Early and Periodic Screening Diagnostic and Treatment (EPSDT) Program

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Early and Periodic Screening Diagnostic and Treatment (EPSDT) Program

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

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children and youth ages 20 and under, who are enrolled in Medicaid. EPSDT is key to ensuring that children and youth receive appropriate preventive, dental, mental health, developmental and specialty services.

Early	Assessing and identifying problems early
Periodic	Checking children's health at periodic, age-appropriate intervals
Screening	Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
Diagnostic	Performing diagnostic tests to follow up when a risk is identified
Treatment	Control, correct or reduce health problems found

One of the goals of EPSDT is to establish a regular pattern of healthcare through routine health screenings, diagnostic, and treatment services.

All states are required to complete a report to the federal government on April 1 of each year as to the numbers of services received by the EPSDT eligible members. All states have a minimum requirement of 80% of the children and youth receiving at least one screening visit per year.

Providers should refer to the Code of Colorado Regulations, Program Rules (10 CCR 2505-10.8.280), for specific information when providing EPSDT care.

General Billing Information

National Provider Identifier (NPI)

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

Paper Claims

Electronic claims format shall be required unless hard copy claims submittals are specifically authorized by the Department of Health Care Policy and Financing (the Department). Requests may be sent to 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 approval)
- Claims that, by policy, require attachments
- Reconsideration claims

Paper claims do not require an NPI, but do require the Colorado Medical Assistance Program provider number. Electronically mandated claims submitted on paper are processed, denied, and marked with the message "Electronic Filing Required".

Electronic Claims

Instructions for completing and submitting electronic claims are available through the following:

- X12N Technical Report 3 (TR3) for the 837P, 837I, or 837D (http://www.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. For additional electronic information, please refer to the Medicaid Provider Information manual located on the Department's website (Colorado.gov/hcpf) → For Our Providers → Provider Services → Billing Manuals.

General Program Provisions

A comprehensive EPSDT Periodic Screening examination includes the following components:

- Comprehensive health & developmental history
- Comprehensive unclothed physical examination
- Assessment of physical, emotional & developmental growth
- Assessment of mouth, oral cavity and teeth, including referral to a dentist
- Assessment of nutritional status
- Family planning services and adolescent maternity care
- Vision assessment
- Immunizations *appropriate to age & health history*
- Laboratory tests (including lead blood level assessment appropriate to age & risk)
- Assessment of mental/behavioral health
- Hearing as sessment
- Health education (including anticipatory guidance)
- Treatment and referrals for any medically necessary further diagnosis and treatment

Types of EPSDT Provider Visits

1) Periodic Screen

The periodic screen includes comprehensive health assessments that are performed soon after birth or as early as possible in a child's life. It is repeated at prescribed intervals until the age of 20, as described in the AAP Bright Futures Periodicity Schedule.

2) Inter-Periodic Visit

An inter-periodic visit is any other healthcare visit the child may need, such as visits for an ear ache, fever or injury.

Outreach and Case Management – Healthy Communities Program

Each family or member is assigned to a Family Health Coordinator in their local area. The Family Health Coordinator's services are a part of the member's Medicaid benefit and offers support services, including the following:

- Ensures that members are informed of program benefits
- Assists child in accessing health care services within a reasonable time period
- Offers assistance in identifying participating Colorado Medical Assistance Program doctors, dentists, other medical specialists and managed care programs or Accountable Care Programs.
- Assists in making and reminds members of appointments, if requested
- Follows up on appointments that may have been missed, if requested by a provider
- Assists with connecting child with non-medical community resources

Coordinate the following types of health care services wherever possible:

- Newborn or well-baby check-ups
- Day care or Head Start physicals
- Routine well child physical exams
- Dental Screenings
- Behavioral Health screenings
- Developmental screenings

Visit the Healthy Communities web page on the Department's website to find a Family Health Coordinator in your area.

Diagnosis and Treatment

A presumptive diagnosis may be made at the time of screening, but it is usually necessary to advise the member of the need for further diagnosis and treatment. Necessary treatments may be rendered by the PCP or MCO practitioner or by referral to an authorized Colorado Medical Assistance Program specialist.

Services

EPSDT is made up of the following screening, diagnostic, and treatment services:

Screening Services

Comprehensive health and developmental history

Comprehensive unclothed physical exam
Appropriate immunizations (according to the Advisory Committee on Immunization Practices)
Laboratory tests (including lead toxicity testing)
Health Education (anticipatory guidance including child development, healthy lifestyles, and accident and disease prevention)

Dental Services
At a minimum, dental services include relief of pain and infections, restoration of teeth, and Maintenance of dental health, including examinations, cleanings and fluoride treatments.

Diagnostic Services
When a screening indicates the need for further evaluation, diagnostic services must be provided.

Hearing Services
At a minimum, diagnosis and treatment for defects in hearing, including hearing aids.

Vision Services
At a minimum, diagnosis and treatment for defects in vision, including eyeglasses.

Lead Screening
Lead screening is a requirement for all Medicaid eligible children at 12 and 24 months or between the ages of 36 and 72 months if not previously tested. Colorado has not received an exemption from this requirement from CMS, therefore all contracted providers are required to provide and report testing for lead at the appropriate physicals at 12 and 24 months and between 36 and 72 months if not previously tested.

Other Necessary Health Care Services
Additional health care services that are coverable under the Federal Medicaid program and found to be medically necessary to treat, correct or reduce illnesses and conditions discovered regardless of whether the service is covered in a state's Medicaid plan. It is the responsibility of states to determine medical necessity on a case-by-case basis (see medical necessity below for more information).

Treatment
Necessary health care services must be made available for treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedures.

Medical Necessity
All Medicaid coverable, medically necessary, services must be provided even if the service is not available under the State plan to other Medicaid eligibles. Benefits not listed are not considered to be a state plan benefit and therefore outside of EPSDT coverage and exceptions. No arbitrary limitations on services are allowed, e.g., one pair of eyeglasses or 10 physical therapy visits per year.

Colorado makes the final determination of medical necessity and it is determined on a case-by-case basis. Provider recommendations will be taken in to consideration, but are not the sole determining factor in coverage. Colorado determines which treatment it will cover among equally effective, available alternative treatments.

EPSDT Medical Necessity Does NOT include:
- Experimental or investigational treatments
- Services or items not generally accepted as effective; and/or not within the normal course and duration of treatment; and/or those without clinical guidelines
- Services for caregiver or providers convenience

Services for which Colorado has a waiver are also not considered to be state plan benefits, and therefore are not a benefit under EPSDT. Items such as respite, behavioral interventions, in-home support services, and home modifications are examples of waiver services.

To request services that a provider feels are medically necessary but are not currently covered by the state plan, a prior authorization request must be completed as well as a letter of medical necessity. Both should be sent to the authorizing agent listed in Appendix D located in the Billing Manuals section of the Department's website.

The provider will receive an initial denial of the benefit, but will then receive a subsequent approval or denial based on the EPSDT review.

For Children Receiving Services Through the Health Care Program for Children with Special Needs Eligible Clients

Developmental Screening
Colorado Medicaid enrolled children aged 0 – 4 (up to 59 months) following the 3 by 3 framework from the AAP. Three (3) screens per year for children aged 0 – 24 months. Colorado Medicaid covers developmental screening for children ages 0 – 4 (up to 59 months), using a standardized, validated developmental screening tool (i.e., PEDS, Ages and Stages, etc.) at the child's periodic visits. In the absence of established risk factors or parental or provider concerns, the AAP recommends developmental screens at the 9-, 18-, and 30-months.

Depression Screening
Colorado Medicaid enrolled individuals aged 11 and over. One (1) screen per year for clients aged 11 and older. mColorado Medicaid covers depression screening for individuals aged 11 and older, using a standardized, validated depression screening tool (i.e., PHQ-9, Edinburgh Postnatal Depression Scale, Columbia Depression Scale, Beck Depression Inventory, Kutcher Adolescent Depression Scale, etc.) at the client's periodic visits. The exact frequency of validated, standardized screening depends on both the concerns of the child's parents or adult client and also the provider as to whether routine surveillance suggests the client may be at risk for depression.

Postpartum Depression Screening
Providers may choose to screen postpartum clients for postpartum depression as part of the client's annual depression screen. When a provider is primarily seeing an infant for a well-child check, the provider may include postpartum screening of the Medicaid mother for depression as a separate service.

Austism Screening
Two (2) screens between the child's 18- and 24-month visit. Colorado Medicaid covers autism screening for children aged 18- and 24-months, using a standardized, validated autism screening tool (i.e., M-CHAT, etc.) at the child's periodic visits. When an autism screen identifies a child as being at risk for an Autism Spectrum Disorder, an ASD Diagnostic Evaluation should follow.

Dental Inspection

The mouth must be examined as part of the physical examination. Providers can provide services under the Cavity Free by Three program and bill Colorado Medicaid for appropriate and covered services when they have been certified to do so. Please visit the Cavity Free at Three web page under Children's Dental on the Department's website.

Children ages one and older, or at the eruption of their first tooth, should be referred to a dentist twice a year for preventive care.

Laboratory Tests

As appropriate for age or medical necessity, perform the following screening tests:

- Anemia
- Sickle-cell trait
- Lead poisoning
- Tuberculosis
- Diabetes
- Other infectious conditions

Administer lab tests according to the *Recommendations for Preventive Pediatric Health Care Schedule.* The Colorado Medical Assistance Program provider is required to test all children for a blood lead level at 12 months **and** 24 months of age and at 36-72 months if age, if not previously tested.

Diagnosis and Follow-Up for Lead Poisoning
If a child is found to have blood lead levels equal to or greater than 10 ug/dL, the laboratory will report results back to the provider and to the Colorado Department of Public Health and Environment. For guidelines covering patient management and treatment, including follow-up blood tests and initiation of investigations to the source of lead where indicated, providers should contact the Colorado Department of Public Health and Environment (Lead Poisoning Prevention Program 1-800-886-7689, Press 1).

Screening Frequency

The State has adopted the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule for physicians in rendering screening examinations.

Screening examinations rendered more frequently are subject to medical review.

Developmental
Colorado Medicaid enrolled children aged 0 – 4 (up to 59 months) following the 3 by 3 framework from the AAP. Three (3) screens per year for children aged 0 – 24 months.

Depression
Colorado Medicaid enrolled individuals aged 11 and over. One (1) screen per year for clients aged 11 and older.

Note: Colorado Medicaid recommends the use of PHQ-9, but other validated, standardized depression screening tools are also acceptable.

Autism
Colorado Medicaid enrolled children aged 18- and 24-months. Two (2) screens between the child's 18- and 24-month visit.

Benefits

Developmental, Depression, and Austism Screenings

Develomental
Colorado Medicaid covers developmental screening for children ages 0 – 4 (up to 59 months), using a standardized, validated developmental screening tool (i.e., PEDS, Ages and Stages, etc.) at the child's periodic visits. In the absence of established risk factors or parental or provider concerns, the AAP recommends developmental screens at the 9-,18-, and 30-months.

Depression
Colorado Medicaid covers depression screening for individuals aged 11 and older, using a standardized, validated depression screening tool (i.e., PHQ-9 (Department recommended), Edinburgh Postnatal Depression Scale, Columbia Depression Scale, Beck Depression Inventory, Kutcher Adolescent Depression Scale, etc.) at the client's periodic visits. The exact frequency of validated, standardized screening depends on both the concerns of the child's parents or adult client and also the provider as to

whether routine surveillance suggests the client may be at risk for depression.

Autism

Colorado Medicaid covers autism screening for children aged 18- and 24-months, using a standardized, validated autism screening tool (i.e., M-CHAT, etc.) at the child's periodic visits. When an autism screen identifies a child as being at risk for an Autism Spectrum Disorder, an ASD Diagnostic Evaluation should follow.

Dental Benefits

A non-emergency oral examination, dental prophylaxis, and fluoride topical application once every six months are benefits of the EPSDT program. The Colorado Medical Assistance Program recommends regular periodic examinations by a dentist with eruption of the first tooth or at age one, and continuing every six (6) months or as recommended by a dentist. Referral from the PCP is **not** required for EPSDT dental services.

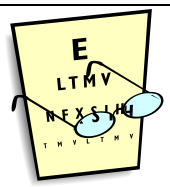
Orthodontia is available for children who have been diagnosed with a severely handicapping malocclusion.

Dentally necessary radiographs, restorations, endodontics, periodontics, prosthodontics and oral surgery are also benefits. Dental services are billed on the 2006 American Dental Association (ADA) claim form or the 837 D. Complete billing instructions for dental services are included in DentaQuest Provider Office Reference Manual (ORM) found under DentaQuest Resources section of DentaQuest's website. Colorado Medicaid dental providers can also call DentaQuest's Provider Relations/Services at 1-855-225-1731 (for TTY assistance, please call AT&T's TTY line at 711).

Hearing Assisted Device Benefits

Audiological benefits include identification, diagnostic evaluation, and treatment for children with hearing impairments. Benefits include hearing aids and other assisted devices, auditory training in the use of hearing aids, therapy for children with hearing impairments, and family-focused home based early language intervention for children, (birth to three years of age), with hearing loss through the Colorado Home Intervention Program (CHIP).

Vision Care Benefits



Vision care services are billed on the CMS 1500 Claim Form.

Vision diagnostic and treatment services may be performed by an ophthalmologist or optometrist. Referral is **not** required for vision care. Single and multifocal vision lenses and frames, as well as repair or replacement of broken lenses or frames, are benefits of EPSDT and may be provided by an ophthalmologist, optometrist, or optician. Contact lenses are available in some medically necessary situations and require prior authorization.

Vision care services are billed on the CMS 1500 Health Insurance claim form or the 837 P. Complete billing instructions for vision services are included in the vision billing manual.

Billing Guidelines

EPSDT Billing

Providers submitting claims electronically must use the 837P.
Providers submitting claims on paper must use the EPSDT paper claim form.

The EPSDT claim form is used by primary care providers who bill fee-for-service for EPSDT periodic screens.

The Department tracks the EPSDT periodic screens by procedure and diagnosis codes appropriate for the screen. Other children's health care services are billed on the CMS 1500, using national standard codes.

Providers must identify if a visit is a result of a referral from an EPSDT Screen

If a provider is seeing a child as a result of a referral from the EPSDT periodic screen for further diagnosis or treatment, the provider should enter a **"Yes" in Box # L** on the CMS 1500.

If the visit is a referral from an EPSDT periodic screen for further diagnosis and treatment, enter a "**Yes" in the service line** (Loop 2400, Segment SV1, Element SV111). It is important to identify these services as they are reported on the Annual EPSDT Participation Report (416) to the Centers for Medicare and Medicaid Services (CMS) along with the number of EPSDT periodic screens.

Referral is not required for EPSDT dental program services

- Dental benefits are billed on the ADA claim form or the 837 D.
- Vision benefits are billed on the CMS 1500 claim form or 837 P.
- If the child is ill, services related to the illness should be billed on the CMS 1500 claim form. An appointment for an EPSDT screening should be made at a later date.
- Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) complete the UB-04 claim form for EPSDT-rendered services. Refer to the FQHC/RHC Billing Manual for specific UB-04 billing instructions. FQHCs and RHCs use V72.0 to bill for the EPSDT Periodic Screen.

EPSDT benefits may include medically necessary covered benefits available for children enrolled in the Medical Assistance Program.

Procedure/HCPCS Codes Overview

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

The Healthcare Common Procedural Coding System (HCPCS) is divided into two principal subsystems, referred to as level I and level II of the HCPCS. Level I of the HCPCS is comprised of 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 completing and submitting a publication preference form. Bulletins include updates on approved procedures codes as well as the maximum allowable units billed per procedure.

EPSDT Procedure Coding

Procedure Code(s)	Description
Periodic Screening: Preventive Medicine Codes*	
99381 – 99385	New Patient (age specific)
99391 – 99395	Established Patient (age specific)
99431	History and examination
99432	Normal newborn care
Periodic Screening: Evaluation and Management Codes	
99203 – 99205	New Patient
99214 – 99215	Established Patient

Note: These codes must be used in conjunction with diagnosis codes for a well-child exam including V20.0 – V20.2 and V70.0, V70.3 and V70.8.

Inter-periodic Visit Codes

Range 99201 – 99350

Note: Used in conjunction with the appropriate diagnosis codes ***excluding*** the well-child diagnosis codes: V20.0 – V20.2 and V70.0, V70.3 and V70.8

CMS 1500 Paper Claim Instructions

The following paper form reference table shows required, optional, and conditional fields and detailed field completion instructions for the EPSDT 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.
4	**Insured's Name**	Not Required	
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.

CMS Field #	Field Label	Field is?	Instructions
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?**	Not Required	
10d	**Reserved for Local Use**		
11	**Insured's Policy, Group or FECA Number**	Not Required	
11a	**Insured's Date of Birth, Sex**	Not Required	
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.

CMS Field #	Field Label	Field is?	Instructions
13	**Insured's or Authorized Person's Signature**	Not Required	
14	**Date of Current Illness Injury or Pregnancy**	Not Required	
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 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.

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

CMS Field #	Field Label	Field is?	Instructions
			All dates of service must by the same date as screening.
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 12 Home 21 Inpatient Hospital 22 Outpatient Hospital 32 Nursing Facility 99 Other Unlisted
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 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	Conditional	Enter the appropriate procedure-related modifier that applies to the billed service. Up to four modifiers may be entered when using the paper claim form. 24 **Evaluation/Management (E/M) service during the postoperative period** Use with E/M codes to report unrelated services by the same physician during the postoperative period. Claim diagnosis code(s)

CMS Field #	Field Label	Field is?	Instructions
			must identify a condition unrelated to the surgical procedure. 26 **Professional component** Use with diagnostic codes to report professional component services (reading and interpretation) billed separately from technical component services. Report separate professional and technical component services only if different providers perform the professional and technical portions of the procedure. Read CPT descriptors carefully. Do not use modifiers if the descriptor specifies professional or technical components. 47 **Anesthesia by surgeon** Use with surgical procedure codes to report general or regional anesthesia by the surgeon. Local anesthesia is included in the surgical reimbursement. 50 **Bilateral procedures** Use to identify the bilateral (second) surgical procedure performed at the same operative session. Read CPT descriptions carefully. Do not use modifier -50 if the procedure descriptor states “Unilateral or bilateral” services. 51 **Multiple Procedures** Use to identify additional procedures that are performed on the same day or at the same session by the same provider. Do not use to designate “add-on” codes. 59 **Multiple Procedures** Use to indicate a service that is distinct or independent from other services that are performed on the same day. These services are not usually reported together but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery,

			different site or organ system or separate lesion or injury. 76 **Repeat procedure by <u>same</u> physician/provider** Use to identify subsequent occurrences of the same service on the same day by the same provider. Not valid with E/M codes. 77 **Repeat procedure by <u>another</u> physician/provider** Use to identify subsequent occurrences of the same service on the same day by different rendering providers. 79 **Unrelated procedure or service by surgeon** Unrelated procedures or services (other than E/M services) by the surgeon during the postoperative period. Use to identify unrelated services by the operating surgeon during the postoperative period. Claim diagnosis code(s) must identify a condition unrelated to the surgical procedure. 80 **Assistant surgeon** Use with surgical procedure codes to identify assistant surgeon services. Note: Assistant surgeon services by non-physician practitioners, physician assistants, perfusionists, etc. are not reimbursable. GY **Item or services statutorily excluded or does not meet the Medicare benefit.** Use with podiatric procedure codes to identify routine, non-Medicare covered podiatric foot care. Modifier -GY takes the place of the required provider certification that the services are not covered by Medicare. The Medicare non-covered services field on the claim record must also be completed. KX **Specific required documentation on file** Use with laboratory codes to certify that the laboratory's equipment is not functioning or the laboratory is not

CMS Field #	Field Label	Field is?	Instructions
			certified to perform the ordered test. The -KX modifier takes the place of the provider's certification, "I certify that the necessary laboratory equipment was not functioning to perform the requested test ", or "I certify that this laboratory is not certified to perform the requested test." UK **Inpatient newborn care billed using mother's State ID and birth date** Use to identify inpatient physician services rendered to newborn infants while the mother remains in the hospital. Services provided to a hospitalized newborn after the mother's discharge must be submitted using the Colorado Medical Assistance Program ID number assigned to the child. Modifier -UK takes the place of the required certification, "Newborn care billed using Mother's State ID". 55 **Postoperative Management only** Use with eyewear codes (lenses, lens dispensing, frames, etc.) to identify eyewear provided after eye surgery. Benefit for eyewear, including contact lenses, for members over age 20 must be related to surgery. Modifier -55 takes the place of the required claim comment that identifies the type and date of eye surgery. The provider must retain and, upon request, furnish records that identify the type and date of surgery.
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.

CMS Field #	Field Label	Field is?	Instructions
			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. 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

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

CMS Field #	Field Label	Field is?	Instructions
			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	
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 fine and imprisonment under state and/or federal law.

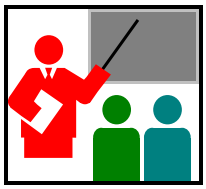
Billing Instruction Detail	Instructions
LBOD Completion Requirements	• Electronic claim formats provide specific fields for documenting the LBOD. • Supporting documentation must be kept on file for 6 years. • For paper claims, follow the instructions appropriate for the claim form you are using. ➢ *UB-04*: Occurrence code 53 and the date are required in FL 31-34. ➢ *CMS 1500*: Indicate "LBOD" and the date in box 19 – Additional Claim Information. ➢ *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.

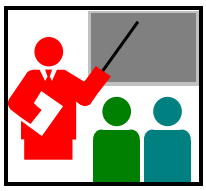
Billing Instruction Detail	Instructions
Denied Paper Claims	If the initial timely filing period has expired and a previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was denied. **Correct the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

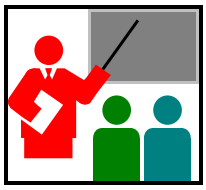
Billing Instruction Detail	Instructions
Delayed Notification of Eligibility	The provider was unable to determine that the patient had Colorado Medical Assistance Program coverage until after the timely filing period expired. **File the claim within 60 days** of the date of notification that the individual had Colorado Medical Assistance Program coverage. Retain correspondence, phone logs, or a signed Delayed Eligibility Certification form (see Certification & Request for Timely Filing Extension in the Provider Services Forms section) 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. Attach a copy of the SPR/ERA if submitting a paper claim and maintain the original SPR/ERA on file. **LBOD** = the Medicare processing date shown on the SPR/ERA.
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

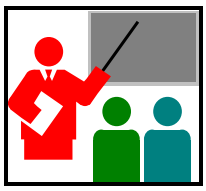
Billing Instruction Detail	Instructions
	denial or rejection, and continue filing in compliance with the 60-day rule until insurance processing information is available. **LBOD** = the date commercial insurance paid or denied.
Correspondence LBOD Authorization	The claim is being submitted in accordance 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.

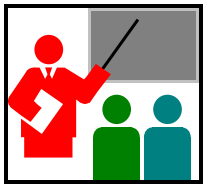
Sterilizations, Hysterectomies and Abortions

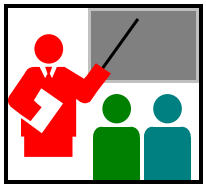
Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions 	**Voluntary Sterilizations** Sterilization for the purpose of family planning is a benefit of the Colorado Medical Assistance Program in accordance with the following procedures: **General Requirements** The following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

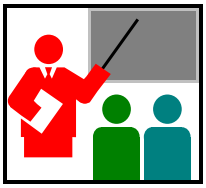
Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions 	The person may not be an "institutionalized individual". Institutionalized includes: • Involuntarily confinement or detention, under a civil or criminal statute, in a correctional or rehabilitative facility including a mental hospital or other facility for the care and treatment of mental illness. • Confinement under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness. **If any of the above requirements are not met, the claim will be denied.** Unpaid or denied charges resulting from clerical errors such as the provider's failure to follow the required procedures in obtaining informed consent or failure to submit required documentation with the claim may not be billed to the member. **Informed Consent Requirements** The person obtaining informed consent must be a professional staff member who is qualified to address all the consenting individual's questions concerning medical, surgical, and anesthesia issues. Informed consent is considered to have been given when the person who obtained consent for the sterilization procedure meets **all** of the following criteria: ➢ Has offered to answer any questions that the individual who is to be sterilized may have concerning the procedure ➢ Has provided a copy of the consent form to the individual ➢ Has verbally provided all of the following information or advice to the individual who is to be sterilized: • Advice that the individual is free to withhold or withdraw consent at any time before the sterilization is done without affecting the right to any future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled • A description of available alternative methods of family planning and birth control • Advice that the sterilization procedure is considered to be irreversible • A thorough explanation of the specific sterilization procedure to be performed • A full description of the discomforts and risks that may accompany or follow the performing of the procedure including an explanation of the type and possible effects of any anesthetic to be used.

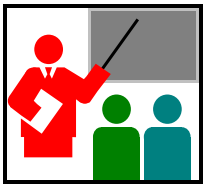
Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions 	• A full description of the benefits or advantages that may be expected as a result of the sterilization • Advice that the sterilization will not be performed for at least 30 days except in the case of premature delivery or emergency abdominal surgery • Suitable arrangements have been made to ensure that the preceding information was effectively communicated to an individual who is blind, deaf, or otherwise handicapped. • The individual to be sterilized was permitted to have a witness of his or her choice present when consent was obtained. • The consent form requirements (noted below) were met. • Any additional requirement of the state or local law for obtaining consent was followed. • Informed consent may <u>not</u> be obtained while the individual to be sterilized is: ▪ In labor or childbirth; ▪ Seeking to obtain or is obtaining an abortion; and/or ▪ Under the influence of alcohol or other substances that may affect the individual's sense of awareness. **MED-178 Consent Form Requirements** Evidence of informed consent must be provided on the MED-178 consent form. The MED-178 form is available on the Department's website (colorado.gov/hcpf)→Provider Services→Forms→Sterilization Consent Forms. The fiscal agent is required to assure that the provisions of the law have been followed before Colorado Medical Assistance Program payment can be made for sterilization procedures. A copy of the MED-178 consent form must be attached to every claim submitted for reimbursement of sterilization charges including the surgeon, the assistant surgeon, the anesthesiologist, and the hospital or ambulatory surgical center. The surgeon is responsible for assuring that the MED-178 consent form is properly completed and providing copies of the form to the other providers for billing purposes. Spanish forms are acceptable. A sterilization consent form initiated in another state is acceptable when the text is complete and consistent with the Colorado form.

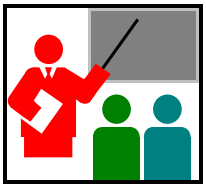
Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions 	**Completion of the MED-178 Consent Form** Please refer to the MED-178 Instructions for completion on the Department's website (colorado.gov/hcpf)→Provider Services→Forms→Sterilization Consent Forms. Information entered on the consent form must correspond directly to the information on the submitted Colorado Medical Assistance Program claim form. Federal regulations require strict compliance with the requirements for completion of the MED-178 consent form or claim payment is denied. Claims that are denied because of errors, omissions, or inconsistencies on the MED-178 may be resubmitted if corrections to the consent form can be made in a legally acceptable manner. **Any corrections to the patient's portion of the sterilization consent must be approved and initialed by the patient.** **Hysterectomies** Hysterectomy is a benefit of the Colorado Medical Assistance Program when performed solely for medical reasons. Hysterectomy is not a benefit of the Colorado Medical Assistance Program if the procedure is performed solely for the purpose of sterilization, or if there was more than one purpose for the procedure and it would not have been performed but for the purpose of sterilization. **The following conditions must be met for payment of hysterectomy claims under the Colorado Medical Assistance Program**. These claims must be filed on paper. ➢ Prior to the surgery, the person who secures the consent to perform the hysterectomy must inform the patient and her representative, if any, verbally and in writing that the hysterectomy will render the patient permanently incapable of bearing children. ➢ The patient and her representative, if any, must sign a written acknowledgment that she has been informed that the hysterectomy will render her permanently incapable of reproducing. The written acknowledgment may be any form created by the provider that states specifically that, "I acknowledge that prior to surgery, I was advised that a hysterectomy is a procedure that will render me permanently incapable of having children." The acknowledgment must be signed and dated by the patient. A written acknowledgment from the patient is not required if: ➢ The patient is already sterile at the time of the hysterectomy, or ➢ The hysterectomy is performed because of a life-threatening emergency in which the practitioner determines that prior acknowledgment is not possible.

Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions (continued) 	If the patient's acknowledgment is not required because of the one of the above noted exceptions, the practitioner who performs the hysterectomy **must certify in writing**, as applicable, one of the following: ➢ A signed and dated statement certifying that the patient was already sterile at the time of hysterectomy and stating the cause of sterility; ➢ A signed and dated statement certifying that the patient required hysterectomy under a life-threatening, emergency situation in which the practitioner determined that prior acknowledgment by the patient was not possible. The statement must describe the nature of the emergency. A copy of the patient's written acknowledgment or the practitioner's certification as described above must be attached to all claims submitted for hysterectomy services. A suggested form on which to report the required information is located in Appendix J. Providers may copy this form, as needed, for attachment to claim(s). Providers may substitute any form that includes the required information. The submitted form or case summary documentation must be signed and dated by the practitioner performing the hysterectomy. The surgeon is responsible for providing copies of the appropriate acknowledgment or certification to the hospital, anesthesiologist, and assistant surgeon for billing purposes. **Claims will be denied if a copy of the written acknowledgment or practitioner's statement is not attached.**

Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions (continued) 	**<u>Abortions</u>** **Induced Abortions** Therapeutic legally induced abortions are a benefit of the Colorado Medical Assistance Program when performed to save the life of the mother. The Colorado Medical Assistance Program also reimburses legally induced abortions for pregnancies that are the result of sexual assault (rape) or incest. A copy of the appropriate certification statement must be attached to all claims for legally induced abortions performed for the above reasons. Because of the attachment requirement, claims for legally induced abortions must be submitted on paper and must **not** be electronically transmitted. Claims for spontaneous abortions (miscarriages), ectopic, or molar pregnancies are not affected by these regulations. The following procedure codes are appropriate for identifying induced abortions: 59840 59841 59851 59852 59850 59855 59856 59857 Diagnosis code ranges: 635.00-635.92 637.00-637.92 Surgical diagnosis codes: 69.01 69.51 69.93 74.91 75.0 **Providers Billing on the CMS 1500 Claim Form** Use the appropriate procedure/diagnosis code from the list above **and** the most appropriate modifier from the list below: G7 - Termination of pregnancy resulting from rape, incest, or certified by a physician as life-threatening. In addition to the required coding, all claims must be submitted with the required documentation. Claims submitted for induced abortion-related services submitted without the required documentation will be denied.

Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions (continued) 	**Providers Billing on the UB-04 Claim Form** Use the appropriate procedure/diagnosis code from those listed previously **and** the most appropriate condition code from the list below: AA Abortion Due to Rape AB Abortion Due to Incest AD Abortion Due to Life Endangerment In addition to the required coding, all claims must be submitted with the required documentation. Claims submitted for induced abortion-related services submitted without the required documentation will be denied. ***Induced abortions to save the life of the mother*** Every reasonable effort to preserve the lives of the mother and unborn child must be made before performing an induced abortion. The services must be performed in a licensed health care facility by a licensed practitioner, unless, in the judgment of the attending practitioner, a transfer to a licensed health care facility endangers the life of the pregnant woman and there is no licensed health care facility within a 30 mile radius of the place where the medical services are performed. "**To save the life of the mother**" means: The presence of a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, as determined by the attending practitioner, which represents a serious and substantial threat to the life of the pregnant woman if the pregnancy is allowed to continue to term. The presence of a psychiatric condition which represents a serious and substantial threat to the life of the pregnant woman if the pregnancy continues to term. All claims for services related to induced abortions to save the life of the mother must be submitted with the following documentation: • Name, address, and age of the pregnant woman • Gestational age of the unborn child • Description of the medical condition which necessitated the performance of the abortion • Description of services performed • Name of the facility in which services were performed • Date services were rendered And, at least one of the following forms with additional supporting documentation that confirms life-endangering circumstances: • Hospital admission summary • Hospital discharge summary • Consultant findings and reports • Laboratory results and findings

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

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

CMS 1500 EPSDT Claim Example

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) [X] | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

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 11 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

6. 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 [ ] NO [X] 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. 17b. 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. Y000 B. V721 C. 7883 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		99393					A	30 00	1	S2	NPI	12345678 / 0123456789
2	01	01	15	01	01	15	11		90705					A	25 00	1	S2	NPI	12345678 / 0123456789
3	01	01	15	01	01	15	11		69210					AC	10 00	1	S2	NPI	12345678 / 0123456789
4																		NPI	
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) YES [X] NO [ ]

28. TOTAL CHARGE $ 65 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 EPSDT Center
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)

EPSDT Revisions Log

Revision Date	Additions/Changes	Pages	Made by
04/21/2009	Drafted Manual	All	jg
07/06/2009	Accepted changes and verified TOC	Throughout	jg
10/19/2009	LBOD	23	jg
01/12/2010	Updated Web site links	Throughout	jg
02/10/2010	Changed EOMB to SPR	25	jg
03/04/2010	Added link to Program Rules	2	jg
12/05/2011	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
05/08/2013	Deleted duplicate GY modifier information	19	jg
09/27/2013	Removed electronic billing and referenced the CO-1500 General billing manual Removed MED-178 instructions and example. Referenced location of form and instructions on p.30	3 30-35	cc
10/03/2013	Formatted Updated TOC	Throughout i	jg
02/03/2014	Updated abortion information	29 & 30	jg
05/14/2014	Updated Billing Manual for removal of the Primary Care Physical Program	Throughout	Mm
8/8/14	Replaced all CO 1500 references with CMS 1500	Throughout	ZS
8/8/14	Updated Professional Claim Billing Instructions section with CMS 1500 information.		ZS
8/8/14	Updated all references of Client to Member	Throughout	ZS
8/8/14	Updated all claims examples to CMS1500		ZS
8/11/14	Updated all weblinks to reflect Department's new site	Throughout	Mm
8/20/2014	Revised General Program Provisions per benefit manager	3-4	GR, MM
8/20/2014	Added Cavity Free at Three information	4	GR, MM
8/20/2014	Added all references to DentaQuest, new Dental ASO	6, Throughout	GR, MM
8/20/2014	Revised Outreach and Case Management to include Healthy Living Program	5	GR, MM
8/20/2014	Removed immunization references	8-10, throughout	GR, MM

10/27/2014	Added frequencies and benefits for developmental, depression, and autism screenings under Services and Benefits.	*6-8*	*MC, RM*
10/27/14	Updated Table of Contents	*1*	*MC*
11/21/14	*Removed Appendix H information, added Timely Filing document information*	*24*	*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.*