed in this section for hospital based transportation services. Complete for laboratory, radiology, physical therapy, occupational therapy, and hospital based transportation. When billing HCPCS codes, the appropriate revenue code must also be billed. HCPCS codes must be identified for the following revenue codes: ▪ 30X LABORATORY ▪ 32X RADIOLOGY – DIAGNOSTIC ▪ 33X RADIOLOGY – THERAPEUTIC ▪ 34X NUCLEAR MEDICINE ▪ 35X CT SCAN ▪ 40X OTHER IMAGING SERVICES ▪ 42X PHYSICAL THERAPY ▪ 43X OCCUPATIONAL THERAPY ▪ 44X SPEECH THERAPY ▪ 54X AMBULANCE ▪ 61X MRI HCPCS codes cannot be repeated for the same date of service. Combine the units in FL 46 (Service Units) to report multiple services. The following revenue codes always require a HCPCS code. Please reference the Provider Services Bulletins section of the Department's Web site for a list of physician-administered drugs that also require an NDC code. When a HCPCS code is repeated more than once per day and billed on separate lines, use modifier 76 to indicate this is a repeat procedure and not a duplicate. 252 Non-Generic Drugs 253 Take Home Drugs 255 Drugs Incident to Radiology 257 Non-Prescription 258 IV Solutions 259 Other Pharmacy 260 IV Therapy General Classification 261 Infusion Pump 262 IV Therapy/Pharmacy Services 263 IV Therapy/Drug/Supply Delivery 264 IV Therapy/Supplies

Form Locator and Label	Completion Format	Instructions
44. HCPCS/Rates /HIPPS Rate Codes (continued)	5 digits	269 Other IV Therapy 631 Single Source Drug 632 Multiple Source Drug 633 Restrictive Prescription 634 Erythropoietin (EPO) <10,000 635 Erythropoietin (EPO) >10,000 636 Drugs Requiring Detailed Coding
45. Service Date	6 digits	Required For span bills only Enter the date of service using MMDDYY format for each detail line completed. Each date of service must fall within the date span entered in the "Statement Covers Period" (FL 6). Not required for single date of service claims.
46. Service Units	3 digits	Required Enter a unit value on each line completed. Use whole numbers only. Do not enter fractions or decimals and do not show a decimal point followed by a 0 to designate whole numbers (e.g., Do not enter 1.0 to signify one unit) The grand total line (Line 23) does not require a unit value. For span bills, the units of service reflect only those visits, miles or treatments provided on dates of service in FL 45.
47. Total Charges	9 digits	Required Enter the total charge for each line item. Calculate the total charge as the number of units multiplied by the unit charge. Do not subtract Medicare or third party payments from line charge entries. Do not enter negative amounts. A grand total in line 23 is required for all charges.
48. Non-Covered Charges	9 digits	Conditional Enter incurred charges that are not payable by the Colorado Medical Assistance Program. Non-covered charges must be entered in both FL 47 (Total Charges) and FL 48 (Non-Covered Charges). Each column requires a grand total. Non-covered charges cannot be billed for outpatient hospital laboratory or hospital based transportation services.

Form Locator and Label	Completion Format	Instructions
50. Payer Name	1 letter and text	Required Enter the payment source code followed by name of each payer organization from which the provider might expect payment. At least one line must indicate The Colorado Medical Assistance Program. Source Payment Codes B Workmen's Compensation C Medicare D Colorado Medical Assistance Program E Other Federal Program F Insurance Company G Blue Cross, including Federal Employee Program H Other - Inpatient (Part B Only) I Other Line A Primary Payer Line B Secondary Payer Line C Tertiary Payer
51. Health Plan ID	8 digits	Required Enter the provider's Health Plan ID for each payer name. Enter the eight digit Colorado Medical Assistance Program provider number assigned to the **billing provider**. Payment is made to the enrolled provider or agency that is assigned this number.
52. Release of Information		Not required Submitted information is not entered into the claim processing system.
53. Assignment of Benefits		Not required Submitted information is not entered into the claim processing system.
54. Prior Payments	Up to 9 digits	Conditional Complete when there are Medicare or third party payments. Enter third party and/or Medicare payments.

Form Locator and Label	Completion Format	Instructions
55. Estimated Amount Due	Up to 9 digits	Conditional Complete when there are Medicare or third party payments. Enter the net amount due from The Colorado Medical Assistance Program after provider has received other third party, Medicare or patient liability amount. **Medicare Crossovers** Enter the sum of the Medicare coinsurance plus Medicare deductible less third party payments and patient payments.
56. National Provider Identifier (NPI)	10 digits	Optional Enter the billing provider's 10-digit National Provider Identifier (NPI).
57. Other Provider ID		Not required Submitted information is not entered into the claim processing system.
58. Insured's Name	Up to 30 characters	Required Enter the client's name on the Colorado Medical Assistance Program line. **Other Insurance/Medicare** Complete additional lines when there is third party coverage. Enter the policyholder's last name, first name, and middle initial.
60. Insured's Unique ID	Up to 20 characters	Required Enter the insured's unique identification number assigned by the payer organization exactly as it appears on the health insurance card. Include letter prefixes or suffixes shown on the card.
61. Insurance Group Name	14 letters	Conditional Complete when there is third party coverage. Enter the name of the group or plan providing the insurance to the insured exactly as it appears on the health insurance card.
62. Insurance Group Number	17 digits	Conditional Complete when there is third party coverage. Enter the identification number, control number, or code assigned by the carrier or fund administrator identifying the group under which the individual is carried.

Form Locator and Label	Completion Format	Instructions
63. Treatment Authorization Code	Up to 18 characters	Conditional Complete when the service requires a PAR. Enter the authorization number in this FL if a PAR is required and has been approved for services.
64. Document Control Number		Not required Submitted information is not entered into the claim processing system.
65. Employer Name	Text	Conditional Complete when there is third party coverage. Enter the name of the employer that provides health care coverage for the individual identified in FL 58 (Insured Name).
66. Diagnosis Version Qualifier		Not required Submitted information is not entered into the claim processing system.
67. Principal Diagnosis Code	Up to 6 digits	Required Enter the exact diagnosis code describing the principal diagnosis that exists at the time of admission or develops subsequently and affects the length of stay. Do not add extra zeros to the diagnosis code.
67A- 67Q. Other Diagnosis	Up to 6 digits	Conditional Enter the exact diagnosis code corresponding to additional conditions that co-exist at the time of admission or develop subsequently and which effect the treatment received or the length of stay. Do not add extra zeros to the diagnosis code.
69. Admitting Diagnosis Code	Up to 6 digits	Optional Enter the diagnosis code as stated by the physician at the time of admission.
70. Patient Reason Diagnosis		Not required Submitted information is not entered into the claim processing system.
71. PPS Code		Not required Submitted information is not entered into the claim processing system.
72. External Cause of Injury Code (E-code)	Up to 6 digits	Optional Enter the diagnosis code for the external cause of an injury, poisoning, or adverse effect. This code must begin with an "E".

Form Locator and Label	Completion Format	Instructions
74. Principal Procedure Code/ Date	Up to 7 characters or Up to 6 digits	Conditional Enter the procedure code for the principal procedure performed during this billing period and the date on which procedure was performed. Enter the date using MMDDYY format. Apply the following criteria to determine the principle procedure: The principal procedure is not performed for diagnostic or exploratory purposes. This code is related to definitive treatment; and The principal procedure is most related to the primary diagnosis.
74A. Other Procedure Code/Date	Up to 7 characters or Up to 6 digits	Conditional Complete when there are additional significant procedure codes. Enter the procedure codes identifying all significant procedures other than the principle procedure and the dates on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principle diagnosis. Enter the date using MMDDYY format.
76. Attending **NPI – Conditional** **QUAL - Conditional** **ID - (Colorado Medical Assistance Provider #) – Required** **Attending- Last/ First Name**	NPI - 10 digits QUAL – Text Medicaid ID - 8 digits Text	Colorado Medical Assistance Program ID Required NPI - Enter the 10-digit NPI and eight-digit Colorado Medical Assistance Program provider number assigned to the physician having primary responsibility for the patient's medical care and treatment. This number is obtained from the physician, and <u>cannot</u> be a clinic or group number. (If the attending physician is not enrolled in the Colorado Medical Assistance Program or if the client leaves the ER before being seen by a physician, the hospital may enter their individual numbers.) Hospitals may enter the client's regular physician's 10-digit NPI and Medical Assistance Program provider ID in the Attending Physician ID form locator if the locum tenens physician is not enrolled in the Colorado Medical Assistance Program. QUAL – Enter "1D " for Medicaid Enter the attending physician's last and first name. This form locator must be completed for all services.

Form Locator and Label	Completion Format	Instructions
77. Operating-NPI/QUAL/ID		Not required Submitted information is not entered into the claim processing system.
78-79. Other ID **NPI – Conditional** **QUAL - Conditional** **ID - (Colorado Medical Assistance Provider #) – Conditional**	NPI - 10 digits QUAL – Text Medicaid ID - 8 digits	Conditional – Colorado Medical Assistance Program ID (see below) Complete when attending physician is not the PCP or to identify additional physicians. NPI - Enter up to two 10-digit NPI and eight digit physician Colorado Medical Assistance Program provider numbers, when applicable. This form locator identifies physicians other than the attending physician. If the attending physician is not the PCP or if a clinic is a PCP agent, enter the PCP eight digit Colorado Medical Assistance Program provider number as the referring physician. The name of the Colorado Medical Assistance Program client's PCP appears on the eligibility verification. Review either for eligibility and PCP. The Colorado Medical Assistance Program does not require that the PCP number appear more than once on each claim submitted. The attending physician's last and first name are optional.
80. Remarks	Text	Optional Enter specific additional information necessary to process the claim or fulfill reporting requirements.
81. Code-Code QUAL/CODE/VALUE (a-d)		Optional Submitted information is not entered into the claim processing system.

Institutional Provider Certification

This is to certify that the foregoing information is true, accurate and complete.

This is to certify that I understand that payment of this claim will be from Federal and State funds and that any falsification, or concealment of material fact, may be prosecuted under Federal and State Laws.

Signature:_____

Date:_____

This document is an addendum to the UB-04 claim form and is required per 42 C.F.R. 445.18 (a) (1-2) to be attached to paper claims submitted on the UB-04.

Colorado 1500 Speech Therapy 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
2. CLIENT DATE OF BIRTH: 01/04/2004
3. MEDICAID ID NUMBER (CLIENT ID NUMBER): Y123456
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:
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
POLICYHOLDER NAME:
GROUP:
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. 31531 Developmental speech-language delay
2. 78460 Organic speceh-language disorder
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
10/01/2012	10/01/2012	11	92506	GN	12345678	98765432	1			$31.60	1		☐	☐	☒
10/01/2012	10/01/2012	11	92507	GN	12345678	98765432	2			$58.00	1		☐	☐	☒
													☐	☐	☐
													☐	☐	☐
													☐	☐	☐
													☐	☐	☐

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 $89.60
LESS
MEDICARE SPR DATE
27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE
30. REMARKS
21. MEDICARE PAID
24. MEDICARE DEDUCTIBLE $.00
28. BILLING PROVIDER NAME: ABC Clinic
22. THIRD PARTY PAID $.00
25. MEDICARE COINSURANCE $.00
29. BILLING PROVIDER NUMBER: 00112233
23. NET CHARGE $89.60
26. MEDICARE DISALLOWED

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

COLORADO 1500

UB-04 Outpatient Speech Therapy Claim Example

1 ABC Hospital
123 First St
Anytown, CO 80000
303-333-3333

2

3a PAT. CNTL. #
b. MED. REC. #

4 TYPE OF BILL: 131

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM: 08/01/12 THROUGH: 08/02/12

7

8 PATIENT NAME a: Client, Ima D
b:

9 PATIENT ADDRESS a: 123 Main St
b: Anytown c: CO d: 80000 e:

10 BIRTHDATE: 04/16/1950
11 SEX: F
12 ADMISSION DATE
13 HR
14 TYPE: 3
15 SRC: 3
16 DHR
17 STAT
18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES
29 ACDT STATE
30

	31 OCCURRENCE CODE	31 OCCURRENCE DATE	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a	40	08/01/12													
b															

38

	39 VALUE CODES CODE	39 VALUE CODES AMOUNT	40 VALUE CODES CODE	40 VALUE CODES AMOUNT	41 VALUE CODES CODE	41 VALUE CODES AMOUNT
a						
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	440	Speech Therapy	92507	08/01/12	1	21 64		
2	440	Speech Therapy	92507	08/02/12	1	21 64		
3								
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23		PAGE 1 OF 1	CREATION DATE		TOTALS	43 28		

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A	Medicaid	12345678					57 OTHER PRV ID	
B								
C								

	58 INSURED'S NAME	59 P. REL.	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Client, Ima D		A123456		
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			
B			
C			

66 DX: 434.91 A B C D E F G H I J K L M N O P Q 68

69 ADMIT DX
70 PATIENT REASON DX a b c
71 PPS CODE
72 ECI a b c
73

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE
75

76 ATTENDING NPI 1234567890 QUAL 87654321
LAST Therapist FIRST Amy
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS

81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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	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 of the Appendices in the Provider Services Billing Manuals section) 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 SPR/ERA. Maintain the original 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 SPR/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.

Billing Instruction Detail	Instructions
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. 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.

Speech Therapy Revisions Log

Revision Date	Additions/Changes	Pages	Made by
10/01/2012	*Stand-alone Speech Therapy Billing Manual created(separated from Physical/Occupational Therapy Manual*	*All*	*MJB*
10/01/2012	*Updated Global information such as Electronic Claim Submission and LBOD*	*3* *54*	*VR*
10/05/2012	*Formatted document.* *Added TOC* *Added CO-1500 and UB-04 claim examples.*	*All* *1* *42-43*	*cc*
10/05/2012	*Reformatted manual* *Added claim examples* *Added TOC*	*All* *41 & 42* *i*	*jg*
10/22/2012	*Replaced UB-04 claim example*	*42*	*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.