

# Children’s Residential Habilitation Program (CHRP) Waiver Program Billing Manual

---

**Children’s Residential Habilitation Program (CHRP) Waiver Program Billing Manual ..... 1**

**Home and Community Based Services (HCBS) for Persons with Developmental Disabilities (DD) Program..... 2**

**Overview ..... 2**

**Claim Submission ..... 2**

*Paper Claims ..... 2*

*Electronic Claims ..... 3*

**Prior Authorization Requests (PARs)..... 3**

**PAR Submission ..... 4**

**Procedure/HCPCS Codes Overview ..... 4**

**Children’s Residential Habilitation Program (CHRP) ..... 4**

**CHRP Procedure Code Table ..... 5**

**Paper Claim Reference Table ..... 5**

**CMS 1500 CHRP Claim Example..... 14**

**Late Bill Override Date ..... 15**

# Home and Community Based Services (HCBS) for Persons with Developmental Disabilities (DD) Program

## Overview

The Home and Community Based Services (HCBS) program provides Colorado Medical Assistance Program benefits to members for certain services in their homes and communities as an alternative to institutional care. HCBS programs for persons with developmental disabilities include the Children’s Habilitation Residential Program (HCBS-CHRP).

Waiver programs provide additional Medicaid benefits to specific populations who meet special eligibility criteria.

Level of care determinations are made annually by the case management agencies (aka Single Entry Points). Members must meet financial, medical, and program criteria to access services under a waiver. The applicant must be at risk of placement in a nursing facility, hospital, or ICF/MR (intermediate care facility for the mentally retarded). To utilize waiver benefits, members must be willing to receive services in their homes or communities. A member who receives services through a waiver is also eligible for all basic Medicaid covered services except nursing facility and long-term hospital care. When a member chooses to receive services under a waiver, the services must be provided by certified Medicaid providers or by a Medicaid contracting Managed Care Organization (MCO).



Each waiver has an enrollment limit. Applicants may apply for more than one (1) waiver, but may only receive services through one (1) waiver at a time.

## Claim Submission

### 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 the Department’s fiscal agent, Xerox State Healthcare, P.O. Box 90, Denver, CO 80201-0090.

The following claims can be submitted on paper and processed for payment:

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

Paper claims do not require an NPI, but do require the Colorado Medical Assistance Program provider number.

## Electronic Claims

Instructions for completing and submitting electronic claims are available through the 837 Professional (837P) Web Portal User guide via the Web Portal and also on the [Department's Colorado Medical Assistance Program Web Portal page](#).

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

The Special Program Indicator (SPI) must be completed on claims submitted electronically. Claims submitted electronically and on paper are identified by using the specific national modifiers along with the procedure code. The appropriate procedure codes and modifiers for each HCBS waiver are noted throughout this manual. When the services are approved, the claim may be submitted to the Department's fiscal agent. For more detailed billing instructions, please refer to the CMS 1500 General Billing Information in the Provider Services [Billing Manuals](#) section.

## **Prior Authorization Requests (PARs)**

Unless otherwise noted, all HCBS services require prior approval before they can be reimbursed by the Colorado Medical Assistance Program. Case management agencies/single entry points complete the Prior Approval and/or Cost Containment requests for their specific programs according to instructions published in the Department of Health Care Policy and Financing's (the Department's) Code of Colorado Regulations, [Program Rules](#) (10 CCR 2505-10, Section 8.500).

The CMAs/SEPs responsibilities include, but not limited to:

- Informing members and/or legal guardian of the eligibility process.
- Submitting a copy of the approved Enrollment Form to the County department of human/social services for a Colorado Medical Assistance Program member identification number.
- Developing the appropriate Prior Approval and/or Cost Containment Record Form of services and projected costs for approval.
- Submitting a copy of the Prior Authorization and/or Cost Containment document to the authorizing agent. A list of authorizing agents can be found by referring to Appendix D of the Appendices in the Provider Services [Billing Manuals](#) section.
- Assessing the member's health and social needs.
- Arranging for face-to-face contact with the member within 30 calendar days of receipt of the referral.
- Monitoring and evaluating services.
- Reassessing each member.
- Demonstrating continued cost effectiveness whenever services increase or decrease.

**Approval of prior authorization does not guarantee Colorado Medical Assistance Program payment and does not serve as a timely filing waiver.** Prior authorization only assures that the approved service is a medical necessity and is considered a benefit of the Colorado Medical Assistance Program. All claims, including those for prior authorized services, must meet eligibility and claim submission requirements (e.g., timely filing, provider information completed appropriately, required attachments included, etc.) before payment can be made.

**Prior approvals must be completed thoroughly and accurately.** If an error is noted on an approved request, it should be brought to the attention of the member's case manager for corrections. Procedure codes, quantities, etc., may be changed or entered by the member's case manager.

The authorizing agent or case management agency/single entry point is responsible for timely submission and distribution of copies of approvals to agencies and providers contracted to provide services.

## **PAR Submission**

All HCBS-CHRP services must be prior authorized by the County Department of Human Social Services and transmitted electronically to the Medicaid Management Information System (MMIS) by the Division Child Welfare Division. The telephone number for the Child Welfare Division is listed in Appendix A of the Appendices in the Provider Services [Billing Manuals](#) section of the Department's website.

## **Procedure/HCPCS Codes Overview**

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

The Healthcare Common Procedural Coding System (HCPCS) is divided into two (2) principal subsystems, referred to as level I and level II of the HCPCS. Level I of the HCPCS is comprised of CPT (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA).

The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes. These include ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DME/Supplies) when used outside a physician's office. Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter followed by four (4) numeric digits. CPT codes are identified using five (5) numeric digits.



## **Children's Residential Habilitation Program (CHRP)**

CHRP is a residential service and support program for children and youth from birth to 22 years of age. CHRP provides residential services for children and youth in foster care who have a developmental disability and extraordinary needs. The children must be at risk for institutionalization. CHRP serves as an alternative to placement in Intermediate Care Facilities/Individuals with Intellectual Disabilities (ICF/IID). The waiver is designed to assist children/youth to acquire, retain, and/or improve self-help, socialization, and adaptive skills necessary to live in the community with a plan to include services. Placements occur through the Colorado County Departments of Human/Social Services once children meet all of the program eligibility requirements.

The following services are provided through CHRP when deemed appropriate and adequate by the child/youth's physician and they are to be provided in the community, as available:



- Self-Advocacy Training
- Independent Living Training
- Cognitive Services
- Communication Services
- Counseling and Therapeutic Services
- Personal Care Services
- Emergency Assistance Training
- Community Connection Training
- Travel Services
- Supervision Services
- Respite Services

### **CHRP Procedure Code Table**

Providers may bill the following procedure codes for CHRP services:

<b>Children’s Habilitation Residential Program (CHRP) (Special Program Code 93)</b>		
<b>Description</b>	<b>Procedure Code + Modifier(s)</b>	
Foster Home Level (of Care) I	H0041	U9
Respite Level (of Care) I	H0045	U9

### **Paper Claim Reference Table**

The following paper form reference table describes required fields for the paper CMS 1500 claim form for HCBS-CHRP claims:

<b>CMS Field #</b>	<b>Field Label</b>	<b>Field is?</b>	<b>Special Instructions</b>
<b>1</b>	<b>Insurance Type</b>	Required	Place an "X" in the box marked as Medicaid.
<b>1a</b>	<b>Insured’s ID Number</b>	Required	Enter the member’s Colorado Medical Assistance Program seven-digit Medicaid ID number as it appears on the Medicaid Identification card. Example: A123456.
<b>2</b>	<b>Patient’s Name</b>	Required	Enter the member’s last name, first name, and middle initial.
<b>3</b>	<b>Patient’s Date of Birth / Sex</b>	Required	Enter the patient’s birth date using two (2) digits for the month, two (2) digits for the date, and two (2) digits for the year. Example: 070114 for July 1, 2014. Place an "X" in the appropriate box to indicate the sex of the member.
<b>4</b>	<b>Insured’s Name</b>	Not Required	
<b>5</b>	<b>Patient’s Address</b>	Not Required	

<b>CMS Field #</b>	<b>Field Label</b>	<b>Field is?</b>	<b>Special Instructions</b>
<b>6</b>	<b>Patient's Relationship to Insured</b>	Not Required	
<b>7</b>	<b>Insured's Address</b>	Not Required	
<b>8</b>	<b>Reserved for NUCC Use</b>	-	
<b>9</b>	<b>Other Insured's Name</b>	Not Required	
<b>9a</b>	<b>Other Insured's Policy or Group Number</b>	Not Required	
<b>9b</b>	<b>Reserved for NUCC Use</b>	-	
<b>9c</b>	<b>Reserved for NUCC Use</b>	-	
<b>9d</b>	<b>Insurance Plan or Program Name</b>	Not Required	
<b>10a-c</b>	<b>Is Patient's Condition Related to?</b>	Not Required	
<b>10d</b>	<b>Reserved for Local Use</b>	-	
<b>11</b>	<b>Insured's Policy, Group or FECA Number</b>	Not Required	
<b>11a</b>	<b>Insured's Date of Birth, Sex</b>	Not Required	
<b>11b</b>	<b>Other Claim ID</b>	Not Required	
<b>11c</b>	<b>Insurance Plan Name or Program Name</b>	Not Required	
<b>11d</b>	<b>Is there another Health Benefit Plan?</b>	Not Required	
<b>12</b>	<b>Patient's or Authorized Person's signature</b>	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.
<b>13</b>	<b>Insured's or Authorized Person's Signature</b>	Not Required	

CMS Field #	Field Label	Field is?	Special Instructions
14	<b>Date of Current Illness Injury or Pregnancy</b>	Not Required	
15	<b>Other Date</b>	Not Required	
16	<b>Date Patient Unable to Work in Current Occupation</b>	Not Required	
17	<b>Name of Referring Physician</b>	Not Required	
18	<b>Hospitalization Dates Related to Current Service</b>	Not Required	
19	<b>Additional Claim Information</b>	Conditional	LBOD Use to document the Late Bill Override Date for timely filing.
20	<b>Outside Lab? \$ Charges</b>	Not Required	
21	<b>Diagnosis or Nature of Illness or Injury</b>	Required	Enter at least one (1) 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. 0 ICD-10-CM (DOS 10/1/15 and after) 9 ICD-9-CM (DOS 9/30/15 and before) <b>HCBS</b> CHRP <u>must</u> use R69

<b>CMS Field #</b>	<b>Field Label</b>	<b>Field is?</b>	<b>Special Instructions</b>
22	<b>Medicaid Resubmission Code</b>	Conditional	<p>List the original reference number for resubmitted claims.</p> <p>When resubmitting a claim, enter the appropriate bill frequency code in the left-hand side of the field.</p> <p>7 Replacement of prior claim</p> <p>8 Void/Cancel of prior claim</p> <p>This field is not intended for use for original claim submissions.</p>
23	<b>Prior Authorization</b>	Not Required	<p>HCBS</p> <p>Leave blank</p>
24	<b>Claim Line Detail</b>	Information	<p>The paper claim form allows entry of up to six detailed billing lines. Fields 24A through 24J apply to each billed line.</p> <p>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.</p> <p>Each claim form must be fully completed (totaled).</p> <p>Do not file continuation claims (e.g., Page 1 of 2).</p>



CMS Field #	Field Label	Field is?	Special Instructions
24D	Modifier	Conditional	<p>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.</p> <p>HCBS</p> <p>Refer to the CHCBS, CLLI or CWA procedure code tables.</p>
24E	Diagnosis Pointer	Required	<p>Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis.</p> <p>At least one (1) diagnosis code reference letter must be entered.</p> <p>When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow.</p> <p>This field allows for the entry of 4 characters in the unshaded area.</p>
24F	\$ Charges	Required	<p>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.</p> <p>Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one (1) procedure from the same group is billed, special multiple pricing rules apply.</p> <p>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 (1) procedure from the same grouping is performed.</p> <p>Submitted charges cannot be more than charges made to non-Colorado Medical Assistance Program covered individuals for the same service.</p> <p>Do not deduct Colorado Medical Assistance Program co-payment or commercial insurance payments from the usual and customary charges.</p>

CMS Field #	Field Label	Field is?	Special Instructions
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.
24G	Days or Units	General Instructions	A unit represents the number of times the described procedure or service was rendered. Except as instructed in this manual or in Colorado Medical Assistance Program bulletins, the billed unit must correspond to procedure code descriptions. The following examples show the relationship between the procedure description and the entry of units. <b>Home &amp; Community Based Services</b> Combine units of services for a single procedure code for the billed time period on one (1) detail line. Dates of service do not have to be reported separately. Example: If forty units of personal care services were provided on various days throughout the month of January, bill the personal care procedure code with a From Date of 01/03/XX and a To Date of 01/31/XX and 40 units.
24H	EPSDT/Family Plan	Not Required	EPSDT (shaded area) Not Required Family Planning (unshaded area) Not Required
24I	ID Qualifier	Not Required	
24J	Rendering Provider ID #	Not Required	
25	Federal Tax ID Number	Not Required	
26	Patient's Account Number	Optional	Enter information that identifies the patient or claim in the provider's billing system. Submitted information appears on the Provider Claim Report (PCR).
27	Accept Assignment?	Required	The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.

CMS Field #	Field Label	Field is?	Special Instructions
28	<b>Total Charge</b>	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	<b>Amount Paid</b>	Not Required	
30	<b>Rsvd for NUCC Use</b>	-	
31	<b>Signature of Physician or Supplier Including Degrees or Credentials</b>	Required	<p>Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent.</p> <p>A holographic signature stamp may be used <u>if</u> authorization for the stamp is on file with the fiscal agent.</p> <p>An authorized agent or representative may sign the claim for the enrolled provider <u>if</u> the name and signature of the agent is on file with the fiscal agent.</p> <p>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 (2) digits for the month, two (2) digits for the date and two (2) digits for the year. Example: 070114 for July 1, 2014.</p> <p><b>Unacceptable signature alternatives:</b></p> <p>Claim preparation personnel may not sign the enrolled provider’s name.</p> <p>Initials are not acceptable as a signature.</p> <p>Typed or computer printed names are not acceptable as a signature.</p> <p>“Signature on file” notation is not acceptable in place of an authorized signature.</p>
32	<b>32- Service Facility Location Information</b> <b>32a- NPI Number</b> <b>32b- Other ID #</b>	Not Required	

CMS Field #	Field Label	Field is?	Special Instructions
33	<b>33- Billing Provider Info &amp; Ph. #</b> <b>33a- NPI Number</b> <b>33b- Other ID #</b>	Required	Enter the name of the individual or organization that will receive payment for the billed services in the following format: 1 <sup>st</sup> Line    Name 2 <sup>nd</sup> Line    Address 3 <sup>rd</sup> Line    City, State and ZIP Code 33a- NPI Number Not Required 33b- Other ID # Enter the eight-digit Colorado Medical Assistance Program provider number of the individual or organization.

# CMS 1500 CHRP Claim Example



**HEALTH INSURANCE CLAIM FORM**

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

1. MEDICARE (Medicare #) <input checked="" type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE (ID#DCDR) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>D444444</b>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Client, Ima A</b>		3. PATIENT'S BIRTH DATE MM DD YY SEX <b>10 16 11 M F <input checked="" type="checkbox"/></b>	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? PLACE (State) YES NO c. OTHER ACCIDENT? YES NO 10d. RESERVED FOR LOCAL USE	
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 <b>Signature on File</b> DATE <b>1/1/15</b>		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 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI		15. OTHER DATE MM DD YY 18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 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? \$ CHARGES YES NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind <b>0</b> A. <b>R69</b> B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. UNIT PRICE I. ID. QUAL. J. RENDERING PROVIDER ID.#			
1 <b>01 01 15 01 01 15 12 H0041 U9 A 53 86 1 NPI</b>			
2 _____ NPI			
3 _____ NPI			
4 _____ NPI			
5 _____ NPI			
6 _____ NPI			
7 _____ NPI			
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 28. TOTAL CHARGE \$ <b>53 86</b> 29. AMOUNT PAID \$ 30. Revd 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 <b>Signature</b> DATE <b>1/1/15</b>		32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH# ( ) <b>CHRP Provider 100 Any Street Any City</b> a. <b>04567890</b>	

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

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

## 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
<b>LBOD Completion Requirements</b>	<ul style="list-style-type: none"> <li>• Electronic claim formats provide specific fields for documenting the LBOD.</li> <li>• Supporting documentation must be kept on file for 6 years.</li> <li>• For paper claims, follow the instructions appropriate for the claim form being used.                             <ul style="list-style-type: none"> <li>➤ <i>UB-04</i>: Occurrence code 53 and the date are required in FL 31-34.</li> <li>➤ <i>CMS 1500</i>: Indicate “LBOD” and the date in box 19 – Additional Claim Information.</li> <li>➤ <i>2006 ADA Dental</i>: Indicate “LBOD” and the date in box 35 - Remarks</li> </ul> </li> </ul>
<b>Adjusting Paid Claims</b>	<p>If the initial timely filing period has expired and a previously submitted claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was paid and now needs to be adjusted, resulting in additional payment to the provider.</p> <p><b>Adjust the claim within 60 days</b> of the claim payment. Retain all documents that prove compliance with timely filing requirements.</p> <p><i>Note: There is no time limit for providers to adjust paid claims that would result in repayment to the Colorado Medical Assistance Program.</i></p>

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

Billing Instruction Detail	Instructions
	<ul style="list-style-type: none"> <li>States that eligibility was backdated or retroactive</li> <li>Identifies the date that eligibility was added to the state eligibility system.</li> </ul> <p><b>LBOD</b> = the date shown on the county letter that eligibility was added to or first appeared on the state eligibility system.</p>
<p><b>Delayed Notification of Eligibility</b></p>	<p>The provider was unable to determine that the patient had Colorado Medical Assistance Program coverage until after the timely filing period expired.</p> <p><b>File the claim within 60 days</b> 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 &amp; Request for Timely Filing Extension in the Provider Services <a href="#">Forms</a> section) that identifies the member, indicates the effort made to identify eligibility, and shows the date of eligibility notification.</p> <ul style="list-style-type: none"> <li>Claims must be filed within 365 days of the date of service. No exceptions are allowed.</li> <li>This extension is available only if the provider had no way of knowing that the individual had Colorado Medical Assistance Program coverage.</li> <li>Providers who render services in a hospital or nursing facility are expected to get benefit coverage information from the institution.</li> <li>The extension does not give additional time to obtain Colorado Medical Assistance Program billing information.</li> <li>If the provider has previously submitted claims for the member, it is improper to claim that eligibility notification was delayed.</li> </ul> <p><b>LBOD</b> = the date the provider was advised the individual had Colorado Medical Assistance Program benefits.</p>
<p><b>Electronic Medicare Crossover Claims</b></p>	<p>An electronic claim is being submitted for Medicare crossover benefits within 120 days of the date of Medicare processing/payment. (Note: On the paper claim form (only), the Medicare SPR/ERA date field documents crossover timely filing and completion of the LBOD is not required.)</p> <p><b>File the claim within 120 days</b> of the Medicare processing/payment date shown on the SPR/ERA. Maintain the original SPR/ERA on file.</p> <p><b>LBOD</b> = the Medicare processing date shown on the SPR/ERA.</p>
<p><b>Medicare Denied Services</b></p>	<p>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.</p> <p><i>Note: This becomes a regular Colorado Medical Assistance Program claim, not a Medicare crossover claim.</i></p>

Billing Instruction Detail	Instructions
	<p><b>File the claim within 60 days</b> of the Medicare processing date shown on the SPR/ERA. Attach a copy of the SPR/ERA if submitting a paper claim and maintain the original SPR/ERA on file.</p> <p><b>LBOD</b> = the Medicare processing date shown on the SPR/ERA.</p>
<p><b>Commercial Insurance Processing</b></p>	<p>The claim has been paid or denied by commercial insurance.</p> <p><b>File the claim within 60 days</b> 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.</p> <p>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.</p> <p><b>LBOD</b> = the date commercial insurance paid or denied.</p>
<p><b>Correspondence LBOD Authorization</b></p>	<p>The claim is being submitted in accordance with instructions (authorization) from the Colorado Medical Assistance Program for a 60 day filing extension for a specific member, claim, services, or circumstances.</p> <p><b>File the claim within 60 days</b> of the date on the authorization letter. Retain the authorization letter.</p> <p><b>LBOD</b> = the date on the authorization letter.</p>
<p><b>Member Changes Providers during Obstetrical Care</b></p>	<p>The claim is for obstetrical care where the patient transferred to another provider for continuation of OB care. The prenatal visits must be billed using individual visit codes but the service dates are outside the initial timely filing period.</p> <p><b>File the claim within 60 days</b> 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.</p> <p><b>LBOD</b> = the last date of OB care by the billing provider.</p>



***CHRP Specialty Manual Revisions Log***

<b><i>Revision Date</i></b>	<b><i>Section/Action</i></b>	<b><i>Pages</i></b>	<b><i>Made by</i></b>
<i>06/17/2013</i>	<i>Split DD, SLS, CES, CHRP and TCM from the combined HCBS manual</i>	<i>All</i>	<i>cc/sm/jg</i>
<i>12/3/2014</i>	<i>Removed CO 1500 information and claim example</i>	<i>Throughout</i>	<i>mc</i>
<i>12/3/2014</i>	<i>Updated links to Provider Services</i>	<i>Throughout</i>	<i>mc</i>
<i>12/3/2014</i>	<i>Removed 1 section of claim information – it was on there twice</i>	<i>Throughout</i>	<i>mc</i>
<i>12/3/2014</i>	<i>Paper Claim Reference Table updated for CMS 1500</i>	<i>4-11</i>	<i>mc</i>
<i>12/3/2014</i>	<i>Added CMS 1500 Claim Form Example and CMS 1500 information</i>	<i>Throughout, 12</i>	<i>mc</i>
<i>12/8/2014</i>	<i>Removed Appendix H information, added Timely Filing document information</i>	<i>16</i>	<i>mc</i>
<i>12/10/2014</i>	<i>Modified the level of care service type for foster home level 1 and respite level 1</i>	<i>4</i>	<i>mc</i>
<i>12/24/2014</i>	<i>Removed inactive codes T1015, T2033 from the procedure code table</i>	<i>4</i>	<i>mc</i>
<i>01/05/2015</i>	<i>Formatting and TOC</i>	<i>Throughout</i>	<i>Bl</i>
<i>8/31/15</i>	<i>Changed font to Tahoma Removed reference to ICD-9, changed ICD-10 codes per policy</i>	<i>Throughout 7</i>	<i>JH</i>
<i>09/08/2015</i>	<i>Header and footer re-added, TOC updated, blank space removal, formatting, and accepted changes</i>	<i>Throughout</i>	<i>bl</i>