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Audiology

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

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

Providers should refer to the Code of Colorado Regulations, Program Rules (10 CCR 2505-10 8.2.3.D.2), for specific information when providing audiology care.

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, Xerox State Healthcare (Xerox), 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 Claim Submission

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

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

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

This provides Xerox 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 Xerox 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 Xerox 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 Xerox 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 Xerox EDI Gateway. Assistance from Xerox 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, Xerox EDI Gateway requires providers to submit all X12N test transactions to EDIFECS prior to submitting them to Xerox 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.

Covered Audiology Benefits

Hearing benefits are limited to the minimum services required to meet the member's medical needs. As stated in Volume 8.280.06, medically necessary, or medical necessity, shall be defined as a Medical Assistance Program service that will, or is reasonably expected to prevent, diagnose, cure, correct, reduce or ameliorate the pain and suffering, or the physical, mental, cognitive or developmental effects of an illness, injury, or disability; and for which there is no other equally effective or substantially less costly course of treatment suitable for the child's needs. Hearing exams, speech therapy, diagnostic testing, surgeries, and related hospitalizations are regular benefits of the Medical Assistance Program. Claims must meet all requirements outlined in this manual.

Newborn Hearing Screening

The Colorado legislature passed House Bill 97-1095, which establishes hearing screenings for newborn infants [25-4-1004.7(VI)(b)]. Appropriate testing and identification of newborn infants with hearing loss makes early intervention and treatment possible and promotes the healthy development of children.

Hearing Conservation Program (HCP) Audiology Regional Coordinators provide consultation information, technical assistance, and referral services to families of children with special health care needs.

Cochlear Implants

Cochlear Implants are a covered benefit for members ages 20 and under who meet the appropriate Prior Authorization criteria outlined in Rule 8.200.3.D.2.e.iv. Replacement of an existing cochlear implant for all ages is a benefit when the currently used component is no longer functional and cannot be repaired.

Hearing Aids

Hearing aids are a covered benefit for members ages 20 and under and for adult members on the Supported Living Services (SLS) Waiver.

When billing for a pair of hearing aids, each individual hearing aid must be listed on a separate line on the claim form and must have the appropriate modifier noted to indicate the ear for which it is fitted. The “RT” modifier indicates the hearing aid is for the right ear, and the “LT” modifier indicates it is for the left ear. Billing for two (2) units of a hearing aid, on the same line, without the appropriate modifier will result in a denial.

Hearing Aid Trial Rental Period

The Trial Rental Period is included in the purchase reimbursement for the hearing aid(s). Use the last day of the rental period as the date of service.

Hearing Aid Replacement

Hearing aids are expected to last 3 – 5 years. Replacement of a hearing aid is covered for members ages 20 and under. Hearing aids may be replaced when they no longer fit, have been lost or stolen, or the current hearing aid is no longer medically appropriate for the child.

Ear Molds

Reimbursement for ear molds is included in the dispensing fee (procedure code V5090) charged in conjunction with the hearing aid code. Ear molds are not independently reimbursable, and are not a covered benefit for noise reduction or swimming.

Softbands (including Bone Anchored Hearing Aids - BAHAs)

Softband hearing devices (including BAHAs) are a covered benefit for members ages 20 and under. All softband purchases require a PAR and must be accompanied by a signed letter from a physician documenting medical necessity. In addition, claims must be submitted on the CMS 1500 paper claim form and include the invoice received for purchasing the item. The Colorado Medical Assistance Program reimburses softband devices using the following methodology: invoice cost + 10%. Please see the table below for a list of procedure codes covered for softband devices.

All Audiology PARs and revisions processed by the ColoradoPAR Program must be submitted through CareWebQI (CWQI). Clinical information is required for a PAR review. When submitting PARs, please answer the clinical questions in CWQI, attach the relevant clinical documentation needed for determinations, and select “Medical” type from the drop-down menu. If “DME” is selected this will result in non-payment of the device.

Covered Softband Procedure Codes					
Code	**Description**	**PAR**	**Required PAR and Claim Modifier**	**Allowed Billing Provider Types**	**Allowed Rendering Provider Types**
L8692	**New.** Auditory osseointegrated device, external sound processor, used without osseointegration, body worn, includes headband or other means of external attachment.	Always	UB	Physician, Pharmacy, Supply, Clinics, Osteopath, Audiologist.	Physician, Osteopath, Audiologist
L8691	**Replacement.** Auditory osseointegrated device, external sound processor.	Always	UB		

Specific Non-Covered Benefits

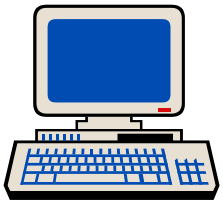
• Training or consultation provided by an Audiologist to an agency, facility, or other institution is not covered	• The upgrading of an existing cochlear implant system or component if the existing unit is properly functioning is not covered	• Hearing aids for adults (Hearing exams and evaluations are a benefit for adults only when a concurrent medical condition exists) are not covered
• Hearing aid insurance is not covered	• Any service not documented in the member's plan of care is not covered	• Ear molds for the purpose of noise reduction or swimming are not covered
• Any audiological services rendered by a non-licensed audiologist (except for licensed otalaryngologists and enrolled CHIP providers, are not covered		

Eligible Providers

- Physicians may provide audiology services, but first must contact the fiscal agent to confirm their enrollment with an otolaryngology specialty.
- Certified audiologists are eligible to become Medical Assistance Program providers.
- Audiologists must be registered with the Department of Regulatory Agencies in order to dispense hearing aids.
- Colorado Home Intervention Program (CHIP) facilitators must be credentialed by Health Care Programs for Children with Special Needs (HCP) administered by the Colorado Department of Public Health and Environment. CHIP facilitators are eligible to become Medical Assistance Program providers and need to enroll in the Colorado Medical Assistance Program.

Prior Authorization Requests (PARs)

Although most procedures can be processed without prior review and approval, certain procedures require prior authorization. A list of authorizing agencies, addresses, and telephone numbers is located in Appendices C and D in the Appendices of the Provider Services Billing Manuals section of Department's Web site. Selected surgical procedures and all services provided outside of Colorado, with the exception of emergency services, require prior authorization. Providers must complete, submit, and receive approval of the Prior Authorization Request (PAR) **before** rendering the service or supply. Surgical procedure codes requiring prior authorization are listed in Appendix M.



Providers are encouraged to submit PARs electronically using the 278 Transaction. Electronically submitted PARs without the minimally required information are rejected. Instructions for completing and submitting electronic PARs are available through the 278 Transaction Companion Guide found on the Department's Web site in the Provider Services Specifications section.

Electronic PAR submission offers the provider:

- Immediate system assignment of a PAR number
- Faster PAR processing

Only Dental Care, Medical Care, and Supply PARs may be submitted electronically through the Web Portal, but *all* PAR type responses are available for inquiry.

PARs submitted to the fiscal agent by paper must be submitted on the correct PAR form using the national Centers for Medicare and Medicaid Services (CMS) and Current Procedural Terminology (CPT) codes described in this manual. PARs submitted to the fiscal agent without utilizing the Healthcare Common Procedural Coding System (HCPCS) codes or on the incorrect form will not be accepted. Paper PAR forms and completion instructions are located in the Provider Services Forms section.

Approval of a PAR does not guarantee Colorado Medical Assistance Program payment and does not serve as a timely filing waiver. Prior authorization only assures that the service 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, Primary Care Physician (PCP) information completed appropriately, third party resources payments pursued, required attachments included, etc.) before payment can be made.

After a PAR has been reviewed, a PAR letter is sent to the provider and the member. For approved services, allow sufficient time for the fiscal agent to enter the PAR data into the Colorado Medical Assistance Program processing system before submitting a claim for the authorized service.

PAR Revisions

Please print “REVISION” in bold letters at the top and enter the PAR number being revised in box # 7. Do not enter the PAR number being revised anywhere else on the PAR.

Paper PAR Instructional Reference

Field Label	Completion Format	Instructions
The upper margin of the PAR form must be left blank. This area is for authorizing agent’s use only.		
Invoice/Pat Account Number	Text	Optional Enter up to 12 characters (numbers, letters, hyphens) to identify the claim or member.
1. Member Name	Text	Required Enter the member's last name, first name and middle initial. Example: Adams, Mary A.
2. Member Identification Number	7 characters, a letter prefix followed by six numbers	Required Enter the member's state identification number. This number consists of a letter prefix followed by six numbers. Example: A123456.
3. Sex	Check box ☐ M ☐ F	Required Enter an "X" in the appropriate box.
4. Date of Birth	6 numbers (MMDDYY)	Required Enter the member's birth date using MMDDYY format. Example: January 1, 2009 = 010109.
5. Member Address	Characters: numbers and letters	Required Enter the member's full address: Street, city, state, and zip code.
6. Member Telephone Number	10 numbers ###-###-####	Optional Enter the member's telephone number.
7. Prior Authorization Number	None	System assigned Do not write in this area. The authorizing agent reviews the PAR, and approves or denies the services. Enter the assigned PAR number in the appropriate field on the claim form when billing for prior authorized services.

Field Label	Completion Format	Instructions
8. Dates Covered by This Request	6 numbers for from date and 6 numbers for through date (MMDDYY)	Required Enter the date(s) for the requested service(s). If left blank, dates are entered by the authorizing agency. Authorized services must be provided within these dates. If retroactive authorization is requested, enter the date(s) of service and provide justification in field 11 (Diagnosis).
9. Does Member Reside in a Nursing Home?	Check box ☐ Yes ☐ No	Required Enter an "X" in the appropriate box.
10. Group Home Name if Patient Resides in a Group Home	Text	Conditional Enter the name of the Group Home if the member lives in a group home.
11. Diagnosis	Text	Required Enter the diagnosis and sufficient relevant diagnostic information to justify the request and include the prognosis. Provide relevant clinical information, other drugs or alternative therapies tried in treating the condition, results of tests, etc., to justify a Colorado Medical Assistance Program determination of medical necessity. If diagnosis codes are used, the narrative is also required. Approval of the PAR is based on documented medical necessity. Attach documents as required.
12. Requesting Authorization for Repairs	None	Not required
13. Indicate Length of Necessity	None	Not required
14. Estimated Cost of Equipment	None	Not required
15. Services to be Authorized Line Number	None	Preprinted Do not alter preprinted line numbers. No more than five services or items can be requested on one form.

Field Label	Completion Format	Instructions
16. Describe Procedure, Supply, or Drug to be Provided	Text	Required Enter a description of the service(s) that will be provided.
17. Procedure, Supply or Drug Code	Revenue codes - 3 numbers CMS codes - 5 Characters	Required Enter the revenue and/or CMS code(s) for each service that will be billed on the claim form. The code(s) indicated on the PAR form must be used for billing.
18. Requested Number of Services	3 numbers	Required Enter the number of visits, services, procedures requested. If this field is blank, the authorizing agency will complete it.
19. Authorized No. Of Services	None	Leave Blank The authorizing agency indicates the number of services authorized. This number may or may not equal the number requested in field 18 (Number of Services).
20. Approved Denied	None	Leave Blank No longer used. Refer to the PAR letter or check the PAR online.
21. Primary Care Physician (PCP) Name **Telephone Number**	Text	Conditional If the member has a primary care physician, enter the name of the primary care physician in this field. Optional Enter the primary care physician's phone number.
22. Primary Care Physician Address	Text	Optional Enter the address of the primary care physician.
23. PCP Provider Number	8 numbers	Conditional If the member has a primary care physician, enter the primary care physician's provider number in this field.

Field Label	Completion Format	Instructions
24. Name and Address of Physician Requesting Prior Authorization	Text	Required Enter the complete name and address of the provider requesting the PAR. If the clinic is requesting a PAR, enter the audiologist's complete name and address
25. Name and address of Provider Who Will Render Service	Text	Required If the clinic is requesting a PAR, enter the clinic's name and address. If an independent audiologist is requesting a PAR, enter the audiologist's name and address.
Telephone Number	10 numbers ###-###-####	Required Enter the telephone number of the rendering provider.
26. Requesting Physician Signature	Text	Required The audiologist requesting the service must sign the PAR. A rubber stamp facsimile signature is not acceptable on the PAR.
27. Date Signed	6 numbers (MM/DD/YY)	Required Enter the date the PAR form is signed by the requesting provider
Telephone Number	10 numbers ###-###-####	Optional Enter the requesting provider's telephone number
28. Requesting Physician Provider Number	8 numbers	Required Enter the eight-digit Colorado Medical Assistance Program provider number of the audiologist requesting the service (the audiologist must be enrolled).
Telephone Number	10 numbers ###-###-####	Optional Enter the telephone number of the rendering provider.

Field Label	Completion Format	Instructions
29. Service Provider Number	8 numbers	Required If the clinic is requesting a PAR, enter the clinic's eight-digit Colorado Medical Assistance Program provider number. If an independent audiologist is requesting a PAR, enter the audiologist's eight-digit Colorado Medical Assistance Program provider number. The rendering provider must be enrolled with the Colorado Medical Assistance Program.
30. Comments	Text	This field is completed by the authorizing agency. Refer to the PAR response for comments submitted by the authorizing agency.
31. PA Number Being Revised	Text	This field is completed by the authorizing agency

The authorizing agent reviews all completed PARs. The authorizing agency approves or denies, by individual line item, each requested service or supply listed on the PAR. The results of the PAR review are available through the Web Portal and included in PAR letters. **Read the response carefully as some line items may be approved and others denied.**

Do not render or bill for services until the PAR has been processed. The claim **must** contain the PAR number for payment.

If the PAR is denied, direct inquiries to the authorizing agency listed in Appendix D of the Appendices section in Provider Services Billing Manuals.

Prior Authorization Request (PAR) Form

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND FINANCING

INVOICE/PAT. ACCOUNT NUMBER

MEDICAID PRIOR AUTHORIZATION REQUEST (PAR)

To avoid delay, please answer all questions completely.

1. CLIENT NAME (Last, First, Middle Initial)	2. CLIENT IDENTIFICATION NUMBER	3. SEX ☐ M ☐ F	4. DATE OF BIRTH (MMDDYY)
5. CLIENT ADDRESS (Street, City, State, ZIP Code)			6. CLIENT TELEPHONE NUMBER ( )

7. PRIOR AUTHORIZATION NUMBER * SYSTEM ASSIGNED	8. DATES COVERED BY THIS REQUEST FROM (MMDDYY) THROUGH (MMDDYY)	9. DOES CLIENT RESIDE IN A NURSING FACILITY? ☐ YES ☐ NO	10. GROUP HOME NAME - IF PATIENT RESIDES IN A GROUP HOME

11. ICD-9-CM DIAGNOSIS CODE and DESCRIPTION (Must include Diagnosis Code and Description, Prognosis, Clinical Information and Other Medications presently prescribed)

12. REQUESTING AUTHORIZATION FOR REPAIRS EQUIPMENT MUST BE OWNED BY THE CLIENT - THE SERIAL NUMBER MUST BE ENTERED

13. INDICATE LENGTH OF NECESSITY (IN MONTHS AND YEARS) I.E., HOW LONG WILL THIS EQUIPMENT BE NEEDED?

14. ESTIMATED COST OF EQUIPMENT

SERVICES TO BE AUTHORIZED

15. LINE NO.	16. DESCRIBE THE PROCEDURE OR SUPPLY TO BE PROVIDED — INCLUDE MODEL NUMBER FOR DME PURCHASE OR SERIAL NUMBER FOR REPAIR	17. PROCEDURE OR SUPPLY CODE	18. REQUESTED NUMBER OF SERVICES	19. AUTHORIZED NO. OF SERVICES (LEAVE BLANK **)	20. APPROVED/DENIED (LEAVE BLANK **)
01					
02					
03					
04					
05					

21. PRIMARY CARE PHYSICIAN (PCP) NAME		22. PRIMARY CARE PHYSICIAN ADDRESS (Street, City, State, ZIP code)
TELEPHONE NUMBER ( )	23. PCP PROVIDER NUMBER	
24. NAME AND ADDRESS OF PHYSICIAN REQUESTING PRIOR AUTHORIZATION		25. NAME AND ADDRESS OF PROVIDER WHO WILL RENDER SERVICE
26. REQUESTING PHYSICIAN SIGNATURE	27. DATE SIGNED	

TELEPHONE NUMBER ( )	28. REQUESTING PHYSICIAN PROVIDER NUMBER	TELEPHONE NUMBER ( )	29. SERVICE PROVIDER NUMBER

If services are provided according to the manner prescribed by State of Colorado Laws and Regulations, reimbursement will be provided for authorized services following submission of an appropriately completed Medicaid claim.

30. COMMENTS **

☐ ATTACH COPY OF THIS PAR TO CLAIM(S) **

SIGNATURE OF STATE AGENCY REPRESENTATIVE **	DATE **	31. PA NUMBER BEING REVISED **

* THE ASSIGNED PAR NUMBER APPEARS ON THE PAR LETTER. ENTER THE PAR NUMBER FROM THE LETTER ON THE CLAIM WHEN BILLING FOR THE SERVICES. ** THESE FIELDS ARE COMPLETED BY THE AUTHORIZING AGENT

FORM NO. 10013 (REV. 12/98)
COL — 106

White - AUTHORIZING AGENT Yellow - ORIGINATOR

Procedure/HCPCS Codes Overview

The codes used for submitting claims for services provided to Colorado Medical Assistance Program members represent services that are approved by the Centers for Medicare and Medicaid Services (CMS) and services that may be provided by an enrolled Colorado Medical Assistance Program provider.

The Healthcare Common Procedural Coding System (HCPCS) is divided into two principal subsystems, referred to as level I and level II of the HCPCS. Level I of the HCPCS is comprised of Current Procedural Terminology (CPT), 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, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter followed by 4 numeric digits, while CPT codes are identified using 5 numeric digits.

HIPAA requires providers to comply with the coding guidelines of the AMA CPT Procedure Codes and the International Classification of Disease, Clinical Modification Diagnosis Codes. If there is no time designated in the official descriptor, the code represents one unit or session. Providers should regularly consult monthly bulletins in the Provider Services Bulletins section. To receive electronic provider bulletin notifications, an email address can be entered into the Web Portal in the *(MMIS) Provider Data Maintenance* area or by filling out a publication preference form. Bulletins include updates on approved procedure codes as well as the maximum allowable units billed per procedure.

Paper Claim Reference Table

The following paper form reference table shows required, optional, and conditional fields and detailed field completion instructions for the CMS 1500 claim form.

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.

CMS Field #	Field Label	Field is?	Instructions
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**		
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.

CMS Field #	Field Label	Field is?	Instructions
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	
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

CMS Field #	Field Label	Field is?	Instructions
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 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 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

CMS Field #	Field Label	Field is?	Instructions
			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 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 a "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 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: permissible if the same service (same procedure code) is provided on consecutive dates.
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

CMS Field #	Field Label	Field is?	Instructions
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-threatening 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 SCI procedure code that specifically describes the service for which payment is requested.
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.
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.

CMS Field #	Field Label	Field is?	Instructions
			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) Not Required
24I	**ID Qualifier**	Not Required	
24J	**Rendering Provider ID #**	Required	In the shaded 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.

CMS Field #	Field Label	Field is?	Instructions
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	**Reserved for NUCC Use**		
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 registered 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 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 #**	Not Required	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).

CMS Field #	Field Label	Field is?	Instructions
			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 & Phone #** **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 Not Required 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 19 – 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 appeared on the state eligibility system.

Billing Instruction Detail	Instructions
Delayed Notification of Eligibility	The provider was unable to determine that the patient had Colorado Medical Assistance Program coverage until after the timely filing period expired. **File the claim within 60 days** of the date of notification that the individual had Colorado Medical Assistance Program coverage.
Delayed Notification of Eligibility	Retain correspondence, phone logs, or a signed Delayed Eligibility Certification form (see Certification & Request for Timely Filing Extension in the Provider Services Forms 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.
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.

Billing Instruction Detail	Instructions
	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.

Audiology 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 A
2. CLIENT DATE OF BIRTH: 08/05/1946
3. MEDICAID ID NUMBER (CLIENT ID NUMBER): D444444
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. 6850
2.
3.
4.
TRANSPORTATION CERTIFICATION ATTACHED ☐ YES
DURABLE MEDICAL EQUIPMENT
Line # Make Model Serial Number
PRIOR AUTHORIZATION #:

19A DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. PROCEDURE CODE (HCPCS)	MODIFIERS	D. RENDERING PROVIDER NUMBER	E. REFERRING PROVIDER NUMBER	F. DIAGNOSIS P	S	T	G. CHARGES	H. DAYS OR UNITS	I. COPAY	J. EMERGENCY	K. FAMILY PLANNING	L. EPSDT
08/05/2011	08/05/2011	24	11770		01234567	09876543	1			$517.00			☐	☐	☐
													☐	☐	☐
													☐	☐	☐
													☐	☐	☐
													☐	☐	☐
													☐	☐	☐

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 $517.00
LESS
MEDICARE SPR DATE

27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE
Authrized Signature 08/06/2014
28. BILLING PROVIDER NAME
ABC Surgery Center
29. BILLING PROVIDER NUMBER
04564891
30. REMARKS

21. MEDICARE PAID
22. THIRD PARTY PAID $.00
23. NET CHARGE $517.00
24. MEDICARE DEDUCTIBLE $.00
25. MEDICARE COINSURANCE $.00
26. MEDICARE DISALLOWED

COL-101
FORM NO. 94320 (REV. 01/2011)

COLORADO 1500

Audiology Revisions Log

Revision Date	Additions/Changes	Pages	Made by
01/05/2009	*Drafted Manual*	*All*	*jg*
05/11/2009	*Web site addresses updated*	*Throughout*	*jg*
07/06/2009	*Accepted changes and verified TOC*	*Throughout*	*jg*
10/08/2009	*Deleted allowable amount column*	*11-13*	*vr*
10/19/2009	*Updated PAR instructions*	*6-9*	*jg*
10/19/2009	*LBOD*	*25*	*jg*
01/12/2010	*Updated Web site links*	*Throughout*	*jg*
02/10/2010	*Changed EOMB to SPR*	*22 & 27*	*jg*
03/04/2010	*Added link to Program Rules*	*2*	*jg*
03/11/2010	*Changed No to Yes in PAR column for code V5090*	*12*	*jg*
03/11/2010	*Added SPR to Special Instructions for Medicare SPR Date field*	*21*	*jg*
07/09/2010	*Updated date examples for field 19A* *Updated claim example*	*18* *28*	*jg*
07/14/2010	*Added Electronic Remittance Advice (ERA) to Special Instructions for Medicare SPR Date field and* *to Electronic Medicare Crossover Claims & to Medicare Denied Services in Late Bill Override Date section.*	*21* *26*	*jg*
08/03/2011	*Procedure Code Table* *UpdateBenefits statement* *Updated Cochlear Implants statement* *Updated PAR Reference Table* *Updated Paper Reference Table*	*11-13* *4* *5* *6-10* *15, 18*	*vr*
08/03/2011	*Updated TOC* *Reformatted* *Updated claim example*	*1* *Throughout* *27*	*Jg*
12/06/2011	*Replaced 997 with 999* *Replaced http://www.wpc-edi.com/hipaa) with http://www.wpc-edi.com/* *Replaced Implementation Guide with Technical Report 3 (TR3)*	*4* *2* *2*	*ss*
01/27/2012	*Changed authorizing agent to authorizing agency*	*Throughout*	*jg*

Revision Date	Additions/Changes	Pages	Made by
01/27/2012	*Removed: "* Hearing services for children have been a Medical Assistance Program benefit since 1979. The Colorado Department of Public Health and Environment, Health Care Program..."	*2*	*Jg*
7/21/2014	*Updated all web links for new 2014 HCPF website*	*Throughout*	*mm*
7/21/2014	*Updated all references of Client to Member*	*Throughout*	*Mm*
7/21/2014	*Expanded on and recreated the Non-covered benefits table per Benefit Manager*	*Page 6*	*mm*
7/21/2014	*Added information regarding Hearing Aids and BAHAs per Benefit Manager*	*Page 8*	*Mm*
7/24/2014	*Revised table of contents to show additions made by benefit manager*		*ZS*
10/14/2014	*Added Ear Molds section and information*	*5*	*AW*
10/14/2014	*Revised Softbands section*	*5*	*AW*
10/27/2014	*Added Ear Molds section to Table of Contents*	*1*	*RM*
10/27/2014	*Revised Paper Claim Reference Table to CMS 1500 data*	*14-22*	*RM*
10/29/2014	*Removed "Pacific" from hyperlinks*	*Throughout*	*MC*
10/29/2014	*Switched ACS to Xerox*	*2-4*	*RM*
11/21/2014	*Removed Appendix H information, added Timely Filing document information*	*25*	*RM*

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.