Colorado 1500
General Billing Information

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General 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)

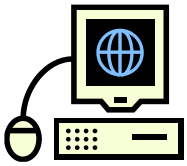
The Colorado Medical Assistance Program collects electronic claim information interactively through the Colorado Medical Assistance Program Secure Web Portal (Web Portal) or via batch submission through a host system.

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.

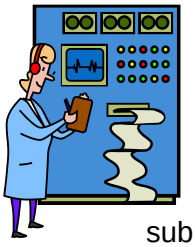
An enrollment package may be obtained by contacting the Department's fiscal agent or by downloading it from the Provider Services EDI Support section.

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.

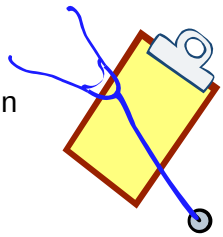


The number of required test transmissions depends on the number of format errors on a transmission and the relative severity of these errors. Additional testing may be required in the future to verify any changes made to the MMIS have not affected provider submissions. Also, changes to the ANSI formats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

Colorado 1500
Billing Instructions

This section of the provider manual contains a reference table that describes fields and general completion instructions for the Colorado 1500 paper claim form. Fields are presented in order as they appear. The table is presented in three columns containing the Field Label, Completion Format and Instructions.



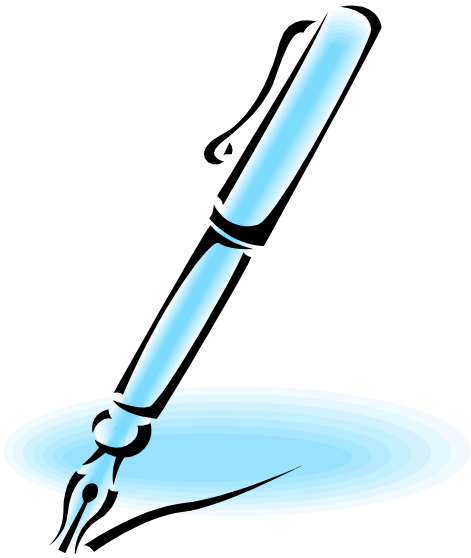
The following services are billed as a professional claim format:

- Practitioner services
- Independent laboratory services
- Durable Medical Equipment and Supplies
- Non-hospital based transportation
- Home and community based services

The Colorado 1500 claim form is available under Claim Forms in the Provider Services Forms section of the Department's Web site.

The form is available as an interactive form and can be completed online. Completed Colorado 1500 paper claims, including hardcopy crossover claims, should be mailed to the Department's fiscal agent at the address noted in Appendix B of the Provider Services Appendices section.

Instructions for completing electronic claim information can be found in the 837P Companion Guide, the 837P Transaction Data Guide, the 837P Technical Report 3 (TR3), or the Web Portal User Guide.



Colorado 1500 Claim Form

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND

INVOICE/PAT ACCT NUMBER

SPECIAL PROGRAM CODE

HEALTH INSURANCE CLAIM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL)
2. CLIENT DATE OF BIRTH
3. MEDICAID ID NUMBER (CLIENT ID NUMBER)
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NUMBER
5. CLIENT SEX MALE ☐ ☐ FEMALE
6. MEDICARE ID NUMBER (HIC OR SSN)
7. CLIENT RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐
8. ☐ CLIENT IS COVERED BY EMPLOYER HEALTH PLAN AS EMPLOYEE OR DEPENDENT
EMPLOYER NAME:
POLICYHOLDER NAME:
GROUP
9. OTHER HEALTH INSURANCE COVERAGE — INSURANCE COMPANY NAME, ADDRESS, PLAN NAME, AND POLICY NUMBER(S)
TELEPHONE NUMBER
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 ☐ HMO ☐ NURSING FACILITY ☐

PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF: ILLNESS (FIRST SYMPTON) 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:
17. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (IF OTHER THAN HOME OR OFFICE)
PROVIDER NUMBER
17A. CHECK BOX IF LABORATORY WORK WAS PERFORMED OUTSIDE THE PHYSICIANS OFFICE ☐ YES
18. ICD-9-CM
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. IN COLUMN F, RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE NUMBERS 1, 2, 3, OR 4
1.
2.
3.
4.
TRANSPORTATION CERTIFICATION ATTACHED ☐ YES
DURABLE MEDICAL EQUIPMENT
Line # Make Model Serial Number
PRIOR AUTHORIZATION #:

19A DATE OF SERVICE FROM TO	B. PLACE OF SERVICE	C. PROCEDURE CODE (HCPCS)	MOD	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

20. TOTAL CHARGES
LESS
MEDICARE EOMB DATE
21. MEDICARE PAID
22. THIRD PARTY PAID
23. NET CHARGE
24. MEDICARE DEDUCTIBLE
25. MEDICARE COINSURANCE
26. MEDICARE DISALLOWED
27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE
28. BILLING PROVIDER NAME
29. BILLING PROVIDER NUMBER
30. REMARKS

COL-101

FORM NO. 94320 (REV. 02/99)

COLORADO 1500

Colorado 1500 Interactive Claim Form

Print

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

PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF: ILLNESS (FIRST SYMPTOM) 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 PAYIDENY DATE:
15. NAME OF SUPERVISING PHYSICIAN
PROVIDER NUMBER
16. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES
ADMITTED: DISCHARGED:
17. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (IF OTHER THAN HOME OR OFFICE
PROVIDER NUMBER
17A. CHECK BOX IF LABORATORY WORK WAS PERFORMED OUTSIDE THE PHYSICIANS OFFICE ☐ YES
18. ICD-9-CM
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. IN COLUMN F, RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE NUMBERS 1, 2, 3, OR 4
1.
2.
3.
4.
TRANSPORTATION CERTIFICATION ATTACHED ☐ YES
DURABLE MEDICAL EQUIPMENT
Line # Make Model Serial Number
PRIOR AUTHORIZATION #:

19A. DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. PROCEDURE CODE (HCPCS)	MODIFIERS	D. RENDERING PROVIDER NUMBER	E. REFERRING PROVIDER NUMBER	F. DIAGNOSIS P	S	T	G. CHARGES	H. DAYS OR UNITS	I. COPAY	J. EMERGENCY	K. FAMILY PLANNING	L. EPSDT
													☐	☐	☐
													☐	☐	☐
													☐	☐	☐
													☐	☐	☐
													☐	☐	☐
													☐	☐	☐

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 FALSE ENTRIES, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS.

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

COL-101
FORM NO. 94030 (REV. 02/99)
ELETRONIC APPLICATION

COLORADO 1500

Colorado 1500 Paper Claim Instructional Reference

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	Required for all Home and Community Based Service programs. Please refer to the HCBS billing instruction manuals located on the Department's Provider Services Billing Manuals Web page.
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) Example: 01/01/2010	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: 07012010 for 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.
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 "Medicare-Medicaid enrollee" refers to a person who is eligible for both Colorado Medical Assistance Program and Medicare benefits.

Field Label	Completion format	Instructions
7. Client relationship to Insured	Check box Self ☐ Spouse ☐ Child ☐ Other ☐	Conditional Complete if the client is covered by a commercial health care insurance policy. 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.
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)	20 characters	Conditional Complete for DME purchases, repairs, and labor. Enter the model and serial number of the equipment.

Field Label	Completion format	Instructions
12. Pregnancy **PHP** **Nursing Facility Resident**	Check box ☐ Check box ☐ Check box ☐	Conditional Complete if the client is in the maternity cycle (i.e., pregnant or within 6 weeks postpartum). Conditional Complete if the client is enrolled in a Colorado Medical Assistance HMO. Conditional Complete if the client is a nursing facility resident.
13. Date of illness or injury or pregnancy	6 digits: MMDDYY	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.

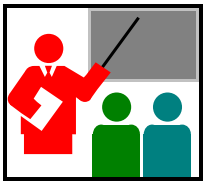
Field Label	Completion format	Instructions
14A. Other Coverage Denied	Check box No ☐ Yes ☐ Pay/Deny Date 6 digits: MMDDYY	Conditional Complete if the client has commercial health care insurance coverage. Enter a check mark or an "**x**" in the "No" box if the other coverage has paid a portion of the 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** / **Claim Entry** Septic shock / 785.59 / 7 8 5 5 9 Fractured ankle / 824 / 8 2 4 X Dehydration / 276.5 / 2 7 6 5 X Normal pregnancy / V22 / V 2 2 X Independent labs may use diagnosis V71 on all claims. HCBS may use 7999.
Diagnosis or nature of illness or injury	Text	Written description is not required. If entered, the written description must match the code(s).
Transportation Certification attached	Check box ☐	Conditional Complete for emergency transportation and wheelchair van services. Enter a check mark or an "**x**" to certify that you have a transportation certificate or trip sheet on file for this service.

Field Label	Completion format	Instructions
Prior Authorization No.	6 characters: Letter plus 5 digits	Conditional Enter the 6 character prior authorization number 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 agent or the fiscal agent. **Transportation** Complete for transportation services that require prior authorization. **HCBS** Complete when the service requires prior authorization. **Durable Medical Equipment & Supplies** Complete for medical equipment and supplies that require prior authorization.
19A.-19L. Detail Billing Lines – Labels	At least one detail billing line must be completed fully	Required The paper claim form allows entry of up to six detailed billing lines. Fields 19A through 19L apply to each billed line. **Do not enter more than six lines of information** on the paper claims. If more than six lines of information are entered, the additional lines will not be entered for processing. Each claim form must be fully completed (totaled). **Do not file continuation claims** (e.g., Page 1 of 2).
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 Practitioner claims must be consecutive days.

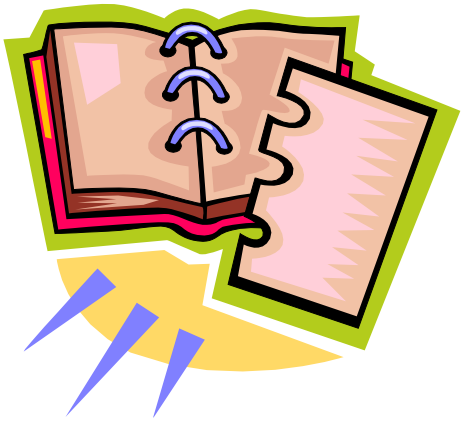
Field Label	Completion format	Instructions
19A. Date of Service (continued)	From: 6 digits MMDDYY To: 6 digits MMDDYY	Single Date of Service: Enter the six digit date of service in the "From" field. Completion of the "To" field is not required. Do not spread the date entry across the two fields. Span billing: Span billing is permissible if the same service (same procedure code) is provided on consecutive dates. **County transportation and Community based services** Providers should refer to specific billing instructions on the use of span billing. **Durable Medical Equipment Rental** The To (i.e., Through) date of service must represent the last date of the rental period. **Global Obstetrical care** For global obstetrical care, the "From" and "To" dates of service must be entered as the date of delivery.
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. 03 School 04 Homeless Shelter 05 IHS Free-Standing Facility 06 Provider-Based Facility 07 Tribal 638 Free-Standing 08 Tribal 638 Provider-Based 11 Office 12 Home 15 Mobile Unit 20 Urgent Care Facility 21 Inpatient hospital 22 Outpatient hospital 23 Emergency room hospital 24 ASC 25 Birthing Center 26 Military Treatment Center 31 Skilled Nursing Facility 32 Nursing facility 33 Custodial Care Facility

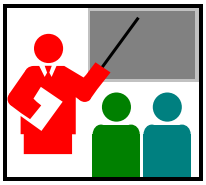
Field Label	Completion format	Instructions
19B. Place of Service (continued)	2 digits	34 Hospice 41 Transportation Land 42 Air or water transportation 50 Federally Qualified Health Center 51 Inpatient Psychiatric Facility 52 Psychiatric Facility Partial Hospitalization 53 Community mental health center 54 Intermediate Care Facility - MR 55 Residential Treatment Facility 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 72 Rural Health Clinic 81 Independent lab 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 Physicians Current Procedural Terminology (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.
Mod(ifier)	2 characters: Letters or digits May enter up to two 2 character modifiers	Conditional Enter the appropriate procedure-related modifier that applies to the billed service. Up to four modifiers may be entered when using the interactive paper claim form.

Billing instruction detail	Instructions
Modifiers 	**-26** **Professional component** Use with diagnostic codes to report professional component services (reading and interpretation) billed separately from technical component services. Report separate professional and technical component services only if different providers perform the professional and technical portions of the procedure. Read CPT descriptors carefully. Do not use modifiers if the descriptor specifies professional or technical components. **-TC** **Technical component** Use with diagnostic codes to report technical component services billed separately from professional component services. Report separate technical and professional component services only if different providers perform the professional and technical portions of the procedure. Read CPT descriptors carefully. Do not use modifiers if the descriptor specifies professional or technical components. **-KX** **Specific required documentation on file** Use with laboratory codes to certify that the laboratory's equipment is not functioning or the laboratory is not certified to perform the ordered test. The -KX modifier takes the place of the provider's certification, "I certify that the necessary laboratory equipment was not functioning to perform the requested test," or "I certify that this laboratory is not certified to perform the requested test".

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.
19F. Diagnosis Each billed line must have at least one primary diagnosis referenced.	**P** **S** **T** 1 digit per column	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. 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	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. See special instructions for Anesthesia and Psychiatric services.



Billing instruction detail	Instructions
Units of Service 	**General Instructions** A unit represents the number of times the described procedure or service was rendered. Except as instructed in this manual or in Colorado Medical Assistance Program bulletins, the billed unit must correspond to procedure code description. The following examples show the relationship between the procedure description and the entry of units. Note: The codes used in the examples are not actual CPT codes. They are used for illustration only. **Transportation** Transportation services are identified per trip and per mile. Providers must read the procedure descriptions carefully to assure that the proper billing unit is applied. **Home & Community Based Services** Combine units of services for a single procedure code for the billed time period on one detail line. Dates of service do not have to be reported separately. Example: If forty units of personal care services were provided on various days throughout the month of January, bill the personal care procedure code with a From Date of 1/3/YY and a To Date of 1/31/YY and 40 units. **Codes that define units as inclusive numbers** Some services such as allergy testing define units by the number of services as an inclusive number, not as additional services. Code — Description 11111 — Patch or application tests, up to 10 tests 22222 — 11-20 tests 33333 — 21-30 tests 44444 — More than 30 tests Billing example Total tests: 8 — Bill 11111 - 1 unit Total tests: 14 — Bill 22222 - 1 unit and 22222 - 2 units (Do not bill both 11111 and 22222) Total tests: 35 — Bill 44444 - 1 unit

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	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.
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.

Field Label	Completion format	Instructions
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.

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.

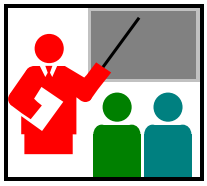
Billing Instruction Detail	Instructions
LBOD Completion Requirements	• Electronic claim formats provide specific fields for documenting the LBOD. • Supporting documentation must be kept on file for 6 years. • For paper claims, follow the instructions appropriate for the claim form you are using. ➢ *UB-04*: 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.

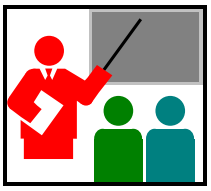
Billing Instruction Detail	Instructions
Denied Paper Claims	If the initial timely filing period has expired and a previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was denied. **Correct the 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.

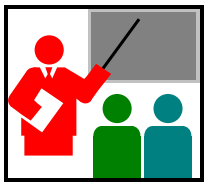
Billing Instruction Detail	Instructions
Delayed Notification of Eligibility	The provider was unable to determine that the patient had Colorado Medical Assistance Program coverage until after the timely filing period expired. **File the claim within 60 days** of the date of notification that the individual 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.

Sterilizations, Hysterectomies and Abortions

Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions 	**Voluntary sterilizations** Sterilization for the purpose of family planning is a benefit of the Colorado Medical Assistance Program in accordance with the following procedures: **General requirements** The following requirements must be followed precisely or payment will be denied. These claims **must** be filed on paper. A copy of the sterilization consent form (MED-178) must be attached to each related claim for service including the hospital, anesthesiologist, surgeon, and assistant surgeon. ♦ The individual must be at least 21 years of age at the time the consent is obtained. ♦ The individual must be mentally competent. An individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose cannot consent to sterilization. The individual can consent if she has been declared competent for purposes that include the ability to consent to sterilization. ♦ The individual must voluntarily give "informed" consent as documented on the MED-178 consent form (see illustration) and specified in the "Informed Consent Requirements" described in these instructions. ♦ At least 30 days but not more than 180 days must pass between the date of informed consent and the date of sterilization with the following exceptions: **Emergency Abdominal Surgery:** An individual may consent to sterilization at the time of emergency abdominal surgery if at least 72 hours have passed since he/she gave informed consent for the sterilization. **Premature Delivery:** A woman may consent to sterilization at the time of a premature delivery if at least 72 hours have passed since she gave informed consent for the sterilization and the consent was obtained at least 30 days prior to the expected date of delivery. The person may not be an "institutionalized individual". Institutionalized includes: ➢ Involuntarily confinement or detention, under a civil or criminal statute, in a correctional or rehabilitative facility including a mental hospital or other facility for the care and treatment of mental illness. ➢ Confinement under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.

Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions 	**If any of the above requirements are not met, the claim will be denied.** Unpaid or denied charges resulting from clerical errors such as the provider's failure to follow the required procedures in obtaining informed consent or failure to submit required documentation with the claim may not be billed to the client. **Informed consent requirements** The person obtaining informed consent must be a professional staff member who is qualified to address all the consenting individual's questions concerning medical, surgical, and anesthesia issues. Informed consent is considered to have been given when the person who obtained consent for the sterilization procedure meets **all** of the following criteria: ♦ Has offered to answer any questions that the individual who is to be sterilized may have concerning the procedure ♦ Has provided a copy of the consent form to the individual ♦ Has verbally provided all of the following information or advice to the individual who is to be sterilized: ➢ Advice that the individual is free to withhold or withdraw consent at any time before the sterilization is done without affecting the right to any future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled ➢ A description of available alternative methods of family planning and birth control ➢ Advice that the sterilization procedure is considered to be irreversible ➢ A thorough explanation of the specific sterilization procedure to be performed ➢ A full description of the discomforts and risks that may accompany or follow the performing of the procedure including an explanation of the type and possible effects of any anesthetic to be used. ➢ A full description of the benefits or advantages that may be expected as a result of the sterilization ➢ Advice that the sterilization will not be performed for at least 30 days except in the case of premature delivery or emergency abdominal surgery ➢ Suitable arrangements have been made to ensure that the preceding information was effectively communicated to an individual who is blind, deaf, or otherwise handicapped. ➢ The individual to be sterilized was permitted to have a witness of his or her choice present when consent was obtained. ➢ The consent form requirements (noted below) were met. ➢ Any additional requirement of the state or local law for obtaining consent was followed.

Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions 	➢ Informed consent may <u>not</u> be obtained while the individual to be sterilized is: ▪ In labor or childbirth; ▪ Seeking to obtain or is obtaining an abortion; and/or ▪ Under the influence of alcohol or other substances that may affect the individual's sense of awareness. **MED-178 consent form requirements** Evidence of informed consent must be provided on the MED-178 consent form. The MED-178 form is available from the Colorado Medical Assistance Program fiscal agent. The fiscal agent is required to assure that the provisions of the law have been followed before Colorado Medical Assistance Program payment can be made for sterilization procedures. A copy of the MED-178 consent form must be attached to every claim submitted for reimbursement of sterilization charges including the surgeon, the assistant surgeon, the anesthesiologist, and the hospital or ambulatory surgical center. The surgeon is responsible for assuring that the MED-178 consent form is properly completed and providing copies of the form to the other providers for billing purposes. Spanish forms are acceptable. **A sterilization consent form initiated in another state is acceptable when the text is complete and consistent with the Colorado form.** **Completion of the MED-178 consent form** The following information describes the proper completion of the MED-178 consent form and corresponds to the illustrated MED-178 form. Information entered on the consent form must correspond directly to the information on the submitted Colorado Medical Assistance Program claim form. Federal regulations require strict compliance with the requirements for completion of the MED-178 consent form or claim payment is denied. Claims that are denied because of errors, omissions, or inconsistencies on the MED-178 may be resubmitted if corrections to the consent form can be made in a legally acceptable manner. Any corrections to the patient's portion of the sterilization consent must be approved and initialed by the patient.

MED 178 Instructional Reference

Field	Completion Format	Instructions
■ Consent to Sterilization ■		
Doctor or Clinic Required	Text	Enter the name of the doctor or clinic providing the services.
Name of sterilization procedure Required	Text	Enter the name of the sterilization procedure. The procedure name must correspond to the procedure code submitted on the claim form. The name of the surgery must be consistent throughout the form. Abbreviations are acceptable.
Month **Day** **Year** Required	8 digits	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 (MMDDCCYY format). Example: 07011986 for July 1, 1986.
Name of client being sterilized Required	Text	Enter the client's last name, first name, and middle initial. The name must be legible. If the client has changed names since the signing of the consent, the provider must submit an explanation with the claim. Legal documentation of the name change is required.
Doctor Required	Text	Enter the name of the Colorado Medical Assistance Program practitioner who will perform the sterilization. If the practitioner who actually performs the sterilization procedure is not the practitioner who was supposed to perform the procedure at the time of consent, a note of explanation must be made on the claim form in the remarks section or attached to the claim form.
Name of sterilization procedure Required	Text	Enter the name of the sterilization procedure. The procedure name must correspond to the procedure named previously and to the procedure code submitted on the claim form.
Signature and Date Required	Text & digits	Obtain the signature of the client and enter the date that the client signed the consent form. The individual must be at least 21 years of age at the time the consent is signed. Court ordered documentation does not override this requirement. Any format is acceptable as long as it is legible.
State ID Required	7 characters	Enter the Colorado Medical Assistance Program client state ID number. The ID must be legible and complete.
Race and Ethnicity Designation Optional	☐ Check box	Enter a check mark in the appropriate box.

Field	Completion Format	Instructions
■ Interpreter's Statement ■		
Language designation Conditional	Text	Enter the language used for interpretation, if applicable.
Interpreter Signature Conditional	Text & digits	Obtain the interpreter's signature and date signed. If an interpreter is provided for the individual to be sterilized, the interpreter must certify that he/she has translated the information and advice presented verbally to the individual; that he/she has read and explained the contents of the consent form to the individual; and that, to the best of the interpreter's knowledge and belief, the individual understands what the interpreter has told him/her. The interpreter may be office staff, family member, friend, etc.
■ Statement of Person Obtaining Consent ■		
Name of individual Required	Text	Enter the name of the client. The name entered must match exactly the name in the Consent to Sterilization section. The name must be legible.
Sterilization Operation Required	Text	Enter the name of sterilization procedure. The procedure must be consistent with the procedure named previously and the procedure code entered on the claim form.
Signature of Person Obtaining Consent and Date Required	Text & digits	Obtain the signature of individual obtaining informed consent and date signed. By signing the consent form, the individual obtaining consent certifies that: ♦ He/she advised the patient **before** he/she signed the consent form that no benefits provided by federally funded programs and projects will be withdrawn or withheld because of the decision not to be sterilized. ♦ He/she verbally explained the requirements as set forth on the consent form for informed consent to the individual to be sterilized. ♦ To the best of his/her knowledge and belief, the individual to be sterilized appeared mentally competent and knowingly and voluntarily consented to sterilization. If the practitioner performing the sterilization procedure is also the person who obtains the informed consent, both the statement of the person obtaining consent **and** the practitioner's statement must be signed and dated.

Field	Completion Format	Instructions
Facility Required	Text	Enter the name of the clinic or practitioner with whom the person obtaining the informed consent is associated or employed. The name of the facility must be legible and complete.
Address Required	Text	Enter the address of the employing or associated clinic or practitioner. The address of the facility must be legible and complete, including zip code.
■ Physician's Statement ■		
Name of Individual To Be Sterilized Required	Text	Enter the name of the client to be sterilized. The name entered must match exactly the name in the Consent to Sterilization and Statement of Person Obtaining Consent sections.
Date of Sterilization Operation Required.	6 digits	Enter the date that the sterilization procedure was performed. The date must match exactly the date entered on the claim form. The date must be legible and complete.
Specify Type of Operation Required	Text	Enter the name of the sterilization procedure. The name must be consistent with the procedure named previously **and** to the procedure code entered on the claim form.
Alternative Final Paragraphs Required	Text	This area is completed by the operating surgeon to certify that: Paragraph (1): At least 30 days have passed between the date of the individual's signature on the consent form and the date that the sterilization was performed. **or** Paragraph (2): That the sterilization procedure was performed less than 30 days from the signature date but more than 72 hours after the signature date because of premature delivery or emergency abdominal surgery. The paragraph that is not applicable must be crossed out or the submitted claim will be denied. Circling or highlighting a paragraph or number is not acceptable.
Premature Delivery or Emergency Abdominal Surgery Conditional	Check box and/or text	If premature delivery is checked, enter the expected date of delivery. **If an expected date of delivery is not entered, the claim will be denied.** If emergency abdominal surgery is indicated, describe the circumstances of the emergency. **If the circumstances are not clearly described, the claim will be denied.**

Field	Completion Format	Instructions
Physician Signature Required	Text	Obtain the signature of the practitioner performing the sterilization procedure.
Date Required	6 digits	Enter the date that the operating surgeon signed the physician's statement. The date of signature cannot precede the date of surgery. If the practitioner signs and dates the form before the procedure is performed, all claims will be denied. The date must be legible and complete.

MED 178 Form

Colorado Medical Assistance Program Sterilization Consent Form
MED 178

NOTICE: YOUR DECISION AT ANY TIME TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITH HOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ (Doctor or Clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or the Medical Assistance Program that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks, and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the with-holding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____ (Month Day Year).

I, _____, hereby consent of my own free will to be sterilized by _____ (Doctor), by the method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about this operation to:

Representatives of the Department of Health, Education, and Welfare or

Employees of programs or projects funded by that Department but only for determining of Federal laws were observed.

I have received a copy of this form.

_____ (Signature) Date _____ (Month Day Year)

Client's Medical Assistance Program ID #:_____

You are requested to supply the following information, but it is not required:

Race and Ethnicity Designation (please check)

- ☐ American Indian or Alaska Native
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ Asian or Pacific Islander
- ☐ White (not of Hispanic origin)

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining the consent. I have also read him/her the consent form in the _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____
Interpreter Signature

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ (Name of Individual) signed the consent form, I explain to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____ (Signature of person obtaining consent) _____ (Date)

_____
Facility

_____
Address + Zip code(required)

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____ (Name of individual to be sterilized) on _____ (Date of sterilization operation).

I explained to him/her the nature of the sterilization operation _____ (Specify Type of Operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. **Cross out the paragraph, which is not used.**)

(1) At least thirty days have passed between the date of the individual's signature on the consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (**check applicable box and fill in information requested**):

- ☐ Premature delivery:
- ☐ Individual's expected date of delivery: _____
- ☐ Emergency abdominal surgery: _____

(Describe circumstances) _____

_____ (Physician's Signature) _____ (Date)

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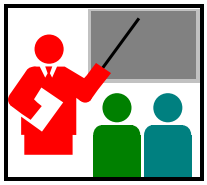
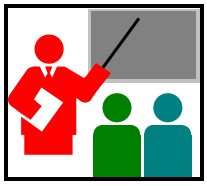
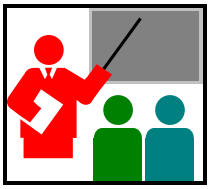
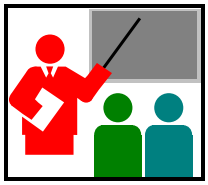
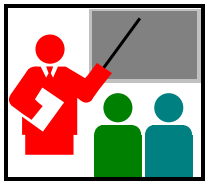
Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions (continued) 	**Hysterectomies** Hysterectomy is a benefit of the Colorado Medical Assistance Program when performed solely for medical reasons. Hysterectomy is not a benefit of the Colorado Medical Assistance Program if the procedure is performed solely for the purpose of sterilization, or if there was more than one purpose for the procedure and it would not have been performed but for the purpose of sterilization. **The following conditions must be met for payment of hysterectomy claims under the Colorado Medical Assistance Program**. These claims must be filed on paper. • Prior to the surgery, the person who secures the consent to perform the hysterectomy must inform the patient and her representative, if any, verbally and in writing that the hysterectomy will render the patient permanently incapable of bearing children. • The patient and her representative, if any, must sign a written acknowledgment that she has been informed that the hysterectomy will render her permanently incapable of reproducing. The written acknowledgment may be any form created by the provider that states specifically that, "I acknowledge that prior to surgery, I was advised that a hysterectomy is a procedure that will render me permanently incapable of having children." The acknowledgment must be signed and dated by the patient. A written acknowledgment from the patient is not required if: • The patient is already sterile at the time of the hysterectomy, or • The hysterectomy is performed because of a life-threatening emergency in which the practitioner determines that prior acknowledgment is not possible. If the patient's acknowledgment is not required because of the one of the above noted exceptions, the practitioner who performs the hysterectomy **must certify in writing**, as applicable, one of the following: • A signed and dated statement certifying that the patient was already sterile at the time of hysterectomy and stating the cause of sterility; • A signed and dated statement certifying that the patient required hysterectomy under a life-threatening, emergency situation in which the practitioner determined that prior acknowledgment by the patient was not possible. The statement must describe the nature of the emergency.

Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions (continued) 	A copy of the patient's written acknowledgment or the practitioner's certification as described above must be attached to all claims submitted for hysterectomy services. A suggested form on which to report the required information is located in Appendix J. Providers may copy this form, as needed, for attachment to claim(s). Providers may substitute any form that includes the required information. The submitted form or case summary documentation must be signed and dated by the practitioner performing the hysterectomy. The surgeon is responsible for providing copies of the appropriate acknowledgment or certification to the hospital, anesthesiologist, and assistant surgeon for billing purposes. **Claims will be denied if a copy of the written acknowledgment or practitioner's statement is not attached.** **Abortions** **Induced abortions** Therapeutic legally induced abortions are a benefit of the Colorado Medical Assistance Program when performed to save the life of the mother. The Colorado Medical Assistance Program also reimburses legally induced abortions for pregnancies that are the result of sexual assault (rape) or incest. A copy of the appropriate certification statement must be attached to all claims for legally induced abortions performed for the above reasons. Because of the attachment requirement, claims for legally induced abortions must be submitted on paper and must **not** be electronically transmitted. Claims for spontaneous abortions (miscarriages), ectopic, or molar pregnancies are not affected by these regulations. The following procedure codes are appropriate for identifying induced abortions: 59840 59841 59851 59852 59850 59855 59856 59857 Diagnosis code ranges: 635.00-635.92 637.00-637.92 Surgical diagnosis codes: 69.01 69.51 69.93 74.91 75.0

Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions (continued) 	**Providers billing on the Colorado 1500 claim form** Use the appropriate procedure/diagnosis code from the list above **and** the most appropriate modifier from the list below: • G7 - Termination of pregnancy resulting from rape or incest In addition to the required coding, all claims must be submitted with the required documentation. Claims submitted for induced abortion-related services submitted without the required documentation will be denied. ***Induced abortions to save the life of the mother*** Every reasonable effort to preserve the lives of the mother and unborn child must be made before performing an induced abortion. The services must be performed in a licensed health care facility by a licensed practitioner, unless, in the judgment of the attending practitioner, a transfer to a licensed health care facility endangers the life of the pregnant woman and there is no licensed health care facility within a 30 mile radius of the place where the medical services are performed. "**To save the life of the mother**" means: The presence of a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, as determined by the attending practitioner, which represents a serious and substantial threat to the life of the pregnant woman if the pregnancy is allowed to continue to term. The presence of a psychiatric condition which represents a serious and substantial threat to the life of the pregnant woman if the pregnancy continues to term. All claims for services related to induced abortions to save the life of the mother must be submitted with the following documentation: ➢ Name, address, and age of the pregnant woman ➢ Gestational age of the unborn child ➢ Description of the medical condition which necessitated the performance of the abortion ➢ Description of services performed ➢ Name of the facility in which services were performed ➢ Date services were rendered

Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions (continued) 	And, at least one of the following forms with additional supporting documentation that confirms life-endangering circumstances: ➢ Hospital admission summary ➢ Hospital discharge summary ➢ Consultant findings and reports ➢ Laboratory results and findings ➢ Office visit notes ➢ Hospital progress notes **A suggested form on which to report the required information is in Appendix K**. Providers may copy this form, as needed, for attachment to claim(s). Providers may substitute any form that includes the required information. The submitted form or case summary documentation must be signed and dated by the practitioner performing the abortion service. For psychiatric conditions lethal to the mother if the pregnancy is carried to term, the attending practitioner must: ➢ Obtain consultation with a physician specializing in psychiatry. ➢ Submit a report of the findings of the consultation unless the pregnant woman has been receiving prolonged psychiatric care. ***The practitioner performing the abortion is responsible for providing the required documentation to other providers (facility, anesthetist, etc.) for billing purposes.*** ***Induced abortions when pregnancy is the result of sexual assault (rape) or incest*** Sexual assault (including rape) is defined in the Colorado Revised Statutes (C.R.S.) 18-3-402 through 405, 405.3, or 405.5. Incest is defined in C.R.S. 18-6-301. Providers interested in the legal basis for the following abortion policies should refer to these statutes. All claims for services related to induced abortions resulting from sexual assault (rape) or incest **must** be submitted with the "Certification Statement for abortion for sexual assault (rape) or incest". **A suggested form is located in Appendix L**. This form **must**: ➢ Be signed and dated by the patient or guardian **and** by the practitioner performing the induced abortion AND ➢ Indicate if the pregnancy resulted from sexual assault (rape) or incest. Reporting the incident to a law enforcement or human services agency is not mandated. If the pregnant woman did report the incident, that information should be included on the Certification form. No additional documentation is required. The practitioner performing the abortion is responsible for providing the required documentation to other providers (facility, anesthetist, etc.) for billing purposes.

Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions (continued) 	**Spontaneous Abortion (Miscarriage)** ***Ectopic and molar pregnancies*** Surgical and/or medical treatment of pregnancies that have terminated spontaneously (miscarriages) and treatment of ectopic and molar pregnancies are routine benefits of the Colorado Medical Assistance Program. Claims for treatment of these conditions do not require additional documentation. The claim must indicate an ICD-9-CM diagnosis code that specifically demonstrates that the termination of the pregnancy was not performed as a therapeutic legally induced abortion. The following diagnosis codes are appropriate for identifying conditions that may properly be billed for Colorado Medical Assistance Program reimbursement. 630 Hydatidiform Mole 631 Other Abnormal Products of Conception 632 Missed Abortion 633-633.9 Ectopic Pregnancy 634-639.9 Spontaneous Abortion 656.4 Intrauterine Death The following HCPCS (CPT) procedure codes may be submitted for covered abortion and abortion related services. 58120 D & C For Hydatidiform Mole 59100-59101 Hysterectomy For Removal of Hydatidiform Mole 59800-59830 Medical and Surgical Treatment of Abortion ***Fetal anomalies incompatible with life outside the womb*** Therapeutic abortions performed due to fetal anomalies incompatible with life outside the womb are not a Colorado Medical Assistance Program benefit.

General Billing Information Revisions Log

Revision Date	Section	Pages/ Action	Made by
02/10/2007	*Late Bill Override Date – Reformatted*	*B-76; B-77*	*jg*
12/05/2011	*Replaced 997 with 999* *Replaced Implementation Guide with Technical Report 3 (TR3)*	*B-5* *B-3, B-7, B-35*	*ss*
12/06/2011	*Replaced www.chcpf.state.co.us with www.colorado.gov/hcpf*	*B-5, B-6, B-61*	*ss*
04/16/2012	*Updated TOC* *Updated General Billing Information* *Replaced Colorado 1500 claim form sample* *Updated Professional Claim Billing Instructions section* *Updated LBOD section* *Updated Sterilizations, Hysterectomies and Abortions section*	*1* *2-4* *7* *5-28* *67-70* *71-83*	*jg*
07/10/2012	*Updated TOC* *Added link to Appendices* *Removed UB-04 Billing Information* *Reformatted manual*	*I* *4* *25-32* *all*	*jg*
12/05/2012	*Replaced Dually Eligible with Medicare-Medicaid enrollee*	*7*	*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.