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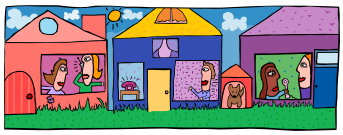
Home and Community Based Services (HCBS)

General Information



Medicaid is a health care program for low income Coloradans. Applicants must meet eligibility criteria for one of the Medicaid Program categories in order to qualify for benefits. Major program categories include:

- Aid to Families with Dependent Children/Medicaid Only
- Aid to the Needy Disabled
- Baby Care/Kids Care
- Colorado Works/TANF (Temporary Assistance for Needy Families)
- Aid to the Blind
- Old Age Pension

Waiver programs provide additional Medicaid benefits to specific populations who meet special eligibility criteria.

Level of care determinations are made annually by the case management agencies (aka Single Entry Points). Clients must meet financial, medical, and program criteria to access services under a waiver. The applicant must be at risk of placement in a nursing facility, hospital, or ICF/MR (intermediate care facility for the mentally retarded). To utilize waiver benefits, clients must be willing to receive services in their homes or communities. A client who receives services through a waiver is also eligible for all basic Medicaid covered services except nursing facility and long-term hospital care. When a client chooses to receive services under a waiver, the services must be provided by certified Medicaid providers or by a Medicaid contracting managed care organization (MCO).

Each waiver has an enrollment limit. Applicants may apply for more than one waiver, but may only receive services through one waiver at a time.

Prior Authorization Requests (PARs) and/or Cost Containment

Unless otherwise noted, all HCBS services require prior approval before they can be reimbursed by the Colorado Medical Assistance Program. Case management agencies/single entry points complete the Prior Approval and/or Cost Containment requests for their specific programs according to instructions published in the regulations for the Department of Health Care Policy and Financing (the Department). All HCBS-Developmental Disability (DD), services must be prior authorized by the Division for Developmental Disabilities (DDD). The telephone numbers are listed in Appendix A of the Appendices in the Provider Services Billing Manuals section.

DDD transmits electronic PAR information to the Medicaid Management Information System (MMIS) for the Comprehensive Services waiver, the Supported Living Services waiver, the Children's Extensive Support waiver, and Targeted Case Management authorizations.

For the Home and Community Based Services Brain Injury (HCBS-BI) waiver, the following services must be submitted by the case management agency (CMA)/single entry point (SEP) and approved by the Brain Injury Waiver Coordinator with the Department of Health Care Policy and Financing:

- Mental Health Counseling (more than 30 cumulative visits)
- Respite Care (Nursing Facility)
- Substance Abuse Counseling (more than 30 cumulative visits)
- Assistive Technology above and beyond medication reminders
- All services above cost containment

Providers may contact the CMA/SEP for the status of the PAR or inquire electronically through the Colorado Medical Assistance Program Web Portal.

The CMAs/SEPs responsibilities include, but not limited to:

- Informing clients and/or legal guardian of the eligibility process.
- Submitting a copy of the approved Enrollment Form to the County department of human/social services for a Colorado Medical Assistance Program client identification number.
- Developing the appropriate Prior Approval and/or Cost Containment Record Form of services and projected costs for approval.
- Submitting a copy of the Prior Authorization and/or Cost Containment document to the authorizing agent. A list of authorizing agents can be found by referring to Appendix D of the Appendices in the Provider Services Billing Manuals section.
- Assessing the client's health and social needs.
- Arranging for face-to-face contact with the client within 30 calendar days of receipt of the referral.
- Monitoring and evaluating services.
- Reassessing each client.
- Demonstrating continued cost effectiveness whenever services increase or decrease.

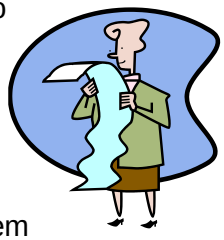
Approval of prior authorization does not guarantee Colorado Medical Assistance Program payment and does not serve as a timely filing waiver. Prior authorization only assures that the approved service is a medical necessity and is considered a benefit of the Colorado Medical Assistance Program. All claims,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

Prior approvals must be completed thoroughly and accurately. If an error is noted on an approved request, it should be brought to the attention of the client's case manager for corrections. Procedure codes, quantities, etc., may be changed or entered by the client's case manager.

The authorizing agent or case management agency/single entry point is responsible for timely submission and distribution of copies of approvals to agencies and providers contracted to provide services.

Procedure/HCPCS Codes Overview

The Department develops procedure codes that are approved by the Centers for Medicare & Medicaid Services (CMS). The codes are used to submit claims for services provided to Colorado Medical Assistance Program clients. The procedure codes represent services that may be provided by enrolled certified Colorado Medical Assistance Program providers.



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 (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA).

The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes. These include ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DME/Supplies) 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. CPT codes are identified using 5 numeric digits.

Claim Submission

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

For more detailed Colorado 1500 billing instructions, please refer to the Colorado 1500 General Billing Information manual in the Provider Services Billing Manuals section.

Electronic Claims

Instructions for completing and submitting electronic claims are available through the 837 Professional (837P) Web Portal User guide via the Web Portal and also on the Department's Colorado Medical Assistance Program Web Portal page.

Electronically mandated claims submitted on paper are processed, denied, and marked with the message "Electronic Filing Required."

The Special Program Indicator (SPI) must be completed on claims submitted electronically. Claims submitted electronically and on paper are identified by using the specific national modifiers along with the procedure code. The appropriate procedure codes and modifiers for each HCBS waiver are noted throughout this manual. When the services are approved, the claim may be submitted to the Department's fiscal agent. For more detailed billing instructions, please refer to the Colorado 1500 General Billing Information in the Provider Services Billing Manuals section.

Home and Community Based Services for People with Brain Injury (HCBS-BI)

The Home and Community Based Services Brain Injury (HCBS-BI) waiver program provides a variety of services to qualified clients with brain injury as an alternative to inpatient hospital and rehabilitation facility placement. Clients meeting program eligibility requirements are certified as medically eligible for HCBS-BI by the case manager.

HCBS-BI Procedure Code Table

Providers may bill the following procedure codes for HCBS-BI services:

HCBS-BI Procedure Code Table (Special Program Code 89)			
Description	**Procedure Code + Modifier(s)**		**Units**
Adult Day Care	S5102	U6	1 unit = 1 day
Day Treatment	H2018	U6	1 unit = 1 day
Respite Care			
Description	**Procedure Code + Modifier(s)**		**Units**
Residential	S5150	U6	1 unit = 15 minutes
Institutional	H0045	U6	1 unit = 1 day
Substance Abuse Counseling			
Description	**Procedure Code + Modifier(s)**		**Units**
Individual	H0047	U6, HF	1 unit = 1 hour
Group	H0047	U6, HQ	1 unit = 1 hour
Family	T1006	U6	1 unit = 1 hour
Mental Health Services			
Description	**Procedure Code + Modifier(s)**		**Units**
Individual	H0004	U6	1 unit = 15 minutes
Group	H0004	U6, HQ	1 unit = 15 minutes
Family	H0004	U6, HR	1 unit = 15 minutes
Supported Living Program	T2033	U6	1 unit = 1 day
Behavioral Education Behavioral Management	H0025	U6	1 unit = 30 minutes
Independent Living Skills Trng	T2013	U6	1 unit = 1 hour

HCBS-BI Procedure Code Table (Special Program Code 89)			
Mental Health Services			
Description	**Procedure Code + Modifier(s)**		**Units**
Assistive Technology	T2029	U6	Negotiated by case manager through prior authorization
Non-Medical Transportation	T2001	U6	1 unit = 1 one way trip
Non-Medical Transportation – to and from adult day program	T2001	U6, HB	1 unit = one way trip
Non-Medical Transportation Taxi	A0100	U6	1 unit=one way trip
Non-Medical Transportation Taxi- to and from adult day	A0100	U6, HB	1 unit=one way trip
Non-Medical Transportation - Mobility Van	A0120	U6	1 unit=one way trip
Non-Medical Transportation - Mobility Van-to and from adult day	A0120	U6, HB	1 unit=one way trip
Non-Medical Transportation – Wheelchair Van	A0130	U6	1 unit=one way trip
Non-Medical Transportation – Wheelchair Van-to and from adult day	A0130	U6, HB	1 unit=one way trip
Non-Medical Transportation – Wheelchair Van Mileage	A0425	U6	1 unit= 1 mile
Non-Medical Transportation – Wheelchair Van Mileage-to and from adult day	A0425	U6, HB	1 unit= 1 mile
Home Modifications	S5165	U6	1 unit = per service
Personal Care	T1019	U6	1 unit = 15 minutes
Relative Personal Care	T1019	U6, HR	1 unit = 15 minutes
Transitional Living	T2016	U6	1 unit = 1 day
Electronic Monitoring			
Description	**Procedure Code + Modifier(s)**		**Units**
Purchase/Installation	S5160	U6	Negotiated by case manager through prior authorization.
One Month of Service	S5161	U6	Negotiated by case manager through prior authorization.

HCBS- BI Paper Claim Reference Table

The following paper form reference table gives required and/or conditional fields for the paper Colorado 1500 claim form for HCBS-BI claims:

Field Label	Special Instructions
Special Program Code	Required Code 89 identifies the HCBS-BI program.
1. Client Name	Required
2. Client Date of Birth	Required
3. Colorado Medical Assistance Program ID Number (Client ID Number)	Required
4. Client Sex	Required
18. ICD-9-CM	Required
19A. Date of Service	Required
19B. Place of Service	Required Enter place of service code **11**-Office or **12 -**Patient's residence.
19C. Procedure Code (HCPCS code) **MOD**	Required Refer to the BI procedure code table.
19F. Diagnosis	Required
19G. Charges	Required
19H. Days or Units	Required
20. Total Charges	Required
23 Net Charge	Required
27. Signature	Required
28. Billing Provider Name	Required
29. Billing Provider Number	Required

HCBS-BI Claim Example

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND FINANCING

INVOICE/PAT ACCT NUMBER: SMI00124

SPECIAL PROGRAM CODE: 89

HEALTH INSURANCE CLAIM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL): Smith, Jane
2. CLIENT DATE OF BIRTH: 05 13 1972
3. MEDICAID ID NUMBER (CLIENT ID NUMBER): A657321
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)
   TELEPHONE NUMBER
5. CLIENT SEX: MALE [ ] [X] 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
9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)
   TELEPHONE NUMBER
10. WAS CONDITION RELATED TO:
   A. CLIENT EMPLOYMENT YES [ ]
   B. ACCIDENT AUTO [ ] OTHER [ ]
   C. DATE OF ACCIDENT
11. CHAMPUS SPONSORS SERVICE/SSN
12. PREGNANCY [ ] NURSING FACILITY RESIDENT [ ]

PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF: ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR FIRST PREGNANCY(LMP)
14. MEDICARE DENIAL: 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 RENDERED (IF OTHER THAN HOME OR OFFICE) — PROVIDER NUMBER
17A. CHECK BOX IF LABORATORY WORK PERFORMED OUSIDE 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. 319
   2.
   3.
   4.
TRANSPORTATION CERTIFICATION ATTACHED YES [ ]
DURABLE MEDICAL EQUIPMENT: Line No Make Model Serial Number
PRIOR AUTHORIZATION NO.:

19 A. DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. PROCEDURE CODE (HCPCS)	MOD	D. RENDERING PROVIDER NO.	E. REFERRING PROVIDER NO.	F. DIAGNOSIS P	S	T	G. CHARGES	H. DAYS OR UNITS	I. CO PAY	J. EMERG-ENCY	K. FAMILY PLAM-NING	L. EPSDT
04 01 08	04 30 08	12	S 5 1 0 2	U6			1			630 00	15				

20,-. TOTAL CHARGES → 630 00

LESS ↓ MEDICARE EOMB DATE

21. MEDICARE PAID
22. THIRD PARTY PAID
23. NET CHARGE: 630 00
24. MEDICARE DEDUCTIBLE
25. MEDICARE COINSURANCE
26. MEDICARE DISALLOWED

27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE: *Authorized Signature MM/DD/YY*
28. BILLING PROVIDER NAME: HCBS-BI Provider
29. BILLING PROVIDER NUMBER: 12345678
30. REMARKS

COL-101

COLORADO 1500

Children's Home and Community Based Services (CHCBS)

The Children's Home and Community Based Services (CHCBS) waiver program is for disabled children who are at risk of institutionalization in a hospital or nursing facility. These children would not otherwise qualify for Colorado Medical Assistance due to parental income and/or resources. All state plan Colorado Medical Assistance benefits and case management are provided to children birth through age 17. The children must meet the established minimum criteria for hospital or nursing facility level of care. Clients meeting program eligibility requirements are certified as medically eligible for CHCBS by the case manager.

CHCBS Procedure Code Table

Providers may bill the following procedure codes for HCBS-CHCBS services:

HCBS-CHCBS Procedure Code Table (Special Program Code 88)			
Case Management (HCBS – CM)			
Description	**Procedure Code + Modifier(s)**		**Units**
Case Management	T1016	U5	1 unit = 15 minutes

In-Home Support Services (IHSS)

IHSS is limited to health maintenance activities, which include support for activities of daily living or instrumental activities of daily living. Additionally, IHSS providers must provide core independent living skills.

HCBS-CHCBS Procedure Code Table (Special Program Code 88)			
In-Home Support (HCBS-IHSS)			
Description	**Procedure Code + Modifier(s)**		**Units**
Health Maintenance Activities	H0038	U5	1 unit = 15 minutes

CHCBS Paper Claim Reference Table

The following paper form reference table gives required and/or conditional fields for the paper Colorado 1500 claim form for HCBS-CHCBS claims:

Field Label	Special Instructions
Special Program Code	Required Special Program Code 88 identifies the CHCBS program.
1. Client Name	Required

Field Label	Special Instructions
2. Client Date of Birth	Required
3. Colorado Medical Assistance Program ID Number (Client ID Number)	Required
4. Client Sex	Required
18. ICD-9-CM	Required
19A. Date of Service	Required
19B. Place of Service	Required Enter place of service code **11**-Office or **12**-Patient's residence.
19C. Procedure Code (HCPCS code) **MOD**	Required Refer to the CHCBS procedure code table.
19F. Diagnosis	Required
19G. Charges	Required
19H. Days or Units	Required
20. Total Charges	Required
23. Net Charge	Required
27. Signature	Required
28. Billing Provider Name	Required
29. Billing Provider Number	Required

CHCBS Claim Example

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND FINANCING

INVOICE/PAT ACCT NUMBER: SMI00124
SPECIAL PROGRAM CODE: 88

HEALTH INSURANCE CLAIM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL): Smith, Jane
2. CLIENT DATE OF BIRTH: 05 13 1991
3. MEDICAID ID NUMBER (CLIENT ID NUMBER): A111111
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NUMBER
5. CLIENT SEX: MALE [ ] [X] 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
9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NUMBER
10. WAS CONDITION RELATED TO:
A. CLIENT EMPLOYMENT YES [ ]
B. ACCIDENT AUTO [ ] OTHER [ ]
C. DATE OF ACCIDENT
11. CHAMPUS SPONSORS SERVICE/SSN
12. PREGNANCY [ ] NURSING FACILITY RESIDENT [ ]

PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF:
ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR FIRST PREGNANCY(LMP)
14. MEDICARE DENIAL: 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 RENDERED (IF OTHER THAN HOME OR OFFICE)
PROVIDER NUMBER
17A. CHECK BOX IF LABORATORY WORK PERFORMED OUSIDE 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. 7 9 9 9
2.
3.
4.
TRANSPORTATION CERTIFICATION ATTACHED YES [ ]
DURABLE MEDICAL EQUIPMENT
Line No Make Model Serial Number
PRIOR AUTHORIZATION NO.:

19 A. DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. PROCEDURE CODE (HCPCS)	MOD	D. RENDERING PROVIDER NO.	E. REFERRING PROVIDER NO.	F. DIAGNOSIS P	S	T	G. CHARGES	H. DAYS OR UNITS	I. CO PAY	J. EMERG-ENCY	K. FAMILY PLAM-NING	L. EPSDT
04 05 08	04 26 08	12	T 1 0 1 6	U5			1			30 00	4				

20,-. TOTAL CHARGES 30 00
LESS
MEDICARE EOMB DATE

27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE
Authorized Signature M M /DD/YY
28. BILLING PROVIDER NAME
Childen's Health Management Agency
29. BILLING PROVIDER NUMBER
04444444
30. REMARKS
21. MEDICARE PAID
22. THIRD PARTY PAID
23. NET CHARGE 30 00
24. MEDICARE DEDUCTIBLE
25. MEDICARE COINSURANCE
26. MEDICARE DISALLOWED

COL-101

COLORADO 1500

Home and Community Based Services for Children with Autism (HCBS-CWA)

The Home and Community Based Services for Children with Autism (HCBS-CWA) waiver program is for children from birth to age six (6) with a medical diagnosis of Autism. The children must meet the institutional level of care for an Intermediate Care Facility for the Mentally Retarded (ICF/MR). Level of care determinations are made annually by the case management agency/single entry point. Eligible children qualify for behavioral therapies provided through the waiver as well as for all state plan Colorado Medical Assistance benefits.

HCBS-CWA Procedure Code Table

Providers may bill the following procedure codes for HCBS-CWA services:

HCBS-CWA Procedure Code Table (Special Program Code 96)			
Description	**Procedure Code + Modifier(s)**		**Units**
Behavioral Therapies, Lead Therapist	H0004	UL	1 unit = 15 minutes
Behavioral Therapies, Senior Therapist	H0004	UL, 52	1 unit = 15 minutes
Behavioral Therapies, Line Staff	H2019	UL	1 unit = 15 minutes

HCBS- CWA Paper Claim Reference Table

The following paper form reference table describes required fields for the paper Colorado 1500 claim form for HCBS-CWA claims:

Field Label	Special Instructions
Special Program Code	Required Special Program Code 96 identifies the HCBS-CWA waiver.
1. Client Name	Required
2. Client Date of Birth	Required
3. Colorado Medical Assistance Program ID Number (Client ID Number)	Required
5. Client Sex	Required
18. ICD-9-CM	Required, must be 299.00

Field Label	Special Instructions
19A. Date of Service	Required
19B. Place of Service	Required Enter place of service code **12**-Patient's residence.
19C. Procedure Code (HCPCS code) **MOD**	Required Refer to the CWA procedure code table.
19F. Diagnosis	Required
19G. Charges	Required
19H. Days or Units	Required
20. Total Charges	Required
23. Net Charge	Required
27. Signature	Required
28. Billing Provider Name	Required
29. Billing Provider Number	Required

HCBS-CWA Claim Example

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND FINANCING

INVOICE/PAT ACCT NUMBER: SMI00124
SPECIAL PROGRAM CODE: 96

HEALTH INSURANCE CLAIM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL): Brown, Anna
2. CLIENT DATE OF BIRTH: 01 06 1995
3. MEDICAID ID NUMBER (CLIENT ID NUMBER): A222222
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)
   TELEPHONE NUMBER
5. CLIENT SEX: MALE [ ] [X] 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
9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)
   TELEPHONE NUMBER
10. WAS CONDITION RELATED TO:
   A. CLIENT EMPLOYMENT YES [ ]
   B. ACCIDENT AUTO [ ] OTHER [ ]
   C. DATE OF ACCIDENT
11. CHAMPUS SPONSORS SERVICE/SSN
12. PREGNANCY [ ] NURSING FACILITY RESIDENT [ ]

PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF:
ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR FIRST PREGNANCY(LMP)
14. MEDICARE DENIAL: 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 RENDERED (IF OTHER THAN HOME OR OFFICE)
PROVIDER NUMBER
17A. CHECK BOX IF LABORATORY WORK PERFORMED OUSIDE 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 9 9
2.
3.
4.
TRANSPORTATION CERTIFICATION ATTACHED [ ] YES
DURABLE MEDICAL EQUIPMENT
Line No Make Model Serial Number
PRIOR AUTHORIZATION NO.:

19 A. DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. PROCEDURE CODE (HCPCS)	MOD	D. RENDERING PROVIDER NO.	E. REFERRING PROVIDER NO.	F. DIAGNOSIS P	S	T	G. CHARGES	H. DAYS OR UNITS	I. CO PAY	J. EMERGENCY	K. FAMILY PLANNING	L. EPSDT
04 05 08	04 26 08	12	H 0 0 0 4	UL			1			87 00	4				

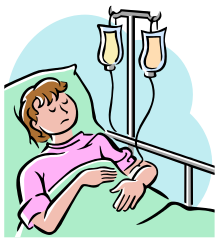
20.-. TOTAL CHARGES → 87 00
LESS
MEDICARE EOMB DATE

27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE
Authorized Signature MM/DD/YY
28. BILLING PROVIDER NAME
Childen's Health Management Agency
29. BILLING PROVIDER NUMBER
04444444
30. REMARKS
21. MEDICARE PAID
22. THIRD PARTY PAID
23. NET CHARGE 87 00
24. MEDICARE DEDUCTIBLE
25. MEDICARE COINSURANCE
26. MEDICARE DISALLOWED

COL-101

COLORADO 1500

Home and Community Based Services for Pediatric Hospice Waiver (PHW)



The Home and Community Based Services for Pediatric Hospice Waiver (PHW) program is for children from birth to age 19 with a medical diagnosis of a life-limiting illness who meet the institutional level of care for inpatient hospitalization. Level of care determinations are made annually by the single entry point/case management agencies. Eligible children qualify for respite care, counseling, expressive therapies, and/or palliative/supportive care provided through the waiver as well as all state plan Colorado Medical Assistance benefits, including curative care. There is no requirement for a six-month terminal prognosis.

HCBS-PHW Procedure Code Table

Providers may bill the following procedure codes for HCBS-PHW services**:**

HCBS-PHW Procedure Code Table (Special Program Code 97)				
Description	**Procedure Code + Modifiers(s)**		**Place of Service**	**Units**
Expressive Therapy	G0176	UD	03 - School 11 - Office 12 - Home	1 unit = 1 hour
Individual Counseling	H0004	UD	03 - School 11 - Office 12 - Home	1 unit = 15 minutes
Family Counseling	H0004	UD, HR	03 - School 11 - Office 12 - Home	1 unit = 15 minutes
Group Counseling	H0004	UD, HQ	03 - School 11 - Office 12 - Home	1 unit = 15 minutes
Respite Care Unskilled, In Home	S5150	UD	12 - Home	1 unit = 15 minutes
Respite Care Unskilled, ACF	S5151	UD	12 - Home	1 unit = 1 day

HCBS-PHW Procedure Code Table (Special Program Code 97)				
Description	**Procedure Code + Modifiers(s)**		**Place of Service**	**Units**
Respite Care Skilled RN/LPN	S9125	UD	12 - Home 34 - Hospice	1 unit = 1 day
Palliative/Supportive Care Skilled RN/LPN	S9126	UD	03 - School 12 - Home	1 unit = 1 day
Respite Care Skilled RN/LPN	T1005	UD	12 - Home 34 - Hospice	1 unit = 15 minutes
Palliative/Supportive Care Skilled RN/LPN	T2043	UD	03 - School 12 - Home	1 unit = 1 hour

Service Limitations

Reimbursement for HCBS-PHW counseling services (H0004 with any “UD” modifier) shall be limited to 98 hours per 365 days. Reimbursement for HCBS-PHW respite care services (T1005, S9125, S5150 and S5151) shall be limited to 30 days (unique dates of service) per 365 days. Reimbursement for HCBS-PHW respite care services (T1005, S9125, S5150 and S5151) shall not be duplicated on the same date of service as state plan Home Health or Palliative/Supportive Care services (T2043 and S9126) and shall be denied.

HCBS- PHW Paper Claim Reference Table

The following paper form reference table describes required fields for the paper Colorado 1500 claim form for HCBS-PHW claims:

Field Label	Special Instructions
Special Program Code	Required Special Program Code 97 identifies the HCBS-PHW waiver.
1. Client Name	Required
2. Client Date of Birth	Required
3. Colorado Medical Assistance Program ID Number (Client ID Number)	Required
5. Client Sex	Required
18. ICD-9-CM	Required
19A. Date of Service	Required

Field Label	Special Instructions
19B. Place of Service	Required Enter place of service code **03** - School, **11** - Office, **12** - Patient's Residence or **34** – Hospice.
19C. Procedure Code (HCPCS code) **MOD**	Required Refer to the PHW procedure code table.
19F. Diagnosis	Required
19G. Charges	Required
19H. Days or Units	Required
20. Total Charges	Required
23. Net Charge	Required
27. Signature	Required
28. Billing Provider Name	Required
29. Billing Provider Number	Required

HCBS-PHW Claim Example

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND FINANCING

INVOICE/PAT ACCT NUMBER: SMI00124
SPECIAL PROGRAM CODE: 97

HEALTH INSURANCE CLAIM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL): Brown, Anna
2. CLIENT DATE OF BIRTH: 01 06 1995
3. MEDICAID ID NUMBER (CLIENT ID NUMBER): A333333
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NUMBER
5. CLIENT SEX: MALE [ ] [X] 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
9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NUMBER
10. WAS CONDITION RELATED TO:
A. CLIENT EMPLOYMENT YES [ ]
B. ACCIDENT AUTO [ ] OTHER [ ]
C. DATE OF ACCIDENT
11. CHAMPUS SPONSORS SERVICE/SSN
12. PREGNANCY [ ] NURSING FACILITY RESIDENT [ ]

PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF:
ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR FIRST PREGNANCY(LMP)
14. MEDICARE DENIAL: 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 RENDERED (IF OTHER THAN HOME OR OFFICE)
PROVIDER NUMBER
17A. CHECK BOX IF LABORATORY WORK PERFORMED OUSIDE 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 9 9
2.
3.
4.
TRANSPORTATION CERTIFICATION ATTACHED [ ] YES
DURABLE MEDICAL EQUIPMENT
Line No Make Model Serial Number
PRIOR AUTHORIZATION NO.:

19 A. DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. PROCEDURE CODE (HCPCS)	MOD	D. RENDERING PROVIDER NO.	E. REFERRING PROVIDER NO.	F. DIAGNOSIS P S T	G. CHARGES	H. DAYS OR UNITS	I. CO PAY	J. EMERG-ENCY	K. FAMILY PLAN-NING	L. EPSDT
04 05 08	04 26 08	12	H0004	UD			1	87 00	4				

20. TOTAL CHARGES 87 00
LESS
MEDICARE EOMB DATE

27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE
Authorized Signature MM/DD/YY
28. BILLING PROVIDER NAME
Childen's Health Management Agency
29. BILLING PROVIDER NUMBER
04444444
30. REMARKS
21. MEDICARE PAID
22. THIRD PARTY PAID
23. NET CHARGE 87 00
24. MEDICARE DEDUCTIBLE
25. MEDICARE COINSURANCE
26. MEDICARE DISALLOWED

COL-101

COLORADO 1500

Home and Community Based Services for the Developmentally Disabled (HCBS-DD) Programs

The Home and Community Based Services (HCBS) program provides Colorado Medical Assistance Program benefits to clients for certain services in their homes as an alternative to institutional care. HCBS-DD programs include:

- Comprehensive Services Waiver (HCBS-DD)
- Supported Living Services (SLS)
- Children's Extensive Support (CES)
- Children's Habilitation Residential Program (CHRP)
- Targeted Case Management (TCM) – State Plan Benefit

Comprehensive Services (HCBS-DD)

The Comprehensive Services waiver provides persons with developmental disabilities services and support outside the home allowing them to continue to live in the community. Services include:

- Residential Habilitation
- Day Habilitation Services and Supports (includes Specialized Habilitation and Supported Community Connection)
- Supported Employment Services
- Transportation Services
- Behavioral Services
- Specialized Medical Equipment and Supplies
- Dental Services
- Vision Services

Supported Living Services (SLS)

The Supported Living Services (SLS) waiver provides services and support to assist persons with developmental disabilities to live in the person's own home, apartment, family home, or rental unit that qualifies as an SLS setting. Services include:

- Personal Care
- Respite
- Homemaker
  - Basic
  - Enhanced
- Mentorship
- Day habilitation Services
  - Specialized Habilitation
  - Supported Community Connections
- Professional services
  - Hippotherapy
  - Movement Therapy
  - Massage
- Personal Emergency Response System (PERS)
- Home Accessibility Adaptations
- Vehicle Modifications
- Assistive Technology
- Dental Services

- Supported Employment Services
- Non-Medical Transportation
- Behavioral Services
- Vision Services
- Specialized Medical Equipment and Supplies

Children's Extensive Support (CES)

The Children's Extensive Support (CES) Waiver is for children ages birth to 18 with developmental disabilities *or* for children ages four (4) and under who are at risk of a developmental delay. Services include:

- Personal Care
- Respite
- Homemaker
  - Basic
  - Enhanced
- Community Connector
- Behavior Services
- Professional Services
  - Hippotherapy
  - Movement Therapy
  - Massage Therapy
- Specialized Medical Equipment and Supplies
- Adaptive Therapeutic Recreational Equipment and Fees
- Home Accessibility Adaptations
- Vehicle Modifications
- Assistive Technology
- Vision Services
- Parent Education

Children's Residential Habilitation Program (CHRP)

CHRP is a residential service and support program for children and youth birth to 22 years of age who are developmentally disabled and meet all of the program eligibility requirements. Placements occur through the Colorado County Departments of Human/Social Services. The children are at risk of institutionalization and CHRP serves as an alternative to placement in Intermediate Care Facilities (ICF/IID).

The following services are provided through CHRP when deemed appropriate and adequate by the child/youth's physician and they are to be provided in the community, as available:

- Self-Advocacy Training
- Independent Living Training
- Cognitive Services
- Communication Services
- Counseling and Therapeutic Services
- Personal Care Services
- Emergency Assistance Training
- Community Connection Training
- Travel Services
- Supervision Services
- Respite Services

Early Intervention Services (EI)

Early Intervention Services provides developmental supports and services to children birth to three (3) years of age who have either a significant developmental delay or a diagnosed condition that has a high probability of resulting in a developmental delay and are determined to be eligible for the program.

Targeted Case Management (TCM) Services are provided through the Community Centered Boards (CCB) for children actively enrolled in Early Intervention Services program and the Colorado Medical Assistance Program.

Targeted Case Management (TCM)

Targeted Case Management is an optional Colorado Medical Assistance Program benefit for clients who have been determined by a CCB to have a developmental disability and are actively enrolled in one of the programs listed below:

- Comprehensive Services Waiver
- Supported Living Services Waiver
- Children's Extensive Support Waiver
- Early Intervention Program

Services include, but are not limited to:

- Locating, coordinating, and monitoring needed developmental disabilities services;
- Coordinating with other non-developmental disabilities funded services to ensure non-duplication of services; and
- Monitoring the effective and efficient provision of services across multiple funding sources.

HCBS-DD Procedure Code Table

Providers may bill the following procedure codes for HCBS-DD services:

HCBS-DD Procedure Code Table (Special Program Code 85)				
Comprehensive Services (HCBS-DD)				
Description	**Proc. Code**	**Modifier(s)**	**Level**	**Unit Designation**
Residential Habilitation				
Group Home	T2016	U3, HQ	Level 1	Day
	T2016	U3, 22, HQ	Level 2	Day
	T2016	U3, TF, HQ	Level 3	Day
	T2016	U3, TF, 22, HQ	Level 4	Day
	T2016	U3, TG, HQ	Level 5	Day
	T2016	U3, TG, 22, HQ	Level 6	Day
	T2016	U3, SC, HQ	Level 7	Day
Personal Care Alternative (PCA)	T2016	U3	Level 1	Day
	T2016	U3, 22	Level 2	Day
	T2016	U3, TF	Level 3	Day
	T2016	U3, TF, 22	Level 4	Day
	T2016	U3, TG	Level 5	Day
	T2016	U3, TG, 22	Level 6	Day
	T2016	U3, SC	Level 7	Day

HCBS-DD Procedure Code Table (Special Program Code 85)				
Comprehensive Services (HCBS-DD)				
Description	**Proc. Code**	**Modifier(s)**	**Level**	**Unit Designation**
Host Home	T2016	U3, TT	Level 1	Day
	T2016	U3, 22, TT	Level 2	Day
	T2016	U3, TF, TT	Level 3	Day
	T2016	U3, TF, 22, TT	Level 4	Day
	T2016	U3, TG, TT	Level 5	Day
	T2016	U3, TG, 22, TT	Level 6	Day
	T2016	U3, SC, TT	Level 7	Day
Day Habilitation Services				
Specialized Habilitation				
Day Habilitation-Facility Based	T2021	U3, HQ	Level 1	15 Minutes
	T2021	U3, 22, HQ	Level 2	15 Minutes
	T2021	U3, TF, HQ	Level 3	15 Minutes
	T2021	U3, TF, 22, HQ	Level 4	15 Minutes
	T2021	U3, TG, HQ	Level 5	15 Minutes
	T2021	U3, TG, 22, HQ	Level 6	15 Minutes
	T2921	U3, SC, HQ	Level 7	15 Minutes
Supported Community Connections				
Day Habilitation-Non-Facility	T2021	U3	Level 1	15 Minutes
	T2021	U3, 22	Level 2	15 Minutes
	T2021	U3, TF	Level 3	15 Minutes
	T2021	U3, TF, 22	Level 4	15 Minutes
	T2021	U3, TG	Level 5	15 Minutes
	T2021	U3, TG, 22	Level 6	15 Minutes
	T2921	U3, SC	Level 7	15 Minutes
Supported Employment				
Group	T2019	U3, HQ	Level 1	15 Minutes
	T2019	U3, 22, HQ	Level 2	15 Minutes
	T2019	U3, TF, HQ	Level 3	15 Minutes
	T2019	U3, TF, 22, HQ	Level 4	15 Minutes
	T2019	U3, TG, HQ	Level 5	15 Minutes
	T2019	U3, TG, 22, HQ	Level 6	15 Minutes
Individual	T2019	U3, SC	Single	15 Minutes
**SE – DVR ***Job Development and Job Placement are available as waiver services only when those services are first denied by the Department of Vocational Rehabilitation (DVR) or those DVR services are not available to the client due to an order of selection.				
*SE Job Development- Group	H2023	U3, HQ	Single	15 Minutes
*SE Job Development- Individual	H2023	U3	Level 1-2	15 Minutes
*SE Job Development- Individual	H2023	U3, 22	Level 3-4	15 Minutes
*SE Job Development- Individual	H2023	U3, TF	Level 5-6	15 Minutes
*SE Job Placement- Group	H2024	U3, HQ	Single	Dollar
*SE Job Placement- Individual	H2024	U3	Single	Dollar

HCBS-DD Procedure Code Table (Special Program Code 85)				
Comprehensive Services (HCBS-DD)				
Description	**Proc. Code**	**Modifier(s)**	**Level**	**Unit Designation**
Transportation				
Other (Public Conveyance)	T2004	U3	Single	Dollar
Mileage Range 1	T2003	U3	0 - 10	2 Trips / Day
Mileage Range 2	T2003	U3, 22	11 - 20	2 Trips / Day
Mileage Range 3	T2003	U3, TF	21 & Up	2 Trips / Day
Behavioral Services				
Behavioral Line Staff	H2019	U3	Single	15 Minutes
Behavioral Consultation	H2019	U3, 22, TG	Single	15 Minutes
Behavioral Counseling- Individual	H2019	U3, TF, TG	Single	15 Minutes
Behavioral Counseling- Group	H2019	U3, TF, HQ	Single	15 Minutes
Behavioral Plan Assessment	T2024	U3, 22	Single	15 Minutes
Specialized Medical				
Specialized Med Supplies/Disposable	T2029	U3	Single	Dollar
Specialized Medical Equipment	T2028	U3	Single	Dollar
Dental Services				
Basic	D2999	U3	Single	Dollar
Major	D2999	U3, 22	Single	Dollar
Vision	V2799	U3	Single	Dollar

HCBS-SLS Procedure Code Table

Providers may bill the following procedure codes for HCBS-SLS services:

Supported Living Services (SLS) (Special Program Code 92)				
Description	**Proc Code**	**Modifier(s)**	**Level**	**Unit Designation**
Personal Care	T1019	U8	Single	15 Minutes
Respite Care				
Individual	S5150	U8	Single	15 Minutes
Individual	S5151	U8	Single	Day
Group	S5151	U8, HQ	Single	Dollar
Camp	T2036	U8	Single	Dollar
Homemaker				
Basic	S5130	U8	Single	15 Minutes
Enhanced	S5130	U8, 22	Single	15 Minutes
Mentorship	H2021	U8	Single	15 minutes

Supported Living Services (SLS) (Special Program Code 92)				
Description	**Proc Code**	**Modifier(s)**	**Level**	**Unit Designation**
Day Habilitation				
Specialized Habilitation	T2021	U8, HQ	Level 1	15 Minutes
	T2021	U8, 22, HQ	Level 2	15 Minutes
	T2021	U8, TF, HQ	Level 3	15 Minutes
	T2021	U8, TF, 22, HQ	Level 4	15 Minutes
	T2021	U8, TG, HQ	Level 5	15 Minutes
	T2021	U8, TG, 22, HQ	Level 6	15 Minutes
Supported Community Connections	T2021	U8	Level 1	15 Minutes
	T2021	U8, 22	Level 2	15 Minutes
	T2021	U8, TF	Level 3	15 Minutes
	T2021	U8, TF, 22	Level 4	15 Minutes
	T2021	U8, TG	Level 5	15 Minutes
	T2021	U8, TG, 22	Level 6	15 Minutes
Supported Employment				
Group	T2019	U8, HQ	Level 1	15 Minutes
	T2019	U8, 22, HQ	Level 2	15 Minutes
	T2019	U8, TF, HQ	Level 3	15 Minutes
	T2019	U8, TF, 22, HQ	Level 4	15 Minutes
	T2019	U8, TG, HQ	Level 5	15 Minutes
	T2019	U8, TG, 22, HQ	Level 6	15 Minutes
Individual	T2019	U8, SC	Single	15 Minutes
Supported Employment (SE) – Department of Vocational Rehabilitation (DVR)				
SE Job Development- Group	H2023	U8, HQ	Single	15 Min.
SEJob Development- Individual	H2023	U8	Level 1-2	15 Min.
SE.Job Development- Individual	H2023	U8, 22	Level 3-4	15 Min.
SE Job Development- Individual	H2023	U8, TF	Level 5-6	15 Min.
SE Job Placement- Group	H2024	U8, HQ	Single	Dollar
SE Job Placement- Individual	H2024	U8	Single	Dollar
Non-Medical Transportation				
Day Program – Mileage Range 1	T2003	U8	0 to 10	2 Trips / Day
Day Program – Mileage Range 2	T2003	U8, 22	11 to 20	2 Trips / Day
Day Program – Mileage Range 3	T2003	U8, TF	21 and Up	2 Trips / Day
Not Day Program	T2003	U8, SC	Single	4 Trips / Week
Other (Public Conveyance)	T2004	U8	Single	Dollar
Behavioral Services				
Behavioral Line Staff	H2019	U8	Single	15 Minutes
Behavioral Consultation	H2019	U8, 22, TG	Single	15 Minutes
Behavioral Counseling- Individual	H2019	U8, TF, TG	Single	15 Minutes
Behavioral Counseling- Group	H2019	U8, TF, HQ	Single	15 Minutes
Behavioral Plan Assessment	T2024	U8, 22	Single	15 Minutes

Supported Living Services (SLS) (Special Program Code 92)				
Description	**Proc Code**	**Modifier(s)**	**Level**	**Unit Designation**
Professional Services				
Massage Therapy	97124	U8	Single	15 Minutes
Movement Therapy Bachelors	G0176	U8	Single	15 Minutes
Movement Therapy Masters	G0176	U8, 22	Single	15 Minutes
Hippotherapy- Individual	S8940	U8	Single	15 Minutes
Hippotherapy- Group	S8940	U8, HQ	Single	15 Minutes
Fee (Rec Pass)	S5199	U8	Single	Dollar
Specialized Medical				
Supplies and Disposable	T2028	U8	Single	Dollar
Equipment	T2029	U8	Single	Dollar
Personal Emergency Response System (PERS)	S5161	U8	Single	Dollar
Home Accessibility Adaptations	S5165	U8	Single	Dollar
Vehicle Modifications	T2039	U8	Single	Dollar
Assistive Technology	T2035	U8	Single	Dollar
Dental Services				
Basic	D2999	U8	Single	Dollar
Major	D2999	U8, 22	Single	Dollar
Vision Services	V2799	U8	Single	Dollar

CES Procedure Code Table

Providers may bill the following procedure codes for HCBS-CES services:

Children's Extensive Support (CES) (Special Program Code 90)			
Description	**Proc Code**	**Modifier(s)**	**Unit Designation**
Personal Care	T1019	U7	15 Minutes
Respite Care			
Individual	S5150	U7	15 Minutes
Individual	S5151	U7	Day
Group	S5151	U7, HQ	Dollar
Camp	T2036	U7	Dollar
Homemaker			
Basic	S5130	U7	15 Minutes
Enhanced	S5130	U7, 22	15 Minutes
Community Connector	H2021	U7	15 Minutes

Children's Extensive Support (CES) (Special Program Code 90)			
Description	**Proc Code**	**Modifier(s)**	**Unit Designation**
Behavioral Services			
Behavioral Line Staff	H2019	U7	15 Minutes
Behavioral Consultation	H2019	U7, 22, TG	15 Minutes
Behavioral Counseling- Individual	H2019	U7, TF, TG	15 Minutes
Behavioral Counseling- Group	H2019	U7, TF, HQ	15 Minutes
Behavioral Plan Assessment	T2024	U7, 22	15 Minutes
Professional Services			
Massage Therapy	97124	U7	15 Minutes
Movement Therapy Bachelors	G0176	U7	15 Minutes
Movement Therapy Masters	G0176	U7, 22	15 Minutes
Hippotherapy Individual	S8940	U7	15 Minutes
Hippotherapy Group	S8940	U7, HQ	15 Minutes
Specialized Medical			
Supplies and Disposable	T2028	U7	Dollar
Equipment	T2029	U7	Dollar
Adapted Therapeutic Recreational			
Equipment	T1999	U7	Dollar
Fees	S5199	U7	Dollar
			Maximum $1,000/yr Combined
Home Accessibility Adaptations	S5165	U7	Dollar
Vehicle Modifications	T2039	U7	Dollar
Assistive Technology	T2035	U7	Dollar
Vision Services	V2799	U7	Dollar
Parent Education	H1010	U7	Dollar / $1,000 Max. Year

Targeted Case Management (TCM)- CES, DD, SLS (Special Code 87)			
Description	**Proc Code**	**Modifier(s)**	**Unit Designation**
Targeted Case Management	T1017	U4	15 Minutes

Targeted Case Management- Early Intervention- CES, DD, SLS (Special Code 87)			
Description	**Proc Code**	**Modifier(s)**	**Unit Designation**
Targeted Case Management – Early Intervention Services	T1017	U4, HA	15 Minutes

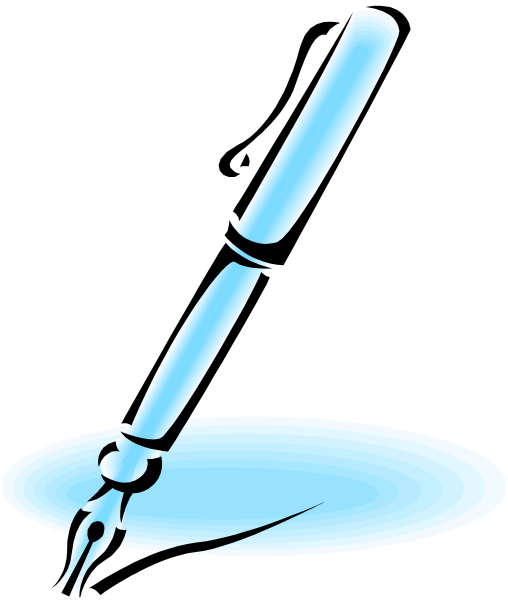
Children's Habilitation Residential Program (CHRP) (Special Program Code 93)		
Description	**Procedure Code + Modifier(s)**	
Level (of Care) I	T1015	U9
Level (of Care) II	H0041	U9
Level (of Care) III	T2033	U9
Respite	H0045	U9

CES, HCBS-DD, and HCBS- SLS Paper Claim Reference Table

The following paper form reference table describes required fields for the paper Colorado 1500 claim form for HCBS-CES, HCBS- DD, and HCBS- SLS claims:

Field Label	Completion Requirement
Special Program Code	Required Enter the code that identifies the program under which services are being billed. 85 – Comprehensive Services (HCB-DD) 87 - Targeted Case Management (DD-TCM) 90 - Children's Extensive Support (CES) 92 - Supported Living Services (SLS) 93 - Children's Habilitation Residential Program (CHRP)
1. Client Name	Required
2. Client Date of Birth	Required
3. Colorado Medical Assistance Program ID Number (Client ID Number)	Required
5. Client Sex	Required
18. ICD-9-CM	Required Enter 7999
19A. Date of Service	Required
19B. Place of Service	Required Enter place of service code **12** - Home.
19C. Procedure Code MOD	Required Refer to the DD procedure code tables.
19F. Diagnosis	Required
19G. Charges	Required
19H. Days or Units	Required

Field Label	Completion Requirement
20. Total Charges	Required
23. Net Charge	Required
27. Signature	Required
28. Billing Provider Name	Required
29. Billing Provider Number	Required



HCBS-DD Claim Example

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND FINANCING

INVOICE/PAT ACCT NUMBER

SPECIAL PROGRAM CODE 85

HEALTH INSURANCE CLAIM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL): Long, Georgia
2. CLIENT DATE OF BIRTH: 05 05 1935
3. MEDICAID ID NUMBER (CLIENT ID NUMBER): D555555
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)
   TELEPHONE NUMBER
5. CLIENT SEX: MALE [ ] [X] 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
9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)
   TELEPHONE NUMBER
10. WAS CONDITION RELATED TO:
   A. CLIENT EMPLOYMENT YES [ ]
   B. ACCIDENT AUTO [ ] OTHER [ ]
   C. DATE OF ACCIDENT
11. CHAMPUS SPONSORS SERVICE/SSN
12. PREGNANCY [ ] NURSING FACILITY RESIDENT [ ]

PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF:
ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR FIRST PREGNANCY(LMP)
14. MEDICARE DENIAL: 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 RENDERED (IF OTHER THAN HOME OR OFFICE)
PROVIDER NUMBER
17A. CHECK BOX IF LABORATORY WORK PERFORMED OUSIDE 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. 317
2.
3.
4.
TRANSPORTATION CERTIFICATION ATTACHED YES [ ]
DURABLE MEDICAL EQUIPMENT
Line No Make Model Serial Number
PRIOR AUTHORIZATION NO.:

19 A. DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. PROCEDURE CODE (HCPCS)	MOD	D. RENDERING PROVIDER NO.	E. REFERRING PROVIDER NO.	F. DIAGNOSIS P	S	T	G. CHARGES	H. DAYS OR UNITS	I. CO PAY	J. EMERG-ENCY	K. FAMILY PLAN-NING	L. EPSDT
04 03 08	04 03 08	12	T 2 0 1 6	U3			1			30 00	4				

20,-. TOTAL CHARGES 30 00

LESS

MEDICARE EOMB DATE

21 MEDICARE PAID
22. THIRD PARTY PAID
23. NET CHARGE 30 00
24. MEDICARE DEDUCTIBLE
25. MEDICARE COINSURANCE
26. MEDICARE DISALLOWED

27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE
Authorized Signature MM/DD/YY
28. BILLING PROVIDER NAME
DD Special Services
29. BILLING PROVIDER NUMBER
04555555
30. REMARKS

COL-101

COLORADO 1500

Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD), Community Mental Health Services (HCBS-CMHS), and Persons Living with AIDS (HCBS-PLWA)

The HCBS-EBD, MI, and PLWA waiver programs provide a variety of services to the Elderly, Blind and Disabled (EBD), Community Mental Health Services (HCBS-CMHS) formally known as Persons with Major Mental Illness (MI), and Persons Living With AIDS (PLWA) as an alternative to nursing facility, inpatient hospital, and rehabilitation facility placement to qualified clients. Clients meeting program eligibility requirements are certified by the case management agency/single entry point as medically eligible for these HCBS waiver programs. These three waivers offer all of the following services:

- Adult Day Care – Services furnished four (4) or more hours per day on a regularly scheduled basis, for one or more days per week. Services provided in an outpatient setting, encompassing both health and social services needed to assure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a “full nutritional regimen” (3 meals per day). Physical, occupational and speech therapies indicated in the individual’s plan of care would be furnished as component parts of this service if such services are not being provided in the participant’s home.
- Electronic Monitoring/Personal Emergency Response Systems – An electronic device, which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable “help” button to allow for mobility. The system is connected to the person’s phone and programmed to signal a response center once a “help” button is activated. Monitoring of the device is included in the PERS service. The response center is staffed by trained professionals.
- Homemaker – Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker. Provided when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.
- Personal Care – Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. These services may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the service plan, this service may also include such housekeeping chores as bed making, dusting and vacuuming. Services are incidental to the care furnished, or are essential to the health and welfare of the individual, rather than the individual’s family. Payment will not be made for services furnished to a minor by the child’s parent (or step parent), or to an individual by the person’s spouse.
- Relative Personal Care – Personal Care providers may be members of the individual’s family. The number of Medicaid personal care units for provided by any single member of the client’s family shall not exceed the equivalent of 444 personal care units per annual certification.

Payment will not be made for services furnished to an individual by an individual's spouse employed by a Personal Care agency.

- Non-medical Transportation – Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the service plan. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State Plan, defined at 42 CFR 440.170 (a) (if applicable), and shall not replace them. Effective September 1, 2009, non-medical transportation will be limited to two (2) round-trips per week. Trips to and from adult day programs are not subject to this cap.

The HCBS-EBD program offers the following additional services:

Consumer Directed Attendant Support Services (CDASS) – CDASS is a service delivery option that offers HCBS-EBD and HCBS-MI clients the opportunity to direct personal care, homemaker and health maintenance tasks. Clients may also designate an authorized representative to direct these activities on their behalf.

In-Home Support Services (IHSS) – IHSS includes health maintenance activities, support for activities of daily living or instrumental activities of daily living, personal care service and homemaker services. Additionally, IHSS providers are required to provide the core independent living skills. This service is only available for EBD and CHCBS clients.

Community Transition Services (CTS) – CTS assists Medical Assistance Program clients in transitioning from nursing facilities to community-based residences. CTS are administered by provider specialty Transition Coordination Agency (TCA). TCAs have to provide at least two Independent Living Core Services and have to be certified by the Department to provide CTS.

Medication Reminders – Medication reminders are devices, controls, or appliances which enable an individual at high risk of institutionalization to increase their abilities to perform activities of daily living, such as medication administration. Medication reminders shall include devices or items that remind or signal the client to take prescribed medications. Medication reminders may include other devices necessary for the proper functioning of such items, and may also include durable and non-durable medical equipment not available as a State plan benefit.

HCBS-EBD Procedure Code Table

Providers may bill the following procedure codes for HCBS-EBD, HCBS-MI, and HCBS-PLWA services:

HCBS-EBD Procedure Code Table (Special Program Code 82)			
Description	**Procedure Code**	**Modifier(s)**	**Units**
Adult Day Care	S5105	U1	1 unit = 4-5 hours
Alternative Care Facility	T2031	UA	1 unit =1 day
Non-Medical Transportation	T2001	U1	1 unit = 1 one way trip
Non-Medical Transportation – to and from adult day program	T2001	U6, HB	1 unit = one way trip
Non-Medical Transportation Taxi	A0100	U1	1 unit=one way trip

HCBS-EBD Procedure Code Table (Special Program Code 82)			
Description	**Procedure Code**	**Modifier(s)**	**Units**
Non-Medical Transportation Taxi- to and from adult day	A0100	U1, HB	1 unit=one way trip
Non-Medical Transportation -Mobility Van	A0120	U1	1 unit=one way trip
Non-Medical Transportation -Mobility Van-to and from adult day	A0120	U1, HB	1 unit=one way trip
Non-Medical Transportation – Wheelchair Van	A0130	U1	1 unit=one way trip
Non-Medical Transportation – Wheelchair Van-to and from adult day	A0130	U1, HB	1 unit=one way trip
Non-Medical Transportation – Wheelchair Van Mileage	A0425	U1	1 unit= 1 mile
Non-Medical Transportation – Wheelchair Van Mileage-to and from adult day	A0425	U1, HB	1 unit= 1 mile
Homemaker	S5130	U1	1 unit = 15 minutes
Personal Care	T1019	U1	1 unit = 15 minutes
Relative Providing Personal Care	T1019	U1, HR	1 unit = 15 minutes
Respite Care - Nursing Facility	H0045	U1	1 unit =1 day
Home Modifications	S5165	U1	1 unit =1 modification
Electronic Monitoring	S5160	U1	1 unit = purchase and installation
Electronic Monitoring	S5161	U1	1 unit =1 month of service
CTS Items	T2038	U1, 52	1 unit = purchase
CTS Case Management	T2038	U1	1 unit = 1 transition
In-Home Respite Care	S5150	U1	1 unit = 15 minutes
Respite Care ACF	S5151	U1	1 unit = 1 day
Medication Reminder	S5185	U1	1 unit per month
Medication Reminder Install/Purchase	T2029	U1	1 unit = 1 purchase
Consumer Directed Attendant Support Services	T2025	U1	Negotiated by case manager through prior authorization.
Consumer Directed Attendant Support Services Administration	T2025	U1, 52	Negotiated by case manager through prior authorization.

HCBS-EBD Procedure Code Table (Special Program Code 82)			
Description	**Procedure Code**	**Modifier(s)**	**Units**
Consumer Directed Attendant Support Services Administration Cost - Per Member/Per Month	T2040	U1, UA	Negotiated by case manager through prior authorization.

Providers may bill the following procedure codes for HCBS-EBD IHSS services:

HCBS-EBD IHSS Procedure Code Table (Special Program Code 82)			
Description	**Procedure Code**	**Modifier(s)**	**Units**
IHSS Health Maintenance Activities	H0038	U1	1 unit = 15 minutes
IHSS Personal Care Service	T1019	U1, KX	1 unit = 15 minutes
IHSS Relative Personal Care	T1019	U1, HR, KX	1 unit = 15 minutes
IHSS Homemaker Service	S5130	U1, KX	1 unit = 15 minutes

HCBS-CMHS Procedure Code Table

Providers may bill the following procedure codes for HCBS-CMHS services:

HCBS-CMHS Procedure Code Table (Special Program Code 94)			
Description	**Procedure Code**	**Modifier(s)**	**Units**
Adult Day Care	S5105	UA	1 unit = 3-5 hours
Non-Medical Transportation	T2001	UA	1 unit = 1 one way trip
Non-Medical Transportation – to and from adult day program	T2001	U6, HB	1 unit = one way trip
Non-Medical Transportation Taxi	A0100	U1	1 unit=one way trip
Non-Medical Transportation Taxi- to and from adult day	A0100	U1, HB	1 unit=one way trip
Non-Medical Transportation -Mobility Van	A0120	U1	1 unit=one way trip
Non-Medical Transportation -Mobility Van-to and from adult day	A0120	U1, HB	1 unit=one way trip
Non-Medical Transportation – Wheelchair Van	A0130	U1	1 unit=one way trip
Non-Medical Transportation – Wheelchair Van-to and from adult day	A0130	U1, HB	1 unit=one way trip

HCBS-CMHS Procedure Code Table (Special Program Code 94)			
Description	**Procedure Code**	**Modifier(s)**	**Units**
Non-Medical Transportation – Wheelchair Van Mileage	A0425	U1	1 unit= 1 mile
Non-Medical Transportation – Wheelchair Van Mileage-to and from adult day	A0425	U1, HB	1 unit= 1 mile
Homemaker	S5130	UA	1 unit = 15 minutes
Personal Care	T1019	UA	1 unit = 15 minutes
Relative Providing Personal Care	T1019	UA, HR	1 unit = 15 minutes
Respite Care - Nursing Facility	H0045	UA	1 unit =1 day
Home Modifications	S5165	UA	1 unit =1 modification
Alternative Care Facility	T2031	UA	1 unit =1 day
Electronic Monitoring	S5160	UA	1 unit = purchase and installation
Electronic Monitoring	S5161	UA	1 unit =1 month of service
Respite Care- ACF	S5151	UA	1 unit = 1 day
Consumer Directed Attendant Support Services	T2025	UA	Negotiated by case manager through prior authorization.
Consumer Directed Attendant Support Services Administration	T2025	UA, 52	Negotiated by case manager through prior authorization.
Consumer Directed Attendant Support Services Administration Cost - Per Member/Per Month	T2040	U1, UA	Negotiated by case manager through prior authorization.
Medication Reminder	S5185	UA	1 unit per month
Medication Reminder Install/Purchase	T2029	UA	1 unit = 1 purchase

HCBS-PLWA Procedure Code Table

Providers may bill the following procedure codes for HCBS-PLWA services:

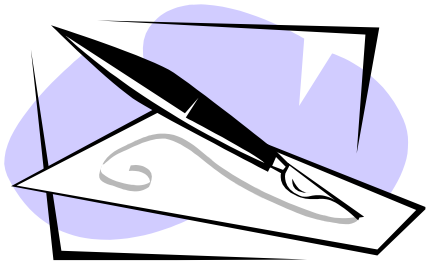
HCBS-PLWA Procedure Code Table (Special Program Code 83)			
Description	**Procedure Code**	**Modifier(s)**	**Units**
Adult Day Services	S5105	U2	1 unit =3-5 hours
Non-Medical Transportation	T2001	U2	1 unit = 1 one way trip

HCBS-PLWA Procedure Code Table (Special Program Code 83)			
Description	**Procedure Code**	**Modifier(s)**	**Units**
Non-Medical Transportation – to and from adult day program	T2001	U2, HB	1 unit = one way trip
Non-Medical Transportation Taxi	A0100	UA	1 unit=one way trip
Non-Medical Transportation Taxi- to and from adult day	A0100	UA, HB	1 unit=one way trip
Non-Medical Transportation -Mobility Van	A0120	UA	1 unit=one way trip
Non-Medical Transportation -Mobility Van-to and from adult day	A0120	UA, HB	1 unit=one way trip
Non-Medical Transportation – Wheelchair Van	A0130	UA	1 unit=one way trip
Non-Medical Transportation – Wheelchair Van-to and from adult day	A0130	UA, HB	1 unit=one way trip
Non-Medical Transportation – Wheelchair Van Mileage	A0425	UA	1 unit= 1 mile
Non-Medical Transportation – Wheelchair Van Mileage-to and from adult day	A0425	UA, HB	1 unit= 1 mile
Homemaker	S5130	U2	1 unit = 15 minutes
Personal Care	T1019	U2	1 unit = 15 minutes
Relative Providing Personal Care	T1019	U2, HR	1 unit = 15 minutes
Electronic Monitoring	S5160	U2	1 unit = purchase and installation
Electronic Monitoring	S5161	U2	1 unit =1 month of service

HCBS-EBD, HCBS-CMHS, and HCBS-PLWA Paper Claim Reference Table

The following paper form reference table gives required and/or conditional fields for the paper Colorado 1500 claim form for HCBS-EBD, HCBS-CMHS, and HCBS-PLWA claims:

Field Label	Special Instructions
Special Program Code	Required Code 82 identifies the HCBS-EBD program Code 94 identifies the HCBS-MI program Code 83 identifies the HCBS-PLWA program
1. Client Name	Required
2. Client Date of Birth	Required
3. Colorado Medical Assistance Program ID Number (Client ID Number)	Required
5. Client Sex	Required
6. ICD-9-CM	Required
19A. Date of Service	Required
19B. Place of Service	Required Enter place of service code **12** - Home. *Note: Use POS Code 12 (Home) for Alternative Care Facility, Adult Day Program, or Respite in the Facility.*
19C. Procedure Code (HCPCS code) **MOD**	Required Refer to the HCBS-EBD, HCBS-MI or HCBS-PLWA procedure code table.
19F. Diagnosis	Required
19G. Charges	Required
19H. Days or Units	Required
20. Total Charges	Required
23. Net Charge	Required
27. Signature	Required
28. Billing Provider Name	Required
29. Billing Provider Number	Required



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.

HCBS-EBD Claim Example

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND FINANCING

INVOICE/PAT ACCT NUMBER: SMI00124
SPECIAL PROGRAM CODE: 82

HEALTH INSURANCE CLAIM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL): Doe, Jane
2. CLIENT DATE OF BIRTH: 03 05 1935
3. MEDICAID ID NUMBER (CLIENT ID NUMBER): D876543
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NUMBER
5. CLIENT SEX: MALE [ ] [X] 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
9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NUMBER
10. WAS CONDITION RELATED TO:
A. CLIENT EMPLOYMENT YES [ ]
B. ACCIDENT AUTO [ ] OTHER [ ]
C. DATE OF ACCIDENT
11. CHAMPUS SPONSORS SERVICE/SSN
12. PREGNANCY [ ] NURSING FACILITY RESIDENT [ ]

PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF:
ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR FIRST PREGNANCY(LMP)
14. MEDICARE DENIAL: [ ] 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 RENDERED (IF OTHER THAN HOME OR OFFICE)
PROVIDER NUMBER
17A. CHECK BOX IF LABORATORY WORK PERFORMED OUSIDE 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. 3 6 9 0 Profound impairment, both eyes
2.
3.
4.
TRANSPORTATION CERTIFICATION ATTACHED [ ] YES
DURABLE MEDICAL EQUIPMENT
Line No Make Model Serial Number
PRIOR AUTHORIZATION NO.:

19 A. DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. PROCEDURE CODE (HCPCS)	MOD	D. RENDERING PROVIDER NO.	E. REFERRING PROVIDER NO.	F. DIAGNOSIS P	S	T	G. CHARGES	H. DAYS OR UNITS	I. CO PAY	J. EMERGENCY	K. FAMILY PLANNING	L. EPSDT
03 01 08	03 31 08	12	T 1 0 1 9	U1			1			128 00	40				

20,-. TOTAL CHARGES 128 00
LESS
MEDICARE EOMB DATE
21 MEDICARE PAID
22. THIRD PARTY PAID
23. NET CHARGE 128 00
24. MEDICARE DEDUCTIBLE
25. MEDICARE COINSURANCE
26. MEDICARE DISALLOWED
27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE
Authorized Signature MM/DD/YY
28. BILLING PROVIDER NAME
Any County Social Services
29. BILLING PROVIDER NUMBER
12345678
30. REMARKS

COL-101

COLORADO 1500

HCBS-EBD CDASS Claim Example

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND FINANCING

INVOICE/PAT ACCT NUMBER: CL012345

SPECIAL PROGRAM CODE: 82

HEALTH INSURANCE CLAIM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL): Client, Ima
2. CLIENT DATE OF BIRTH: 03 01 1945
3. MEDICAID ID NUMBER (CLIENT ID NUMBER): D876543
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NUMBER
5. CLIENT SEX: MALE [ ] [X] 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
9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NUMBER
10. WAS CONDITION RELATED TO:
A. CLIENT EMPLOYMENT YES [ ]
B. ACCIDENT AUTO [ ] OTHER [ ]
C. DATE OF ACCIDENT
11. CHAMPUS SPONSORS SERVICE/SSN
12. PREGNANCY [ ] NURSING FACILITY RESIDENT [ ]

PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF:
ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR FIRST PREGNANCY(LMP)
14. MEDICARE DENIAL: 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 RENDERED (IF OTHER THAN HOME OR OFFICE)
PROVIDER NUMBER
17A. CHECK BOX IF LABORATORY WORK PERFORMED OUSIDE 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. 3690 Profound impairment, both eyes
2.
3.
4.
TRANSPORTATION CERTIFICATION ATTACHED YES [ ]
DURABLE MEDICAL EQUIPMENT
Line No Make Model Serial Number
PRIOR AUTHORIZATION NO.:

19 A. DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. PROCEDURE CODE (HCPCS)	MOD	D. RENDERING PROVIDER NO.	E. REFERRING PROVIDER NO.	F. DIAGNOSIS P	S	T	G. CHARGES	H. DAYS OR UNITS	I. CO PAY	J. EMERGENCY	K. FAMILY PLANNING	L. EPSDT
03 08 08	03 24 08	12	T 2025	U1			1			1600 00	17				
03 08 08	03 24 08	12	T 2025	U1 52			1			160 00	17				

20,-. TOTAL CHARGES 1760 00

LESS

MEDICARE EOMB DATE

21 MEDICARE PAID

22. THIRD PARTY PAID

23. NET CHARGE 1760 00

24. MEDICARE DEDUCTIBLE

25. MEDICARE COINSURANCE

26. MEDICARE DISALLOWED

27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE
Authorized Signature MM/DD/YY

28. BILLING PROVIDER NAME
HCBS Provider

29. BILLING PROVIDER NUMBER
12345678

30. REMARKS

COL-101

COLORADO 1500

HCBS-EBD IHSS Claim Example

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND FINANCING

INVOICE/PAT ACCT NUMBER

SPECIAL PROGRAM CODE: 82

HEALTH INSURANCE CLAIM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL): Doe, Jane
2. CLIENT DATE OF BIRTH: 03 05 1940
3. MEDICAID ID NUMBER (CLIENT ID NUMBER): X123456
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)
   TELEPHONE NUMBER
5. CLIENT SEX: MALE [ ] [X] 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
9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)
   TELEPHONE NUMBER
10. WAS CONDITION RELATED TO:
   A. CLIENT EMPLOYMENT YES [ ]
   B. ACCIDENT AUTO [ ] OTHER [ ]
   C. DATE OF ACCIDENT
11. CHAMPUS SPONSORS SERVICE/SSN
12. PREGNANCY [ ] NURSING FACILITY RESIDENT [ ]

PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF:
ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR FIRST PREGNANCY(LMP)
14. MEDICARE DENIAL: 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 RENDERED (IF OTHER THAN HOME OR OFFICE)
PROVIDER NUMBER
17A. CHECK BOX IF LABORATORY WORK PERFORMED OUSIDE 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. 3 6 9 0 — Profound impairment, both eyes
2.
3.
4.
TRANSPORTATION CERTIFICATION ATTACHED [ ] YES
DURABLE MEDICAL EQUIPMENT
Line No Make Model Serial Number
PRIOR AUTHORIZATION NO.:

19 A. DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. PROCEDURE CODE (HCPCS)	MOD	D. RENDERING PROVIDER NO.	E. REFERRING PROVIDER NO.	F DIAGNOSIS P	S	T	G. CHARGES	H. DAYS OR UNITS	I. CO PAY	J. EMERG-ENCY	K. FAMILY PLAN-NING	L. EPSDT
04 01 08	04 28 08	12	H 0 0 3 8	U1			1			64 50	10				
04 01 08	04 28 08	12	T 1 0 1 9	U1 KX			1			128 00	10				
04 01 08	04 28 08	12	S 5 1 3 0	U1 KX			1			64 00	5				

20.-. TOTAL CHARGES → 256 50

LESS ↓ MEDICARE EOMB DATE

27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE
Authorized Signature MM/DD/YY
28. BILLING PROVIDER NAME
Any County Social Services
29. BILLING PROVIDER NUMBER
87654321
30. REMARKS
21. MEDICARE PAID
22. THIRD PARTY PAID
23. NET CHARGE 256 50
24. MEDICARE DEDUCTIBLE
25. MEDICARE COINSURANCE
26. MEDICARE DISALLOWED

COL-101

COLORADO 1500

HCBS-EBD CTS Claim Example

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND FINANCING

INVOICE/PAT ACCT NUMBER

SPECIAL PROGRAM CODE 82

HEALTH INSURANCE CLAIM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL): Doe, John
2. CLIENT DATE OF BIRTH: 03 05 1935
3. MEDICAID ID NUMBER (CLIENT ID NUMBER): Z987654
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)
   TELEPHONE NUMBER
5. CLIENT SEX: MALE [X] 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
9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)
   TELEPHONE NUMBER
10. WAS CONDITION RELATED TO:
   A. CLIENT EMPLOYMENT YES [ ]
   B. ACCIDENT AUTO [ ] OTHER [ ]
   C. DATE OF ACCIDENT
11. CHAMPUS SPONSORS SERVICE/SSN
12. PREGNANCY [ ] NURSING FACILITY RESIDENT [ ]

PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF:
ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR FIRST PREGNANCY(LMP)
14. MEDICARE DENIAL: 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 RENDERED (IF OTHER THAN HOME OR OFFICE)
PROVIDER NUMBER
17A. CHECK BOX IF LABORATORY WORK PERFORMED OUSIDE 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. 0 9 0 3 Syphilitic keratitis
2.
3.
4.
TRANSPORTATION CERTIFICATION ATTACHED YES [ ]
DURABLE MEDICAL EQUIPMENT
Line No Make Model Serial Number
PRIOR AUTHORIZATION NO.:

19 A. DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. PROCEDURE CODE (HCPCS)	MOD	D. RENDERING PROVIDER NO.	E. REFERRING PROVIDER NO.	F. DIAGNOSIS P	S	T	G. CHARGES	H. DAYS OR UNITS	I. CO PAY	J. EMERGENCY	K. FAMILY PLANNING	L. EPSDT
04 03 08	04 03 08	12	T 2 0 3 8	U1			1			850 00	1				
04 03 08	04 03 08	12	T 2 0 3 8	U1 52						500 00	500				

20. TOTAL CHARGES 1350 00
LESS
MEDICARE EOMB DATE
21. MEDICARE PAID
22. THIRD PARTY PAID
23. NET CHARGE 1350 00
24. MEDICARE DEDUCTIBLE
25. MEDICARE COINSURANCE
26. MEDICARE DISALLOWED
27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE
Authorized Signature MM/DD/YY
28. BILLING PROVIDER NAME
HCBS Provider
29. BILLING PROVIDER NUMBER
12345678
30. REMARKS

COL-101

COLORADO 1500

HCBS-MI Claim Example

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND FINANCING

INVOICE/PAT ACCT NUMBER

SPECIAL PROGRAM CODE
94

HEALTH INSURANCE CLAIM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL): Doe, Jane
2. CLIENT DATE OF BIRTH: 03 05 1935
3. MEDICAID ID NUMBER (CLIENT ID NUMBER): D876543
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)
   TELEPHONE NUMBER
5. CLIENT SEX: MALE [ ] [X] 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
9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)
   TELEPHONE NUMBER
10. WAS CONDITION RELATED TO:
   A. CLIENT EMPLOYMENT YES [ ]
   B. ACCIDENT AUTO [ ] OTHER [ ]
   C. DATE OF ACCIDENT
11. CHAMPUS SPONSORS SERVICE/SSN
12. PREGNANCY [ ] NURSING FACILITY RESIDENT [ ]

PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF: 03 10 08
ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR FIRST PREGNANCY(LMP)
14. MEDICARE DENIAL: 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 RENDERED (IF OTHER THAN HOME OR OFFICE)
PROVIDER NUMBER
17A. CHECK BOX IF LABORATORY WORK PERFORMED OUSIDE 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. 799
2.
3.
4.
TRANSPORTATION CERTIFICATION ATTACHED YES [ ]
DURABLE MEDICAL EQUIPMENT
Line No Make Model Serial Number
PRIOR AUTHORIZATION NO.:

19 A. DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. PROCEDURE CODE (HCPCS)	MOD	D. RENDERING PROVIDER NO.	E. REFERRING PROVIDER NO.	F DIAGNOSIS P	S	T	G. CHARGES	H. DAYS OR UNITS	I. CO PAY	J. EMERGENCY	K. FAMILY PLANNING	L. EPSDT
04 03 08	04 03 08	12	T 1 0 1 9	UA			1			128 00	40				

20.- TOTAL CHARGES 128 00
LESS
MEDICARE EOMB DATE

27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE
Authorized Signature MM/DD/YY
28. BILLING PROVIDER NAME
Any County Social Services
29. BILLING PROVIDER NUMBER
12345678
30. REMARKS
21. MEDICARE PAID
22. THIRD PARTY PAID
23. NET CHARGE 128 00
24. MEDICARE DEDUCTIBLE
25. MEDICARE COINSURANCE
26. MEDICARE DISALLOWED

COL-101

COLORADO 1500

HCBS-PLWA Claim Example

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND FINANCING

INVOICE/PAT ACCT NUMBER

SPECIAL PROGRAM CODE: 83

HEALTH INSURANCE CLAIM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL): Doe, John
2. CLIENT DATE OF BIRTH: 03 05 1935
3. MEDICAID ID NUMBER (CLIENT ID NUMBER): D225885
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)
   TELEPHONE NUMBER
5. CLIENT SEX: MALE [X] 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
9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)
   TELEPHONE NUMBER
10. WAS CONDITION RELATED TO:
   A. CLIENT EMPLOYMENT YES [ ]
   B. ACCIDENT AUTO [ ] OTHER [ ]
   C. DATE OF ACCIDENT
11. CHAMPUS SPONSORS SERVICE/SSN
12. PREGNANCY [ ] NURSING FACILITY RESIDENT [ ]

PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF: 03 10 05
   ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR FIRST PREGNANCY(LMP)
14. MEDICARE DENIAL: 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 RENDERED (IF OTHER THAN HOME OR OFFICE)
   PROVIDER NUMBER
17A. CHECK BOX IF LABORATORY WORK PERFORMED OUSIDE 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. 0 9 0 3 Syphilitic keratitis
   2.
   3.
   4.
TRANSPORTATION CERTIFICATION ATTACHED YES [ ]
DURABLE MEDICAL EQUIPMENT
Line No Make Model Serial Number
PRIOR AUTHORIZATION NO.:

19 A. DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. PROCEDURE CODE (HCPCS)	MOD	D. RENDERING PROVIDER NO.	E. REFERRING PROVIDER NO.	F. DIAGNOSIS P	S	T	G. CHARGES	H. DAYS OR UNITS	I. CO PAY	J. EMERGENCY	K. FAMILY PLANNING	L. EPSDT
02 03 08	02 03 08	12	T 1 0 1 9	U2			1			128 00	40				

20.- TOTAL CHARGES 128 00
LESS
MEDICARE EOMB DATE
21 MEDICARE PAID
22. THIRD PARTY PAID
23. NET CHARGE 128 00
24. MEDICARE DEDUCTIBLE
25. MEDICARE COINSURANCE
26. MEDICARE DISALLOWED
27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE
   Authorized Signature MM/DD/YY
28. BILLING PROVIDER NAME: HCBS Provider
29. BILLING PROVIDER NUMBER: 12345678
30. REMARKS

COL-101

COLORADO 1500

HCBS Specialty Manuals Revisions Log

Revision Date	Section/Action	Pages	Made by
03/10/2007	HCBS-DD – Removed "Revisions Pending" from CHRP	19, 21, 22 & 24	jg
03/10/2007	HCBS-DD – Reworded Comprehensive Services (HCBS-DD)	20	jg
03/10/2007	HCBS-DD – Updated Service descriptions for SLS and CES	20 & 21	jg
03/30/2007	Updated Appendices References	Throughout	jg
07/05/2007	HCBS-BI – Updated codes	2-4	jg
02/20/2008	Added HCBS-EBD Claim for CDASS Services	36	jg
02/22/2008	Added HCBS-PHW Section	43-45	jg
04/01/2008	HCBS-CDCE Section Deleted	29-41	vr
05/01/2008	Entire manual reformatted and renumbered	All	vr
06/29/2008	Updated HCBS-EBD, MI, and PLWA section	30 & 32	jg
06/05/2009	HCBS-DD, SLS, CES – Updated service description & Codes	23-29	nf
06/05/2009	TOC – Updated to reflect correct page numbering.	1	nf
09/14/2009	Updates to non-medical transportation	All sections	s-ck
09/14/2009	Verified and updated TOC	1	jg
01/26/2010	Updated Web site links	2-4	jg
03/13/2012	Corrected modifier for T2001 from U6 to U2	37	jg
04/04/2012	Added procedure code T2040 and description to HCBS-EBD and MI Procedure Code Tables. Reformatted manual	35 & 36 Throughout	Jg
06/25/2012	Add transportation procedure codes for BI- A0100, A0120, A0130, A0425 with modifiers Added transportation procedure codes for EBD- A0100, A0120, A0130, A0425 with modifiers Added transportation procedure codes for MI- A0100, A0120, A0130, A0425 with modifiers Added transportation procedure codes for PLWA- A0100, A0120, A0130, A0425 with modifiers	7 32-33 35 37	Cc
10/03/2012	Revised procedure code description. Removed Behavioral Plan Specialist, Senior Therapist, Lead Therapist, Behavioral Plan Assessment from HCBS-DD, SLS, and CES. Added Behavioral Consultation, Behavioral Counseling-Indi, Behavioral Counseling-Grp, Behavioral Plan Assessment to HCBS-DD, SLS, and CES.	20-29	Cc

Revision Date	***Section/Action***	***Pages***	***Made by***
10/19/2012	*Added detailed claim submission instructions for paper and electronic* *Renamed HCBS-MI to HCBS-CMHS* *Added Late Bill Over Ride information* *Updated TOC*	*5* *30* *38-41* *TOC*	*cc*
10/29/2012	*Reformatted & reviewed manual* *Updated TOC*	*All* *1 & 2*	*jg*

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