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Home and Community Based Services (HCBS) Overview Manual: Children's Home and Community Based Services (CHCBS) Waiver, Children with a Life Limiting Illness (CLLI) Waiver, Children with Autism (CWA) Waiver

Waiver programs provide additional Health First Colorado (Colorado's Medicaid Program) 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 and Community Center Boards). Members must meet financial, medical, and program criteria to access services under a waiver. The applicant must be at risk of placement in a skilled nursing facility, hospital, or ICF/IID (intermediate care facility for Individuals with an Intellectual Disability). 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 Health First Colorado 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 Health First Colorado providers or by a Health First Colorado contracting managed care organization (MCO).

Applicants may apply for more than one waiver, but may only receive services through one waiver at a time.

Case Management Agency Responsibilities

Case Management Agencies (Single Entry Points, Community Centered Boards, and some other case management agencies) are delegated administrative authority over HCBS waivers.

The CMAs responsibilities include, but are 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 Health First Colorado 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 in 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.
- Monitoring and evaluating services.
- Reassessing each member annually or upon change in condition.
- Demonstrating continued cost effectiveness whenever services increase or decrease.

Prior Authorization Requests (PARs)

Unless otherwise noted, all HCBS services require prior approval before they can be reimbursed by the Health First Colorado. Case Management Agencies (CMA) complete the Prior Approval and/or Cost Containment requests for their specific programs according to instructions published in the regulations for the Department of Health Care Policy and Financing (the Department).
Providers may contact the CMA for the status of the PAR or inquire electronically through the Health First Colorado Web Portal.

Approval of prior authorization does not guarantee Health First Colorado 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 Health First Colorado. 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 CMA is responsible for timely submission and distribution of copies of approvals to agencies and providers contracted to provide services.

PAR Submission

The following PAR (CHCBS, CLLI, and CWA) forms are filed via the "Bridge" which directly interfaces with the Colorado interChange System. Access to the Bridge is accomplished via the Medicaid Enterprise User Provisioning System (MEUPS) which can be found at https://home.co-meups.xco.dcs-usps.com/home/.

PAR Form Instructional Reference Table

Field Label	Completion Format	Instructions
PA Number being revised		Conditional Complete if PAR is a revision. Indicate original PAR number assigned.
Revision	Check box ☐ Yes ☐ No	Required Check the appropriate box.
Client Name	Text	Required Enter the member's last name, first name and middle initial. Example: Adams, Mary A.
Client ID	7 characters, a letter prefix followed by six numbers	Required Enter the member's state identification number. This number consists of a letter prefix followed by six numbers. Example: A123456

Field Label	Completion Format	Instructions
Sex	Check box ☐ M ☐ F	Required Check the appropriate box.
Birthdate	6 numbers (MM/DD/YY)	Required Enter the member's birth date using MM/DD/YY format. Example: January 1, 2010 = 01/01/10.
Requesting Provider #	8 numbers	Required Enter the eight-digit Health First Colorado provider number of the requesting provider.
Client's County	Text	Required Enter the member's county of residence
Case Number (Agency Use)	Text	Optional Enter up to 12 characters, (numbers, letters, hyphens) which helps identify the claim or member.
Dates Covered (From/Through)	6 numbers for from date and 6 numbers for through date (MM/DD/YY)	Required Enter PAR start date and PAR end date.
Services Description	Text	N/A List of approved procedure codes for qualified and demonstration services.
Provider	Text	Optional (CMA use) Enter up to 12 characters to identify provider.
Modifier	2 Letters	Required The alphanumeric values in this column are standard and static and cannot be changed.
Max # Units	Number	Required Enter the number of units next to the services being requested for reimbursement.
Cost Per Unit	Dollar Amount	Required Enter cost per unit of service.

Field Label	Completion Format	Instructions
Total $ Authorized	Dollar Amount	Required The dollar amount authorized for this service automatically populates.
Comments	Text	Optional Enter any additional useful information. For example, if a service is authorized for different dates than in "Dates Covered" field, please include the HCPCS procedure code and date span here.
Total Authorized HCBS Expenditures	Dollar Amount	Required Total automatically populates.
Number of Days Covered	Number	Required The number of days covered automatically populates.
Average Cost Per Day	Dollar Amount	Required The member's maximum authorized cost divided by number of days in the care plan period automatically populates.
Immediately prior to HCBS enrollment, this client was in one of the following facility types:	Check box ☐ Nursing Facility ☐ Hospital	Required for CHCBS only Check the appropriate box.
Case Manager Name	Text	Required Enter the name of the Case Manager.
Case Manager Signature	Text	Required Signature of Case Manager.
Agency	Text	Required Enter the name of the case management agency.
Phone #	10 Numbers 123-456-7890	Required Enter the phone number of the Case Manager.
Email	Text	Required Enter the email address of the Case Manager.

Field Label	Completion Format	Instructions
Date	6 Numbers (MM/DD/YY)	Required Enter the date completed.

HCBS-CHCBS PAR Example

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

REQUEST FOR CHILDREN HOME AND COMMUNITY BASED SERVICES (HCBS) PRIOR APPROVAL AND COST CONTAINMENT

CHCBS-U5

COLORADO Department of Health Care Policy & Financing

HCBS - Children's Home and Community Based Services (CHCBS) Waiver

PA Number being revised:

Revision? ☐ Yes ☑ No

1. MEMBER NAME		2. MEMBER ID	3. SEX	4. BIRTHDATE
Member, Ima		A12345	☐ M ☑ F	7/7/2007
5. REQUESTING PROVIDER #	6. MEMBER'S COUNTY	7. CASE NUMBER (AGENCY USE)	8. DATES COVERED	
00112233			From: 07/05/16	Through: 07/04/17

STATEMENT OF REQUESTED SERVICES

9. Description	10. Provider	11. Modifier	12. Max # Units	13. Cost Per Unit	14. Total $ Authorized	15. Comments:
T1016 CHCBS Case Management (U5)			90	$8.43	$758.70	
H0038 IHHS Health Maintenance Activities (U5)			4928	$7.09	$34,939.52	
A						
B						

16. TOTAL AUTHORIZED HCBS EXPENDITURES (SUM OF AMOUNTS IN COLUMN 14 ABOVE)	$35,698.22
17. NUMBER OF DAYS COVERED (FROM FIELD 8 ABOVE)	365
18. AVERAGE COST PER DAY (Member's maximum authorized cost divided by number of days in the care plan period)	$97.80
A. Monthly State Cost Containment Amount	$6,084.00
B. Divided by 30.42 days = Daily Cost Containment Ceiling	$200.00

19. Immediately prior to HCBS enrollment, this member was in one of the following facility types: ☐ Nursing Facility ☑ Hospital

20. CASE MANAGER NAME	21. AGENCY	22. PHONE #	23. EMAIL	24. DATE
Jane Doe 20A. CASE MANAGER SIGNATURE: Jane Doe	AAA	303-111-2222	Jane.Doe@AAA.com	7/1/2016

DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY

25. CASE PLAN: ☐ Approved Date: ☐ Denied Date: Return for correction- Date:

26. REGULATION(S) upon which Denial or Return is based:

27. DEPARTMENT APPROVAL SIGNATURE: 28. DATE:

1 of 2 HCBS-CHCBS Revised: 11/13/14

HCBS-CLLI PAR Example

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

REQUEST FOR CHILDREN HOME AND COMMUNITY BASED SERVICES (HCBS) PRIOR APPROVAL AND COST CONTAINMENT

CLLI-UD

COLORADO Department of Health Care Policy & Financing

HCBS - Children with Life Limiting Illness (CLLI) Waiver

PA Number being revised:

Revision? ☐ Yes ☑ No

1. MEMBER NAME		2. MEMBER ID	3. SEX	4. BIRTHDATE	
Member, Ima		1212121	☐ M ☑ F	1/1/2010	
5. REQUESTING PROVIDER #	6. MEMBER'S COUNTY	7. CASE NUMBER (AGENCY USE)	8. DATES COVERED		
0101010101	Jefferson		From:	06/01/16	Through: 05/31/17

STATEMENT OF REQUESTED SERVICES

9. Description	10. Provider	11. Modifier	12. Max # Units	13. Cost Per Unit	14. Total $ Authorized	15. Comments:
H2032 Art and Play Therapy (UD)		HA	30	$15.41	$462.30	
H2032 Art and Play Therapy Group (UD)		HA, HQ				
H2032 Music Therapy (UD)		-				
H2032 Music Therapy Group (UD)		HQ	30	$8.63	$258.90	
97124 Massage Therapy (UD)		-				
G9012 Care Coordination (UD)		-				
S9123 Pain and Symptom Management (UD)		-				
S5150 Respite Care - Unskilled (4 hours or less) (UD)		-				
S5151 Respite Care - Unskilled (4 hours or more) (UD)		-				
T1005 Respite Care - CNA (4 hours or less) (UD)		-				
S9125 Respite Care - CNA (4 hours or more) (UD)		-				
T1005 Respite Care - Skilled RN, LPN (4 hours or less) (UD)		TD				
S9125 Respite Care - Skilled RN, LPN (4 hours or more) (UD)		TD				
S0257 Bereavement Counseling (UD)		HK				
S0257 Therapeutic Life Limiting Illness Support - Individual (UD)		-				
S0257 Therapeutic Life Limiting Illness Support - Family (UD)		HR				
S0257 Therapeutic Life Limiting Illness Support - Group (UD)		HQ				
A						
B						

16. TOTAL AUTHORIZED HCBS EXPENDITURES (SUM OF AMOUNTS IN COLUMN 14 ABOVE)	$721.20
17. NUMBER OF DAYS COVERED (FROM FIELD 8 ABOVE)	365
18. AVERAGE COST PER DAY (Member's maximum authorized cost divided by number of days in the care plan period)	$1.98
A. Monthly State Cost Containment Amount	$6,084.00
B. Divided by 30.42 days = Daily Cost Containment Ceiling	$200.00

19. CASE MANAGER NAME	20. AGENCY	21. PHONE #	22. EMAIL	23. DATE
John Doe 19A. CASE MANAGER SIGNATURE *John Doe*	BBB	303-111-2222	John.Doe@BBB.com	6/1/2016

DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY

24. CASE PLAN: ☐ Approved Date: ☐ Denied Date: Return for correction- Date:

25. REGULATION(S) upon which Denial or Return is based:

26. DEPARTMENT APPROVAL SIGNATURE: 27. DATE:

1 of 2 HCBS-CLLI Revised: 11/13/14

HCBS-CWA PAR Example

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

REQUEST FOR CHILDREN HOME AND COMMUNITY BASED SERVICES (HCBS) PRIOR APPROVAL AND COST CONTAINMENT

COLORADO Department of Health Care Policy & Financing

HCBS - Children with Autism (CWA) Waiver

CWA-UL

PA Number being revised:

Revision? ☐ Yes ☑ No

1. MEMBER NAME		2. MEMBER ID	3. SEX	4. BIRTHDATE
Member, Ima		A1234567	☐ M ☑ F	
5. REQUESTING PROVIDER #	6. MEMBER'S COUNTY	7. CASE NUMBER (AGENCY USE)	8. DATES COVERED	
555555555	Adams		From: 07/01/16	Through: 06/30/17

STATEMENT OF REQUESTED SERVICES

9. Description	10. Provider	11. Modifier	12. Max # Units	13. Cost Per Unit	14. Total $ Authorized	15. Comments:
H0004 Behavior Therapies, Lead Therapist (UL)			196	$23.31	$4,568.76	
H0004 Behavior Therapies, Senior Therapist (UL)		HN	1600	$12.14	$19,424.00	
H2019 Behavior Therapies, Line Staff (UL)						
H2000 Ongoing Treatment Evaluations (UL)						
H2000 Post Service Evaluation (UL)		TS				
A						
B						

16. TOTAL AUTHORIZED HCBS EXPENDITURES (SUM OF AMOUNTS IN COLUMN 14 ABOVE)	$23,992.76
17. NUMBER OF DAYS COVERED (FROM FIELD 8 ABOVE)	365
18. AVERAGE COST PER DAY (Member's maximum authorized cost divided by number of days in the care plan period)	$65.73
A. Monthly State Cost Containment Amount	$6,084.00
B. Divided by 30.42 days = Daily Cost Containment Ceiling	$200.00

19. CASE MANAGER NAME	20. AGENCY	21. PHONE #	22. EMAIL	23. DATE
Jane Doe 19A. CASE MANAGER SIGNATURE *Jane Doe*	CCC	111-222-3333	Jane.Doe@CCC.com	7/1/2016

DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY

24. CASE PLAN: ☐ Approved Date: ☐ Denied Date: Return for correction- Date:

25. REGULATION(S) upon which Denial or Return is based:

26. DEPARTMENT APPROVAL SIGNATURE: 27. DATE:

1 of 2 HCBS-CWA Revised: 11/13/14

Claim Submission

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. Certain Provider Types are not able to obtain an NPI. Those providers will be assigned a Health First Colorado provider number.

Paper Claims

Electronic claims format shall be required unless hard copy claims submittals are specifically prior authorized by the Department. Requests may be sent to DXC Technology (DXC), P.O. Box 30, Denver, CO 80201-0030. The following claims can be submitted on paper and processed for payment:

- Claims from providers who consistently submit five (5) claims or fewer per month (requires prior approval)
- Claims that, by policy, require attachments
    - Note: Attachments can be submitted electronically
- Reconsideration claims

Paper claims require an NPI for those provider types that can obtain one. Providers that cannot obtain an NPI are required to use and assigned Health First Colorado provider number on their claims. 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 EDI support section of the Department's website (edi-support)
- Online Portal User Guide (via within the Online Portal)

The Health First Colorado collects electronic claim information interactively through the Health First Colorado Secure Online Portal (Online Portal) or via batch submission through a host system. Please refer to the Colorado General Provider Information Manual for additional electronic information.

Interactive Claim Submission and Processing

Interactive claim submission through the Online Portal is a real-time exchange of information between the provider and the Health First Colorado. Health First Colorado 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 Health First Colorado Online Portal (OP).

The Online Portal contains training, user guides and help that describe claim completion requirements, edits that verify the format and validity of the entered information, and edits that assure that required fields are completed.

The Health First Colorado OP reviews the claim information for compliance with Health First Colorado billing policy and passes the claim to the Colorado interChange system for adjudication and reporting on the Health First Colorado Provider Remittance Advice (RA).

The OP immediately returns a response to the provider about that single transaction indicating whether the claim will be rejected, suspended or paid.

- If the claim is rejected, the OP sends a rejection response that identifies the rejection reason. The rejected claim can immediately be resubmitted.
- If the claim is suspended then it needs additional manual review by the Fiscal Agent.
- If the claim is accepted, the provider receives a message indicating that the claim is will be paid.

The Online 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 Remittance Advice to providers. The Online Portal also provides access to reports and transactions generated from claims submitted via paper and through electronic data submission methods other than the Online Portal. The reports and transactions include:

- Accept/Reject Report
- Remittance Advice
- 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 Online Portal. Access the Online Portal through Secured Site at colorado.gov/hcpf. For help with claim submission via the Online Portal, please choose the *User Guide* option available for each Online Portal transaction.

For additional electronic billing information, please refer to the appropriate Companion Guide located in the Provider Services Specifications section of the Department's 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 Health First Colorado members. The procedure codes represent services that may be provided by enrolled certified Health First Colorado providers.

The Healthcare Common Procedural Coding System (HCPCS) is divided into two principal subsystems, referred to as level I and level II of the HCPCS. Level I of the HCPCS is comprised of 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 4 numeric digits. CPT codes are identified using 5 numeric digits.

Children's Home and Community Based Services (CHCBS)

The Children's Home and Community Based Services (CHCBS) waiver program is for medically fragile children who are at risk of institutionalization in a hospital or skilled nursing facility, and would not otherwise qualify for Health First Colorado services due to parental income and/or resources. All state plan Health First Colorado benefits are provided to children birth through age 17. The children must meet the established minimum criteria for hospital or skilled nursing facility level of care. Members that meet program eligibility requirements receive an annual long term care certification by their case manager (can be a Single Entry Point, Community Centered Board, or Private Case Management Agency).

CHCBS Procedure Code Table

Providers may bill the following procedure codes for HCBS-CHCBS services:

HCBS-CHCBS Procedure Code Table			
Case Management (HCBS – CM)			
Description	**Procedure Code + Modifier(s)**		**Units**
Case Management	T1016	U5	1 unit = 15 minutes

In-Home Support Services (IHSS)

IHSS within the CHCBS waiver is limited to health maintenance activities, which include support for activities of daily living or instrumental activities of daily living. Additionally, IHSS providers must provide core independent living skills.

HCBS-CHCBS Procedure Code Table			
In-Home Support (HCBS-IHSS)			
Description	**Procedure Code + Modifier(s)**		**Units**
Health Maintenance Activities	H0038	U5	1 unit = 15 minutes

Home and Community Based Services for Children with Life Limiting Illness (CLLI)

The Home and Community Based Services for Children with Life Limiting Illness (CLLI) Waiver is for children from birth through age 18 with a medical diagnosis of a life-limiting illness who meet the institutional level of care for inpatient hospitalization. Level of care determinations are conducted annually by the Single Entry Point case management agencies. Services include Bereavement Counseling, Expressive Therapy (Art, Play, and Music), Massage Therapy, Palliative/Supportive Care (Care Coordination and Pain & Symptom Management), Respite Care, and Therapeutic Life Limiting Illness Support Services. Members that are enrolled in the waiver also have access to all state plan Health First Colorado benefits, including curative care. There is no requirement for a nine-month terminal prognosis.

HCBS-CLLI Procedure Code Table

Providers may bill the following procedure codes for HCBS-CLLI services**:**

HCBS-CLLI Procedure Code Table				
Description	Procedure Code + Modifier(s)		Place of Service	Units
Art and Play Therapy	H2032	UD, HA	11 - Office 12 - Home	1 unit = 15 minutes
Art and Play Therapy - Group	H2032	UD, HA, HQ	11 - Office 12 - Home	1 unit = 15 minutes
Music Therapy	H2032	UD	11 - Office 12 - Home	1 unit = 15 minutes
Music Therapy - Group	H2032	UD, HQ	11 - Office 12 - Home	1 unit = 15 minutes
Massage Therapy	97124	UD	11 - Office 12 - Home	1 unit = 15 minutes
Care Coordination	G9012	UD	11 - Office 12 - Home	1 unit = 15 minutes
Pain and Symptom Management	S9123	UD	12 – Home 11 - Office 34 - Hospice	1 unit = 1 hour
Respite Care – Unskilled (4 hours or less)	S5150	UD	12 - Home	1 unit = 15 minutes
Respite Care – Unskilled (4 hours or more)	S5151	UD	12 - Home	1 unit = 1 day
Respite Care – CNA (4 hours or less)	T1005	UD	12 - Home	1 unit = 15 minutes
Respite Care – CNA (4 hours or more)	S9125	UD	12 - Home	1 unit = 1 day
Respite Care - Skilled RN, LPN (4 hours or less)	T1005	UD, TD	12 - Home	1 unit = 15 minutes
Respite Care - Skilled RN, LPN (4 hours or more)	S9125	UD, TD	12 - Home	1 unit = 1 day
Bereavement Counseling	S0257	UD, HK	12 – Home 11 - Office	1 unit = lump sum
Therapeutic Life Limiting Illness Support – Individual	S0257	UD	12 – Home 11 - Office	1 unit = 15 minutes
Therapeutic Life Limiting Illness Support – Family	S0257	UD, HR	12 – Home 11 - Office	1 unit = 15 minutes

HCBS-CLLI Procedure Code Table				
Description	**Procedure Code + Modifier(s)**		**Place of Service**	**Units**
Therapeutic Life Limiting Illness Support - Group	S0257	UD, HQ	12 – Home 11 - Office	1 unit = 15 minutes

Service Limitations

Reimbursement for HCBS-CLLI Therapeutic Life Limiting Illness Support services (S0257 with any "UD" modifier) shall be limited to 98 hours per annual certification. Reimbursement for HCBS-CLLI respite care services (T1005, S9125, S5150 and S5151) shall be limited to 30 days (unique dates of service) per annual certification. Reimbursement for HCBS-CLLI respite care services (T1005, S9125, S5150 and S5151) shall not be duplicated at the same time of service as state plan Home Health or Palliative/Supportive Care services (S9123) and shall be denied. Expressive Therapy (H2032 – Art, Play, and Music) is limited to 39 hours per annual certification. Massage Therapy (97124) is limited to 24 hours per annual certification.

Home and Community Based Services for Children with Autism (HCBS-CWA)

The Home and Community Based Services for Children with Autism (HCBS-CWA) waiver program is for children from birth through age 5 with a medical diagnosis of autism. The children must meet the institutional level of care for an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID). Level of care determinations are made annually by the Community Centered Board. Eligible children qualify for behavioral therapies provided through the waiver as well as for all state plan Health First Colorado benefits. Eligible children may not access behavioral therapy through the waiver and through the State Plan simultaneously. Note: There is a limit of $25,000 annually per child for CWA services.

HCBS-CWA Procedure Code Table

Providers may bill the following procedure codes for HCBS-CWA services:

HCBS-CWA Procedure Code Table			
Description	**Procedure Code + Modifier(s)**		**Units**
Behavioral Therapies, Lead Therapist	H0004	U2	1 unit = 15 minutes
Behavioral Therapies, Senior Therapist	H0004	U2, HN	1 unit = 15 minutes
Behavioral Therapies, Line Staff	H2019	U2	1 unit = 15 minutes
Initial/ Ongoing Treatment Evaluation	H2000	U2	1 unit = 15 minutes
Post Service Evaluation	H2000	U2, TS	1 unit = 15 minutes

CHCBS, CLLI, and CWA Paper Claim Reference Table

The following paper form reference table gives required and/or conditional fields for the paper CMS 1500 claim form for HCBS-CHCBS, CLLI, and CWA claims:

CMS Field #	Field Label	Field is?	Instructions
1	**Insurance Type**	Required	Place an "X" in the box marked as Medicaid.
1a	**Insured's ID Number**	Required	Enter the member's Health First Colorado seven-digit Medicaid ID number as it appears on the Medicaid Identification card. Example: A123456.
2	**Patient's Name**	Required	Enter the member's last name, first name, and middle initial.
3	**Patient's Date of Birth / Sex**	Required	Enter the member's birth date using two digits for the month, two digits for the date, and two digits for the year. Example: 070115 for July 1, 2015. Place an "X" in the appropriate box to indicate the sex of the member.
4	**Insured's Name**	Not Required	
5	**Patient's Address**	Not Required	
6	**Patient's Relationship to Insured**	Not Required	
7	**Insured's Address**	Not Required	
8	**Reserved for NUCC Use**		
9	**Other Insured's Name**	Not Required	

CMS Field #	Field Label	Field is?	Instructions
9a	**Other Insured's Policy or Group Number**	Not Required	
9b	**Reserved for NUCC Use**		
9c	**Reserved for NUCC Use**		
9d	**Insurance Plan or Program Name**	Not Required	
10a-c	**Is Patient's Condition Related to?**	Not Required	
10d	**Reserved for Local Use**		
11	**Insured's Policy, Group or FECA Number**	Not Required	
11a	**Insured's Date of Birth, Sex**	Not Required	
11b	**Other Claim ID**	Not Required	
11c	**Insurance Plan Name or Program Name**	Not Required	
11d	**Is there another** Health **Benefit** Plan**?**	Not Required	
12	**Patient's or Authorized Person's signature**	Required	Enter "Signature on File", "SOF", or legal signature. If there is no signature on file, leave blank or enter "No Signature on File". Enter the date the claim form was signed.

CMS Field #	Field Label	Field is?	Instructions
13	**Insured's or Authorized Person's Signature**	Not Required	
14	**Date of Current Illness Injury or Pregnancy**	Not Required	
15	**Other Date**	Not Required	
16	**Date Patient Unable to Work in Current Occupation**	Not Required	
17	**Name of Referring Physician**	Conditional	
18	**Hospitalization Dates Related to Current Service**	Not Required	
19	**Additional Claim Information**	Conditional	
20	**Outside Lab?** **$ Charges**	Not Required	
21	**Diagnosis or Nature of Illness or Injury**	Required	Enter at least one but no more than twelve diagnosis codes based on the member's diagnosis/condition. Enter applicable ICD indicator to identify which version of ICD codes is being reported. 0 ICD-10-CM (DOS 10/1/15 and after) 9 ICD-9-CM (DOS 9/30/15 and before) **HCBS** CHCBS and CLLI may use R69 CWA may use F84.0

CMS Field #	Field Label	Field is?	Instructions
22	**Medicaid Resubmission Code**	Conditional	List the original reference number for adjusted claims. When resubmitting a claim as a replacement or a void, enter the appropriate bill frequency code in the left-hand side of the field. 7 Replacement of prior claim 8 Void/Cancel of prior claim This field is not intended for use for original claim submissions.
23	**Prior Authorization**	Not Required	**HCBS** Leave blank
24	**Claim Line Detail**	Information	The paper claim form allows entry of up to six detailed billing lines. Fields 24A through 24J apply to each billed line. **Do not enter more than six lines of information** on the paper claim. If more than six lines of information are entered, the additional lines will not be entered for processing. Each claim form must be fully completed (totaled). **Do not file continuation claims** (e.g., Page 1 of 2).
24A	**Dates of Service**	Required	The field accommodates the entry of two dates: a "From" date of services and a "To" date of service. Enter the date of service using two digits for the month, two digits for the date and two digits for the year. Example: 010116 for January 1, 2016 From: **01 01 16** To: (blank) Or From: **01 01 16** To: **01 01 16** Span dates of service From: **01 01 16** To: **01 31 16** Single Date of Service: Enter the six digit date of service in the "From" field. Completion of the "To field is not required.

CMS Field #	Field Label	Field is?	Instructions
			Do not spread the date entry across the two fields. Span billing: permissible if the same service (same procedure code) is provided on consecutive dates.
24B	**Place of Service**	Required	Enter the Place of Service (POS) code that describes the location where services were rendered. The Health First Colorado accepts the CMS place of service codes. 03 School 11 Office 12 Home 34 Hospice
24C	**EMG**	Not Required	
24D	**Procedures, Services, or Supplies**	Required	Enter the HCPCS procedure code that specifically describes the service for which payment is requested. **HCBS** Refer to the CHCBS, CLLI or CWA procedure code tables.
24D	**Modifier**	Conditional	Enter the appropriate procedure-related modifier that applies to the billed service. Up to four modifiers may be entered when using the paper claim form. **HCBS** Refer to the CHCBS, CLLI or CWA procedure code tables.
24E	Diagnosis **Pointer**	Required	Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis. At least one diagnosis code reference letter must be entered. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. This field allows for the entry of 4 characters in the unshaded area.

CMS Field #	Field Label	Field is?	Instructions
24F	**$ Charges**	Required	Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number. Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one procedure from the same group is billed, special multiple pricing rules apply. The base procedure is the procedure with the highest allowable amount. The base code is used to determine the allowable amounts for additional CPT surgical procedures when more than one procedure from the same grouping is performed. Submitted charges cannot be more than charges made to non-Health First Colorado covered individuals for the same service. Do not deduct Health First Colorado co-payment or commercial insurance payments from the usual and customary charges.
24G	**Days or Units**	Required	Enter the number of services provided for each procedure code. Enter whole numbers only- do not enter fractions or decimals.
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 Health First Colorado 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. **Home & Community Based Services** Combine units of services for a single procedure code for the billed time period on one 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.

CMS Field #	Field Label	Field is?	Instructions
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 #**	Required	In the shaded portion of the field, enter the NPI of the Colorado Medicaid provider assigned to the individual who actually performed or rendered the billed service. This number cannot be assigned to a group or clinic.
25	**Federal Tax ID Number**	Not Required	
26	**Patient's Account Number**	Optional	Enter information that identifies the member or claim in the provider's billing system. Submitted information appears on the Remittance Advice (RA).
27	**Accept Assignment?**	Required	The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.
28	**Total Charge**	Required	Enter the sum of all charges listed in field 24F. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
29	**Amount Paid**	Not Required	
30	**Rsvd for NUCC Use**		

CMS Field #	Field Label	Field is?	Instructions
31	**Signature of Physician or Supplier Including Degrees or Credentials**	Required	Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent. A holographic signature stamp may be used if authorization for the stamp is on file with the fiscal agent. An authorized agent or representative may sign the claim for the enrolled provider if the name and signature of the agent is on file with the fiscal agent. Each claim must have the date the enrolled provider or registered authorized agent signed the claim form. Enter the date the claim was signed using two digits for the month, two digits for the date and two digits for the year. Example: 070115 for July 1, 2015. **Unacceptable signature alternatives:** Claim preparation personnel may not sign the enrolled provider's name. Initials are not acceptable as a signature. Typed or computer printed names are not acceptable as a signature. "Signature on file" notation is not acceptable in place of an authorized signature.
32	**32- Service Facility Location Information** **32a- NPI Number** **32b- Other ID #**	Conditional	Complete for services provided in a hospital or nursing facility in the following format: 1st Line Facility Name 2nd Line Address 3rd Line City, State and ZIP Code 32a- NPI Number Enter the NPI of the service facility (if known).
33	**33- Billing Provider Info & Ph #** **33a- NPI Number** **33b- Other ID #**	Required	Enter the name of the individual or organization that will receive payment for the billed services in the following format: 1st Line Name 2nd Line Address 3rd Line City, State and ZIP Code 33a- NPI Number Enter the NPI of the billing provider

CMS 1500 CHCBS Claim Example

HEALTH INSURANCE CLAIM FORM

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

PICA PICA

CARRIER

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): D444444

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Client, Ima A

3. PATIENT'S BIRTH DATE MM DD YY: 10 16 11 SEX M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED Signature on File DATE 10/1/16

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

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. R69 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 CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 10	01	16	10	01	16	12		T1016	U5	A	33 72	4		NPI	
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. Optional

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE $ 33 72

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Signature DATE 10/16

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

CHCBS Provider
100 Any Street
Any City

a. b. 1234567890

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

CMS 1500 HCBS-CLLI Claim Example

HEALTH INSURANCE CLAIM FORM

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

PICA | PICA | CARRIER

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): D444444

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Client, Ima A

3. PATIENT'S BIRTH DATE (MM DD YY): 10 16 11 SEX: M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) / CITY / STATE / ZIP CODE / TELEPHONE (Include Area Code)

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street) / CITY / STATE / ZIP CODE / TELEPHONE (Include Area Code)

8. RESERVED FOR NUCC USE

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? YES NO PLACE (State); c. OTHER ACCIDENT? YES NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH (MM DD YY) SEX M F

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO X — If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: Signature on File DATE: 10/1/16

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) QUAL.

15. OTHER DATE QUAL.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. R69 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 CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 01 16	10 01 16	12		S9125	UD	A	155 29	1		NPI	
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: Optional

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE: $ 155 29

29. AMOUNT PAID: $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED: Signature DATE: 10/16

32. SERVICE FACILITY LOCATION INFORMATION a. b.

33. BILLING PROVIDER INFO & PH # ( )

CLLI Provider
100 Any Street
Any City

a. b. 1234567890

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PATIENT AND INSURED INFORMATION | PHYSICIAN OR SUPPLIER INFORMATION

CMS 1500 HCBS-CWA Claim Example

HEALTH INSURANCE CLAIM FORM

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

PICA PICA

CARRIER

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): D444444

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Client, Ima A

3. PATIENT'S BIRTH DATE MM DD YY: 10 16 11 SEX M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED Signature on File DATE 10/1/16

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

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. R69 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 01 16	10 01 16	12		S9125	UD	A	155 29	1		NPI	
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. Optional

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE $ 155 29

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Signature DATE 10/16

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

CLLI Provider
100 Any Street
Any City

a. b. 1234567890

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Timely Filing

The Health First Colorado Late Bill Override Date (LBOD) allows providers to document compliance with timely filing requirements when the initial timely filing period has expired. Health First Colorado 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.

HCBS-CHCBS, CWA, and CLLI Specialty Manuals Revisions Log

Revision Date	*Section/Action*	*Pages*	*Made by*
12/01/2016	*Manual revised for interChange implementation. For manual revisions prior to 12/01/2016, please refer to Archive.*	*All*	*HPE (now DXC)*
12/27/2016	*Updates based on Colorado iC Stage II Provider Billing Manuals Comment Log v0_2.xlsx*	*10, 14, 18*	*HPE (now DXC)*
1/10/2017	*Updates based on Colorado iC Stage II Provider Billing Manual Comment Log v0_3.xlsx*	*Multiple*	*HPE (now DXC)*
1/19/2017	*Updates based on Colorado iC Stage II Provider Billing Manual Comment Log v0_4.xlsx*	*Multiple*	*HPE (now DXC)*
1/26/2017	*Updates based on Department 1/20/2017 approval email*	*Accepted tracked changes throughout*	*HPE (now DXC)*
2/10/2017	*Removed all references to Special Program Codes*	*Throughout*	*RC*
3/13/2017	*Changed Modifier code from UL to U2*	*14*	*RC*
5/26/2017	*Updates based on Fiscal Agent name change from HPE to DXC*	*10*	*DXC*

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.*