Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

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Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

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 C.C.R. 2505-10), for specific information when providing FQHC and RHC services.

Federally Qualified Health Centers (FQHCs)

The U.S. Department of Health and Human Services certifies Federally Qualified Health Centers (FQHCs) that qualify as FQHCs. FQHCs may be either freestanding or federally defined as "provider based". FQHC services must be medically necessary and provided in outpatient settings only. Inpatient hospital stays are not included.

Rural Health Clinics (RHCs)

Rural Health Clinics (RHCs) are clinics that are located in rural areas and that have been certified under Medicare. These clinics are either freestanding or hospital affiliated. RHCs cannot be rehabilitation facilities or facilities primarily for the care and treatment of mental illness.

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 may be sent to the fiscal agent, Affiliated Computer Services (ACS), P.O. Box 90, Denver, CO 80201-0090. The following claims can be submitted on paper and processed for payment:

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

Paper claims do not require an NPI, but do require the Colorado Medical Assistance Program provider number. In addition, the UB-04 Certification document must be completed and attached to all claims submitted on the paper UB-04.

Electronically mandated claims submitted on paper are processed, denied, and marked with the message "Electronic Filing Required".

Electronic Claims

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

- X12N Technical Report 3 (TR3) for the 837P, 837I, or 837D (wpc-edi.com/)
- Companion Guides for the 837P, 837I, or 837D (in the Provider Services Specifications section of the Department's Web site.
- Web Portal User Guide (via within the 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.

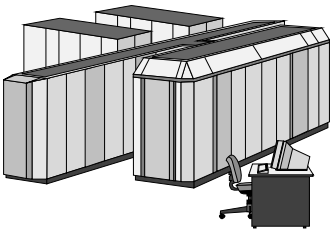
Because a claim submitter connects to the Web Portal through the Internet, there is no delay for "dialing up" when submitting claims. The Web Portal provides immediate feedback directly to the submitter. All claims are processed to provide a weekly Health Care Claim Payment/Advice (Accredited Standards 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.

Batch Electronic Claims Submission



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

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

Any entity sending electronic claims to ACS Electronic Data Interchange (EDI) Gateway for processing where reports and responses will be delivered must complete an EDI enrollment package. This provides ACS EDI Gateway the information necessary to assign a Logon Name, Logon ID, and Trading Partner ID, which are required to submit electronic claims. You may obtain an EDI enrollment package by contacting the Medical Assistance Program fiscal agent or by downloading it from the Provider Services EDI Support section.

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

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

Testing and Vendor Certification

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

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

In order to expedite testing, ACS EDI Gateway requires providers to submit all X12N test transactions to Edifecs prior to submitting them to ACS EDI Gateway.

The Edifecs service is free to providers to certify X12N readiness. Edifecs offers submission and rapid result turnaround 24 hours a day, 7 days a week. For more information, go to edifecs.com.

Federally Qualified Health Center (FQHC) Benefits

Core services that are medically necessary are FQHC benefits. Core benefits include the following outpatient services:

- Physician services
- Physician assistant services
- Nurse practitioner services
- Nurse midwife services
- Clinical psychologist services
- Clinical social worker services
- Pneumococcal & influenza vaccines and administration
- Services and supplies incidental to professional services
- Part-time or intermittent nursing care and related medical supplies for homebound individuals
- Other reimbursable ambulatory services
- Dental

Federally Qualified Health Centers (FQHCs) that offer the Nurse Home Visitor Program and/or the Prenatal Plus Program are instructed to submit fee-for-service claims for services rendered under these programs. Claims for services should be submitted using the CMS 1500 and will be reimbursed based upon the supplemental fee schedule. All services provided under these two programs must be excluded from the cost report as they are not considered when determining the encounter rates paid to FQHCs.

The Nurse Home Visitor Program is a home visitation program available to first-time moms in Colorado. Medicaid reimburses NHVP for targeted case management services provided to Medicaid members. The Prenatal Plus Program provides women access to a multidisciplinary care team throughout their pregnancy. Both programs have unique payment models and reporting mechanisms that necessitate Medicaid reimbursement remain separate from the encounter rate.

Rural Health Clinic (RHC) Services

RHC services include:

- Services provided by a physician
- Services provided by physician assistants, nurse practitioners, and nurse midwives under the supervision of a physician

    - Incidental related services and supplies, including visiting nurse care, and related medical supplies
    - Other ambulatory services which meet specific programmatical requirements
- EPSDT services which are not part of RHC services and meet EPSDT requirements
- Clinical psychologist services
- Clinical social worker services

FQHC and RHC Coding

FQHCs and RHCs use revenue codes to bill the Colorado Medical Assistance Program.

Freestanding FQHCs and RHCs

The **valid revenue codes** for reimbursement for freestanding services to the Colorado Medical Assistance Program are:

Facility	Revenue code
FQHC	529
RHC	521

Freestanding FQHC and RHC services are priced at an encounter rate. All routine services are included in the encounter rate.

In order to provide the Medicaid program with basic clinical information for use in evaluating services requested and received by Medicaid members, FQHCs are required to include all CPT codes and HCPCS codes for services provided during a visit on claims. In order to be reimbursed, an FQHC or RHC that submits a UB-04 or 837 Institutuional (837I) electronic transaction must have at least one (1) claim line that identifies revenue code 0529 for FQHCs or revenue code 0521 for RHCs. All other lines on the claim should have the revenue code most appropriate for the service. The line item with revenue code 0529 or 0521 can appear at any line on the claim and with any procedure code.

CDT dental codes must be included on dental claims.

Beginning July 1, 2014, all FQHC claims for dental services and dentures must be submitted to DentaQuest, the Dental Administrative Service Organization (ASO), on the 2006 ADA Dental Claim form or by submitting the 837D electronic transaction via the DentaQuest Provider Web Portal. Information about claims submission for dental services can be found in the Office Reference Manual (ORM) under 'DentaQuest Resources' located on the Dentist page of DentaQuest's website..

Rates for FQHCs are determined using an alternative payment methodology.

UB-04 Paper Claim Reference Table

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

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

The UB-04 Certification document (located after the Sterilizations, Hysterectomies, and Abortions instructions and in the Provider Services Forms section) must be completed and attached to all claims submitted on the paper UB-04. Completed UB-04 paper Colorado Medical Assistance Program claims, including hardcopy Medicare claims, should be mailed to the correct fiscal agent address located in Appendix A of the Appendices in the Provider Services Billing Manuals section.

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

The Paper Claim Reference Table below lists the required, optional and/or conditional form locators for submitting the paper UB-04 claim form to the Colorado Medical Assistance Program for FQHC and RHC services.

Form Locator and Label	Completion Format	Instructions
1. Billing Provider Name, Address, Telephone Number	Text	Street/Post Office box City State Zip Code Abbreviate the state using standard post office abbreviations. Enter the telephone number.
2. Pay-to Name, Address, City, State	Text	Required only if different from FL 1 Enter the provider or agency name and complete mailing address of the provider who will receive payment for the services: Street/Post Office box City State Zip Code Abbreviate the state using standard post office abbreviations.

Form Locator and Label	Completion Format	Instructions
3a. Patient Control Number	Up to 20 characters: Letters, numbers or hyphens	Optional Enter information that identifies the member or claim in the provider's billing system. Submitted information appears on the Provider Claim Report.
3b. Medical Record Number	Up to 17 digits	Optional Enter the number assigned to the patient to assist in retrieval of medical records.
4. Type of Bill	3 digits	Required Use type of bill 71X Enter the three-digit number indicating the specific type of bill. The three-digit code requires one digit each in the following sequences (Type of facility, Bill classification, and Frequency): <u>Digit 1</u> <u>Type of Facility</u> 1 Hospital 2 Skilled Nursing Facility 3 Home Health 4 Religious Non-Medical Health Care Institution Hospital Inpatient 5 Religious Non-Medical Health Care Institution Post-Hospital Extended Care Services 6 Intermediate Care 7 Clinic (Rural Health/FQHC/Dialysis Center) 8 Special Facility (Hospice, RTCs) <u>Digit 2</u> <u>Bill Classification (Except clinics & special facilities)</u>: 1 Inpatient (Including Medicare Part A) 2 Inpatient (Medicare Part B only) 3 Outpatient 4 Other (for hospital referenced diagnostic services or home health not under a plan of treatment) 5 Intermediate Care Level I 6 Intermediate Care Level II 7 Sub-Acute Inpatient (revenue code 19X required with this bill type) 8 Swing Beds 9 Other

Form Locator and Label	Completion Format	Instructions
4. Type of Bill (continued)	3 digits	Digit 2 Bill Classification (Clinics Only): 1 Rural Health/FQHC 2 Hospital Based or Independent Renal Dialysis Center 3 Freestanding 4 Outpatient Rehabilitation Facility (ORF) 5 Comprehensive Outpatient Rehabilitation Facilities (CORFs) 6 Community Mental Health Center Digit 2 Bill Classification (Special Facilities Only): 1 Hospice (Non-Hospital Based) 2 Hospice (Hospital Based) 3 Ambulatory Surgery Center 4 Freestanding Birthing Center 5 Critical Access Hospital 6 Residential Facility Digit 3 Frequency: 0 Non-Payment/Zero Claim 1 Admit through discharge claim 2 Interim - First claim 3 Interim - Continuous claim 4 Interim - Last claim 7 Replacement of prior claim 8 Void of prior claim
5. Federal Tax Number	None	Submitted information is not entered into the claim processing system.
6. Statement Covers Period – From/Through	From: 6 digits MMDDYY Through: 6 digits MMDDYY	Required Each date of service must be billed on a separate line. Split an entire month into two claims. This FL must reflect the beginning and ending dates of service listed on the detail dates of service lines.

Form Locator and Label	Completion Format	Instructions
8a. Patient Identifier		Submitted information is not entered into the claim processing system.
8b. Patient Name	Up to 25 characters: Letters & spaces	Required Enter the member's last name, first name and middle initial.
9a. Patient Address – Street	Characters Letters & numbers	Required Enter the member's street/post office box as determined at the time of admission.
9b. Patient Address – City	Text	Required Enter the member's city exactly as determined at the time of admission.
9c. Patient Address – State	Text	Required Enter the member's state as determined at the time of admission.
9d. Patient Address – Zip	Digits	Required Enter the member's zip code as determined at the time of admission.
9e. Patient Address – Country Code	Digits	Optional
10. Birthdate	8 digits (MMDDCCYY)	Required Enter the member's birthdate using two digits for the month, two digits for the date, and four digits for the year. (Example: 07012009 for July 1, 2009.
11. Patient Sex	1 letter	Required Enter an M (male) or F (female) to indicate the member's sex.
12. Admission Date	6 digits	Not Required
13. Admission Hour	6 digits	Not Required
14. Admission Type	1 digit	Conditional

Form Locator and Label	Completion Format	Instructions
		Complete for emergency visits. 1 – Emergency Member requires immediate intervention as a result of severe, life threatening or potentially disabling conditions. Exempts outpatient hospital claims from co-payment and PCP only if revenue code 450 or 459 is present. This is the only benefit service for an undocumented alien. If span billing, emergency services cannot be included in the span bill and must be billed separately from other outpatient services.
15. Source of Admission	1 digit	Not Required
16. Discharge Hour	2 digits	Not Required
17. Patient Discharge Status	2 digits	Not Required
18-28. Condition Codes	2 Digits	Conditional Complete with as many codes necessary to identify conditions related to this bill that may affect payer processing. <u>Condition Codes</u> 01 Military service related 02 Employment related 04 HMO enrollee 05 Lien has been filed 06 ESRD patient - First 18 months entitlement 07 Treatment of non-terminal condition/hospice patient 17 Patient is homeless 25 Patient is a non-US resident 39 Private room medically necessary 60 DRG (Day outlier)

Form Locator and Label	Completion Format	Instructions
18-28. Condition Codes (continued)	2 Digits	Conditional Complete with as many codes necessary to identify conditions related to this bill that may affect payer processing. <u>Renal dialysis settings</u> 71 Full care unit 72 Self care unit 73 Self care training 74 Home care 75 Home care - 100 percent reimbursement 76 Back-up facility <u>Special Program Indicator Codes</u> A1 EPSDT/CHAP A2 Physically Handicapped Children's Program A4 Family Planning A6 PPV/Medicare A7 Induced Abortion - Danger to Life A8 Induced Abortion - Victim Rape/Incest A9 Second Opinion Surgery B3 Pregnancy Indicator <u>PRO Approval Codes</u> C1 Approved as billed C2 Automatic approval as billed - Based on focused review C3 Partial approval C4 Admission/Services denied C5 Post payment review applicable C6 Admission preauthorization C7 Extended authorization
29. Accident State		Not required
31-34. Occurrence Code/Date	2 digits and 6 digits	Conditional Complete both the code and date of occurrence.

Form Locator and Label	Completion Format	Instructions
		Enter the appropriate code and the date on which it occurred. Enter the date using MMDDYY format. Occurrence Codes: 01 Accident/Medical Coverage 02 Auto Accident - No Fault Liability 03 Accident/Tort Liability 04 Accident/Employment Related 05 Other Accident/No Medical Coverage or Liability Coverage 06 Crime Victim 20 Date Guarantee of Payment Began 24* Date Insurance Denied 25* Date Benefits Terminated by Primary Payer 26 Date Skilled Nursing Facility Bed Available 27 Date of Hospice Certification or Re-certification 40 Scheduled Date of Admission (RTD) 50 Medicare Pay Date 51 Medicare Denial Date 53 Late Bill Override Date 55 Insurance Pay Date A3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer indicated in FL 50, line A B3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer indicated in FL 50, line B C3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer indicated in FL 50, line C **Other Payer occurrence codes 24 and 25 must be used when applicable. The claim must be submitted with the third party information.*

Form Locator and Label	Completion Format	Instructions
35-36. Occurrence Span Code From/ Through	2 digits and 6 digits	Not Required
38. Responsible Party Name/ Address	None	Leave blank
39-41. Value Code and Amount	2 characters and up to 9 digits	Conditional Enter appropriate codes and related dollar amounts to identify monetary data or number of days using whole numbers, necessary for the processing of this claim. Never enter negative amounts. Codes must be in ascending order. If a value code is entered, a dollar amount or numeric value related to the code <u>must</u> always be entered. 01 Most common semiprivate rate (Accommodation Rate) 06 Medicare blood deductible 14 No fault including auto/other 15 Worker's Compensation 31 Patient Liability Amount 32 Multiple Patient Ambulance Transport 37 Pints of Blood Furnished 38 Blood Deductible Pints 40 New Coverage Not Implemented by HMO 45 Accident Hour Enter the hour when the accident occurred that necessitated medical treatment. Use the same coding used in FL 18 (Admission Hour). 49 Hematocrit Reading - EPO Related 58 Arterial Blood Gas (PO2/PA2) 68 EPO-Drug 80 Covered Days 81 Non-Covered Days
39-41. Value Code and Amount (continued)	2 characters and up to 9 digits	*Enter the deductible amount applied by indicated payer:* A1 Deductible Payer A B1 Deductible Payer B

Form Locator and Label	Completion Format	Instructions
		C1 Deductible Payer C *Enter the amount applied to member's co-insurance by indicated payer:* A2 Coinsurance Payer A B2 Coinsurance Payer B C2 Coinsurance Payer C *Enter the amount paid by indicated payer:* A3 Estimated Responsibility Payer A B3 Estimated Responsibility Payer B C3 Estimated Responsibility Payer C
42. Revenue Code	3 digits	Required **FQHCs** ➢ FQHC Medical Claims Use revenue code 0529 on oneeach line of the claim regardless of the type of service identified in locator 44. All other lines should use the revenue code appropriate for the service. ➢ FQHC Dental Claims For claims with dates of service prior to July 1, 2014, use revenue code 529 on each line of the claim regardless of the type of services identified in locator 44. For claims with dates of service after July 1, 2014, refer to the Office Reference Manual (ORM) under 'DentaQuest Resources' located on the Dentist page of DentaQuest's website. **RHCs** Use revenue code 0521 on one line of the claim regardless of the type of service identified in locator 44. All other lines should use the revenue code appropriate for the serviceand list other revenue codes as informational.
43. Revenue Code Description	Text	Required Enter the revenue code description or abbreviated description.
44. HCPCS/Rates/ HIPPS Rate Codes	5 digits	**FQHC** Required There may be multiple lines, each identified by revenue code 529 in locator 42. For each line enter a valid CPT code or HCPCS code that reflects the

Form Locator and Label	Completion Format	Instructions
		services rendered during the encounter. This includes any medical, laboratory, radiology, physical therapy, occupational therapy, pharmacy, supply or other service rendered during the encounter. CPT and HCPCS codes cannot be repeated for the same date of service. Combine the units in FL 46 (Units) to report multiple services. On dental claims the D-code must be put in locator 44 on each line for dates of services prior to July 1, 2014. For dates of services after July 1, 2014, refer to the Office Reference Manual (ORM) under 'DentaQuest Resources' located on the Dentist page of DentaQuest's website. **RHC** Conditional Enter only the HCPCS code for each detail line. Complete for laboratory, radiology, physical therapy, occupational therapy, and hospital based transportation. When billing HCPCS codes, the appropriate revenue code must also be billed. **Services Requiring HCPCS** With the exception of outpatient lab and hospital-based transportation, outpatient radiology services can be billed with other outpatient services. HCPCS codes must be identified for the following revenue codes: ▪ 32X Radiology – Diagnostic ▪ 33X Radiology – Therapeutic ▪ 34X Nuclear Medicine ▪ 35X CT Scan ▪ 40X Other Imaging Services ▪ 61X MRI HCPCS codes cannot be repeated for the same date of service. Combine the units in FL 46 (Units) to report multiple services.

Form Locator and Label	Completion Format	Instructions
45. Service Date	6 digits	**FQHC** Enter the date of service using MMDDYY format for each detail line completed. Each date of service must fall within the date span **RHC** For span bills only Enter the date of service using MMDDYY format for each detail line completed. Each date of service must fall within the date span
46. Service Units	Up to 3 digits	Required Enter a unit value on each line completed. Use whole numbers only. Do not enter fractions or decimals and do not show a decimal point followed by a 0 to designate whole numbers (e.g., Do not enter 1.0 to signify one unit)
47. Total Charges	Up to 9 digits	Required Enter the total charge for each line item. Calculate the total charge as the number of units multiplied by the unit charge. Do not subtract Medicare or third party payments from line charge entries. Do not enter negative amounts.. A grand total line in 23 is required for all charges.
48. Non-Covered Charges	Up to 9 digits	Required Enter incurred charges that are not payable by the Colorado Medical Assistance Program. Non-covered charges must be entered in both FL 47 (Total Charges) and FL 48 (Non-Covered Charges.) Each column requires a grand total. Non-covered charges cannot be billed for outpatient hospital laboratory or hospital based transportation services.
50. Payer Name	1 letter and text	Required Enter the payment source code followed by name of each payer organization from which the provider might expect payment. At least one line must indicate The Colorado Medical Assistance Program. Source Payment Codes

Form Locator and Label	Completion Format	Instructions
		B Workmen's Compensation C Medicare D Colorado Medical Assistance Program E Other Federal Program F Insurance Company G Blue Cross, including Federal Employee Program H Other - Inpatient (Part B Only) I Other Line A Primary Payer Line B Secondary Payer Line C Tertiary Payer
51. Health Plan ID	8 digits	Required Enter the provider's Health Plan ID for each payer name. Enter the eight digit Colorado Medical Assistance Program provider number assigned to the **billing provider**. Payment is made to the enrolled provider or agency that is assigned this number.
52. Release of Information	None	
53. Assignment of Benefits	None	

Form Locator and Label	Completion Format	Instructions
54. Prior Payments	Up to 9 digits	Conditional Complete when there are Medicare or third party payments. Enter third party and/or Medicare payments.
55. Estimated Amount Due	Up to 9 digits	Conditional Complete when there are Medicare or third party payments. Enter the net amount due from The Colorado Medical Assistance Program after provider has received other third party, Medicare or patient liability on the Colorado Medical Assistance Program line. **Medicare Crossovers** Enter the sum of the Medicare coinsurance plus Medicare deductible less third party payments and patient liability amount.
56. National Provider Identifier (NPI)	10 digits	Optional Enter the billing provider's 10-digit National Provider Identifier (NPI).
57. Other Provider ID		Submitted information is not entered into the claim processing system.
58. Insured's Name	Up to 30 characters	Required Enter the member's name on the Colorado Medical Assistance Program line. **Other Insurance/Medicare** Complete additional lines when there is third party coverage. Enter the policyholder's last name, first name, and middle initial exactly as it appears on the eligibility verification or on the health insurance card.
60. Insured's Unique ID	Up to 20 characters	Required Enter the insured's unique identification number assigned by the payer organization exactly as it appears on the eligibility verification or on the health insurance card. Include letter prefixes or suffixes.

Form Locator and Label	Completion Format	Instructions
61. Insurance Group Name	14 letters	Conditional Complete when there is third party coverage. Enter the name of the group or plan providing the insurance to the insured exactly as it appears on the health insurance card.
62. Insurance Group Number	17 digits	Conditional Complete when there is third party coverage. Enter the identification number, control number, or code assigned by the carrier or fund administrator identifying the group under which the individual is carried.
63. Treatment Authorization Code	Up to 18 characters	Conditional Complete when the service requires a PAR. Enter the PAR/authorization number in this FL, if a PAR is required and has been approved for services.
64. Document Control Number		Submitted information is not entered into the claim processing system.
65. Employer Name	Text	Conditional Complete when there is third party coverage. Enter the name of the employer that provides health care coverage for the individual identified in FL 58 (Insured Name).
66. Diagnosis Version Qualifier		Submitted information is not entered into the claim processing system.
67. Principal Diagnosis Code	Up to 6 digits	Required Enter the exact diagnosis code describing the principal diagnosis that exists at the time of admission or develops subsequently and affects the length of stay. Do not add extra zeros to the diagnosis code. Enter applicable ICD indicator to identify which version of ICD codes is being reported. 0 ICD-10-CM (DOS 10/1/15 and after) 9 ICD-10-CM (DOS 9/30/15 and before)

Form Locator and Label	Completion Format	Instructions
		Use diagnosis code Z00.00-10 Z00.110-Z00.111 Z00.121-Z00.129 Z00.6-Z00.8 Z02.0-Z02.6 Z02.81-Z02.89 Z76.2 for EPSDT screenings.
67A- 67Q. Other Diagnosis	6 digits	Optional Enter the exact diagnosis code corresponding to additional conditions that co-exist at the time of admission or develop subsequently and which effect the treatment received or the length of stay. Do not add extra zeros to the diagnosis code. Enter applicable ICD indicator to identify which version of ICD codes is being reported. 0 ICD-10-CM (DOS 10/1/15 and after) 9 ICD-10-CM (DOS 9/30/15 and before)
69. Admitting Diagnosis Code	6 digits	Not Required
70. Patient Reason Diagnosis		Submitted information is not entered into the claim processing system.

Form Locator and Label	Completion Format	Instructions
71. PPS Code		Submitted information is not entered into the claim processing system.
72. External Cause of Injury Code (E-code)	6 digits	**FQHC** Required if known Enter the diagnosis code for the external cause of an injury, poisoning, or adverse effect. This code must begin with an "E". **RHC** Optional Enter the diagnosis code for the external cause of an injury, poisoning, or adverse effect. This code must begin with an "E".
74. Principal Procedure Code/ Date	7 characters and 6 digits	Required Enter the procedure code for the principal procedure performed during this billing period and the date on which procedure was performed. Enter the date using MMDDYY format. Apply the following criteria to determine the principle procedure: The principal procedure is not performed for diagnostic or exploratory purposes. This code is related to definitive treatment; and The principal procedure is most related to the primary diagnosis.
74A. Other Procedure Code/Date	7 characters and 6 digits	Conditional Complete when there are additional significant procedure codes. Enter the procedure codes identifying all significant procedures other than the principle procedure and the dates on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principle diagnosis. Enter the date using MMDDYY format.

Form Locator and Label	Completion Format	Instructions
76. Attending **NPI – Conditional** **QUAL - Conditional** **ID - (Colorado Medical Assistance Provider #) – Required** **Attending- Last/ First Name**	NPI - 10 digits QUAL – Text Medicaid ID - 8 digits Text	NPI - Enter the 10-digit NPI assigned to the provider having primary responsibility for the patient's medical care and treatment. QUAL – Enter "1D" for Medicaid followed by the provider's eight-digit Colorado Medical Assistance Program provider ID. Medicaid ID - Enter the eight-digit Colorado Medical Assistance Program provider number assigned to the provider having primary responsibility for the patient's medical care and treatment. Numbers are obtained from the provider, and cannot be a clinic or group number. (If the attending provider is not enrolled in the Colorado Medical Assistance Program or if the member leaves the ER before being seen by a physician, the hospital may enter their individual numbers.) Enter the attending provider's last and first name. This form locator must be completed for all services.
77. Operating- NPI/QUAL/ID		Submitted information is not entered into the claim processing system.
78-79. Other ID **NPI – Conditional** **QUAL - Conditional** **ID - (Colorado Medical Assistance Provider #) – Conditional**	NPI - 10 digits QUAL – Text Medicaid ID - 8 digits	Conditional Complete when attending provider is not the PCP or to identify additional providers. Enter up to two 10-digit NPI and eight digit provider Colorado Medical Assistance Program provider numbers, when applicable. This form locator identifies providers other than the attending provider. If the attending provider is not the primary care provider (PCP) or if a clinic is a PCP agent, enter the PCP eight digit Colorado Medical Assistance Program provider number in FL 78. The name of the Colorado Medical Assistance Program member's PCP appears on the eligibility verification. The Colorado Medical Assistance Program does not require that the primary care physician number appear more than once on each claim submitted. The "other" provider's last and first name is optional.
80. Remarks	Text	Enter specific additional information necessary to process the claim or fulfill reporting requirements.

Form Locator and Label	Completion Format	Instructions
81. Code-Code-QUAL/CODE/VALUE (a-d)		Submitted information is not entered into the claim processing system.

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.

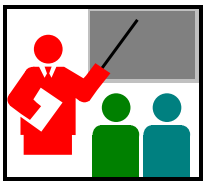
Billing Instruction Detail	Instructions
LBOD Completion Requirements	• Electronic claim formats provide specific fields for documenting the LBOD. • Supporting documentation must be kept on file for six (6) years. • For paper claims, follow the instructions appropriate for the claim form you are using.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

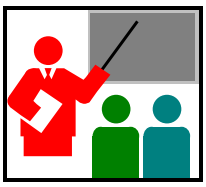
Billing Instruction Detail	Instructions
	LBOD = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the payment.
Denied Paper Claims	If the initial timely filing period has expired and a previously submitted paper claim that was filed within the original Colorado Medical 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 member by name

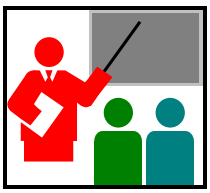
Billing Instruction Detail	Instructions
	• States that eligibility was backdated or retroactive • Identifies the date that eligibility was added to the state eligibility system. **LBOD** = the date shown on the county letter that eligibility was added to or first appeared on the state eligibility system.
Delayed Notification of Eligibility	The provider was unable to determine that the member 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 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.*

Billing Instruction Detail	Instructions
	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 member, rendered services, and shows the payment or denial date. Claims must be filed within 365 days of the date of service. No exceptions are allowed. If the claim is nearing the 365-day limit and the commercial insurance company has not completed processing, file the claim, receive a denial or rejection, and continue filing in compliance with the 60-day rule until insurance processing information is available. **LBOD** = the date commercial insurance paid or denied.
Correspondence LBOD Authorization	The claim is being submitted in accordance with instructions (authorization) from the Colorado Medical Assistance Program for a 60 day filing extension for a specific member, claim, services, or circumstances. **File the claim within 60 days** of the date on the authorization letter. Retain the authorization letter. **LBOD** = the date on the authorization letter.
Member Changes Providers during Obstetrical Care	The claim is for obstetrical care where the member 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 member transferred to another provider for continuation of OB care. **LBOD** = the last date of OB care by the billing provider.

Sterilizations, Hysterectomies, and Abortions

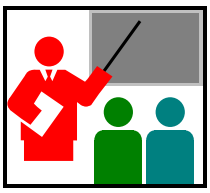
Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions 	**Voluntary sterilizations** Sterilization for the purpose of family planning is a benefit of the Colorado Medical Assistance Program in accordance with the following procedures: **General requirements** The following 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)→For Our Providers →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.

Sterilizations, Hysterectomies, and Abortions

(continued)



Completion of the MED-178 consent form

Please refer to the MED-178 Instructions on the Department's website (colorado.gov/hcpf)→For Our Providers →Provider Services→Forms→Sterilization Consent. 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 me's portion of the sterilization consent must be approved and initialed by the member.

Hysterectomies

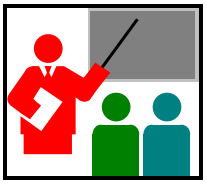
Hysterectomy is a benefit of the Colorado Medical Assistance Program when performed solely for medical reasons. Hysterectomy is not a benefit of the Colorado Medical Assistance Program if the procedure is performed solely for the purpose of sterilization, or if there was more than one purpose for the procedure and it would not have been performed but for the purpose of sterilization.

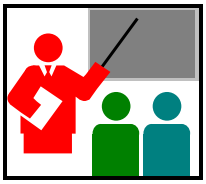
The following conditions must be met for payment of hysterectomy claims under the Colorado Medical Assistance Program. These claims must be filed on paper.

- Prior to the surgery, the person who secures the consent to perform the hysterectomy must inform the member and her representative, if any, verbally and in writing that the hysterectomy will render the member permanently incapable of bearing children.
- The member 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 member.

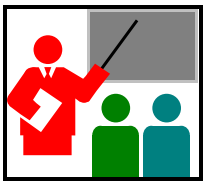
A written acknowledgment from the member is not required if:

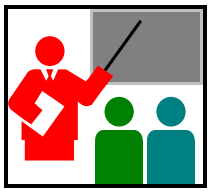
- The member is already sterile at the time of the hysterectomy, or
- The hysterectomy is performed because of a life-threatening emergency in which the practitioner determines that prior acknowledgment is not possible.

Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions (continued) 	If the member'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 member was already sterile at the time of hysterectomy and stating the cause of sterility; • A signed and dated statement certifying that the member required hysterectomy under a life-threatening, emergency situation in which the practitioner determined that prior acknowledgment by the member was not possible. The statement must describe the nature of the emergency. A copy of the member'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 of the Appendices in the Provider Services Billing Manuals section. Providers may copy this form, as needed, for attachment to claim(s). Providers may substitute any form that includes the required information. The submitted form or case summary documentation must be signed and dated by the practitioner performing the hysterectomy. The surgeon is responsible for providing copies of the appropriate acknowledgment or certification to the hospital, anesthesiologist, and assistant surgeon for billing purposes. **Claims will be denied if a copy of the written acknowledgment or practitioner's statement is not attached.** ## Abortions ### Induced abortions Therapeutic legally induced abortions are a benefit of the Colorado Medical Assistance Program when performed to save the life of the mother. The Colorado Medical Assistance Program also reimburses legally induced abortions for pregnancies that are the result of sexual assault (rape) or incest. A copy of the appropriate certification statement must be attached to all claims for legally induced abortions performed for the above reasons. Because of the attachment requirement, claims for legally induced abortions must be submitted on paper and must **not** be electronically transmitted. Claims for spontaneous abortions (miscarriages), ectopic, or molar pregnancies are not affected by these regulations. The following procedure codes are appropriate for identifying induced abortions: 59840 59841 59851 59852 59850 59855 59856 59857

Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions (continued) 	Diagnosis code ranges: O04.5, O04.6, O04.7, O04.80, O04.81, O04.82, O04.83, O04.84, O04.85, O04.86, O04.87, O04.88, O04.89, Z33.2 Surgical diagnosis codes: 10A07ZZ 10A08ZZ 0U7C7DZ 10A00ZZ 10A072X 10A07ZW 10A03ZZ 10A04ZZ **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 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. **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

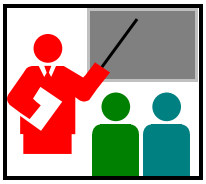
Billing Instruction Detail	Instructions
	represents a serious and substantial threat to the life of the pregnant woman if the pregnancy is allowed to continue to term.

Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions (continued) 	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 ➤ Office visit notes ➤ Hospital progress notes **A suggested form on which to report the required information is in Appendix K** of the Appendices in the Provider Services Billing Manuals Billing Manuals section. 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.

Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions (continued) 	**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** of the Appendices in the Provider Services Billing Manuals. This form **must**: ➢ Be signed and dated by the member 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.

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 a 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.

O01.0	Classical hydatidiform mole√
O01.1	Incomplete and partial hydatidiform mole
O01.9	Hydatidiform mole, unspecified
O02.81	Inappropriate change in quantitative human chorionic gonadotropin (hCG) in early pregnancy
O02.1	Missed Abortion
O00.0	Abdominal pregnancy
O00.1	Tubal pregnancy
O00.2	Ovarian pregnancy
O00.8	Other ectopic pregnancy
O00.9	Ectopic pregnancy, unspecified
O03.5	Genital tract and pelvic infection following complete or unspecified spontaneous abortion
O03.87	Sepsis following complete or unspecified spontaneous abortion
O08.9	Unspecified complication following an ectopic and molar pregnancy
O36.4xx0	Maternal care for intrauterine death, not applicable or unspecified

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

Billing Instruction Detail	Instructions
	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.

Institutional Provider Certification

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

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

Signature: _____ ***Date:*** _____

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

FQHC Claim Example

1 FQHC Clinic
100 Saginaw Street
Anytown, CO 80201
303-333-3333

2

3a PAT. CNTL. #
b. MED. REC. #
5 FED. TAX NO.
4 TYPE OF BILL: 711
6 STATEMENT COVERS PERIOD FROM: 07/01/11 THROUGH: 071/01/11
7

8 PATIENT NAME a
b Client, Ima D.

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

10 BIRTHDATE: 02/13/1980
11 SEX: F
12 ADMISSION DATE 13 HR 14 TYPE 15 SRC 16 DHR 17 STAT 18 19 20 21 22 23 24 25 26 27 28 29 ACDT STATE 30

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

38

39 VALUE CODES CODE AMOUNT 40 VALUE CODES CODE AMOUNT 41 VALUE CODES CODE AMOUNT

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	529	Free Standing Clinic - General	99213	07/01/11	1	131 00		
2	529	Free Standing Clinic - General	88215	07/01/11	1	50 00		
3	529	Free Standing Clinic - General	A4554	07/01/11	1	50 00		
4	529	Free Standing Clinic - General	J7602	07/01/11	1	50 00		
5	529	Free Standing Clinic - General	90732	07/01/11	1	50 00		
23		PAGE 1 OF 1	CREATION DATE		TOTALS	331 00		

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

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

63 TREATMENT AUTHORIZATION CODES 64 DOCUMENT CONTROL NUMBER 65 EMPLOYER NAME

66 DX: 0092 2809 B C D E F G H 68
I J K L M N O P Q

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

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

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

80 REMARKS
81CC a b c d

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

FQHC Dental Claim Example for services prior to July 1, 2014

Print Form

1 FQHC Clinic
100 Saginaw Street
Anytown, CO 80201
303-333-3333

2

3a PAT. CNTL #
b. MED. REC. #
4 TYPE OF BILL: 711
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM: 07/01/11 THROUGH: 071/01/11
7

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

10 BIRTHDATE: 02/13/1995
11 SEX: F
12 ADMISSION DATE 13 HR 14 TYPE 15 SRC 16 DHR 17 STAT
18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES
29 ACDT STATE 30

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

38

39 VALUE CODES CODE AMOUNT 40 VALUE CODES CODE AMOUNT 41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
529	Free Standing Clinic - General	D9230	07/01/11	1	35 00		
529	Free Standing Clinic - General	D2150	07/01/11	1	138 00		
529	Free Standing Clinic - General	D2150	07/01/11	1	138 00		
529	Free Standing Clinic - General	D2160	07/01/11	1	149 00		
	PAGE 1 OF 1	CREATION DATE		TOTALS	460 00		

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

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

63 TREATMENT AUTHORIZATION CODES 64 DOCUMENT CONTROL NUMBER 65 EMPLOYER NAME

66 DX: 521 A B C D E F G H I J K L M N O P Q 68

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

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

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

80 REMARKS 81CC a b c d

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

FQHC Crossover Claim Example

1 FQHC Clinic
100 Saginaw Street
Anytown, CO 80201
303-333-3333

2

3a PAT. CNTL #: PCN0123456789
b. MED. REC. #:
4 TYPE OF BILL: 711
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM: 07/01/11 THROUGH: 07/01/11
7

8 PATIENT NAME a
b Client, Ima D.
9 PATIENT ADDRESS a 123 Main Street
b Anytown c CO d 88888 e
10 BIRTHDATE: 02/13/1980
11 SEX: F
12 ADMISSION DATE 13 HR 14 TYPE 15 SRC 16 DHR 17 STAT
18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES
29 ACDT STATE 30

31 CODE	31 DATE	32 CODE	32 DATE	33 CODE	33 DATE	34 CODE	34 DATE	35 CODE	OCCURRENCE SPAN FROM	THROUGH	36 CODE	OCCURRENCE SPAN FROM	THROUGH	37
a 50	07/30/11													a
b														b

38

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a	A1	80 00				
b	A2	20 00				
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	529	Free Standing Clinic - General		07/01/11	1	131 00		1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23		PAGE 1 OF 1	CREATION DATE		TOTALS	131 00		23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A	C - Medicare						57	A
B	D - Medicaid	12345678				100 00	OTHER	B
C							PRV ID	C

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

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

66 DX: 0092 | 2809 | B | C | D | E | F | G | H | 68
I | J | K | L | M | N | O | P | Q

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

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

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

80 REMARKS
81CC a b c d

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

FQHC with BHO Diagnosis Code Claim Example

1 FQHC Clinic
100 Saginaw Street
Anytown, CO 80201
303-333-3333

4 TYPE OF BILL: 711

6 STATEMENT COVERS PERIOD FROM: 08/01/11 THROUGH: 08/01/11

8 PATIENT NAME: b Client, Ima D.

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

10 BIRTHDATE: 02/13/1980 | 11 SEX: F | 15 SRC: 1 | 17 STAT: 01 | 18: 85

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
529	Free Standing Clinic - General	99213	01/01/09	1	131:00	
529	Free Standing Clinic - General	96101	01/01/09	1	87:00	
	PAGE 1 OF 1 CREATION DATE			TOTALS	218:00	

50 PAYER NAME: D-Medicaid
51 HEALTH PLAN ID: 12345678

58 INSURED'S NAME: Client, Ima D.
60 INSURED'S UNIQUE ID: A123456

66 DX: 2978 7941

76 ATTENDING: NPI; QUAL 1D; 87654321; LAST Provider; FIRST Ima

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

RHC Claim Example

1 RHC Clinic
100 Saginaw Street
Anytown, CO 80201
303-333-3333

2

3a PAT. CNTL. #
b. MED. REC. #
4 TYPE OF BILL: 711
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 07/01/11 THROUGH 07/01/11
7

8 PATIENT NAME a
b Client, Ima D.
9 PATIENT ADDRESS a 123 Main Street
b Anytown c CO d 88888 e
10 BIRTHDATE 02/13/1980
11 SEX F
12 DATE
ADMISSION 13 HR 14 TYPE 15 SRC
16 DHR
17 STAT
CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28
29 ACDT STATE
30

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

38

39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
521	RHC Clinic - General		07/01/11	1	131:00		
	PAGE 1 OF 1	CREATION DATE		TOTALS	131:00		

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

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

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX: 0092 2809 B C D E F G H I J K L M N O P Q
68

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

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

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

80 REMARKS
81CC a b c d

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

RHC Crossover Claim Example

1 RHC Clinic 100 Saginaw Street Anytown, CO 80201 303-333-3333	4 TYPE OF BILL: 711
5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 07/01/11 THROUGH 0/01/11
8 PATIENT NAME: Client, Ima D.	9 PATIENT ADDRESS: 123 Main Street; Anytown; CO; 88888
10 BIRTHDATE: 02/13/1980	11 SEX: F
31 OCCURRENCE CODE DATE: a 50 07/30/11	

39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a A1	80:00				
b A2	20:00				

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
521	RHC Clinic - General		07/01/11	1	131:00		
	PAGE 1 OF 1	CREATION DATE		TOTALS	131:00		

50 PAYER NAME	51 HEALTH PLAN ID	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
A C - Medicare				57
B D - Medicaid	12345678		100:00	OTHER
C				PRV ID

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

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

66 DX: 0092 (I) 2809 (J) B (K) C (L) D (M) E (N) F (O) G (P) H (Q) 68

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

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

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

80 REMARKS | 81CC a b c d

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

FQHC/RHC Revisions Log

Revision Date	Addition/Changes	Pages	Made by
02/13/2008	*Electronic Claims – Updated first two paragraphs with bullets*	*1 & 2*	*pr-z*
11/05/2008	*Updated web addresses*	*Throughout*	*jg*
03/25/2009	*General Updates*	*Throughout*	*jg*
02/30/2009	*Updated instructions and additional claim examples*	*Throughout*	*jg*
10/16/2009	*Formatting*	*Throughout*	*jg*
01/18/2010	*Updated Web site links*	*Throughout*	*jg*
02/17/2010	*Changed EOMB to SPR*	*25*	*jg*
03/04/2010	*Added link to Program Rules*	*1*	*jg*
07/28/2011	*Added FQHC with BHO Diagnosis Code Claim Example* *Updated Claim Examples*	*45* *42-44, 46 & 47*	*jg*
12/06/2011	*Replaced 997 with 999* *Replaced wpc-edi.com/hipaa with wpc-edi.com/* *Replaced Implementation Guide with Technical Report 3 (TR3)*	*3* *2* *2*	*ss*
10/02/2013	*Removed MED-178 instructions and example. Referenced location of form and instructions on p 28*	*28-34*	*cc*
10/03/2013	*Reformatting - Sterilizations, Hysterectomies, and Abortions section* *Updated TOC*	*26-34* *i*	*jg*
02/03/2014	*Updated abortion information*	*31*	*jg*
04/11/2014	*Added: Rate determinidation method example illustration*	*5*	*rd*
04/21/2014	*Re-formatted*	*Throughout*	*Jg*
7/14/14	*Replaced all CO 1500 references with CMS 1500*	*Throughout*	*ZS*
7/21/2014	*Updated all web links to reflect those of the new website*	*Throughout*	*mm*
7/21/2014	*Updated all references of Client to Member*	*Throughout*	*Mm*
7/30/2014	*Updated information for Dental information* *Page 5: Claim Submission* *Page 14: Revenue Code after 7/1/14* *Page 44: FQHC Locater Code after 7/1/14*	*5, 14, 44*	*mm*

11/21/14	*Removed Appendix H information, added Timely Filing document information*	*24*	*Rm*
3/6/15	*Richard revised page 6 to include the FQHC/RHC line billing instructions for rev codes 0529 and 0521, viewed for formatting throughout, viewed for client/patient changes throughout, swapped out seal.*	*5* *Throughout*	*JH*
03/09/2015	*TOC and formatting*	*Throughout*	*Bl*
3/17/2015	*Per Richard Delaney, switched words physician(s) to provider(s) where appropriate in section 76 and section 78.*	*23*	*Jh, rd*
8/31/15	*Reviewed for PAR'd procedure codes, cwqi, coloradopar.* *Replaced ICD-9 with ICD-10 codes*	*Throughout* *19, 33, 37*	*JH*
9/8/15	*Added codes for EPSDT reporting.* *Removed dx code O03.5 from the abortion.*		*RD, JH*
09/08/2015	*Formatting, TOC updates, blank space removal*	*Throughout*	*bl*

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.