Home and Community Based Services for Persons with Developmental Disabilities Waiver Programs

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Program Overview

The Home and Community Based Services (HCBS) waiver programs provide Colorado Medical Assistance Program members who meet special eligibility criteria access to additional services in their homes and communities as an alternative to institutional care. The Home and Community Based Services programs for person with developmental disabilities include:

- Home and Community Based Services for Persons with Developmental Disabilities Waiver (HCBS-DD)
- HCBS- Supported Living Services (HCBS-SLS)
- HCBS- Children's Extensive Support (HCBS- CES)
- Targeted Case Management– State Plan Benefit (TCM)

Level of care determinations are made annually by the case management agencies (aka Community Centered 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 nursing facility, hospital, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). 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, ICF/IID, and long-term hospital care. When a member chooses to receive services under a waiver, the services must be provided by certified Medicaid providers.

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

Persons with Developmental Disabilities Waiver (HCBS-DD)

The HCBS-DD Waiver provides persons with developmental disabilities access to services and supports 24 hours a day to allow them to a live safely and participate in their community. Services include:

- Residential Habilitation
- Day Habilitation Services and Supports (includes Specialized Habilitation and Supported Community Connections)
- Prevocational Services
- Supported Employment Services
- Non-Medical Transportation Services
- Behavioral Services
- Specialized Medical Equipment and Supplies
- Dental Services
- Vision Services

Supported Living Services (SLS)

The HCBS-SLS Waiver provides services and supports to assist persons with developmental disabilities to live in the person's own home, apartment, family home, or rental unit that qualifies as an SLS setting. Services include:

- Personal Care
- Respite
- Homemaker
  - Basic
  - Enhanced
- Mentorship
- Day habilitation Services
  - Specialized Habilitation
  - Supported Community Connections
  - Prevocational Services
- Supported Employment Services
- Non-Medical Transportation
- Behavioral Services
- Professional services
  - Hippotherapy
  - Movement Therapy
  - Massage Therapy
- Personal Emergency Response System (PERS)
- Home Accessibility Adaptations
- Vehicle Modifications
- Assistive Technology
- Dental Services
- Vision Services
- Specialized Medical Equipment and Supplies

Children's Extensive Support (CES)

The HCBS-CES Waiver is for children ages birth to 18 with developmental disabilities *or* for children ages four (4) and under who are at risk of a developmental delay. Services include:

- Personal Care
- Respite
- Homemaker
  - Basic
  - Enhanced
- Community Connector
- Behavioral Services
- Professional Services
  - Hippotherapy
  - Movement Therapy
  - Massage Therapy
- Specialized Medical Equipment and Supplies
- Adapted Therapeutic Recreational Equipment and Fees
- Home Accessibility Adaptations
- Vehicle Modifications
- Assistive Technology
- Vision Services
- Parent Education

Early Intervention Services (EI)

Early Intervention Services provides developmental supports and services to children birth to three (3) years of age who have either a significant developmental delay or a diagnosed condition that has a high probability of resulting in a developmental delay and are determined to be eligible for the program.

Targeted Case Management (TCM) Services are provided through the Community Centered Boards (CCB) for children actively enrolled in Early Intervention Services program and the Colorado Medical Assistance Program.

Targeted Case Management (TCM)

Targeted Case Management is an optional Colorado Medical Assistance Program benefit for members who have been determined by a CCB to have a developmental disability and are actively enrolled in one of the programs listed below:

- Persons with Developmental Disabilities (HCBS-DD) Waiver
- Supported Living Services (HCBS-SLS) Waiver
- Children's Extensive Support (HCBS-CES) Waiver
- Early Intervention Program (EI)

Services include, but are not limited to:

- Locating, coordinating, and monitoring needed developmental disabilities services;
- Coordinating with other non-developmental disabilities funded services to ensure non-duplication of services; and
- Monitoring the effective and efficient provision of services across multiple funding sources.

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/CCB's 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). The telephone numbers for the aforementioned Departments are listed in Appendix A on the Department's website (colorado.gov/hcpf)→ Provider Services → For Our Providers → Billing Manuals→ Appendices→ Appendix A.

The case management agencies/single entry points transmit electronic PAR information to the Medicaid Management Information System (MMIS) for the HCBS-DD Waiver, HCBS-SLS Waiver, HCBS-CES Waiver, and TCM authorizations through the DDDWeb/CCMS application.

The CMAs/CCBs 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 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 located on the Department's website→ Provider Services→ Billing Manuals→ Appendices→ Appendix D.
- 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/CCB is responsible for timely submission and distribution of copies of approvals to agencies and providers contracted to provide services.

PAR Submission

Prior Authorization Requests are submitted electronically via the DDD Web/CCMS Application located on the Department of Human Services website (colorado.gov/cdhs)→ Developmental Disabilities→ DDDWeb.

Claim Submission

Paper Claims

Electronic claims format shall be required unless hard copy claims submittals are specifically authorized by 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

For more detailed CMS 1500 billing instructions, please refer to the CMS 1500 General Billing Information manual in the Provider Services Billing Manuals section.

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.

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 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.

HCBS-DD Procedure Code Table

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

HCBS-DD Procedure Code Table (Special Program Code 85)				
Persons with Developmental Disabilities (HCBS-DD)				
Description	**Proc. Code**	**Modifier(s)**	**Level**	**Unit Designation**
Residential Habilitation				
Group Residential Services and Supports (GRSS)	T2016	U3, HQ	Level 1	Day
	T2016	U3, 22, HQ	Level 2	Day
	T2016	U3, TF, HQ	Level 3	Day
	T2016	U3, TF, 22, HQ	Level 4	Day
	T2016	U3, TG, HQ	Level 5	Day
	T2016	U3, TG, 22, HQ	Level 6	Day
	T2016	U3, SC, HQ	Level 7	Day
Individual Residential Services and Supports (IRSS)	T2016	U3	Level 1	Day
	T2016	U3, 22	Level 2	Day
	T2016	U3, TF	Level 3	Day
	T2016	U3, TF, 22	Level 4	Day
	T2016	U3, TG	Level 5	Day
	T2016	U3, TG, 22	Level 6	Day
	T2016	U3, SC	Level 7	Day

HCBS-DD Procedure Code Table (Special Program Code 85)				
Persons with Developmental Disabilities (HCBS-DD)				
Description	**Proc. Code**	**Modifier(s)**	**Level**	**Unit Designation**
Individual Residential Services and Supports/Host Home (IRSS/HH)	T2016 T2016 T2016 T2016 T2016 T2016 T2016	U3, TT U3, 22, TT U3, TF, TT U3, TF, 22, TT U3, TG, TT U3, TG, 22, TT U3, SC, TT	Level 1 Level 2 Level 3 Level 4 Level 5 Level 6 Level 7	Day Day Day Day Day Day Day
Day Habilitation Services				
Specialized Habilitation	T2021 T2021 T2021 T2021 T2021 T2021 T2021	U3, HQ U3, 22, HQ U3, TF, HQ U3, TF, 22, HQ U3, TG, HQ U3, TG, 22, HQ U3, SC, HQ	Level 1 Level 2 Level 3 Level 4 Level 5 Level 6 Level 7	15 Minutes 15 Minutes 15 Minutes 15 Minutes 15 Minutes 15 Minutes 15 Minutes
Supported Community Connections	T2021 T2021 T2021 T2021 T2021 T2021 T2021	U3 U3, 22 U3, TF U3, TF, 22 U3, TG U3, TG, 22 U3, SC	Level 1 Level 2 Level 3 Level 4 Level 5 Level 6 Level 7	15 Minutes 15 Minutes 15 Minutes 15 Minutes 15 Minutes 15 Minutes 15 Minutes
Supported Employment *Job Development and Job Placement are available as waiver services only when those services are first denied by the Division of Vocational Rehabilitation (DVR) or those DVR services are not available to the member due to an order of selection (DVR waiting list)				
Job Coaching (Group)	T2019 T2019 T2019 T2019 T2019 T2019	U3, HQ U3, 22, HQ U3, TF, HQ U3, TF, 22, HQ U3, TG, HQ U3, TG, 22, HQ	Level 1 Level 2 Level 3 Level 4 Level 5 Level 6	15 Minutes 15 Minutes 15 Minutes 15 Minutes 15 Minutes 15 Minutes
Job Coaching (Individual)	T2019	U3, SC	All Levels	15 Minutes
Job Development (Group)	H2023	U3, HQ		
Job Development (Individual)	H2023 H2023 H2023	U3 U3, 22 U3, TF	Level 1-2 Level 3-4 Level 5-6	15 Minutes 15 Minutes 15 Minutes
Job Placement (Group)	H2024	U3, HQ	All Levels	Dollar
Job Placement (Individual)	H2024	U3	All Levels	Dollar
Pre Vocational Services	T2015 T2015 T2015 T2015 T2015	U3, HQ U3, 22, HQ U3, TF, HQ U3, TF, 22, HQ U3, TG, HQ	Level 1 Level 2 Level 3 Level 4 Level 5	15 Minutes 15 Minutes 15 Minutes 15 Minutes 15 Minutes

HCBS-DD Procedure Code Table (Special Program Code 85)				
Persons with Developmental Disabilities (HCBS-DD)				
Description	**Proc. Code**	**Modifier(s)**	**Level**	**Unit Designation**
	T2015	U3, TG, 22, HQ	Level 6	15 Minutes
Non-Medical Transportation (NMT)				
Other (Public Conveyance)	T2004	U3	Single	Dollar
Mileage Range 1 Mileage Range 2 Mileage Range 3	T2003 T2003 T2003	U3 U3, 22 U3, TF	0-10 miles 11-20miles > 20 miles	Trip Trip Trip
Behavioral Services				
Behavioral Line Staff	H2019	U3	Single	15 Minutes
Behavioral Consultation	H2019	U3, 22, TG	All Levels	15 Minutes
Behavioral Counseling (Individual)	H2019	U3, TF, TG	All Levels	15 Minutes
Behavioral Counseling (Group)	H2019	U3, TF, HQ	All Levels	15 Minutes
Behavioral Plan Assessment	T2024	U3, 22	All Levels	15 Minutes
Specialized Medical Equipment and Supplies				
Disposable Supplies	T2028	U3	All Levels	Dollar
Equipment	T2029	U3	All Levels	Dollar
Dental Services				
Basic/Preventative	D2999	U3	All Levels	Dollar
Major	D2999	U3, 22	All Levels	Dollar
Vision	V2799	U3	All Levels	Dollar

HCBS-SLS Procedure Code Table

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

Supported Living Services (SLS) (Special Program Code 92)				
Description	**Proc. Code**	**Modifier(s)**	**Level**	**Unit Designation**
Personal Care	T1019	U8	All Levels	15 Minutes
Respite Care				
Individual	S5150 S5151	U8 U8	All Levels All Levels	15 Minutes Day
Group	S5151	U8, HQ	All Levels	Dollar
Group Overnight (Camp)	T2036	U8	All Levels	Dollar
Homemaker				
Basic Enhanced	S5130 S5130	U8 U8, 22	All Levels All Levels	15 Minutes 15 Minutes
Mentorship	H2021	U8	All Levels	15 minutes

Supported Living Services (SLS) (Special Program Code 92)				
Description	**Proc. Code**	**Modifier(s)**	**Level**	**Unit Designation**
Day Habilitation				
Specialized Habilitation	T2021 T2021 T2021 T2021 T2021 T2021	U8, HQ U8, 22, HQ U8, TF, HQ U8, TF, 22, HQ U8, TG, HQ U8, TG, 22, HQ	Level 1 Level 2 Level 3 Level 4 Level 5 Level 6	15 Minutes 15 Minutes 15 Minutes 15 Minutes 15 Minutes 15 Minutes
Supported Community Connections	T2021 T2021 T2021 T2021 T2021 T2021	U8 U8, 22 U8, TF U8, TF, 22 U8, TG U8, TG, 22	Level 1 Level 2 Level 3 Level 4 Level 5 Level 6	15 Minutes 15 Minutes 15 Minutes 15 Minutes 15 Minutes 15 Minutes
Pre Vocational Services	T2005 T2005 T2005 T2005 T2005 T2005	U8, HQ U8, 22, HQ U8, TF, HQ U8, TF, 22, HQ U8, TG, HQ U8, TG, 22, HQ	Level 1 Level 2 Level 3 Level 4 Level 5 Level 6	15 Minutes 15 Minutes 15 Minutes 15 Minutes 15 Minutes 15 Minutes
Supported Employment *Job Development and Job Placement are available as waiver services only when those services are first denied by the Division of Vocational Rehabilitation (DVR) or those DVR services are not available to the member due to an order of selection (DVR waiting list).				
Job Coaching (Group)	T2019 T2019 T2019 T2019 T2019 T2019	U8, HQ U8, 22, HQ U8, TF, HQ U8, TF, 22, HQ U8, TG, HQ U8, TG, 22, HQ	Level 1 Level 2 Level 3 Level 4 Level 5 Level 6	15 Minutes 15 Minutes 15 Minutes 15 Minutes 15 Minutes 15 Minutes
Job Coaching (Individual)	T2019	U8, SC	All Levels	15 Minutes
SE Job Development- Group	H2023	U8, HQ	All Levels	15 Min.
SE Job Development- Individual	H2023 H2023 H2023	U8 U8, 22 U8, TF	Level 1-2 Level 3-4 Level 5-6	15 Min. 15 Min. 15 Min.
SE Job Placement- Group	H2024	U8, HQ	All Levels	Dollar
SE Job Placement- Individual	H2024	U8	All Levels	Dollar

Supported Living Services (SLS) (Special Program Code 92)				
Description	**Proc. Code**	**Modifier(s)**	**Level**	**Unit Designation**
Non-Medical Transportation (NMT)				
Day Program – Mileage Range 1 Day Program – Mileage Range 2 Day Program – Mileage Range 3	T2003 T2003 T2003	U8 U8, 22 U8, TF	0 to 10 11 to 20 21 and Up	Trip Trip Trip
Not Day Program	T2003	U8, SC	All Distances	Trip
Other (Public Conveyance)	T2004	U8	All Distances	Dollar
Behavioral Services				
Behavioral Line Staff	H2019	U8	All Levels	15 Minutes
Behavioral Consultation	H2019	U8, 22, TG	All Levels	15 Minutes
Behavioral Counseling (Individual)	H2019	U8, TF, TG	All Levels	15 Minutes
Behavioral Counseling (Group)	H2019	U8, TF, HQ	All Levels	15 Minutes
Behavioral Plan Assessment	T2024	All Levels	All Levels	15 Minutes
Professional Services				
Massage Therapy	97124	U8	All Levels	15 Minutes
Movement Therapy Bachelors Movement Therapy Masters	G0176 G0176	U8 U8, 22	All Levels	15 Minutes 15 Minutes
Hippotherapy- Individual Hippotherapy- Group	S8940 S8940	U8 U8, HQ	All Levels	15 Minutes 15 Minutes
Recreational Facility Fees/Passes	S5199	U8	All Levels	Dollar
Specialized Medical				
Supplies and Disposable	T2028	U8	All Levels	Dollar
Equipment	T2029	U8	All Levels	Dollar
Personal Emergency Response System (PERS)	S5161	U8	All Levels	Dollar
Home Accessibility Adaptations	S5165	U8	All Levels	Dollar
Vehicle Modifications	T2039	U8	All Levels	Dollar
Assistive Technology	T2035	U8	All Levels	Dollar
Dental Services				
Basic / Preventative	D2999	U8	All Levels	Dollar
Major	D2999	U8, 22	All Levels	Dollar
Vision Services	V2799	U8	All Levels	Dollar

CES Procedure Code Table

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

Children's Extensive Support (CES) (Special Program Code 90)			
Description	**Proc Code**	**Modifier(s)**	**Unit Designation**
Personal Care	T1019	U7	15 Minutes
Respite Care			
Individual	S5150 S5151	U7 U7	15 Minutes Day
Group	S5151	U7, HQ	Dollar
Group Overnight (Camp)	T2036	U7	Dollar
Homemaker			
Basic Enhanced	S5130 S5130	U7 U7, 22	15 Minutes 15 Minutes
Community Connector	H2021	U7	15 Minutes
Behavioral Services			
Behavioral Line Staff	H2019	U7	15 Minutes
Behavioral Consultation	H2019	U7, 22, TG	15 Minutes
Behavioral Counseling (Individual)	H2019	U7, TF, TG	15 Minutes
Behavioral Counseling (Group)	H2019	U7, TF, HQ	15 Minutes
Behavioral Plan Assessment	T2024	U7, 22	15 Minutes
Professional Services			
Massage Therapy	97124	U7	15 Minutes
Movement Therapy Bachelors Movement Therapy Masters	G0176 G0176	U7 U7, 22	15 Minutes 15 Minutes
Hippotherapy Individual Hippotherapy Group	S8940 S8940	U7 U7, HQ	15 Minutes 15 Minutes
Specialized Medical Equipment and Supplies			
Disposable Supplies Equipment	T2028 T2029	U7 U7	Dollar Dollar
Adapted Therapeutic Recreational			
Equipment Recreational Facility Fees/Passes	T1999 S5199	U7 U7	Dollar Dollar
Home Accessibility Adaptations	S5165	U7	Dollar
Vehicle Modifications	T2039	U7	Dollar
Assistive Technology	T2035	U7	Dollar
Vision Services	V2799	U7	Dollar
Parent Education	H1010	U7	Dollar / $1,000 Max. Year

TCM Procedure Code Table

Providers may bill the following procedure codes for TCM services:

Targeted Case Management (TCM)- CES, DD, SLS (Special Code 87)			
Description	**Proc Code**	**Modifier(s)**	**Unit Designation**
Targeted Case Management	T1017	U4	15 Minutes
Targeted Case Management- Early Intervention (Special Code 87)			
Description	**Proc Code**	**Modifier(s)**	**Unit Designation**
Targeted Case Management – Early Intervention Services	T1017	U4, HA	15 Minutes

HCBS- CES, DD, and SLS Paper Claim Reference Table

The following paper form reference table describes required fields for the paper CMS 1500 claim form for HCBS-CES, HCBS- DD, and HCBS- SLS 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 Colorado Medical Assistance Program seven-digit Medicaid ID number as it appears on the Medicaid Identification card. Example: A123456.
2	**Patient’s Name**	Required	Enter the member’s last name, first name, and middle initial.
3	**Patient’s Date of Birth / Sex**	Required	Enter the patient’s birth date using two digits for the month, two digits for the date, and two digits for the year. Example: 070114 for July 1, 2014. Place an “X” in the appropriate box to indicate the sex of the member.
4	**Insured’s Name**	Not Required	
5	**Patient’s Address**	Not Required	

CMS Field #	Field Label	Field is?	Instructions
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	
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	

CMS Field #	Field Label	Field is?	Instructions
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.
13	**Insured's or Authorized Person's Signature**	Not Required	
14	**Date of Current Illness Injury or Pregnancy**	Not Required	
15	**Other Date**	Not Required	
16	**Date Patient Unable to Work in Current Occupation**	Not Required	
17	**Name of Referring Physician**	Not Required	
18	**Hospitalization Dates Related to Current Service**	Not Required	
19	**Additional Claim Information**	Conditional	**LBOD** Use to document the Late Bill Override Date for timely filing.

CMS Field #	Field Label	Field is?	Instructions
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. 9 ICD-9-CM 0 ICD-10-CM **HCBS** DD,CES and SLS must use 799.9
22	**Medicaid Resubmission Code**	Conditional	List the original reference number for resubmitted claims. When resubmitting a claim, enter the appropriate bill frequency code in the left-hand side of the field. 7 Replacement of prior claim 8 Void/Cancel of prior claim This field is not intended for use for original claim submissions.
23	**Prior Authorization**	Not Required	**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

CMS Field #	Field Label	Field is?	Instructions
			the date and two digits for the year. Example: 010114 for January 1, 2014 From To 01 01 14 Or From To 01 01 14 01 01 14 Span dates of service From To 01 01 14 01 31 14 <u>Single Date of Service</u>: Enter the six digit date of service in the "From" field. Completion of the "To field is not required. Do not spread the date entry across the two fields. <u>Span billing</u>: permissible if the same service (same procedure code) is provided on consecutive dates.
24B	**Place of Service**	Required	Enter the Place of Service (POS) code that describes the location where services were rendered. The Colorado Medical Assistance Program accepts the CMS place of service codes. 12 Home
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 HCBS-DD, HCBS-CES or HCBS-SLS 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 HCBS-DD, HCBS-CES or HCBS-SLS procedure code tables.

CMS Field #	Field Label	Field is?	Instructions
24E	**Diagnosis Pointer**	Required	Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis. At least one diagnosis code reference letter must be entered. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. This field allows for the entry of 4 characters in the unshaded area.
24F	**$ Charges**	Required	Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number. Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one procedure from the same group is billed, special multiple pricing rules apply. The base procedure is the procedure with the highest allowable amount. The base code is used to determine the allowable amounts for additional CPT surgical procedures when more than one procedure from the same grouping is performed. Submitted charges cannot be more than charges made to non-Colorado Medical Assistance Program covered individuals for the same service. Do not deduct Colorado Medical Assistance Program co-payment or commercial insurance payments from the usual and customary charges.
24G	**Days or Units**	Required	Enter the number of services provided for each procedure code. Enter whole numbers only- do not enter fractions or decimals.
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

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

CMS Field #	Field Label	Field is?	Instructions
29	**Amount Paid**	Not Required	
30	**Rsvd for NUCC Use**		
31	**Signature of Physician or Supplier Including Degrees or Credentials**	Required	Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent. A holographic signature stamp may be used if authorization for the stamp is on file with the fiscal agent. An authorized agent or representative may sign the claim for the enrolled provider if the name and signature of the agent is on file with the fiscal agent. Each claim must have the date the enrolled provider or registered authorized agent signed the claim form. Enter the date the claim was signed using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. **Unacceptable signature alternatives:** Claim preparation personnel may not sign the enrolled provider's name. Initials are not acceptable as a signature. Typed or computer printed names are not acceptable as a signature. "Signature on file" notation is not acceptable in place of an authorized signature.
32	**32- Service Facility Location Information** **32a- NPI Number** **32b- Other ID #**	Not Required	
33	**33- Billing Provider Info & Ph #** **33a- NPI Number**	Required	Enter the name of the individual or organization that will receive payment for the billed services in the following format: 1st Line Name

CMS Field #	Field Label	Field is?	Instructions
	33b- Other ID #		2nd Line Address 3rd Line City, State and ZIP Code 33a- NPI Number Not Required 33b- Other ID # Enter the eight-digit Colorado Medical Assistance Program provider number of the individual or organization.

CMS 1500 HCBS-DD Claim Example

HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

3. PATIENT'S BIRTH DATE MM 10 DD 16 YY 45 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 [ ] NO [X] If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED Signature on File DATE 1/1/15

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

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

15. OTHER DATE 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. 9

A. 799.9 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	01	01	15	01	01	15	12		T2019	U3	SC		A	49 96	4		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) YES [X] NO [ ]

28. TOTAL CHARGE $ 49 96

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED Signature DATE 1/1/15

32. SERVICE FACILITY LOCATION INFORMATION a. b.

33. BILLING PROVIDER INFO & PH # ( )
HCBS DD Provider
100 Any Street
Any City
a. b. 04567890

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

CMS 1500 HCBS-SLS Claim Example

HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

3. PATIENT'S BIRTH DATE MM 10 DD 16 YY 45 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 1/1/15

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

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

15. OTHER DATE 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. 9

A. 799.9 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	01	01	15	01	01	15	12		T2015	U8	TG	HQ		A	80 80	20		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 $ 80 80

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED Signature DATE 1/1/15

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

HCBS SLS Provider
100 Any Street
Any City

a. b. 04567890

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

CMS 1500 HCBS-CES Claim Example

HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

3. PATIENT'S BIRTH DATE MM 10 DD 16 YY 45 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 1/1/15

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

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

15. OTHER DATE MM DD YY QUAL.

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. 17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9

A. 799.9 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	01 01 15	01 01 15	12		H2021	U7	A	982 77	123		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 $ 982 77

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED Signature DATE 1/1/15

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

HCBS CES Provider
100 Any Street
Any City

a. b. 04567890

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

Late Bill Override Date

For electronic claims, a delay reason code must be selected and a date must be noted in the "Claim Notes/LBOD" field.

Valid Delay Reason Codes

1 Proof of Eligibility Unknown or Unavailable

3 Authorization Delays

7 Third Party Processing Delay

8 Delay in Eligibility Determination

9 Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules

11 Other

The Late Bill Override Date (LBOD) allows providers to document compliance with timely filing requirements when the initial timely filing period has expired. Colorado Medical Assistance Program providers have 120 days from the date of service to submit their claim. For information on the 60-day resubmission rule for denied/rejected claims, please see the General Provider Information manual in the Provider Services Billing Manuals section.

Making false statements about timely filing compliance is a misrepresentation and falsification that, upon conviction, makes the individual who prepares the claim and the enrolled provider subject to fine and imprisonment under state and/or federal law.

Billing Instruction Detail	Instructions
LBOD Completion Requirements	• Electronic claim formats provide specific fields for documenting the LBOD. • Supporting documentation must be kept on file for 6 years. • For paper claims, follow the instructions appropriate for the claim form you are using. ➢ *UB-04*: Occurrence code 53 and the date are required in FL 31-34. ➢ *CMS 1500*: Indicate "LBOD" and the date in box 19 – Additional Claim Information. ➢ *2006 ADA Dental*: Indicate "LBOD" and the date in box 35 - Remarks
Adjusting Paid Claims	If the initial timely filing period has expired and a previously submitted claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was paid and now needs to be adjusted, resulting in additional payment to the provider. **Adjust the claim within 60 days** of the claim payment. Retain all documents that prove compliance with timely filing requirements. *Note: There is no time limit for providers to adjust paid claims that would result in repayment to the Colorado Medical Assistance Program.* **LBOD** = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the payment.

Billing Instruction Detail	Instructions
Denied Paper Claims	If the initial timely filing period has expired and a previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was denied. **Correct the claim errors and refile within 60 days** of the claim denial or rejection. Retain all documents that prove compliance with timely filing requirements. **LBOD** = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the denial.
Returned Paper Claims	A previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was returned for additional information. **Correct the claim errors and re-file within 60 days** of the date stamped on the returned claim. Retain a copy of the returned claim that shows the receipt or return date stamped by the fiscal agent. **LBOD** = the stamped fiscal agent date on the returned claim.
Rejected Electronic Claims	An electronic claim that was previously entered within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was rejected and information needed to submit the claim was not available to refile at the time of the rejection. **Correct claim errors and refile within 60 days** of the rejection. Maintain a printed copy of the rejection notice that identifies the claim and date of rejection. **LBOD** = the date shown on the claim rejection report.
Denied/Rejected Due to Member Eligibility	An electronic eligibility verification response processed during the original Colorado Medical Assistance Program timely filing period states that the individual was not eligible but you were subsequently able to verify eligibility. Read also instructions for retroactive eligibility. **File the claim within 60 days** of the date of the rejected eligibility verification response. Retain a printed copy of the rejection notice that identifies the member and date of eligibility rejection. **LBOD** = the date shown on the eligibility rejection report.
Retroactive Member Eligibility	The claim is for services provided to an individual whose Colorado Medical Assistance Program eligibility was backdated or made retroactive. File the claim within 120 days of the date that the individual's eligibility information appeared on state eligibility files. Obtain and maintain a letter or form from the county departments of social services that: • Identifies the patient by name • States that eligibility was backdated or retroactive • Identifies the date that eligibility was added to the state eligibility system. **LBOD** = the date shown on the county letter that eligibility was added to or first appeared on the state eligibility system.

Billing Instruction Detail	Instructions
Delayed Notification of Eligibility	The provider was unable to determine that the patient had Colorado Medical Assistance Program coverage until after the timely filing period expired. **File the claim within 60 days** of the date of notification that the individual had Colorado Medical Assistance Program coverage. Retain correspondence, phone logs, or a signed Delayed Eligibility Certification form (see Appendix H of the Appendices in the Provider Services Billing Manuals section) that identifies the member, indicates the effort made to identify eligibility, and shows the date of eligibility notification. • Claims must be filed within 365 days of the date of service. No exceptions are allowed. • This extension is available only if the provider had no way of knowing that the individual had Colorado Medical Assistance Program coverage. • Providers who render services in a hospital or nursing facility are expected to get benefit coverage information from the institution. • The extension does not give additional time to obtain Colorado Medical Assistance Program billing information. • If the provider has previously submitted claims for the member, it is improper to claim that eligibility notification was delayed. **LBOD** = the date the provider was advised the individual had Colorado Medical Assistance Program benefits.
Electronic Medicare Crossover Claims	An electronic claim is being submitted for Medicare crossover benefits within 120 days of the date of Medicare processing/ payment. (Note: On the paper claim form (only), the Medicare SPR/ERA date field documents crossover timely filing and completion of the LBOD is not required.) **File the claim within 120 days** of the Medicare processing/ payment date shown on the SPR/ERA. Maintain the original SPR/ERA on file. **LBOD** = the Medicare processing date shown on the SPR/ERA.
Medicare Denied Services	The claim is for Medicare denied services (Medicare non-benefit services, benefits exhausted services, or the member does not have Medicare coverage) being submitted within 60 days of the date of Medicare processing/denial. *Note: This becomes a regular Colorado Medical Assistance Program claim, not a Medicare crossover claim.* **File the claim within 60 days** of the Medicare processing date shown on the SPR/ERA. Attach a copy of the SPR/ERA if submitting a paper claim and maintain the original SPR/ERA on file. **LBOD** = the Medicare processing date shown on the SPR/ERA.
Commercial Insurance Processing	The claim has been paid or denied by commercial insurance. **File the claim within 60 days** of the insurance payment or denial. Retain the commercial insurance payment or denial notice that identifies the patient, rendered services, and shows the payment or denial date. Claims must be filed within 365 days of the date of service. No exceptions are allowed. If the claim is nearing the 365-day limit and the commercial insurance

Billing Instruction Detail	Instructions
	company has not completed processing, file the claim, receive a denial or rejection, and continue filing in compliance with the 60-day rule until insurance processing information is available. **LBOD** = the date commercial insurance paid or denied.
Correspondence LBOD Authorization	The claim is being submitted in accordance with instructions (authorization) from the Colorado Medical Assistance Program for a 60 day filing extension for a specific member, claim, services, or circumstances. **File the claim within 60 days** of the date on the authorization letter. Retain the authorization letter. **LBOD** = the date on the authorization letter.
Member Changes Providers during Obstetrical Care	The claim is for obstetrical care where the patient transferred to another provider for continuation of OB care. The prenatal visits must be billed using individual visit codes but the service dates are outside the initial timely filing period. **File the claim within 60 days** of the last OB visit. Maintain information in the medical record showing the date of the last prenatal visit and a notation that the patient transferred to another provider for continuation of OB care. **LBOD** = the last date of OB care by the billing provider.

HCBS-DD, SLS, CES, CHRP, and TCM Specialty Manuals Revisions Log

Revision Date	***Section/Action***	***Pages***	***Made by***
06/17/2013	*Split DD, SLS, CES, CHRP and TCM from the combined HCBS manual*	*All*	*Cc/sm/jg*
10/31/2013	*Edited titles for consistency, added Prevocational Services*	*All*	*LT/DDD*
8/1/14	*Replaced all CO 1500 references with CMS 1500*	Throughout	ZS
8/1/14	*Updated Professional Claim Billing Instructions section with CMS 1500 information.*		ZS
8/1/14	*Changed all references of client to member*	Throughout	ZS
8/1/14	*Updated all claim examples to the cms 1500*		ZS
8/4/14	*Updated all web links to reflect new Department website*	Throughout	Mm
8/8/14	*Updated all instances of 'Single to 'All Levels' in Procedure Code tables per benefit manager.'*	Throughout	mm