

Home and Community Based Services Brain Injury (BI), Community Mental Health Supports (CMHS), and Elderly Blind and Disabled (EBD)

Home and Community Based Services (HCBS) 1

Brain Injury (BI), Community Mental Health Supports (CMHS), and Elderly, Blind and Disabled (EBD) 1

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Home and Community Based Services (HCBS)

Brain Injury (BI), Community Mental Health Supports (CMHS), and Elderly, Blind and Disabled (EBD)



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)

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.

PAR Submission

The HCBS-BI, CMHS, and EBD forms are fillable electronically and are located in the Provider Services section → [Forms](#) → Prior Authorization Request (PAR) Forms → [HCBS PAR Forms-BI, CMHS, EBD, CHCBS, CLLI, and CWA](#) of the Department’s website. Mail all New, Continued Stay Review (CSR), and Revised PARs to the Department’s fiscal agent, Xerox State Healthcare at:

Xerox State Healthcare
PARs
P.O. Box 30
Denver, CO 80201-0030

Note: If submitted to the Department’s fiscal agent, the following correspondence will not be returned to case managers, outreach will not be performed to fulfill the requests, and all such requests will be recycled: 1) Paper PAR forms that do not clearly identify the case management agency in the event the form(s) need to be returned and/or 2) PAR revision requests not submitted on Department approved PAR forms, including typed letters with revision instructions. Should questions arise about what fiscal agent staff can process, please contact the appropriate Department Waiver manager.

Consumer Directed Attendant Support Services (CDASS)

For clients authorized to receive CDASS, case managers will need to enter the data into the web portal maintained [by Public Partnerships, Limited \(PPL\)](#) in addition to sending a PAR to the Department’s fiscal agent.

Case managers may also use the PAR form maintained by PPL to create the entire PAR for a client receiving CDASS as a part of the HCBS program. In addition, case managers will need to fax the final PAR approval letter to PPL before attendant timesheets will be paid.

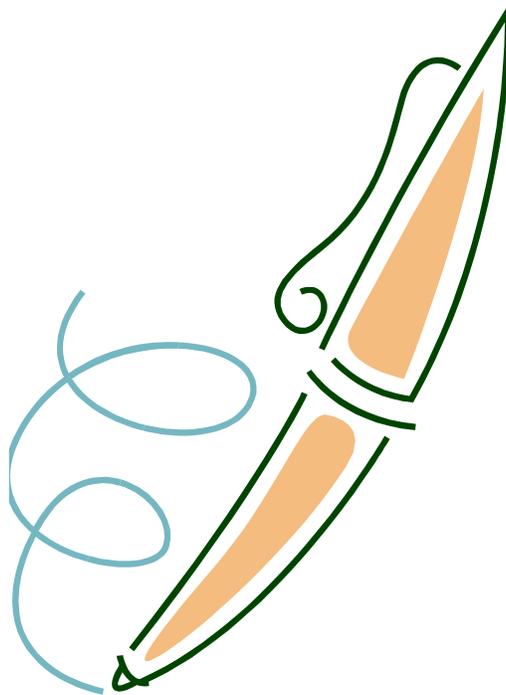
PAR Form Instructional Reference Table

Field Label	Completion Format	Instructions
PA Number being revised		Conditional Complete if PAR is a revision. Indicate original PAR number assigned.
Revision	Check box <input type="checkbox"/> Yes <input type="checkbox"/> No	Required Check the appropriate box.
Client Name	Text	Required Enter the client's last name, first name and middle initial. Example: Adams, Mary A.
Client ID	7 characters, a letter prefix followed by six numbers	Required Enter the client's state identification number. This number consists of a letter prefix followed by six numbers. Example: A123456
Sex	Check box <input type="checkbox"/> M <input type="checkbox"/> F	Required Check the appropriate box.

Field Label	Completion Format	Instructions
Birthdate	6 numbers (MM/DD/YY)	Required Enter the client's birth date using MM/DD/YY format. Example: January 1, 2010 = 01/01/10.
Requesting Physician Provider #	8 numbers	Required Enter the eight-digit Colorado Medical Assistance Program provider number of the requesting provider.
Client's County	Text	Required Enter the client's county of residence
Case Number (Agency Use)	Text	Optional Enter up to 12 characters, (numbers, letters, hyphens) which helps identify the claim or client.
Dates Covered (From/Through)	6 numbers for from date and 6 numbers for through date (MM/DD/YY)	Required Enter PAR start date and PAR end date.
Services Description	Text	Not required List of approved procedure codes for qualified and demonstration services.
Provider	Text	Optional (SEP use) Enter up to 12 characters to identify provider.
Modifier	2 Letters	Required The alphanumeric values in this column are standard and static and cannot be changed.
Max # Units	Number	Required Enter the number of units next to the services being requested for reimbursement.
Cost Per Unit	Dollar Amount	Required Enter cost per unit of service.
Total \$ Authorized	Dollar Amount	Required The dollar amount authorized for this service automatically populates.
Comments	Text	Optional Enter any additional useful information. For example, if a service is authorized for different dates than in "Dates Covered" field, please include the HCPCS procedure code and date span here.

Field Label	Completion Format	Instructions
Total Authorized HCBS Expenditures	Dollar Amount	Required Total automatically populates.
Plus Total Authorized Home Health Expenditures (Sum of Authorized Home Health Services during the HCBS Care Plan Period)	Dollar Amount	Required Enter the total Authorized Home Health expenditures.
Equals Client's Maximum Authorized Cost	Dollar Amount	Required The sum of HCBS Expenditures + Home Health Expenditures automatically populates.
Number of Days Covered	Number	Required The number of days covered automatically populates.
Average Cost Per Day	Dollar Amount	Required The client's maximum authorized cost divided by number of days in the care plan period automatically populates.
CDASS Effective Date Monthly Allocation Amt	Date (MM/DD/YY) Dollar Amount	Required for CMHS and EBD Enter CDASS information (All CDASS information must be entered in PPL's web portal).
Immediately prior to HCBS enrollment, this client lived in a long-term care facility	Check box <input type="checkbox"/> Yes <input type="checkbox"/> No	Required Check the appropriate box.
Case Manager Name	Text	Required Enter the name of the Case Manager.
Agency	Text	Required Enter the name of the agency.
Phone #	10 Numbers 123-456-7890	Required Enter the phone number of the Case Manager.
Email	Text	Required Enter the email address of the Case Manager.
Date	6 Numbers (MM/DD/YY)	Required Enter the date completed.
Case Manager's Supervisor Name	Text	Required Enter the name of the Case Manager's Supervisor.
Agency	Text	Required Enter the name of the agency.

Field Label	Completion Format	Instructions
Phone #	10 Numbers 123-456-7890	Required Enter the phone number of the Case Manager's Supervisor.
Email	Text	Required Enter the email address of the Case Manager's Supervisor.
Date	6 Numbers (MM/DD/YY)	Required Enter the date of PAR completion.



BI PAR Example

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING						
REQUEST FOR ADULT HOME AND COMMUNITY BASED SERVICES (HCBS) PRIOR APPROVAL AND COST CONTAINMENT						BI - U6
HCBS - Persons with a Brain Injury (BI) Waiver						PA Number being revised:
						Revision? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
1. CLIENT NAME		2. CLIENT ID		3. SEX		4. BIRTHDATE
Client, Ima		N555555		<input checked="" type="checkbox"/> M <input type="checkbox"/> F		6/29/1990
5. REQUESTING PROVIDER #		6. CLIENT'S COUNTY		7. CASE NUMBER (AGENCY USE)		8. DATES COVERED
00000001		Douglas				From: 07/01/13 Through: 06/30/14
STATEMENT OF REQUESTED SERVICES						
9. Description	10. Provider	11. Modifier	12. Max # Units	13. Cost Per Unit	14. Total \$ Authorized	15. Comments
S5102 Adult Day Services (U6)						
T2029 Assistive Technology, Per Purchase (U6)						
H0025 Behavioral Programming (U6)						
H2018 Day Treatment (U6)			365	\$78.79	\$28,758.35	
S5165 Home Modifications (U6)						
T2013 Independent Living Skills Training (ILST) (U6)			1825	\$25.50	\$46,537.50	
H0004 Mental Health Counseling, Family (U6)		HR				
H0004 Mental Health Counseling, Group (U6)		HQ				
H0004 Mental Health Counseling, Individual (U6)						
A0100 Non Medical Transportation (NMT), Taxi (U6)						
A0120 NMT, Mobility Van	Mileage Band 3 (over 20 miles) (U6)	TN				
A0120 NMT, Mobility Van To and From Adult Day	Mileage Band 1 (0-10 miles) (U6)					
A0130 NMT, Wheelchair Van	Mileage Band 1 (0-10 miles) (U6)					
A0130 NMT, Wheelchair Van to and From Adult Day	Mileage Band 1 (0-10 miles) (U6)	HB				
T1019 Personal Care (U6)						
T1019 Personal Care, Relative (U6)		HR				
S5160 Personal Emergency Response System (PERS) Install/Purchase (U6)						
S5161 PERS, Monitoring (U6)						
S5150 Respite Care, In Home (U6)						
H0045 Respite Care, NF (U6)						
T1006 Substance Abuse Counseling, Family (U6)		HR, HF				
H0047 Substance Abuse Counseling, Group (U6)		HQ, HF	104	\$32.46	\$3,375.84	
H0047 Substance Abuse Counseling, Individual (U6)		HF				
T2033 Supported Living Program, (U6)						
T2016 Transitional Living, Per Day (U6)						
A						
B						
C						
D						
E						
F						
G						
H						
16. TOTAL AUTHORIZED HCBS EXPENDITURES (SUM OF AMOUNTS IN COLUMN 14 ABOVE)						\$78,671.69
17. PLUS TOTAL AUTHORIZED HOME HEALTH EXPENDITURES (SUM OF AUTHORIZED HOME HEALTH SERVICES DURING THE HCBS CARE PLAN PERIOD)- Excludes In-Home Support Services amounts						\$0.00
18. EQUALS CLIENT'S MAXIMUM AUTHORIZED COST (HCBS EXPENDITURES + HOME HEALTH EXPENDITURES)						\$78,671.69
19. NUMBER OF DAYS COVERED (FROM FIELD 8 ABOVE)						365
20. AVERAGE COST PER DAY (Client's maximum authorized cost divided by number of days in the care plan period)						\$215.54
A. Monthly State Cost Containment Amount						\$0.00
B. Divided by 30.42 days = Daily Cost Containment Ceiling						\$0.00
21. Immediately prior to HCBS enrollment, this client lived in a: <input type="checkbox"/> Long-Term Care Facility <input type="checkbox"/> No <input type="checkbox"/> Hospital <input type="checkbox"/> No						
22. CASE MANAGER NAME		23. AGENCY		24. PHONE #		25. EMAIL
Jane Doe		BI Agency		303-333-3333		Jane.Doe@BIAgency.com
22A. CASE MANAGER SIGNATURE:						26. DATE
<i>Jane Doe</i>						6/30/2013
27. CASE MANAGER'S SUPERVISOR NAME		28. AGENCY		29. PHONE #		30. EMAIL
Joan Doe		BI Agency		303-333-3333		Joan.Doe@BIAgency.com
27A. CASE MANAGER'S SUPERVISOR SIGNATURE:						31. DATE
<i>Joan Doe</i>						6/30/2013
DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY						
32. CASE PLAN <input type="checkbox"/> Approved Date: <input type="checkbox"/> Denied Date: Return for correction- Date:						
33. REGULATION(S) upon which Denial or Return is based:						
34. DEPARTMENT APPROVAL SIGNATURE:						35. DATE:

CMHS PAR Example

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING						
REQUEST FOR ADULT HOME AND COMMUNITY-BASED SERVICES (HCBS) PRIOR APPROVAL AND COST CONTAINMENT					CMHS- UA	
HCBS - Community Mental Health Supports (CMHS) Waiver					PA Number being revised:	
					Revision? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
1. CLIENT NAME Clint, Ima	2. CLIENT ID H222222	3. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	4. BIRTHDATE 9/12/1972			
5. REQUESTING PROVIDER # 00000002	6. CLIENT'S COUNTY Mesa	7. CASE NUMBER (AGENCY USE)	8. DATES COVERED From: 07/15/13 Through: 07/14/14			
STATEMENT OF REQUESTED SERVICES						
9. Description	10. Provider	11. Modifier	12. Max # Units	13. Cost Per Unit	14. Total \$ Authorized	15. Comments:
S5105 Adult Day Services, Basic (UA)						
S5105 Adult Day Services, Specialized (UA)		TF				
T2031 Alternative Care Facility (ACF) (UA)						
T2025 CDASS (Cent/Unit) (UA)						
T2040 CDASS Per Member/ Per Month (PMPM) (UA)						
S5165 Home Modifications (UA)						
S5130 Homemaker (UA)			732	\$3.76	\$2,752.32	1hr/2wk for 26 wks
T2029 Medication Reminder, Install/Purchase (UA)						
S5185 Medication Reminder, Monitoring (UA)						
A0100 NMT, Taxi (UA)						
A0120 NMT, Mobility Van	Mileage Band 1 (0-10 miles) (UA)					
A0120 NMT, Mobility Van To and From Adult Day	Mileage Band 1 (0-10 miles) (UA)	HB				
A0130 NMT, Wheelchair Van	Mileage Band 1 (0-10 miles) (UA)					
A0130 NMT, Wheelchair Van To and From Adult Day	Mileage Band 1 (0-10 miles) (UA)	HB				
T1019 Personal Care (UA)			3900	\$3.76	\$14,664.00	1.16hr/1wk for 62 wks
T1019 Personal Care, Relative (UA)		HR				
S5160 Personal Emergency Response System (PERs) Install/Purchase (UA)						
S5161 PERs, Monitoring (UA)						
S5151 Respite Care, ACF (UA)						
H0045 Respite Care, NF (UA)						
A						
B						
C						
D						
E						
F						
G						
H						
16. TOTAL AUTHORIZED HCBS EXPENDITURES (SUM OF AMOUNTS IN COLUMN 14 ABOVE)					\$17,416.32	
17. PLUS TOTAL AUTHORIZED HOME HEALTH EXPENDITURES (SUM OF AUTHORIZED HOME HEALTH SERVICES DURING THE HCBS CARE PLAN PERIOD)- Excludes In-Home Support Services amounts					\$0.00	
18. EQUALS CLIENT'S MAXIMUM AUTHORIZED COST (HCBS EXPENDITURES +HOME HEALTH EXPENDITURES)					\$17,416.32	
19. NUMBER OF DAYS COVERED (FROM FIELD 8 ABOVE)					365	
20. AVERAGE COST PER DAY (Client's maximum authorized cost divided by number of days in the care plan period)					\$47.72	
A. Monthly State Cost Containment Amount					\$5,361.22	
B. Divided by 30.42 days = Daily Cost Containment Ceiling					\$176.24	
21. CDASS (amounts must match client's allocation worksheet)			Effective Date:	Monthly Allocation Amt:		
				\$0.00		
22. Immediately prior to HCBS enrollment, this client lived in a long term care facility? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
23. CASE MANAGER NAME Jane Doe	24. AGENCY CMHS Agency	25. PHONE # 303-333-3333	26. EMAIL Jane.Doe@CMHSAgency.com		27. DATE 7/1/2013	
23A. CASE MANAGER SIGNATURE: <i>Jane Doe</i>						
28. CASE MANAGER'S SUPERVISOR NAME Joan Doe	29. AGENCY CMHS Agency	30. PHONE # 303-333-3333	31. EMAIL Joan.Doe@CMHSAgency.com		32. DATE 7/1/2013	
28A. CASE MANAGER'S SUPERVISOR SIGNATURE: <i>Joan Doe</i>						
DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY						
33. CASE PLAN: <input type="checkbox"/> Approved Date: <input type="checkbox"/> Denied Date: <input type="checkbox"/> Return for correction- Date:						
34. REGULATION(S) upon which Denial or Return is based:						
35. DEPARTMENT APPROVAL SIGNATURE:					36. DATE:	

EBD PAR Example

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING						
REQUEST FOR ADULT HOME AND COMMUNITY BASED SERVICES (HCBS) PRIOR APPROVAL AND COST CONTAINMENT					EBD-U1	
HCBS - Persons who are Elderly, Blind, and Disabled (EBD) Waiver					PA Number being revised	
					Revision? <input type="checkbox"/> Yes <input type="checkbox"/> No	
1. CLIENT NAME		2. CLIENT ID		3. SEX	4. BIRTHDATE	
Client, Ima		H555555		<input checked="" type="checkbox"/> M <input type="checkbox"/> F	4/14/1958	
5. REQUESTING PROVIDER #		6. CLIENT'S COUNTY		8. DATES COVERED		
00000001		Adams		From: 08/01/13 Through: 07/31/14		
STATEMENT OF REQUESTED SERVICES						
9. Description	10. Provider	11. Modifier	12. Max # Units	13. Cost Per Unit	14. Total \$ Authorized	15. Comments:
S5105 Adult Day Services, Basic (U1)						
S5105 Adult Day Services, Specialized (U1)		TF	416	\$30.13	\$12,534.08	
T2031 Alternative Care Facility (ACF) (U1)						
T2038 Community Transition Services, Coordinator (U1)						
A9900 Community Transition Services, Items Purchased (U1)						
T2025 Consumer Directed Assistance Support Services (CDASS) (Cent/Unit) (U1)			700000	\$0.01	\$7,000.00	
T2040 CDASS Per Member/Per Month (PMPM) (U1)			12	\$310.00	\$3,720.00	
S5185 Home Modifications (U1)						
S5130 Homemaker (U1)						
H0038 IHSS Health Maintenance Activities (U1)						
S5130 IHSS Homemaker (U1)		KX				
T1019 IHSS Personal Care (U1)		KX				
T1019 IHSS Relative Personal Care (U1)		HR, KX				
T2029 Medication Reminder, Install/Purchase (U1)						
S5185 Medication Reminder, Monitoring (U1)						
A0100 NMT, Taxi (U1)						
A0120 NMT, Mobility Van	Mileage Band 1 (0-10 miles) (U1)					
A0120 NMT, Mobility Van To and From Adult Day	Mileage Band 1 (0-10 miles) (U1)	HB				
A0130 NMT, Wheelchair Van	Mileage Band 1 (0-10 miles) (U1)					
A0130 NMT, Wheelchair Van To and From Adult Day	Mileage Band 1 (0-10 miles) (U1)	HB				
T1019 Personal Care (U1)						
T1019 Personal Care, Relative (U1)		HR				
S5160 Personal Emergency Response System (PERs) Install/Purchase (U1)						
S5161 PERs, Monitoring (U1)						
S5151 Respite Care, ACF (U1)						
S5150 Respite Care, In Home (U1)						
H0045 Respite Care, NF (U1)			30	\$124.03	\$3,720.90	
A						
B						
C						
D						
E						
F						
G						
H						
16. TOTAL AUTHORIZED HCBS EXPENDITURES (SUM OF AMOUNTS IN COLUMN 14 ABOVE)					\$26,974.98	
17. PLUS TOTAL AUTHORIZED HOME HEALTH EXPENDITURES (SUM OF AUTHORIZED HOME HEALTH SERVICES DURING THE HCBS CARE PLAN PERIOD)- Excludes In-Home Support Services amounts					\$0.00	
18. EQUALS CLIENT'S MAXIMUM AUTHORIZED COST (HCBS EXPENDITURES + HOME HEALTH EXPENDITURES)					\$26,974.98	
19. NUMBER OF DAYS COVERED (FROM FIELD 8 ABOVE)					365	
20. AVERAGE COST PER DAY (Client's maximum authorized cost divided by number of days in the care plan period)					\$73.90	
A. Monthly State Cost Containment Amount					\$5,082.88	
B. Divided by 30.42 days = Daily Cost Containment Ceiling					\$167.09	
21. CDASS (amounts must match client's allocation worksheet)			Effective Date:	Monthly Allocation Amt:	\$0.00	
22. Immediately prior to HCBS enrollment, this client lived in a long term care facility? <input type="checkbox"/> Yes <input type="checkbox"/> No						
23. CASE MANAGER NAME		24. AGENCY	25. PHONE #	26. EMAIL	27. DATE	
John Doe		EBD Agency	303-333-3333	John.Doe@EBDAgency.com	7/30/2013	
23A. CASE MANAGER SIGNATURE: <i>John Doe</i>						
28. CASE MANAGER'S SUPERVISOR NAME		29. AGENCY	30. PHONE #	31. EMAIL	32. DATE	
Joan Doe		EBD Agency	303-333-3333	Joan.Doe@EBDAgency.com	7/31/2013	
28A. CASE MANAGER'S SUPERVISOR SIGNATURE: <i>Joan Doe</i>						
DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY						
33. CASE PLAN: <input type="checkbox"/> Approved Date:		<input type="checkbox"/> Denied Date:		Return for correction- Date:		
34. REGULATION(S) upon which Denial or Return is based:						
35. DEPARTMENT APPROVAL SIGNATURE:					36. DATE:	

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.



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.

Persons with a 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 Services	S5102	U6	1 unit = 1 day
Assistive Technology	T2029	U6	Negotiated by case manager through prior authorization
Behavioral Programming	H0025	U6	1 unit= 30 minutes
Consumer Directed Attendant Support Services (CDASS) (Cent/Unit)	T2025	U6	Negotiated by case manager through prior authorization.
CDASS Per Member/Per Month (PM/PM)	T2040	U6	Negotiated by case manager through prior authorization.
Day Treatment	H2018	U6	1 unit = 1 day
Home Modifications	S5165	U6	1 unit = per service
Independent Living Skills Training (ILST)	T2013	U6	1 unit = 1 hour
Mental Health Counseling, Family	H0004	U6, HR	1 unit = 15 minutes
Mental Health Counseling, Group	H0004	U6, HQ	1 unit = 15 minutes
Mental Health Counseling, Individual	H0004	U6	1 unit = 15 minutes
Non-Medical Transportation (NMT), Taxi	A0100	U6	1 unit=one way trip
NMT, Mobility Van			
Mileage Band 1 (0-10 miles)	A0120	U6	1 unit=one way trip
Mileage Band 2 (11-20 miles)	A0120	U6, TT	1 unit=one way trip
Mileage Band 3 (over 20 miles)	A0120	U6, TN	1 unit=one way trip

HCBS-BI Procedure Code Table (Special Program Code 89)			
NMT, Mobility Van, To and From Adult Day			
Mileage Band 1 (0-10 miles)	A0120	U6, HB	1 unit=one way trip
Mileage Band 2 (11-20 miles)	A0120	U6, TT, HB	1 unit=one way trip
Mileage Band 3 (over 20 miles)	A0120	U6, TN, HB	1 unit=one way trip
NMT, Wheelchair Van			
Mileage Band 1 (0-10 miles)	A0130	U6	1 unit=one way trip
Mileage Band 2 (11-20 miles)	A0130	U6, TT	1 unit=one way trip
Mileage Band 3 (over 20 miles)	A0130	U6, TN	1 unit=one way trip
NMT, Wheelchair Van, To and From Adult Day			
Mileage Band 1 (0-10 miles)	A0130	U6, HB	1 unit=one way trip
Mileage Band 2 (11-20 miles)	A0130	U6, TT, HB	1 unit=one way trip
Mileage Band 3 (over 20 miles)	A0130	U6, TN, HB	1 unit=one way trip
Personal Care	T1019	U6	1 unit = 15 minutes
Personal Care, Relative	T1019	U6, HR	1 unit = 15 minutes
Personal Emergency Response System (PERs) Install/Purchase	S5160	U6	Negotiated by case manager through prior authorization.
PERs, Monitoring	S5161	U6	Negotiated by case manager through prior authorization.
Respite Care, In Home	S5150	U6	1 unit = 15 minutes
Respite Care, Nursing Facility (NF)	H0045	U6	1 unit = 1 day
Substance Abuse Counseling, Family	T1006	U6	1 unit = 1 hour
Substance Abuse Counseling, Group	H0047	U6, HQ	1 unit = 1 hour
Substance Abuse Counseling, Individual	H0047	U6, HF	1 unit = 1 hour
Supported Living Program	T2033	U6	1 unit = 1 day
Transitional Living, Per Day	T2016	U6	1 unit = 1 day



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	Completion format	Special Instructions
Invoice/Pat Acct Number	Up to 12 characters: letters, numbers or hyphens	Optional Enter information that identifies the patient or claim in the provider's billing system. Submitted information appears on the Provider Claim Report.
Special Program Code	2 digits	Required Code 89 identifies the HCBS-BI program.
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 <input type="checkbox"/> Female <input type="checkbox"/>	Required Enter a check mark or an "x" in the correct box to indicate the client's sex.
6. Medicare ID Number (HIC or SSN)	Up to 11 characters: numbers and letters	Not required
7. Client relationship to Insured	Check box Self Spouse <input type="checkbox"/> <input type="checkbox"/> Child Other <input type="checkbox"/> <input type="checkbox"/>	Not required

Field Label	Completion format	Special Instructions
8. Client is covered by Employer Health Plan	Text	Not required
9. Other Health Insurance Coverage	Text	Not required
9A. Policyholder Name and Address	Text	Not required
10. Was condition related to	Check box A. Client employment <input type="checkbox"/> Check box B. Accident <input type="checkbox"/> 6 digits: MMDDYY C. Date of accident 6 digits: MMDDYY	Not required
11. CHAMPUS Sponsors Service/SSN	10 digits	Not required
Durable Medical Equipment Model/serial number (unlabeled field)	20 characters	Not required
12. Pregnancy PHP Nursing Facility Resident	Check box <input type="checkbox"/> Check box <input type="checkbox"/> Check box <input type="checkbox"/>	Not required Not required Not required
13. Date of illness or injury or pregnancy	6 digits: MMDDYY	Not required
14. Medicare Denial	Check box <input type="checkbox"/> Benefits Exhausted <input type="checkbox"/> Non-covered services	Not required

Field Label	Completion format	Special Instructions
14A. Other Coverage Denied	Check box No <input type="checkbox"/> Yes <input type="checkbox"/> Pay/Deny Date 6 digits: MMDDYY	Not required
15. Name of supervising physician Provider Number	Text 8 digits	Not required
16. For services related to hospitalization	6 digits: MMDDYY	Not required
17. Name and address of facility where services rendered Provider Number	Text (address is optional) 8 digits	Not required
18. ICD-9-CM	1 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 2 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 3 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 4 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Codes: 3, 4, or 5 characters. 1 st character may be a letter.	Required At least one diagnosis code must be entered. HCBS may use 7999.
Diagnosis or nature of illness or injury	Text	Not required If entered the written description must match the code(s).
Transportation Certification attached	Check box <input type="checkbox"/>	Not required
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. Complete when the service requires prior authorization.

Field Label	Completion format	Special Instructions
<p>19A. Date of Service</p>	<p>From: 6 digits MMDDYY To: 6 digits MMDDYY</p>	<p>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 2013 Or From To 01 01 2013 01 01 2013 Span dates of service 01 01 2013 01 31 2013 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..</p>
<p>19B. Place of Service</p>	<p>2 digits</p>	<p>Required Enter place of service code 11-Office or 12 - Patient’s residence.</p>
<p>19C. Procedure Code (HCPCS code)</p>	<p>5 characters: 5 digits or 1 letter plus 4 digits or 2 letters plus 3 digits</p>	<p>Required Refer to the BI procedure code table.</p>
<p>Modifier</p>	<p>2 characters: Letters or digits May enter up to two 2 character modifiers</p>	<p>Required Refer to the modifiers listed in the BI procedure code table.</p>
<p>19D. Rendering Provider No.</p>	<p>8 digits</p>	<p>Not required</p>
<p>19E. Referring Provider No.</p>	<p>8 digits</p>	<p>Not required</p>

Field Label	Completion format	Special Instructions
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.
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 <input type="checkbox"/>	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.
19K. Family Planning	Check box <input type="checkbox"/>	Conditional Enter a check mark or an "x" in the column to indicate the service is rendered for family planning.
19L. EPSDT	Check box <input type="checkbox"/>	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.
20. Total Charges	7 digits: Currency 99999.99	Required Enter the sum of all charges listed in the 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	Not required
22. Third Party Paid	7 digits: Currency 99999.99	Not required

Field Label	Completion format	Special Instructions
<p>23. Net Charge</p>	<p>7 digits: Currency 99999.99</p>	<p>Required</p> <p>Colorado Medical Assistance Program claims (Not Medicare Crossover)</p> <p>Claims without third party payment. Net charge equals the total charge (field 20).</p> <p>Claims with third party payment. Net charge equals the total charge (field 20) minus the third party payment (field 22) amount.</p> <p>Medicare Crossover claims</p> <p>Crossover claims without third party payment. Net charge equals the sum of the Medicare deductible amount (field 24) plus the Medicare coinsurance (field 25) amount.</p> <p>Crossover claims with third party payment. Net charge equals the sum of the Medicare deductible amount (field 24) plus the Medicare coinsurance (field 25) amount minus the third party payment (field 22) amount.</p>
<p>24. Medicare Deductible</p>	<p>7 digits: Currency 99999.99</p>	<p>Not required</p>
<p>25. Medicare Coinsurance</p>	<p>7 digits: Currency 99999.99</p>	<p>Not required</p>
<p>26. Medicare Disallowed</p>	<p>7 digits: Currency 99999.99</p>	<p>Not required</p>
<p>27. Signature</p>	<p>Text</p>	<p>Required</p> <p>Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent.</p> <p>A holographic signature stamp may be used <u>if</u> authorization for the stamp is on file with the fiscal agent.</p> <p>An authorized agent or representative may sign the claim for the enrolled provider <u>if</u> the name and signature of the agent is on file with the fiscal agent.</p> <p>Unacceptable signature alternatives:</p> <p>Claim preparation personnel may not sign the enrolled provider's name.</p> <p>Initials are not acceptable as a signature.</p> <p>Typed or computer printed names are not acceptable as a signature.</p> <p>"Signature on file" notation is not acceptable in place of an authorized signature.</p>

Field Label	Completion format	Special Instructions
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 Late Bill Override Date for timely filing.



HCBS-BI Claim Example

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND
FINANCING

INVOICE/PAT ACCT NUMBER
SPECIAL PROGRAM CODE

HEALTH INSURANCE CLAIM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL) Client, Ima	2. CLIENT DATE OF BIRTH 06/29/1990	3. MEDICAID ID NUMBER (CLIENT ID NUMBER) N555555
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. CLIENT SEX MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/>	6. MEDICARE ID NUMBER (HIC OR SSN)
TELEPHONE NUMBER	7. CLIENT RELATIONSHIP TO INSURED SELF <input checked="" type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. <input type="checkbox"/> CLIENT IS COVERED BY EMPLOYER HEALTH PLAN AS EMPLOYEE OR DEPENDENT EMPLOYER NAME: _____
9. OTHER HEALTH INSURANCE COVERAGE — INSURANCE COMPANY NAME, ADDRESS, PLAN NAME, AND POLICY NUMBER(S) TELEPHONE NUMBER	10. WAS CONDITION RELATED TO: A. CLIENT EMPLOYMENT YES <input type="checkbox"/> B. ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/> C. DATE OF ACCIDENT <input type="text"/>	POLICYHOLDER NAME: _____ GROUP: _____ 11. CHAMPUS SPONSORS SERVICE/SSN
9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE) TELEPHONE NUMBER	12. PREGNANCY <input type="checkbox"/> HMO <input type="checkbox"/> NURSING FACILITY <input type="checkbox"/>	

PHYSICIAN OR SUPPLIER INFORMATION

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

18. ICD-9-CM DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. IN COLUMN F, RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE NUMBERS 1, 2, 3, OR 4	TRANSPORTATION CERTIFICATION ATTACHED <input type="checkbox"/> YES
1. 304	DURABLE MEDICAL EQUIPMENT Line # Make Model Serial Number
2. _____	PRIOR AUTHORIZATION #:
3. _____	
4. _____	

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. EPBDT
07/01/2013 07/31/2013	10	H2018	U6			1	\$2,363.70	30		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE, AND COMPLETE. I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS.	20. TOTAL CHARGES → \$2,363.70	LESS ↓ 21. MEDICARE PAID <input type="text"/>	24. MEDICARE DEDUCTIBLE <input type="text"/> \$0.00
27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE <i>Authorized Signature 11/08/13</i>	30. REMARKS	22. THIRD PARTY PAID <input type="text"/> \$0.00	25. MEDICARE COINSURANCE <input type="text"/> \$0.00
28. BILLING PROVIDER NAME HCBS- BI Provider		23. NET CHARGE <input type="text"/> \$2,363.70	26. MEDICARE DISALLOWED <input type="text"/>
29. BILLING PROVIDER NUMBER 12345678		COLORADO 1500	

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

Community Mental Health Supports (CMHS), and Persons who are Elderly, Blind, and Disabled (EBD)

The HCBS-CMHS and EBD waiver programs provide a variety of services to the Elderly, Blind and Disabled (EBD), and Community Mental Health Supports (HCBS-CMHS), formally known as Persons with Major Mental Illness (MI), 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 Services**– Services furnished between three (3) – five (5) 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.

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:

Note: HCBS-CMHS offers CDASS and Medication Reminders as well.

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-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 Services, Basic	S5105	UA	1 unit = 3-5 hours
Adult Day Services, Specialized	S5105	UA, TF	1 unit = 3-5 hours
Alternative Care Facility	T2031	UA	1 unit =1 day
Consumer Directed Attendant Support Services (CDASS) (Cent/Unit)	T2025	UA	Negotiated by case manager through prior authorization.
CDASS Per Member/Per Month (PM/PM)	T2040	UA	Negotiated by case manager through prior authorization.
Home Modifications	S5165	UA	1 unit =1 modification
Homemaker	S5130	UA	1 unit = 15 minutes
Medication Reminder, Install/Purchase	T2029	UA	1 unit = 1 purchase
Medication Reminder, Monitoring	S5185	UA	1 unit per month
Non-Medical Transportation (NMT), Taxi	A0100	UA	1 unit=one way trip

HCBS-CMHS Procedure Code Table (Special Program Code 94)			
Description	Procedure Code	Modifier(s)	Units
NMT, Mobility Van			
Mileage Band 1 (0-10 miles)	A0120	UA	1 unit=one way trip
Mileage Band 2 (11-20 miles)	A0120	UA, TT	1 unit=one way trip
Mileage Band 3 (over 20 miles)	A0120	UA, TN	1 unit=one way trip
NMT, Mobility Van, To and From Adult Day			
Mileage Band 1 (0-10 miles)	A0120	UA, HB	1 unit=one way trip
Mileage Band 2 (11-20 miles)	A0120	UA, TT, HB	1 unit=one way trip
Mileage Band 3 (over 20 miles)	A0120	UA, TN, HB	1 unit=one way trip
NMT, Wheelchair Van			
Mileage Band 1 (0-10 miles)	A0130	UA	1 unit=one way trip
Mileage Band 2 (11-20 miles)	A0130	UA, TT	1 unit=one way trip
Mileage Band 3 (over 20 miles)	A0130	UA, TN	1 unit=one way trip
NMT, Wheelchair Van, To and From Adult Day			
Mileage Band 1 (0-10 miles)	A0130	UA, HB	1 unit=one way trip
Mileage Band 2 (11-20 miles)	A0130	UA, TT, HB	1 unit=one way trip
Mileage Band 3 (over 20 miles)	A0130	UA, TN, HB	1 unit=one way trip
Personal Care	T1019	UA	1 unit = 15 minutes
Personal Care, Relative	T1019	UA, HR	1 unit = 15 minutes
Personal Emergency Response System (PERs) Install/Purchase	S5160	UA	1 unit = purchase and installation
PERs, Monitoring	S5161	UA	1 unit =1 month of service
Respite Care, Alternative Care Facility (ACF)	S5151	UA	1 unit = 1 day
Respite Care, Nursing Facility (NF)	H0045	UA	1 unit =1 day

HCBS-EBD Procedure Code Table

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

HCBS-EBD Procedure Code Table (Special Program Code 82)			
Description	Procedure Code	Modifier(s)	Units
Adult Day Services, Basic	S5105	U1	1 unit = 3-5 hours
Adult Day Services, Specialized	S5105	U1, TF	1 unit = 3-5 hours
Alternative Care Facility	T2031	U1	1 unit =1 day
Community Transition Services, Coordinator	T2038	U1	1 unit = 1 transition

HCBS-EBD Procedure Code Table (Special Program Code 82)			
Description	Procedure Code	Modifier(s)	Units
Community Transition Services, Items Purchased	A9900	U1	1 unit = purchase
Consumer Directed Attendant Support Services (CDASS) (Cent/Unit)	T2025	U1	Negotiated by case manager through prior authorization.
CDASS Per Member/Per Month (PM/PM)	T2040	U1	Negotiated by case manager through prior authorization.
Home Modifications	S5165	U1	1 unit =1 modification
Homemaker	S5130	U1	1 unit = 15 minutes
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
Medication Reminder, Install/Purchase	T2029	U1	1 unit = 1 purchase
Medication Reminder, Monitoring	S5185	U1	1 unit per month
Non-Medical Transportation (NMT), Taxi	A0100	U1	1 unit=one way trip
NMT, Mobility Van			
Mileage Band 1 (0-10 miles)	A0120	U1	1 unit=one way trip
Mileage Band 2 (11-20 miles)	A0120	U1, TT	1 unit=one way trip
Mileage Band 3 (over 20 miles)	A0120	U1, TN	1 unit=one way trip
NMT, Mobility Van, To and From Adult Day			
Mileage Band 1 (0-10 miles)	A0120	U1, HB	1 unit=one way trip
Mileage Band 2 (11-20 miles)	A0120	U1, TT, HB	1 unit=one way trip
Mileage Band 3 (over 20 miles)	A0120	U1, TN, HB	1 unit=one way trip
NMT, Wheelchair Van			
Mileage Band 1 (0-10 miles)	A0130	U1	1 unit=one way trip
Mileage Band 2 (11-20 miles)	A0130	U1, TT	1 unit=one way trip
Mileage Band 3 (over 20 miles)	A0130	U1, TN	1 unit=one way trip
NMT, Wheelchair Van, To and From Adult Day			
Mileage Band 1 (0-10 miles)	A0130	U1, HB	1 unit=one way trip
Mileage Band 2 (11-20 miles)	A0130	U1, TT, HB	1 unit=one way trip
Mileage Band 3 (over 20 miles)	A0130	U1, TN, HB	1 unit=one way trip
Personal Care	T1019	U1	1 unit = 15 minutes
Personal Care, Relative	T1019	U1, HR	1 unit = 15 minutes
Personal Emergency Response System (PERs) Install/Purchase	S5160	U1	1 unit = purchase and installation
PERs, Monitoring	S5161	U1	1 unit =1 month of service

HCBS-EBD Procedure Code Table (Special Program Code 82)			
Description	Procedure Code	Modifier(s)	Units
Respite Care, Alternative Care Facility (ACF)	S5151	U1	1 unit = 1 day
Respite Care, In Home	S5150	U1	1 unit = 15 minutes
Respite Care - Nursing Facility (NF)	H0045	U1	1 unit =1 day



HCBS-CMHS and EBD 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-CMHS and HCBS-EBD claims:

Field Label	Completion Format	Special Instructions
Invoice/Pat Acct Number	Up to 12 characters: letters, numbers or hyphens	Optional Enter information that identifies the patient or claim in the provider's billing system. Submitted information appears on the Provider Claim Report.
Special Program Code	2 digits	Required Code 94 identifies the HCBS-CMHS program Code 82 identifies the HCBS-EBD program
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. Colorado Medical Assistance Program 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 <input type="checkbox"/> Female <input type="checkbox"/>	Required Enter a check mark or an "x" in the correct box to indicate the client's sex.
6. Medicare ID Number (HIC or SSN)	Up to 11 characters: numbers and letters	Not required
7. Client relationship to Insured	Check box Self Spouse <input type="checkbox"/> <input type="checkbox"/> Child Other <input type="checkbox"/> <input type="checkbox"/>	Not required

Field Label	Completion Format	Special Instructions
8. Client is covered by Employer Health Plan	Text	Not required
9. Other Health Insurance Coverage	Text	Not required
9A. Policyholder Name and Address	Text	Not required
10. Was condition related to	Check box A. Client employment <input type="checkbox"/> Check box B. Accident <input type="checkbox"/> 6 digits: MMDDYY C. Date of accident 6 digits: MMDDYY	Not required
11. CHAMPUS Sponsors Service/SSN	10 digits	Not required
Durable Medical Equipment Model/serial number (unlabeled field)	20 characters	Not required
12. Pregnancy PHP Nursing Facility Resident	Check box <input type="checkbox"/> Check box <input type="checkbox"/> Check box <input type="checkbox"/>	Not required Not required Not required
13. Date of illness or injury or pregnancy	6 digits: MMDDYY	Not required
14. Medicare Denial	Check box <input type="checkbox"/> Benefits Exhausted <input type="checkbox"/> Non-covered services	Not required
14A. Other Coverage Denied	Check box No <input type="checkbox"/> Yes <input type="checkbox"/> Pay/Deny Date 6 digits: MMDDYY	Not required
15. Name of supervising physician Provider Number	Text 8 digits	Not required
16. For services related to hospitalization	6 digits: MMDDYY	Not required

Field Label	Completion Format	Special Instructions
17. Name and address of facility where services rendered Provider Number	Text (address is optional) 8 digits	Not required
18. ICD-9-CM	1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/> Codes: 3, 4, or 5 characters. 1 st character may be a letter.	Required At least one diagnosis code must be entered. HCBS may use 7999.
Diagnosis or nature of illness or injury	Text	Not required
Transportation Certification attached	Check box <input type="checkbox"/>	Not required
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. Complete when the service requires prior authorization.



Field Label	Completion Format	Special Instructions
19A. Date of Service	From: 6 digits MMDDYY To: 6 digits MMDDYY	Required The field accommodates the entry of two dates: a “beginning” or “from” date of service and an “ending” or “to” date of service. Single date of service From To 01 01 2013 Or From To 01 01 2013 01 01 2013 Span dates of service 01 01 2013 01 31 2013 Single Date of Service: Enter the six digit date of service in the “From” field. Completion of the “To” field is not required. Do not spread the date entry across the two fields. Span billing: Span billing is permissible if the same service (same procedure code) is provided on consecutive dates.
19B. Place of Service	2 digits	Required Enter place of service code 12 - Home. <i>Note: Use POS Code 12 (Home) for Alternative Care Facility, Adult Day Program, or Respite in the Facility.</i>
19C. Procedure Code (HCPCS code)	5 characters:	Required Refer to the HCBS-EBD or HCBS-CMHS procedure code table.
Modifier	2 characters: Letters or digits May enter up to two 2 character modifiers	Required Refer to the modifiers listed in the BI procedure code table.
19D. Rendering Provider No.	8 digits	Not required
19E. Referring Provider No.	8 digits	Not required

Field Label	Completion Format	Special Instructions																										
<p>19F. Diagnosis Each billed line must have at least one primary diagnosis referenced.</p>	<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px; text-align: center;">P</td> <td style="width: 20px; text-align: center;">S</td> <td style="width: 20px; text-align: center;">T</td> </tr> <tr> <td style="width: 20px; text-align: center;">1</td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> </tr> </table> <p>1 digit per column</p>	P	S	T	1			<p>Required</p> <p>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.</p> <p>From field 18 To field(s) 19F</p> <table style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px;">1</td> <td style="width: 40px; border: 1px solid black; text-align: center;">7 9 9 9 </td> <td style="width: 50px; text-align: center;">↓</td> <td style="width: 40px; border: 1px solid black; text-align: center;">P S T</td> </tr> <tr> <td>2</td> <td style="border: 1px solid black; text-align: center;"> </td> <td></td> <td style="border: 1px solid black; text-align: center;"> </td> </tr> <tr> <td>3</td> <td style="border: 1px solid black; text-align: center;"> </td> <td style="text-align: center;">Line 1</td> <td style="border: 1px solid black; text-align: center;">1 </td> </tr> <tr> <td>4</td> <td style="border: 1px solid black; text-align: center;"> </td> <td style="text-align: center;">Line 2</td> <td style="border: 1px solid black; text-align: center;">1 </td> </tr> <tr> <td></td> <td></td> <td style="text-align: center;">Line 3</td> <td style="border: 1px solid black; text-align: center;">1 </td> </tr> </table>	1	7 9 9 9	↓	P S T	2				3		Line 1	1	4		Line 2	1			Line 3	1
P	S	T																										
1																												
1	7 9 9 9	↓	P S T																									
2																												
3		Line 1	1																									
4		Line 2	1																									
		Line 3	1																									
<p>19G. Charges</p>	<p>7 digits: Currency 99999.99</p>	<p>Required</p> <p>Enter the usual and customary charge for the service represented by the procedure code on the detail line.</p> <p>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.</p> <p>Submitted charges cannot be more than charges made to non-Colorado Medical Assistance Program covered individuals for the same service.</p> <p>Do not deduct Colorado Medical Assistance Program co-payment or commercial insurance payments from usual and customary charges</p>																										
<p>19H. Days or Units</p>	<p>4 digits</p>	<p>Required</p> <p>Enter the number of services provided for each procedure code. Enter whole numbers only. Do not enter fractions or decimals. See special instructions for Anesthesia and Psychiatric services.</p>																										

Field Label	Completion Format	Special 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 <input type="checkbox"/>	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.
19K. Family Planning	Check box <input type="checkbox"/>	Conditional Enter a check mark or an "x" in the column to indicate the service is rendered for family planning.
20. Total Charges	7 digits: Currency 99999.99	Required Enter the sum of all charges listed in the 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	Not required
22. Third Party Paid	7 digits: Currency 99999.99	Not required
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.

Field Label	Completion Format	Special Instructions
24. Medicare Deductible	7 digits: Currency 99999.99	Not required
25. Medicare Coinsurance	7 digits: Currency 99999.99	Not required
26. Medicare Disallowed	7 digits: Currency 99999.99	Not required
27. Signature	Text	<p>Required</p> <p>Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent.</p> <p>A holographic signature stamp may be used <u>if</u> authorization for the stamp is on file with the fiscal agent.</p> <p>An authorized agent or representative may sign the claim for the enrolled provider <u>if</u> the name and signature of the agent is on file with the fiscal agent.</p> <p>Unacceptable signature alternatives:</p> <p>Claim preparation personnel may not sign the enrolled provider's name.</p> <p>Initials are not acceptable as a signature.</p> <p>Typed or computer printed names are not acceptable as a signature.</p> <p>"Signature on file" notation is not acceptable in place of an authorized signature.</p>
28. Billing Provider Name	Text	<p>Required</p> <p>Enter the name of the individual or organization that will receive payment for the billed services.</p>
29. Billing Provider Number	8 digits	<p>Required</p> <p>Enter the eight-digit Colorado Medical Assistance Program provider number assigned to the individual or organization that will receive payment for the billed services.</p>
30. Remarks	Text	<p>Conditional</p> <p>Use to document Late Bill Override Date for timely filing.</p>

HCBS-CMHS Claim Example

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND
FINANCING

INVOICE/PAT ACCT NUMBER
SPECIAL PROGRAM CODE

HEALTH INSURANCE CLAIM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL) Client, Ima	2. CLIENT DATE OF BIRTH 09/12/1972	3. MEDICAID ID NUMBER (CLIENT ID NUMBER) H222222
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. CLIENT SEX MALE <input type="checkbox"/> FEMALE <input checked="" type="checkbox"/>	6. MEDICARE ID NUMBER (HIC OR SSN)
TELEPHONE NUMBER	7. CLIENT RELATIONSHIP TO INSURED SELF <input checked="" type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. <input type="checkbox"/> CLIENT IS COVERED BY EMPLOYER HEALTH PLAN AS EMPLOYEE OR DEPENDENT
9. OTHER HEALTH INSURANCE COVERAGE — INSURANCE COMPANY NAME, ADDRESS, PLAN NAME, AND POLICY NUMBER(S)	10. WAS CONDITION RELATED TO: A. CLIENT EMPLOYMENT YES <input type="checkbox"/> B. ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/> C. DATE OF ACCIDENT <input type="text"/>	EMPLOYER NAME: _____ POLICYHOLDER NAME: _____ GROUP: _____ 11. CHAMPUS SPONSORS SERVICE/SSN
9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)		
TELEPHONE NUMBER		
12. PREGNANCY <input type="checkbox"/> HMO <input type="checkbox"/> NURSING FACILITY <input type="checkbox"/>		

PHYSICIAN OR SUPPLIER INFORMATION

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

18. ICD-9-CM DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. IN COLUMN F, RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE NUMBERS 1, 2, 3, OR 4	TRANSPORTATION CERTIFICATION ATTACHED <input type="checkbox"/> YES
1. 799	DURABLE MEDICAL EQUIPMENT Line # Make Model Serial Number
2. _____	
3. _____	
4. _____	PRIOR AUTHORIZATION #

19A. DATE OF SERVICE FROM	B. PLACE OF SERVICE	C. PROCEDURE CODE (HCPCS)	MODIFIERS	D. RENDERING PROVIDER NUMBER	E. REFERRING PROVIDER NUMBER	F. DIAGNOSIS P S T	G. CHARGES	H. DAYS OR UNITS	I. COPAY	J. EMERGENCY	K. FAMILY PLANNING	L. EPSDT
07/15/2013	08/15/2013	12	S5130	UA		1	\$30.08	8		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE, AND COMPLETE. I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS.

20. TOTAL CHARGES → **\$30.08**

LESS ↓ **\$30.08**

MEDICARE SPR DATE

27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE <i>Authorized Signature 09/08/13</i>	30. REMARKS	21. MEDICARE PAID <input type="text"/>	24. MEDICARE DEDUCTIBLE \$0.00
28. BILLING PROVIDER NAME HCBS- CMHS Provider		22. THIRD PARTY PAID <input type="text"/>	25. MEDICARE COINSURANCE \$0.00
29. BILLING PROVIDER NUMBER 12345678		23. NET CHARGE \$30.08	26. MEDICARE DISALLOWED <input type="text"/>

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

COLORADO 1500

HCBS-EBD Claim Example

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND
FINANCING

INVOICE/PAT ACCT NUMBER
SPECIAL PROGRAM CODE

HEALTH INSURANCE CLAIM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL) Client, Ima	2. CLIENT DATE OF BIRTH 04/04/1958	3. MEDICAID ID NUMBER (CLIENT ID NUMBER) H555555
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. CLIENT SEX MALE <input type="checkbox"/> FEMALE <input checked="" type="checkbox"/>	6. MEDICARE ID NUMBER (HIC OR SSN)
TELEPHONE NUMBER	7. CLIENT RELATIONSHIP TO INSURED SELF <input checked="" type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. <input type="checkbox"/> CLIENT IS COVERED BY EMPLOYER HEALTH PLAN AS EMPLOYEE OR DEPENDENT EMPLOYER NAME: _____
9. OTHER HEALTH INSURANCE COVERAGE — INSURANCE COMPANY NAME, ADDRESS, PLAN NAME, AND POLICY NUMBER(S)	10. WAS CONDITION RELATED TO: A. CLIENT EMPLOYMENT YES <input type="checkbox"/> B. ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/> C. DATE OF ACCIDENT <input type="text"/>	POLICYHOLDER NAME: _____ GROUP: _____ 11. CHAMPUS SPONSORS SERVICE/SSN
TELEPHONE NUMBER	9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)	
TELEPHONE NUMBER		
12. PREGNANCY <input type="checkbox"/> HMO <input type="checkbox"/> NURSING FACILITY <input type="checkbox"/>		

PHYSICIAN OR SUPPLIER INFORMATION

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

18. ICD-9-CM DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. IN COLUMN F, RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE NUMBERS 1, 2, 3, OR 4	14B. TRANSPORTATION CERTIFICATION ATTACHED <input type="checkbox"/> YES
1. 7999	DURABLE MEDICAL EQUIPMENT Line # Make Model Serial Number
2. _____	PRIOR AUTHORIZATION #:
3. _____	
4. _____	

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. EPBDT
08/01/2013 08/31/2013	12	T2031	U1			1	\$903.90	30		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE, AND COMPLETE. I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS.		20. TOTAL CHARGES → \$903.90	LESS ↓ 21. MEDICARE PAID <input type="text"/>	24. MEDICARE DEDUCTIBLE <input type="text"/> \$0.00
27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE <i>Authorized Signature 09/08/13</i>	30. REMARKS	22. THIRD PARTY PAID <input type="text"/> \$0.00	25. MEDICARE COINSURANCE <input type="text"/> \$0.00	
28. BILLING PROVIDER NAME HCBS- EBD Provider		23. NET CHARGE <input type="text"/> \$903.90	26. MEDICARE DISALLOWED <input type="text"/>	
29. BILLING PROVIDER NUMBER 12345678		COLORADO 1500		

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

Late Bill Override Date

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

Valid Delay Reason Codes

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



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

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

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

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

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

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



HCBS-BI, CMHS, and EBD Specialty Manuals Revisions Log

<i>Revision Date</i>	<i>Section/Action</i>	<i>Pages</i>	<i>Made by</i>
<i>07/12/2013</i>	<i>Created</i>	<i>All</i>	<i>cc, sm, jg</i>
<i>12/30/2013</i>	<i>Added CDASS services to BI</i>	<i>11</i>	<i>cc</i>
<i>03/19/2014</i>	<i>Removed all PLWA content</i>	<i>Throughout</i>	<i>mm</i>