Dialysis

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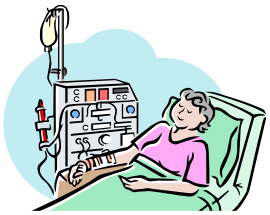
Dialysis

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

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

The Colorado Medical Assistance Program provides hemodialysis benefits to eligible Members in an outpatient, state-approved freestanding dialysis treatment center, and in the home setting. These services are billed on the UB-04 paper claim form or as an 837 Institutional (837I) electronic transaction.

State-approved non-routine services provided outside the routine dialysis treatment should be billed and reimbursed separately. The services must be billed on the CMS 1500 paper claim form or as an 837 Professional (837P) electronic transaction using the dialysis center provider number. Providers should refer to the appropriate CMS 1500 billing manual for field completion format and instructions.



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

Dialysis may be provided as part of inpatient hospital treatment and included in the hospital inpatient claim (see the Dialysis Benefits chart below).

Billing Information

National Provider Identifier (NPI)

The Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities (i.e., health plans, health care clearinghouses, and those health care providers who transmit any health information electronically in connection with a transaction for which the Secretary of Health and Human Services has adopted a standard) use NPIs in standard transactions.

Paper Claims

Electronic claims format shall be required unless hard copy claims submittals are specifically prior authorized by the Department of Health Care Policy and Financing (the Department). Requests for paper claim submission may be sent to the fiscal agent, Affiliated Computer Services (ACS), P.O. Box 90, Denver, CO 80201-0090. The following claims can be submitted on paper and processed for payment:

- Claims from providers who consistently submit 5 claims or fewer per month (requires prior approval)
- Claims that, by policy, require attachments
- Reconsideration claims

Paper claims do not require an NPI, but do require the Colorado Medical Assistance Program provider number. In addition, the UB-04 Certification document must be completed and attached to all claims submitted on the paper UB-04. 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 provider and the Colorado Medical Assistance Program. Colorado Medical Assistance Program providers may create and transmit HIPAA compliant 837P (Professional), 837I (Institutional), and 837D (Dental) claims electronically one at a time. These claims are transmitted through the Colorado Medical Assistance Program OnLine Transaction Processor (OLTP).

The Colorado Medical Assistance Program OLTP reviews the claim information for compliance with Colorado Medical Assistance Program billing policy and returns a response to the provider's personal computer about that single transaction. If the claim is rejected, the OLTP sends a rejection response that identifies the rejection reason.

If the claim is accepted, the provider receives an acceptance message and the OLTP passes accepted claim information to the Colorado Medical Assistance Program claim processing system for final adjudication and reporting on the Colorado Medical Assistance Program Provider Claim Report (PCR).

The Web Portal contains online training, user guides and help that describe claim completion requirements, a mechanism that allows the user to create and maintain a data base of frequently used information, edits that verify the format and validity of the entered information, and edits that 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 Provider Claim Report to providers. The Web Portal also provides access to reports and transactions generated from claims submitted via paper and through electronic data submission methods other than the Web Portal. The reports and transactions include:

- Accept/Reject Report
- Provider Claim Report
- Health Care Claim Payment/Advice (ASC X12N 835)
- Managed Care Reports such as Primary Care Physician Rosters
- Eligibility Inquiry (interactive and batch)
- Claim Status Inquiry

Claims may be adjusted, edited and resubmitted, and voided in real time through the Web Portal. Access the Web Portal through Secured Site at colorado.gov/hcpf. For help with claim submission via the Web Portal, please choose the *User Guide* option available for each Web Portal transaction.

For additional electronic billing information, please refer to the appropriate Companion Guide located in the Provider Services Specifications section of the Department's Web site.

Batch Electronic Claims Submission

Batch billing refers to the electronic creation and transmission of several claims in a group. Batch billing systems usually extract information from an automated accounting or patient billing system to create a group of claim transactions. Claims may be transmitted from the provider's office or sent through a billing vendor or clearinghouse.

All batch claim submission software must be tested and approved by the Colorado Medical Assistance Program fiscal agent.

Any entity sending electronic claims to ACS Electronic Data Interchange (EDI) Gateway for processing where reports and responses will be delivered must complete an EDI enrollment package.

This provides ACS EDI Gateway the information necessary to assign a Logon Name, Logon ID, and Trading Partner ID, which are required to submit electronic claims. You may obtain an EDI enrollment package by contacting the Medical Assistance Program fiscal agent or by downloading it from the Provider Services EDI Support section of the Department's Web site.

The X12N 837 Professional, Institutional, or Dental transaction data will be submitted to the EDI Gateway, which validates submission of American National Standards Institute (ANSI) X12N format(s). The TA1 Interchange Acknowledgement reports the syntactical analysis of the interchange header and trailer. If the data is corrupt or the trading partner relationship does not exist within the Medicaid Management Information System (MMIS), the interchange will reject and a TA1 along with the data will be forwarded to the ACS State Healthcare Clearinghouse (SHCH) Technical Support for review and follow-up with the sender. An X12N 999 Functional Acknowledgement is generated when a file that has passed the header and trailer check passes through the ACS SHCH.

If the file contains syntactical error(s), the segment(s) and element(s) where the error(s) occurred will be reported. After validation, the ACS SHCH will then return the X12N 835 Remittance Advice containing information related to payees, payers, dollar amount, and payments. These X12N transactions will be returned to the Web Portal for retrieval by the trading partner, following the standard claims processing cycle.

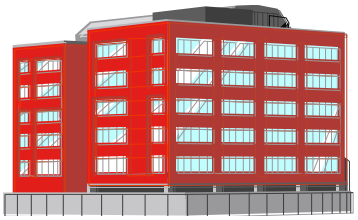
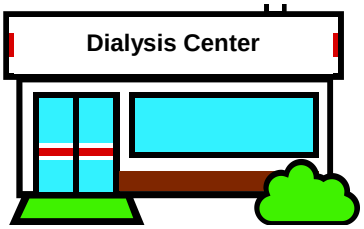
Testing and Vendor Certification

Completion of the testing process must occur prior to submission of electronic batch claims to ACS EDI Gateway. Assistance from ACS EDI business analysts is available throughout this process. Each test transmission is inspected thoroughly to ensure no formatting errors are present. Testing is conducted to verify the integrity of the format, not the integrity of the data; however, in order to simulate a production environment, EDI requests that providers send real transmission data.

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

In order to expedite testing, ACS EDI Gateway requires providers to submit all X12N test transactions to EDIFECS prior to submitting them to ACS EDI Gateway. The EDIFECS service is free to providers to certify X12N readiness. EDIFECS offers submission and rapid result turnaround 24 hours a day, 7 days a week. For more information, go to http://www.edifecs.com.

Dialysis Benefits

Setting	Benefit provisions
Inpatient hospital 	Inpatient hemodialysis is a benefit when: Hospitalization is required for an acute medical condition requiring hemodialysis treatment. Hospitalization is required for a covered medical condition and the member receives regular maintenance outpatient hemodialysis treatment. Hospitalization is required for placement or repair of the hemodialysis route (shunt or cannula). Inpatient hemodialysis payment is included as part of the Diagnosis Related Group (DRG). Hospital admissions solely for hemodialysis are not a Colorado Medical Assistance Program benefit.
Outpatient hospital **State-approved dialysis treatment center**  	A dialysis treatment center is a health institution or a department of a licensed hospital that is planned, organized, operated and maintained to provide outpatient hemodialysis treatment and/or training for home use of hemodialysis equipment. Other conditions for participation are those specifically entered into the agreement with the Department. Continued outpatient hemodialysis is a benefit when: ▪ Training of the eligible recipient to perform self-treatment in the home environment is contraindicated; or ▪ The eligible member is not a proper candidate for self-treatment in a home environment; or ▪ The home environment of the eligible member contraindicates self-treatment; or ▪ The eligible member is awaiting a kidney transplant.
Home 	The high costs of dialysis treatments and the budgetary limitations of the Medicaid program require that all Medicaid patients be considered for the most cost efficient method of dialysis based upon their individual medical diagnosis and condition. Such treatments include home dialysis and peritoneal methods of dialysis. The participating separate dialysis unit within a hospital or the free-standing dialysis treatment center shall be responsible for the provision and maintenance of all equipment and necessary fixtures required for home dialysis and provision of all supplies. All eligible Members approved for self-treatment must be trained in the use of hemodialysis equipment while undergoing outpatient hemodialysis treatments.

Home	Training must be provided by qualified personnel of a hospital with a separate dialysis unit or by qualified personnel of a freestanding dialysis treatment center. The participating hospital or dialysis treatment center must provide and install quality hemodialysis equipment to be used by the member at home and must provide routine medical surveillance of the member's adaptation and adjustment to the self-treatment at home.

Any facility providing regularly scheduled outpatient or chronic dialysis treatments at a free-standing facility or billing for supplies necessary to perform the various types of home dialysis treatments shall apply for a separate Medicaid provider number from the fiscal agent. Such provider number shall be designated solely for the purpose of claims submission for dialysis services.

The amount of payment for regularly scheduled routine outpatient dialysis or necessary supplies to perform home dialysis treatments, when provided by a separate unit within a hospital or a free standing dialysis treatment center approved for participation by the Department, shall be the lesser of the unit's charges or the currently posted Medicaid rate.

The amount of payment for non-routine outpatient dialysis treatments, when provided by a separate unit within a hospital or free standing dialysis treatment center, shall be based upon the Medicaid fee schedule.

Ancillary services performed in addition to the routine dialysis treatment shall be considered as part of the composite rate and billed on the UB-04 claim form or electronically on the 837I transaction.

Non-routine ancillary services performed in addition to the dialysis treatment shall be reimbursed separately and billed on the CMS 1500 claim form or electronically as an 837P transaction. This requires the provider use the appropriate Healthcare Common Procedure Coding System (HCPCS) codes designated for the service provided.

The following dialysis services are reimbursed at the lower of the composite Medicare rate ceiling or the individual center's Medicare facility rate:

- Outpatient hemodialysis
- Outpatient peritoneal dialysis
- Continuous Ambulatory Peritoneal Dialysis (CAPD)
- Continuous Cycling Peritoneal Dialysis (CCPD)

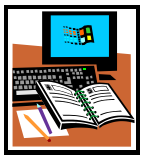
There is no reimbursement for home dialysis, only for necessary home dialysis equipment and supplies.

The following applies to services provided in either a free-standing dialysis center or outpatient hospital setting:

- Charges by a dialysis facility for routine drugs, electrocardiograms (EKGs) and X-rays are considered part of the dialysis treatment. Non-routine drugs must be billed on the CMS 1500 paper claim form or as an 837 Professional (837P) electronic transaction using the dialysis center provider number.
- Drugs not dispensed by the dialysis provider are billed by and reimbursed to the dispensing pharmacy. Physician's charges for EKG or X-ray services must be billed by the physician.
- A physician must supervise the process when blood is furnished and may bill for any professionally rendered covered service using his/her Colorado Medical Assistance Program Provider Number
- Routine laboratory services are included as part of the dialysis service reimbursement.

Non-routine laboratory services are reimbursed as laboratory services separate from the dialysis treatment.

- Hospitals having separate dialysis units must submit services according to outpatient hospital laboratory regulations and UB-04 billing instructions.
- A free-standing dialysis center that performs its own laboratory tests must be licensed as an independent clinical laboratory and enrolled in the Colorado Medical Assistance Program as an independent laboratory. The non-routine laboratory services must be billed under the independent laboratory's Colorado Medical Assistance Program Provider Number on the CMS 1500 claim form or electronically as an 837P transaction.
- If an outside laboratory provides the service, that laboratory must bill for the service.



All routine laboratory services performed by a dialysis treatment facility, with the designation as a certified clinical laboratory, or as a certified independent laboratory are included as part of the dialysis treatment reimbursement. All routine tests must be performed by the facility, with designation as a certified clinical laboratory, and reimbursed as part of the composite rate or performed by a certified independent outside laboratory and billed to the facility performing the dialysis treatment.

The following required procedures constitute routine laboratory services that are considered medically necessary. These laboratory tests are included as part of the dialysis service reimbursement.

Per Treatment

Hematocrit		

Weekly

Prothrombin time for patients on anti-coagulant therapy	Serum Creatinine	BUN

Monthly

HCT	Hgb	Dialysate Protein
Alkaline Phosphatase Magnesium	CBC Sodium	LDH
Potassium	Serum Albumin	CO 2
Serum Calcium	Serum Chloride	Specimen Collection
Serum Phosphorous	Serum Potassium	SGOT
Total Protein	All Hematocrit and Clotting time tests	Serum Bicarbonate

Drugs considered part of the routine dialysis treatment:

Heparin	Protamine	Mannitol	Glucose	Saline
Dextrose	Pressor Drugs	Antihistamines	Antiarrhythmics	Antihypertensives

Drugs considered non-routine:

Antibiotics	Anabolics	Hematinics	Sedatives
Analgesics	Tranquilizers	Muscle Relaxants	

Nonparenteral items may not be billed separately by the dialysis center, but may be billed directly to Medicaid by the supplier. Nonparenteral items administered during the dialysis treatment are reimbursed as part of the composite rate.

UB-04 Paper Claim Reference Table

Dialysis treatment center claims that are submitted on paper must be submitted on the UB-04 claim form.

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

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

The UB-04 Certification document (located after the Late Bill Override instructions and in the Provider Services Forms section of the Department's Web site) must be completed and attached to all claims submitted on the UB-04 paper claim form.

Completed UB-04 paper claims for Colorado Medical Assistance Program services, including hardcopy Medicare claims, should be mailed to the correct fiscal agent address located in Appendix A in the Appendices of the Provider Services Billing Manuals section of the Department's Web site.

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

The paper claim reference table below lists the required, optional and/or conditional form locators for submitting the UB-04 paper claim form to the Colorado Medical Assistance Program for dialysis services.

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

Form Locator and Label	Completion Format	Instructions
2. Pay-to Name, Address, City, State	Text	Required only if different from FL 1. Enter the provider or agency name and complete mailing address of the provider who will receive payment for the services: Street/Post Office box City State Zip Code Abbreviate the state using standard post office abbreviations.
3a. Patient Control Number	Up to 20 characters: Letters, numbers or hyphens	Optional Enter information that identifies the member or claim in the provider's billing system. Submitted information appears on the Provider Claim Report.
3b. Medical Record Number	17 digits	Optional Enter the number assigned to the patient to assist in retrieval of medical records.
4. Type of Bill	3 digits	Required Enter the three-digit number indicating the specific type of bill. The three-digit code requires one digit each in the following sequences (Type of facility, Bill classification, and Frequency): For Dialysis, use TOB 72X Digit 1 — Type of Facility 1 — Hospital 2 — Skilled Nursing Facility 3 — Home Health 4 — Religious Non-Medical Health Care Institution Hospital Inpatient 5 — Religious Non-Medical Health Care Institution Post-Hospital Extended Care Services 6 — Intermediate Care 7 — Clinic (Rural Health/FQHC/Dialysis Center) 8 — Special Facility (Hospice, RTCs)

Form Locator and Label	Completion Format	Instructions
4. Type of Bill (continued)	3 digits	Digit 2 Bill Classification (Except clinics & special facilities): 1 Inpatient (Including Medicare Part A) 2 Inpatient (Medicare Part B only) 3 Outpatient 4 Other (for hospital referenced diagnostic services or home health not under a plan of treatment) 5 Intermediate Care Level I 6 Intermediate Care Level II 7 Sub-Acute Inpatient (revenue code 019X required with this bill type) 8 Swing Beds 9 Other Digit 2 Bill Classification (Clinics Only): 1 Rural Health/FQHC 2 Hospital Based or Independent Renal Dialysis Center 3 Freestanding 4 Outpatient Rehabilitation Facility (ORF) 5 Comprehensive Outpatient Rehabilitation Facilities (CORFs) 6 Community Mental Health Center Digit 2 Bill Classification (Special Facilities Only): 1 Hospice (Non-Hospital Based) 2 Hospice (Hospital Based) 3 Ambulatory Surgery Center 4 Freestanding Birthing Center 5 Critical Access Hospital 6 Residential Facility

Form Locator and Label	Completion Format	Instructions
4. Type of Bill (continued)	3 digits	Digit 3 Frequency: 0 Non-Payment/Zero Claim 1 Admit through discharge claim 2 Interim - First claim 3 Interim - Continuous claim 4 Interim - Last claim 7 Replacement of prior claim 8 Void of prior claim
5. Federal Tax Number	None	Submitted information is not entered into the claim processing system.
6. Statement Covers Period – From/Through	From: 6 digits MMDDYY Through: 6 digits MMDDYY	Required This form locator must reflect the beginning and ending dates of service. When span billing for multiple dates of service and multiple procedures, complete FL 45 (Service Date). Providers not wishing to span bill following these guidelines, must submit one claim per date of service. "From" and "Through" dates must be the same. All line item entries must represent the same date of service.
8a. Patient Identifier		Submitted information is not entered into the claim processing system.
8b. Patient Name	Up to 25 characters: Letters & spaces	Required Enter the member's last name, first name and middle initial.
9a. Patient Address – Street	Characters Letters & numbers	Required Enter the member's street/post office as determined at the time of admission.
9b. Patient Address – City	Text	Required Enter the member's city as determined at the time of admission.
9c. Patient Address – State	Text	Required Enter the member's state as determined at the time of admission.
9d. Patient Address – Zip	Digits	Required Enter the member's zip code as determined at the time of admission.
9e. Patient Address – Country Code	Digits	Optional

Form Locator and Label	Completion Format	Instructions
10. Birthdate	8 digits (MMDDCCYY)	Required Enter the member's birthdate using two digits for the month, two digits for the date, and four digits for the year (MMDDCCYY format). Example: 01012010 for January 1, 2010.
11. Patient Sex	1 letter	Required Enter an M (male) or F (female) to indicate the member's sex.
12. Admission Date		Not required
13. Admission Hour		Not required
14. Admission Type		Not required
15. Source of Admission		Not Required
16. Discharge Hour		Not Required
17. Patient Discharge Status	2 digits	Required Dialysis must use code 01.
18-28. Condition Codes	2 Digits	Conditional Complete with as many codes necessary to identify conditions related to this bill. <u>Condition Codes</u> 06 ESRD patient – First 18 months entitlement <u>Renal dialysis settings</u> 71 Full care unit 72 Self care unit 73 Self care training 74 Home care 75 Home care – 100 ercent reimbursement 76 Back-up faclity
29. Accident State		Optional

Form Locator and Label	Completion Format	Instructions
31-34. Occurrence Code/Date	2 digits and 6 digits	Conditional Complete both the code and date of occurrence. Enter the appropriate code and the date on which it occurred. Enter the date using MMDDYY format. <u>Occurrence Codes</u>: 01 Accident/Medical Coverage 02 Auto Accident - No Fault Liability 03 Accident/Tort Liability 04 Accident/Employment Related 05 Other Accident/No Medical Coverage or Liability Coverage 06 Crime Victim 20 Date Guarantee of Payment Began 24* Date Insurance Denied 25* Date Benefits Terminated by Primary Payer 26 Date Skilled Nursing Facility Bed Available 27 Date of Hospice Certification or Re-certification 40 Scheduled Date of Admission (RTD) 50 Medicare Pay Date 51 Medicare Denial Date 53 Late Bill Override Date 55 Insurance Pay Date

Form Locator and Label	Completion Format	Instructions
31-34. Occurrence Code/Date (continued)	2 digits and 6 digits	A3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer A indicated in FL 50 B3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer B indicated in FL 50 C3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer C indicated in FL 50 **Other Payer occurrence codes 24 and 25 must be used when applicable. T*
35-36. Occurrence Span Code From/ Through	None	Leave blank
38. Responsible Party Name/ Address	None	Leave blank
39-41. Value Code and Amount	2 characters and 9 digits	Conditional Enter appropriate codes and related dollar amounts to identify monetary data or number of days using whole numbers, necessary for the processing of this claim. Never enter negative amounts. Codes must be in ascending order. If a value code is entered, a dollar amount or numeric value related to the code <u>must</u> always be entered. 01 Most common semiprivate rate (Accommodation Rate) 06 Medicare blood deductible 14 No fault including auto/other 15 Worker's Compensation 31 Patient Liability Amount 32 Multiple Patient Ambulance Transport

Form Locator and Label	Completion Format	Instructions
39-41. Value Code and Amount (continued)	2 characters and 9 digits	37 Pints of Blood Furnished 38 Blood Deductible Pints 40 New Coverage Not Implemented by HMO 45 Accident Hour Enter the hour when the accident occurred that necessitated medical treatment. Use the same coding used in FL 18 (Admission Hour). 49 Hematocrit Reading - EPO Related 58 Arterial Blood Gas (PO2/PA2) 68 EPO-Drug 80 Covered Days 81 Non-covered Days *Enter the deductible amount applied by indicated payer:* A1 Deductible Payer A B1 Deductible Payer B C1 Deductible Payer C *Enter the amount applied to member's co-insurance by indicated payer:* A2 Coinsurance Payer A B2 Coinsurance Payer B C2 Coinsurance Payer C *Enter the amount paid by indicated payer:* A3 Estimated Responsibility Payer A B3 Estimated Responsibility Payer B C3 Estimated Responsibility Payer C
42. Revenue Code	3 digits	Required Enter the revenue code which identifies the specific service provided. List revenue codes in ascending order. Please refer to Appendix Q of the Appendices in the Provider Services Billing Manuals section at for valid dialysis revenue codes. A revenue code must appear only once per date of service. * If more than one of the same service is provided on the same day, combine the units and charges on one line accordingly.

Form Locator and Label	Completion Format	Instructions
43. Revenue Code Description	Text	Required Enter the revenue code description or abbreviated description.
44. HCPCS/Rates/ HIPPS Rate Codes	5 digits	Conditional Enter only the HCPCS code for each detail line. Use approved modifiers listed in this section for hospital based transportation services. Complete for laboratory, radiology, physical therapy, occupational therapy, and hospital based transportation. When billing HCPCS codes, the appropriate revenue code must also be billed. **Services Requiring HCPCS** ▪ Anatomical Laboratory: Bill with TC modifier ▪ Hospital Based Transportation ▪ Outpatient Laboratory: Use only HCPCS 80000s - 89000s. ▪ Outpatient Radiology Services Enter HCPCS and revenue codes for each radiology line. The only valid modifier for OP radiology is TC. Refer to the annual HCPCS bulletin for instructions in the Provider Services Bulletins section of the Web site. With the exception of outpatient lab and hospital-based transportation, outpatient radiology services can be billed with other outpatient services. HCPCS codes must be identified for the following revenue codes: 030X Laboratory • 032X Radiology – Diagnostic • 033X Radiology – Therapeutic • 034X Nuclear Medicine • 035X CT Scan • 040X Other Imaging Services • 042X Physical Therapy • 043X Occupational Therapy • 054X Ambulance • 061X MRI and MRA HCPCS codes cannot be repeated for the same date of service. Combine the units in FL 46 (Units) to report multiple services.

Form Locator and Label	Completion Format	Instructions
45. Service Date	6 digits	Conditional For span bills only Enter the date of service using MMDDYY format for each detail line completed. Each date of service must fall within the date span entered in the "Statement Covers Period" (FL 6).
46. Service Units	3 digits	Required Enter a unit value on each line completed. Use whole numbers only. Do not enter fractions or decimals and do not show a decimal point followed by a 0 to designate whole numbers (e.g., Do not enter 1.0 to signify one unit) For span bills, the units of service reflect only those visits, miles or treatments provided on dates of service in FL 45.
47. Total Charges	9 digits	Required Enter the total charge for each line item. Calculate the total charge as the number of units multiplied by the unit charge. Do not subtract Medicare or third party payments from line charge entries. Do not enter negative amounts. A grand total in line 23 is required for all charges.
48. Non-Covered Charges	9 digits	Required Enter incurred charges that are not payable by the Colorado Medical Assistance Program. Non-covered charges must be entered in both FL 47 (Total Charges) and FL 48 (Non-Covered Charges.) Each column requires a grand total on line 23. Non-covered charges cannot be billed for outpatient hospital laboratory or hospital based transportation services.

Form Locator and Label	Completion Format	Instructions
50. Payer Name	1 letter and text	Required Enter the payment source code followed by name of each payer organization from which the provider might expect payment. At least one line must indicate The Colorado Medical Assistance Program. Source Payment Codes B Workmen's Compensation C Medicare D Colorado Medical Assistance Program E Other Federal Program F Insurance Company G Blue Cross, including Federal Employee Program H Other - Inpatient (Part B Only) I Other Line A Primary Payer Line B Secondary Payer Line C Tertiary Payer
51. Health Plan ID	8 digits	Required Enter the provider's Health Plan ID for each payer name. Enter the eight digit Colorado Medical Assistance Program provider number assigned to the **billing provider**. Payment is made to the enrolled provider or agency that is assigned this number.
52. Release of Information	None	Submitted information is not entered into the claim processing system.
53. Assignment of Benefits	None	Submitted information is not entered into the claim processing system.
54. Prior Payments	Up to 9 digits	Conditional Complete when there are Medicare or third party payments. Enter third party and/or Medicare payments.

Form Locator and Label	Completion Format	Instructions
55. Estimated Amount Due	Up to 9 digits	Conditional Complete when there are Medicare or third party payments. Enter the net amount due from The Colorado Medical Assistance Program after provider has received other third party, Medicare or patient liability amount on the Colorado Medical Assistance Program line. **Medicare Crossovers** Enter the sum of the Medicare coinsurance plus Medicare deductible less third party payments and patient liability amount.
56. National Provider Identifier (NPI)	10 digits	Optional Enter the billing provider's 10-digit National Provider Identifier (NPI).
57. Other Provider ID		Submitted information is not entered into the claim processing system.
58. Insured's Name	Up to 30 characters	Required Enter the member's name on the Colorado Medical Assistance Program line. **Other Insurance/Medicare** Complete additional lines when there is third party coverage. Enter the policyholder's last name, first name, and middle initial.
60. Insured's Unique ID	Up to 20 characters	Required Enter the insured's unique identification number assigned by the payer organization. Include letter prefixes or suffixes.
61. Insurance Group Name	14 letters	Conditional Complete when there is third party coverage. Enter the name of the group or plan providing the insurance to the insured.
62. Insurance Group Number	17 digits	Conditional Complete when there is third party coverage. Enter the identification number, control number, or code assigned by the carrier or fund administrator identifying the group under which the individual is carried.
63. Treatment Authorization Code	Up to 18 characters	Conditional Complete when the service requires a PAR. Enter the PAR/authorization number in this FL, if a PAR is required and has been approved for services.

Form Locator and Label	Completion Format	Instructions
64. Document Control Number		Submitted information is not entered into the claim processing system.
65. Employer Name	Text	Conditional Complete when there is third party coverage. Enter the name of the employer that provides health care coverage for the individual identified in FL 58 (Insured Name).
66. Diagnosis Version Qualifier		Submitted information is not entered into the claim processing system.
67. Principal Diagnosis Code	Up to 6 digits	Not required
67A- 67Q. Other Diagnosis	6 digits	Optional Enter the exact diagnosis code corresponding to additional conditions that co-exist at the time of admission or develop subsequently and which effect the treatment received or the length of stay. Do not add extra zeros to the diagnosis code.
69. Admitting Diagnosis Code	6 digits	Not Required
70. Patient Reason Diagnosis		Not Required
71. PPS Code		Not Required
72. External Cause of Injury Code (E-code)	6 digits	Optional Enter the diagnosis code for the external cause of an injury, poisoning, or adverse effect. This code must begin with an "E".
74. Principal Procedure Code/ Date	7 characters and 6 digits	Conditional Enter the procedure code for the principal procedure performed during this billing period and the date on which procedure was performed. Enter the date using MMDDYY format. Apply the following criteria to determine the principle procedure: The principal procedure is not performed for diagnostic or exploratory purposes. This code is related to definitive treatment; and The principal procedure is most related to the primary diagnosis.

Form Locator and Label	Completion Format	Instructions
74A. Other Procedure Code/Date	7 characters and 6 digits	Conditional Complete when there are additional significant procedure codes. Enter the procedure codes identifying all significant procedures other than the principle procedure and the dates on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principle diagnosis. Enter the date using MMDDYY format.
76. Attending **NPI – Conditional**	NPI - 10 digits	NPI - Enter the 10-digit NPI assigned to the physician having primary responsibility for the patient's medical care and treatment.
QUAL - Conditional	QUAL – Text	QUAL – Enter “1D“ for Medicaid followed by the provider’s eight-digit Colorado Medical Assistance Program provider ID.
ID - (Colorado Medical Assistance Provider #) – Required	Medicaid ID - 8 digits	Medicaid ID - Enter the eight-digit Colorado Medical Assistance Program provider number assigned to the physician having primary responsibility for the patient's medical care and treatment. Numbers are obtained from the physician, and cannot be a clinic or group number. (If the attending physician is not enrolled in the Colorado Medical Assistance Program or if the member leaves the ER before being seen by a physician, the hospital may enter their individual numbers.)
Attending- Last/ First Name	Text	Enter the attending physician’s last and first name. This form locator must be completed for all services.
77. Operating- NPI/QUAL/ID		Submitted information is not entered into the claim processing system.

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

CMS 1500 Paper Claim Reference Table

The Paper Claim Reference Table below lists the required, optional and/or conditional fields for submitting the paper CMS 1500 claim form to the Colorado Medical Assistance Program when billing for State-approved non-routine services provided outside the routine dialysis treatment.

CMS Field #	Field Label	Field is?	Instructions
1	**Insurance Type**	Required	Place an "X" in the box marked as Medicaid.
1a	**Insured's ID Number**	Required	Enter the member's Colorado Medical Assistance Program seven-digit Medicaid ID number as it appears on the Medicaid Identification card. Example: A123456.
2	**Patient's Name**	Required	Enter the member's last name, first name, and middle initial.
3	**Patient's Date of Birth / Sex**	Required	Enter the patient's birth date using two digits for the month, two digits for the date, and two digits for the year. Example: 070114 for July 1, 2014. Place an "X" in the appropriate box to indicate the sex of the member.
4	**Insured's Name**	Conditional	Complete if the member is covered by a **Medicare** health insurance policy. Enter the insured's full last name, first name, and middle initial. If the insured used a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name.
5	**Patient's Address**	Not Required	
6	**Patient's Relationship to Insured**	Conditional	Complete if the member is covered by a commercial health insurance policy. Place an "X" in the box that identifies the member's relationship to the policyholder.
7	**Insured's Address**	Not Required	
8	**Reserved for NUCC Use**		

CMS Field #	Field Label	Field is?	Instructions
9	**Other Insured's Name**	Conditional	If field 11d is marked "yes", enter the insured's last name, first name and middle initial.
9a	**Other Insured's Policy or Group Number**	Conditional	If field 11d is marked "yes", enter the policy or group number.
9b	**Reserved for NUCC Use**		
9c	**Reserved for NUCC Use**		
9d	**Insurance Plan or Program Name**	Conditional	If field 11d is marked "yes", enter the insurance plan or program name.
10a-c	**Is Patient's Condition Related to?**	Conditional	When appropriate, place an "X" in the correct box to indicate whether one or more of the services described in field 24 are for a condition or injury that occurred on the job, as a result of an auto accident or other.
10d	**Reserved for Local Use**		
11	**Insured's Policy, Group or FECA Number**	Conditional	Complete if the member is covered by a **Medicare** health insurance policy. Enter the insured's policy number as it appears on the ID card. Only complete if field 4 is completed.
11a	**Insured's Date of Birth, Sex**	Conditional	Complete if the member is covered by a **Medicare** health insurance policy. Enter the insured's birth date using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. Place an "X" in the appropriate box to indicate the sex of the insured.
11b	**Other Claim ID**	Not Required	

CMS Field #	Field Label	Field is?	Instructions
11c	**Insurance Plan Name or Program Name**	Not Required	
11d	**Is there another Health Benefit Plan?**	Conditional	When appropriate, place an "X" in the correct box. If marked YES, complete 9, 9a and 9d.
12	**Patient's or Authorized Person's signature**	Required	Enter "Signature on File", "SOF", or legal signature. If there is no signature on file, leave blank or enter "No Signature on File". Enter the date the claim form was signed.
13	**Insured's or Authorized Person's Signature**	Not Required	
14	**Date of Current Illness Injury or Pregnancy**	Conditional	Complete if information is known. Enter the date of illness, injury or pregnancy, (date of the last menstrual period) using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. Enter the applicable qualifier to identify which date is being reported 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period
15	**Other Date**	Not Required	
16	**Date Patient Unable to Work in Current Occupation**	Not Required	
17	**Name of Referring Physician**	Not Required	
18	**Hospitalization Dates Related to Current Service**	Conditional	Complete for services provided in an inpatient hospital setting. Enter the date of hospital admission and the date of discharge using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. If the member is still hospitalized, the discharge date may be omitted. This

CMS Field #	Field Label	Field is?	Instructions
			information is not edited.
19	**Additional Claim Information**	Conditional	**LBOD** Use to document the Late Bill Override Date for timely filing.
20	**Outside Lab?** **$ Charges**	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.
21	**Diagnosis or Nature of Illness or Injury**	Required	Enter at least one but no more than twelve diagnosis codes based on the member's diagnosis/condition. Enter applicable ICD indicator to identify which version of ICD codes is being reported. 9 ICD-9-CM 0 ICD-10-CM
22	**Medicaid Resubmission Code**	Conditional	List the original reference number for resubmitted claims. When resubmitting a claim, enter the appropriate bill frequency code in the left-hand side of the field. 7 Replacement of prior claim 8 Void/Cancel of prior claim This field is not intended for use for original claim submissions.
23	Prior Authorization	Not Required	
24	**Claim Line Detail**	Information	The paper claim form allows entry of up to six detailed billing lines. Fields 24A through 24J apply to each billed line. **Do not enter more than six lines of information** on the paper claim. If more than six lines of information are entered, the additional lines will not be entered for

CMS Field #	Field Label	Field is?	Instructions
			processing. Each claim form must be fully completed (totaled). **Do not file continuation claims** (e.g., Page 1 of 2).
24A	**Dates of Service**	Required	The field accommodates the entry of two dates: a "From" date of services and an "To" date of service. . Enter the date of service using two digits for the month, two digits for the date and two digits for the year. Example: 010114 for January 1, 2014 From To 01 01 14 | | | Or From To 01 01 14 01 01 14 Span dates of service From To 01 01 14 01 31 14 Practitioner claims must be consecutive days. <u>Single Date of Service</u>: 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. <u>Span billing</u>: permissible if the same service (same procedure code) is provided on consecutive dates. **Supplemental Qualifier** To enter supplemental information, begin at 24A by entering the qualifier and then the information. ZZ Narrative description of unspecified code N4 National Drug Codes VP Vendor Product Number OZ Product Number CTR Contract Rate JP Universal/National Tooth Designation JO Dentistry Designation System for

CMS Field #	Field Label	Field is?	Instructions
			Tooth & Areas of Oral Cavity
24B	**Place of Service**	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. 11 Office
24C	**EMG**	Conditional	Enter a "Y" for YES or leave blank for NO in the bottom, unshaded area of the field to indicate the service is rendered for a life-threaening condition or one that requires immediate medical intervention. If a "Y" for YES is entered, the service on this detail line is exempt from co-payment requirements.
24D	**Procedures, Services, or Supplies**	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.
24D	**Modifier**	Not Required	
24E	**Diagnosis Pointer**	Required	Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis. At least one diagnosis code reference letter must be entered. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. This field allows for the entry of 4 characters in the unshaded area.

CMS Field #	Field Label	Field is?	Instructions
24F	**$ Charges**	Required	Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number. 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 the usual and customary charges.
24G	**Days or Units**	Required	Enter the number of services provided for each procedure code. Enter whole numbers only- do not enter fractions or decimals.
24H	**EPSDT/Family Plan**	Conditional	**EPSDT** (shaded area) For Early & Periodic Screening, Diagnosis, and Treatment related services, enter the response in the shaded portion of the field as follows: AV Available- Not Used S2 Under Treatment ST New Service Requested NU Not Used **Family Planning** (unshaded area) No entry required.
24I	**ID Qualifier**	Not Required	

CMS Field #	Field Label	Field is?	Instructions
24J	**Rendering Provider ID #**	Required	In the unshaded portion of the field, 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. NOTE: When billing a paper claim form, do not use the individual's NPI.
25	**Federal Tax ID Number**	Not Required	
26	**Patient's Account Number**	Optional	Enter information that identifies the patient or claim in the provider's billing system. Submitted information appears on the Provider Claim Report (PCR).
27	**Accept Assignment?**	Required	The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.
28	**Total Charge**	Required	Enter the sum of all charges listed in field 24F. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
29	**Amount Paid**	Conditional	Enter the total amount paid by Medicare or any other commercial health insurance that has made payment on the billed services. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
30	**Rsvd for NUCC Use**	Not Required	
31	**Signature of Physician or Supplier Including Degrees or Credentials**	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. Each claim must have the date the enrolled provider or registed authorized agent signed the claim form. Enter the date the claim was signed using two digits for the month, two digits for the date and two

CMS Field #	Field Label	Field is?	Instructions
			digits for the year. Example: 070114 for July 1, 2014. **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.
32	**32- Service Facility Location Information** **32a- NPI Number** **32b- Other ID #**	Conditional	Complete for services provided in a hospital or nursing facility in the following format: 1st Line Name 2nd Line Address 3rd Line City, State and ZIP Code 32a- NPI Number Enter the NPI of the service facility (if known). 32b- Other ID # Enter the eight-digit Colorado Medical Assistance Program provider number of the service facility (if known). The information in field 32, 32a and 32b is not edited.
33	**33- Billing Provider Info & Ph #** **33a- NPI Number** **33b- Other ID #**	Required	Enter the name of the individual or organization that will receive payment for the billed services in the following format: 1st Line Name 2nd Line Address 3rd Line City, State and ZIP Code 33a- NPI Number Enter the NPI of the billing provider 33b- Other ID # Enter the eight-digit Colorado Medical Assistance Program provider number of the individual or organization.

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 a 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. ➤ *CMS 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 Member 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 member and date of eligibility rejection. **LBOD** = the date shown on the eligibility rejection report.
Retroactive Member 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

Billing Instruction Detail	Instructions
	appeared on the state eligibility system.
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.
Delayed Notification of Eligibility	Retain correspondence, phone logs, or a signed Delayed Eligibility Certification form (see Appendix H in the Appendices in the Provider Services Billing Manuals section of the Department's Web site) that identifies the member, 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 member, 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 member 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. 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 member, 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.
Member 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.

Colorado Medical Assistance Program

Institutional Provider Certification

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

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

Signature: _____ *Date:* _____

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

Dialysis UB-04 Claim Example

1 Dialysis Center
100 Saginaw Street
Anytown, CO 80201
303-333-3333

2

3a PAT. CNTL. #
b. MED. REC. #
4 TYPE OF BILL: 721
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 01/01/11 THROUGH 01/31/11
7

8 PATIENT NAME a b Client, Ima D.
9 PATIENT ADDRESS a 123 Main Street b Anytown c CO d 88888 e

10 BIRTHDATE: 02/13/1963
11 SEX: F
12 DATE
13 HR
14 TYPE: 2
15 SRC
16 DHR
17 STAT: 01
18: 71
19 20 21 22 23 24 25 26 27 28 CONDITION CODES
29 ACDT STATE
30

31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	01	228.00				
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	821	Hemo/Composite		01/02/11	1	100.00		
2	821	Hemo/Composite		01/05/11	1	100.00		
3	821	Hemo/Composite		01/09/11	1	100.00		
4	821	Hemo/Composite		01/12/11	1	100.00		
5	821	Hemo/Composite		01/16/11	1	100.00		
6	821	Hemo/Composite		01//19/11	1	100.00		
7	821	Hemo/Composite		01/23/11	1	100.00		
8	821	Hemo/Composite		01/26/11	1	100.00		
9	821	Hemo/Composite		01/28/11	1	100.00		
10	821	Hemo/Composite		01/31/11	1	100.00		
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23		PAGE 1 OF 1	CREATION DATE		TOTALS	1000.00		

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

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

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

66 DX: 585 A B C D E F G H 68
I J K L M N O P Q

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

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

76 ATTENDING NPI QUAL 1D 87654321
LAST Provider FIRST Ima
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS
81CC a b c d

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

Dialysis UB-04 Crossover Claim Example

1 Dialysis Center
100 Saginaw Street
Anytown, CO 80201
303-333-3333

2

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

4 TYPE OF BILL: 721

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM: 01/01/11 THROUGH: 01/15/11

7

8 PATIENT NAME a
b Client, Ima D.

9 PATIENT ADDRESS a 123 Main Street
b Anytown c CO d 88888 e

10 BIRTHDATE: 02/13/1957
11 SEX: F
12 ADMISSION DATE
13 HR
14 TYPE: 2
15 SRC
16 DHR
17 STAT: 01
18 CONDITION CODES: 71
19 20 21 22 23 24 25 26 27 28
29 ACDT STATE
30

31 OCCURRENCE CODE / DATE: a 50 11/19/10; b
32 OCCURRENCE CODE / DATE
33 OCCURRENCE CODE / DATE
34 OCCURRENCE CODE / DATE
35 OCCURRENCE SPAN CODE / FROM / THROUGH
36 OCCURRENCE SPAN CODE / FROM / THROUGH
37

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	A2	228:00				
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	821	Hemo/Composite		01/02/11	1	500:00		
2	821	Hemo/Composite		01/05/11	1	100:00		
3	821	Hemo/Composite		01/09/11	1	100:00		
23		PAGE 1 OF 1	CREATION DATE		TOTALS	700:00		

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
A	C - Medicare				472:00		57
B	D - Medicaid	12345678				228:00	OTHER
C							PRV ID

	58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Client, Ima D.		111223333A		
B	Client, Ima D.		A123456		
C					

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

66 DX: 585 A B C D E F G H I J K L M N O P Q 68

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

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

76 ATTENDING NPI QUAL 1D 87654321
LAST Provider FIRST Ima
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS
81CC a b c d

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

Dialysis CMS 1500 Claim Example

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#): X
1a. INSURED'S I.D. NUMBER (For Program in Item 1): D444444
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Client, Ima A
3. PATIENT'S BIRTH DATE MM 10 DD 16 YY 45 SEX M F X
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)
6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other
7. INSURED'S ADDRESS (No., Street)
CITY STATE
8. RESERVED FOR NUCC USE
CITY STATE
ZIP CODE TELEPHONE (Include Area Code) ( )
ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (Current or Previous) YES NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. RESERVED FOR NUCC USE
b. AUTO ACCIDENT? YES NO PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE
c. OTHER ACCIDENT? YES NO
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED Signature on File DATE 1/1/15

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.
15. OTHER DATE MM DD YY QUAL.
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a. 71b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9
A. 586 B. C. D.
E. F. G. H.
I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01 01 15	01 01 15	11		99211		1	20 00	1		NPI	12345678 0123456789
2	01 01 15	01 01 15	11		99211		1	10 00	1		NPI	12345678 0123456789
3	01 01 15	01 01 15	11		99211		1	9 00	1		NPI	12345678 0123456789
4	01 01 15	01 01 15	11		99211		1	14 00	1		NPI	12345678 0123456789
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO. Optional
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO
28. TOTAL CHARGE $ 53 00
29. AMOUNT PAID $
30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED Signature DATE 1/1/15
32. SERVICE FACILITY LOCATION INFORMATION
a. b.
33. BILLING PROVIDER INFO & PH # ( )
ABC Dialysis Clinic
100 Any Street
Any City
a. 1234567890 b. 04567890

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

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): Clint, Ima
2. CLIENT DATE OF BIRTH: 12/05/1948
3. MEDICAID ID NUMBER (CLIENT ID NUMBER): D555555
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NUMBER
5. CLIENT SEX: MALE ☐ ☒ FEMALE
6. MEDICARE ID NUMBER (HIC OR SSN)
7. CLIENT RELATIONSHIP TO INSURED: SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐
8. ☐ CLIENT IS COVERED BY EMPLOYER HEALTH PLAN AS EMPLOYEE OR DEPENDENT
EMPLOYER NAME:
9. OTHER HEALTH INSURANCE COVERAGE — INSURANCE COMPANY NAME, ADDRESS, PLAN NAME, AND POLICY NUMBER(S)
TELEPHONE NUMBER
10. WAS CONDITION RELATED TO:
A. CLIENT EMPLOYMENT YES ☐
B. ACCIDENT AUTO ☐ OTHER ☐
C. DATE OF ACCIDENT
POLICYHOLDER NAME:
GROUP :
11. CHAMPUS SPONSORS SERVICE/SSN
9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NUMBER
12. PREGNANCY ☐ HMO ☐ NURSING FACILITY ☐

PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF: ILLNESS (FIRST SYMPTON) OR INJURY (ACCIDENT) OR FIRST PREGNANCY (LMP)
14. MEDICARE DENIAL (ATTACH THE MEDICARE STANDARD PAPER REMITTANCE (SPR) IF EITHER BOX IS CHECKED) ☐ BENEFITS EXHAUSTED ☐ NON-COVERED SERVICES
14A. OTHER COVERAGE DENIED ☐ NO ☐ YES PAY/DENY DATE:
15. NAME OF SUPERVISING PHYSICIAN
PROVIDER NUMBER
16. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES
ADMITTED: DISCHARGED:
17. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (IF OTHER THAN HOME OR OFFICE
PROVIDER NUMBER
17A. CHECK BOX IF LABORATORY WORK WAS PERFORMED OUTSIDE THE PHYSICIANS OFFICE ☐ YES
18. ICD-9-CM
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. IN COLUMN F, RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE NUMBERS 1, 2, 3, OR 4
1. 586
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. EMERG ENCY	K. FAMILY PLANNING	L. EPSDT
01/05/2011	01/05/2011	11	99211		12345678	01234567	1			$20.00	1		☐	☐	☐
01/05/2011	01/05/2011	11	99211		12345678	01234567	1			$10.00	1		☐	☐	☐
01/05/2011	01/05/2011	11	99211		12345678	01234567	1			$9.00	1		☐	☐	☐
01/05/2011	01/05/2011	11	99211		12345678	01234567	1			$14.00	1		☐	☐	☐
													☐	☐	☐
													☐	☐	☐

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

20. TOTALCHARGES $53.00
LESS
MEDICARE SPR DATE
27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE
30. REMARKS
21. MEDICARE PAID
22. THIRD PARTY PAID $.00
23. NET CHARGE $53.00
24. MEDICARE DEDUCTIBLE $.00
25. MEDICARE COINSURANCE $.00
26. MEDICARE DISALLOWED
28. BILLING PROVIDER NAME: The Dialysis Clinic
29. BILLING PROVIDER NUMBER: 05678910

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

COLORADO 1500

Dialysis Revisions Log

Revision Date	Additions/Changes	Pages	Made by
02/13/2008	*Electronic Claims – Updated first two paragraphs with bullets*	*1*	*pr-z*
11/05/2008	*Updated web addresses*	*Throughout*	*jg*
02/11/2009	*Updated revenue code instructions*	*13*	*jg*
03/25/2009	*General updates*	*Throughout*	*jg*
01/18/2010	*Updated Web site links*	*Throughout*	*jg*
02/17/2010	*Changed EOMB to SPR*	*28 & 33*	*jg*
03/04/2010	*Added link to Program Rules*	*1*	*jg*
03/10/2010	*Added SPR to Special Instructions for Medicare SPR date field*	*28*	*jg*
03/26/2010	*General Updates*	*Throughout*	*ew/vr*
12/01/2010	*Clarification of Dialysis providers billing for non-routine drugs*	*5*	*ew/vr*
12/01/2010	*Clarification of pharmacies billing for non-routine drugs*	*5*	*ew/vr*
09/22/2011	*Added TOC* *Accepted changes and formatted* *Updated claim examples*	*1* *Throughout* *36-38*	*jg*
12/06/2011	*Replaced 997 with 999* *Replaced wpc-edi.com/hipaa with wpc-edi.com/* *Replaced Implementation Guide with Technical Report 3 (TR3)*	*4* *3* *3*	*ss*
04/21/2014	*Added Additional Condition Codes and Renal Dialysis Setting Codes*	*12*	*al*
04/21/2014	*Modified 030X Lab Codes*	*16*	*al*
04/21/2014	*Formatted* *Updated TOC*	*Throughout* *i*	*Jg*
7/11/14	*Changed CO 1500 claim examples to CMS 1500 claim examples*		*ZS*
7/11/14	*Updated Professional Claim Billing Instructions section with CMS 1500 information.*		*ZS*
7/11/14	*Replaced all CO 1500 references with CMS 1500*	*Throughout*	*ZS*
7/17/14	*Updated web links to reflect the new website*	*Throughout*	*mm*
7/17/14	*Updated references to Client to Member*	*Throughout*	*mm*

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.