Inpatient/Outpatient Hospital

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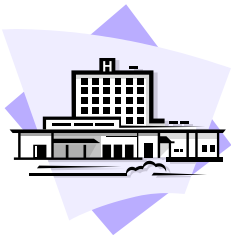
Inpatient/Outpatient Hospital

Providers must be enrolled as a Colorado Medical Assistance Program provider in order to:

- Treat a Colorado Medical Assistance Program member
- Submit claims for payment to the Colorado Medical Assistance Program

Both inpatient and outpatient hospital services are a benefit of the Colorado Medical Assistance Program when medically necessary and supervised by a physician. Hospital benefit services include bed and board, professional services, and ancillary services necessary for diagnosis and treatment.



The Colorado Medical Assistance Program provides outpatient hospital benefits for medical conditions requiring outpatient services. Outpatient hospital benefits include emergency, diagnostic, therapeutic, rehabilitative, preventative, and palliative items and services when provided by or under the directions of a physician in a Colorado Medical Assistance Program-participating hospital. Non-emergency outpatient services are subject to Primary Care Physician Program guidelines.

The Department of Health Care Policy and Financing (the Department) periodically modifies billing information. Therefore, the information in this manual is subject to change, and the manual is updated as new billing information is implemented.

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

Billing Information

National Provider Identifier (NPI)

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

Paper Claims

Electronic claims format shall be required unless hard copy claims submittals are specifically prior authorized by the Department. Requests for paper claim submission 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 prior approval)
- Claims that, by policy, require attachments
- Reconsideration claims

Paper claims do not require an NPI, but do require the Colorado Medical Assistance Program provider number. In addition, the UB-04 Certification document must be completed and attached to all claims submitted on the paper UB-04. Electronically mandated claims submitted on paper are processed, denied, and marked with the message "Electronic Filing Required".

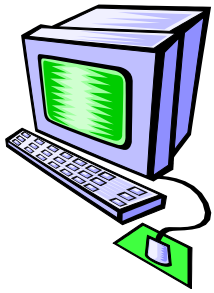
Electronic Claims

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

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

The Colorado Medical Assistance Program collects electronic claim information interactively through the Colorado Medical Assistance Program Secure Web Portal (Web Portal) or via batch submission through a host system. For additional electronic information, please refer to the Medicaid Provider Information manual located on the Department's website (colorado.gov/hcpf/billing-manuals)

General Prior Authorization Requirements



Prior Authorization Requests (PARs) must be completed for:

- All out-of-state Inpatient non-emergency services
- All transplant procedures, except Cornea and Kidney

*Note: Organ transplants are **not** a covered benefit for Non-Citizens.*

All PARs and revisions processed by the ColoradoPAR Program must be submitted using CareWebQI (CWQI). Prior Authorization Requests submitted via fax or mail **will not** be processed by the ColoradoPAR Program and subsequently not reviewed for medical necessity. These PARs will be returned to providers via mail. This requirement only impacts PARs submitted to the ColoradoPAR Program.

The electronic PAR format will be required unless an exception is granted by the ColoradoPAR Program. Exceptions may be granted for providers who submit five (5) or less PARs per month.

To request an exception, more information on electronic submission, or any other questions regarding PARs submitted to the ColoradoPAR Program, please contact the ColoradoPAR Program at 1-888-454-7686 or refer to the Department's ColoradoPAR Program web page.

It is the provider's responsibility to maintain clinical documentation to support services provided in the member's file in the event of an audit or retroactive review. Submitted PARs without minimally required information or with missing or inadequate clinical information will result in a lack of information (LOI) denial.

All accepted PARs are reviewed by the authorizing agency. The authorizing agency approves or denies, by individual line item, each requested service or supply listed on the PAR.

Paper PAR forms and completion instructions are located in the Provider Services Forms section of the Department's website. They must be completed and signed by the member's physician and submitted to the authorizing agency for approval.

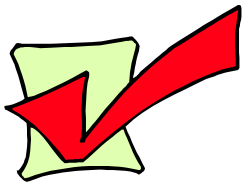
Do not render services or submit claims for services requiring prior authorization before the PAR is approved. When the authorizing agency has reviewed the service, the PAR status is transmitted to the fiscal agent's prior approval system.

The status of the requested services is available through the Web Portal. In addition, after a PAR has been reviewed, both the provider and the member receive a PAR response letter detailing the status

of the requested services. Some services may be approved and others denied. **Check the PAR response carefully as some line items may be approved and others denied.**

Approval of a PAR does **not** guarantee Colorado Medical Assistance Program payment and does **not** serve as a timely filing waiver. 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, Primary Care Physician [PCP] information completed appropriately, third party resources payments pursued, required attachments included, etc.) before payment can be made.



Submitted claim data is checked against the PAR file, therefore, **do not** submit a copy of the PAR with the claim. The fiscal agent identifies the appropriate PAR data using patient identification information and the PAR number noted on the claim.

PAR Revisions

All PAR revisions must be completed through CWQI on the ColoradoPAR Program's website. If a procedure has been prior authorized but the medical decision was changed, a revision must be sent immediately to the authorizing agency to have the PAR adjusted. Without a revised PAR the claim will not pay.

If the PAR is denied, direct inquiries to the authorizing agency listed in Appendix D of the Appendices in the Provider Services Billing Manuals section.

Special Benefits/Limitations/Exclusions

The Colorado Medical Assistance Program benefits are provided for care and treatment services provided in inpatient and outpatient hospital settings. These services must be supervised by a physician.

Hospital services include but are not limited to:

- Bed and board
- Professional services
- Ancillary services necessary for diagnosis and treatment

A Colorado non-participating hospital is considered a participating hospital when providing emergency services to a Colorado Medical Assistance Program member.

Hospitals located outside of Colorado are considered participating when providing emergency services to Colorado Medical Assistance Program members who are temporarily absent from Colorado. Hospitals located in designated out-of-state border towns may provide both emergency and non-emergency services.

Inpatient

Inpatient- a member who is receiving professional services at a participating Colorado Medical Assistance Program Hospital; the services include:

- A room, and
- Continuous care (24-hour-a-day).

Members are considered inpatient typically, by a physician's order if formally admitted as an inpatient, with the expectation that the member will remain at least overnight and occupy a bed; even though it later develops that the member can be discharged or transferred to another hospital and does not actually use a bed overnight.

The following inpatient hospital services are furnished by a participating hospital for the care and treatment of inpatients, and are provided in the hospital by or under the direction of a physician:

- Preventative,
- Surgical,
- Medical, and
- Therapeutic,
- Diagnostic,
- Rehabilitative

Inpatient hospital services are reimbursed by the Colorado Medical Assistance Program on a prospective basis using a Diagnosis Related Group (DRG) method. Claims with discharge date on or after January 1, 2014 will be reimbursed using the All-Patient Refined (APR-DRG) version 30 grouper. Inpatient hospital claims with discharge date prior to January 1, 2014 will be processed using the following grouper versions from CMS:

Discharge Date	Grouper
October 1, 2006 to December 31, 2013	Version 24.0
October 1, 2005 to September 30, 2006	Version 23.0
October 1, 2004 to September 30, 2005	Version 22.0
October 1, 2003 to September 30, 2004	Version 21.0
October 1, 2002 to September 30, 2003	Version 20.0

Payment policies for inpatient hospital claims did not change due to the transition to the new APR-DRG system.

Interim payments for Prospective Payment System (PPS) hospital inpatient with long-term stays

The Colorado Medical Assistance Program APR-DRG payment system requires that claims for inpatient stays in PPS hospitals be submitted after discharge. To accommodate the financial needs of PPS hospitals when long-term stays (e.g. neonates, catastrophic illnesses, and trauma patients) create large account receivables, PPS hospitals may bill interim claims.

Criteria

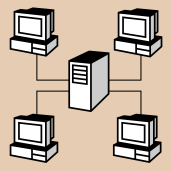
The following criteria must be met in order to receive an interim payment:

Colorado Medical Assistance Program must be the primary payer. Interim payment is not permitted when the recipient has other medical resources such as Medicare or commercial health insurance coverage.

The **Colorado Medical Assistance Program payable amount** (not the billed charges) must be at least $100,000 at the time the interim claim is billed.

After the first interim payment, additional requests may be submitted only when the additional Colorado Medical Assistance Program payment amount reaches or exceeds $100,000.

Procedures



All interim claims should be submitted directly to the Department's fiscal agent.

The first interim claim (type of bill 112 – First Interim Claim) should be billed by the hospital for the services performed from the admission date through the billing date.

Additional interim claims (type of bill 113 - Continuous Interim Claim) can only be billed by the hospital when the total Colorado Medical Assistance Program payment is at least $100,000 more than the previous interim payment. Continuous Interim Claims must always cover the entire stay from the admission date through the billing date. *****

The final interim claim (type of bill 114 – Last Interim Claim) should be billed after the member has been discharged, and should cover the entire stay from the admission date through the discharge date.*****

**** Continuous Interim Claims and Last Interim Claims always result in a credit of any prior interim claims that have been paid.***

Billing for Rehabilitation Stays

The Colorado Medical Assistance Program does not recognized Distinct Part Units (DPUs) separately from the general acute hospital under which they are licensed. One of the reasons for this change is that many admissions to DPUs are for rehabilitation care that is part of the recovery from an immediately preceding inpatient stay in the general acute hospital. The Medical Assistance Program payment to the general acute hospital for these cases is designed to cover the cost of this "recovery rehabilitation." Since the Colorado Medical Assistance Program does not recognize DPUs, hospitals may not submit two claims for a member who is admitted to a general acute hospital and then transferred to the hospital's DPU. A single claim should be submitted for this scenario covering the dates of service from the admission to the general acute facility through the discharge from the DPU.

Maternity and Newborn Billing

Do not show nursery days in FL 6. Nursery days are entered as units on a detail line but are not covered days that represent additional payment. There is no additional inpatient benefit for routine newborn hospitalization. Charges for a **well** newborn remaining in the hospital after the mother's discharge are not a benefit (e.g., placement). Benefits apply under the following conditions:

- If the Mother is in the hospital, the mother and baby's charges (procedure and diagnosis codes) are billed on one claim as one stay.
- Baby remains in hospital for placement. This is not a Colorado Medical Assistance Program benefit. Services may be billed on the mother's claim until the time the mother is discharged.
- Mother is discharged, but the baby remains in hospital and is not transferred to another hospital (i.e., baby is not well.):
    - Baby becomes a patient in its own right.
    - Hospital records reflect the baby's new admission date, which is the date of the mother's discharge.
    - Baby requires its own state (Medicaid) ID number.
    - Baby's charges (procedure and diagnosis codes) beginning with mother's date of discharge through baby's discharge are billed separately from the mother's charges.
    - If the baby is transferred to a different hospital, the Colorado Medical Assistance Program benefits are still applicable. The baby's charges (procedure and diagnosis codes) must be billed separately by the receiving hospital.
- When the mother is not eligible for benefits, the baby's well baby care charges may be billed under the following conditions:
    - The baby is eligible for benefits
    - The baby has an active member ID number
    - If the mother's insurance pays for any portion of the well baby care, this must be included on the claim as a third party payment

Special Instructions for Labor and Delivery Claims

Delivery is a benefit for non-citizens, but sterilization is **not** a covered service. If sterilization is performed in conjunction with the delivery for a non-citizen, the coding and charges for sterilization must be omitted from the claim. Only the codes and charges for the delivery can be billed.

Medicare Part B only coverage

Providers should submit a claim to Medicare for any inpatient services covered by Medicare. When Medicaid denies automatic crossovers for Part B services, submit an inpatient claim to Medicaid. This is *not* a crossover claim.

- Complete the Type of Bill form locator using 111.
- Enter Payer source code H for the Medicare Part B payer.
- Enter the Medicare Part B payment in the Prior Payments form locator for Payer source H.
- Deduct the Medicare Part B payment from the total charges to show the Estimated Amount Due.

The Colorado Medical Assistance Program pays the Medicaid inpatient allowable amount minus the Medicare Part B payment, minus any commercial insurance payment (if applicable) and minus any Medicaid co-payment.

Professional Fees

Costs associated with professional services by salaried physicians are included in the hospital's rate structure and cannot be billed separately to the Colorado Medical Assistance Program. Do not bill professional fees (revenue codes 0960-0989) for emergency and outpatient services as an 837 Institutional (837I) electronic transaction or on the UB-04 claim form.

Professional fees for services provided in the emergency room by contract physicians must be billed by the physician as an 837 Professional (837P) electronic transaction or on the CMS 1500 claim form using the appropriate HCPCS codes. The Colorado Medical Assistance Program payment is made to the physician.

Out-of-State Inpatient Hospital Services

Out-of-state hospitals are classified as urban or rural. A base rate of 90% of the Colorado urban or rural base rate is used for the purpose of reimbursement calculation under the Colorado Medical Assistance APR-DRG program.

Psychiatric/Psychological Services

Inpatient psychiatric benefits

Inpatient psychiatric care is covered by Medicaid. Care is limited to 45 days; longer stays must be approved through concurrent review.

Obtaining authorization for Psychiatric/Psychological services

All Colorado Medical Assistance Program members are assigned to a Behavioral Health Organization (BHO) which is responsible for approval and reimbursement of psychiatric and psychological services. A BHO may refer a member to a hospital for either inpatient or outpatient services. At the time of referral, the BHO will provide the hospital prior authorization and personal health information for the member as necessary.

If a member is referred to a hospital by a BHO, all information necessary for billing will be provided. If a member presents at a hospital requesting services, the hospital will need to submit an eligibility inquiry to verify the member's BHO. The hospital will then contact the BHO in order to obtain prior authorization for treatment.

When a member presents at a hospital requesting emergency services, the hospital provider will be reimbursed by the BHO for medical stabilization of the member, but must contact the BHO tocoordinate any further services.

Refer to the Colorado Medical Assistance Program UB-04 Revenue Code Table (Appendix Q) for a complete listing of services and the corresponding valid revenue codes.

Appendix Q in the Appendices is located in the Provider Services Billing Manuals section of the Department's website.

If the claim is for BHO non-included services then an EOB from the BHO indicating a contractual denial must be attached before payment is made and the following statement must also be present on the claim: "Medical records affirm charges are not covered by Mental Health Plan or Medical records affirms the services indicated on this claim are not covered by the Medicaid Program or abbreviated words i.e.: Med Rec affirm chgs on clm are not covered by Medicaid Program (any variations indicating that the charges are not covered)" in the remarks field (FL 80).

Rehab for Alcohol and Drug Dependence

Substance abuse rehabilitation treatment is not a covered benefit unless individuals are age 20 and under. Services must be provided by facilities which attest to having in place rehabilitation components required by the Department. These facilities must be approved by the Department to receive reimbursement. The Department will review the claims submitted under APR-DRG 772 regularly to ensure only providers that have an attestation with the Department are being reimbursed for these services.

Billing for Combined Stays under the 48Hour Readmission Policy

Effective for dates of service on or after July 1, 2011, if a member is discharged from a hospital and readmitted to the same hospital within 48 hours for symptoms related to, or for evaluation and management of, the prior stay's medical condition, the hospital must bill these tandem admissions as a single hospital stay. The effect of this rule is that the hospital will receive only one payment for what is essentially one episode of care.

The following is the correct billing format when billing for combine stays under the 48-hour readmission policy.

Effective for dates of service on or after July 1, 2011, all claims for hospital readmissions in which a member is readmitted to the same hospital within 48 hours of discharge, will be denied unless the readmission is completely unrelated to the first admission. This will apply to all claims for second admissions dated July 1, 2011 or later.

Example:

A member is admitted January 19, 2012, and is discharged January 23, 2012. The member is readmitted January 25, 2012, and is discharged January 28, 2012.

- The hospital bills from DOS January 19, 2012, through DOS January 28, 2012. The number of covered days is seven. The number of non covered days is two.
- Covered days must be reported using Value code 80
- Non covered Days; must be reported using Value code 81
- Claim details need to include leave of absence revenue code 0180, the units should equal to the non-covered days and charges equal to a non zero amount

The Medicaid Management Information System (MMIS) will automatically deny subsequent claims for readmissions to the same hospital within 48 hours. Providers will have to submit an adjustment claim to correctly reflect the dates of service for the full episode of care. To indicate that a readmission is completely unrelated to the first admission, a claim may be coded with condition code B4 which will allow the separate episode of care. Use the following codes to indicate covered/non-covered days:

A claim example is provided under "Billing for combine stays under the 48 hour readmission policy" on page 59 of this billing manual.

The Quality Improvement Organization (QIO) will continue to retrospectively review all readmissions within 48 hours which are paid with use of condition code B4. If the Department determines that the readmission is not completely unrelated to the first admission, the Department will recoup payment.

The Colorado Medical Assistance Program does not recognize Distinct Part Units (DPUs) or any other units of a hospital separately from the general acute care hospital under which they are licensed. General acute care hospitals may not submit two claims for a member who is transferred between units of a hospital. A single claim should be submitted covering the dates of service from the admission to the general acute care hospital through the discharge from the DPU. When the QIO identifies claims for such transfers, the second admission will be denied. Stays at Transitional Care

Units or any other location that is not part of the hospital are not billable under the hospital's Colorado Medical Assistance Program provider number and will be denied if billed as such.

Swing Bed Services

Hospitals certified to provide Skilled Nursing Facility (SNF) services and/or Intermediate Care Facility (ICF) services to members in swing beds must furnish the services, supplies and equipment required for SNFs and ICFs within the approved per diem rate. Services must be certified as medically necessary.

Inpatient Late Charges

Late charges for inpatient services paid under APR-DRG should not be submitted unless there is additional information that would change the APR-DRG or payment amount (e.g., a different or additional diagnosis, or information that would change the co-pay status). Submit appropriate late charges on an Adjustment Transmittal form, which can be found in the Provider Services Forms section of the Department's website.

Inpatient hospital ancillary late charges for providers reimbursed under a per diem must be recorded in a log and retained for cost reporting purposes. Do not submit late charges if the reimbursement is based on a per diem.

Submit late charges only if they change the APR-DRG or payment.

Transfers

Excluding rehabilitation and specialty-acute hospitals, a member who is transferred from one PPS hospital to another PPS hospital or from a PPS hospital to a hospital designated by the Department as a Non-Prospective Payment System (NPPS) hospital (or the reverse), reimbursement is calculated as follows:

Reimbursement for a member who is transferred from one PPS hospital to another PPS hospital is calculated at a APR-DRG per diem rate for each facility with payment up to the full APR-DRG payment to each facility. If applicable, both hospitals may receive outlier day payments.

Reimbursement for a member who is transferred from a PPS hospital to a NPPS hospital (or the reverse) is calculated at the APR-DRG rate for the PPS facility and at the assigned per diem for the exempt facility.

Per Diem Calculation:

- Per Diem = DRG Base Payment ÷ DRG Average Length of Stay

Transfer Payment Logic:

- IF Covered Days < DRG Average Length of Stay, THEN pay (Per Diem * Covered Days)
- IF Covered Days >= DRG Average Length of Stay, THEN pay DRG Base Payment

Outlier Payment Logic:

- Outlier Days = Covered Days beyond DRG Trim Point
- Outlier Payment = Outlier Days * Per Diem * 80%

When transfer services are billed, complete the following Form Locators for correct reimbursement calculation:

- Form Locator 15, Source of Admission
- Form Locator 17, Patient Status
- Form Locators 39-41, Value Codes

See the instructions for each Form Locator in this provider manual.

"Present on Admission" Indicator on Hospital Claims

Inclusion of "present on admission" (POA) indicator responses are required for inpatient hospital claims submitted through the Web Portal. The Department's policy follows that of the Medicare program for hospitals paid through prospective payment.

The POA response is required for Principle Diagnosis and **all** Other Diagnoses. It is not required for the Admitting Diagnosis. The POA response is to be documented in the gray area to the right of Form Locator 67 (Principal Diagnosis) and 67A -67Q (Other Diagnoses). Allowed responses are limited to:

- ✓ Y = Yes – present at the time of inpatient admission
- ✓ N = No – not present at the time of inpatient admission
- ✓ U = Unknown – the documentation is insufficient to determine if the condition was present at the time of inpatient admission
- ✓ W = Clinically Undetermined – the provider is unable to clinically determined whether the condition was present at the time of inpatient admission or not
- ✓ "Blank" or "1" = Diagnosis is exempt for POA reporting or is not submitted ("blank" to be used on electronics submissions, "1" for paper submissions)

The POA indicator is used to identify claims with Health Care Acquired Conditions (HCAC) and Other Provider Preventable Conditions (OPPC). Specific codes associated with HCAC and OPPC are provided below. These are events which if occurred while in the hospital (POA = N or U) can complicate care and patient outcomes. Because these events can be deemed preventable, CMS does not allow the Department to pay additional costs of a higher APR-DRG assignment arising from HCACs or must deny payment altogether for OPPCs.

Health Care Acquired Conditions (HCAC) – FY2013

	Health Care Acquired Conditions (HCAC)	ICD-9-CM Codes [when CC*/MCC**indicated
1	Foreign Object Retained After Surgery	998.4 (CC) 998.7 (CC)
2	Air Embolism	999.1 (MCC)
3	Blood Incompatibility	999.60 (CC) 999.61 (CC) 999.62 (CC) 999.63 (CC) 999.69 (CC)
4	Pressure Ulcers Stages III & IV	707.23 (MCC) 707.24 (MCC)

	Health Care Acquired Conditions (HCAC)	ICD-9-CM Codes [when CC*/MCC**indicated
5	Falls and Trauma: - Fracture - Dislocation - Intracranial Injury - Crushing Injury - Burn - Other Injuries	Codes within these ranges on the CC/MCC list: (may include 4th or 5th digit) 800-829 830-839 850-854 925-929 940-949 991-994
6	Catheter-Associated Urinary Tract Infection (UTI)	996.64 (CC) Also excludes the following from acting as a CC/MCC: 112.2 (CC) 590.10 (CC) 590.11 (MCC) 590.2 (MCC) 590.3 (CC) 590.80 (CC) 590.81 (CC) 595.0 (CC) 597.0 (CC) 599.0 (CC)
7	Vascular Catheter-Associated Infection	999.31 (CC) 999.32 (CC) 999.33 (CC)
8	Manifestations of Poor Glycemic Control Diabetic Ketoacidosis Nonketotic Hyperosmolar Coma Hypoglycemic Coma Secondary Diabetes with Ketoacidosis Secondary Diabetes with Hyperosmolarity	250.10-250.13 (MCC) 250.20-250.23 (MCC) 251.0 (CC) 249.10-249.11 (MCC) 249.20-249.21 (MCC

	Health Care Acquired Conditions (HCAC)	ICD-9-CM Codes [when CC*/MCC**indicated
9	Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)	519.2 (MCC) And one of the following procedure codes: 36.10–36.19
10	Surgical Site Infection Following Certain Orthopedic Procedures: Spine Neck Shoulder Elbow	996.67 (CC) 998.59 (CC) And one of the following procedure codes: 81.01-81.08, 81.23-81.24, 81.31-81.38, 81.83, or 81.85
11	Surgical Site Infection Following Bariatric Surgery for Obesity: Laparoscopic Gastric Bypass Gastroenterostomy Laparoscopic Gastric Restrictive Surgery	*Principal Diagnosis* – 278.01 539.01 (CC) 539.81 (CC) 998.59 (CC) And one of the following procedure codes: 44.38, 44.39, 44.95
12	Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)	996.61 (CC) 998.59 (CC) And one of the following procedure codes: 00.50, 00.51, 00.52, 00.53, 00.54, 37.74, 37.75, 37.76, 37.77, 37.79, 37.89, 37.80, 37.81, 37.82, 37.83, 37.85, 37.86, 37.87, 37.94, 37.96, 37.98
13	Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures (with pediatric and obstetric exceptions): Total Knee Replacement Hip Replacement	415.11 (MCC) 415.13 (MCC) 415.19 (MCC) 453.40-453.42 (CC) And one of the following procedure codes: 00.85-00.87, 81.51-81.52, 81.54
14	Iatrogenic Pneumothorax with Venous Catheterization	512.1 (CC) And the following procedure code: 38.93

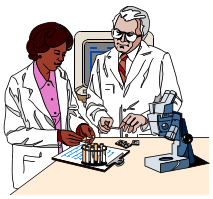
*CC = Complications and Comorbidities **MCC = Major Complications and Comorbidities

Other Provider Preventable Conditions (OPPC) – FY2013

	Other Provider Preventable Conditions (OPPC)
1	Surgery performed on the wrong body part
2	Surgery performed on the wrong patient
3	Wrong surgical procedure performed on a patient

Hospitals are required to submit claims when any of these HCAC or OPPC events occur in an inpatient hospital setting – and also when an OPPC event occurs in an outpatient healthcare setting. Patients may not be billed or balance-billed for services related to these HCACs or OPPCs. The Department will collaborate with hospitals to assure appropriate reimbursement for cases in which a patient receives subsequent care for a HCAC or OPPC in a hospital other than the original site in which the event occurred.

Outpatient



Outpatient hospital benefits are provided for medical conditions requiring outpatient hospital services. Outpatient hospital services are provided for diagnostic, therapeutic, rehabilitative, preventive and palliative items and services when provided by or under the direction of a physician in a Colorado Medical Assistance Program participating hospital. Non-emergency outpatient hospital services are subject to the Primary Care Physician Program guidelines.

Reimbursement for outpatient hospital services is calculated by multiplying the submitted charges by the Medicare Part B cost to charge ratio of the submitting hospital and then by the Colorado Medicaid cost ratio (subject to change). Outpatient laboratory, occupational therapy, physical therapy, and hospital based transportation claims are reimbursed based on the Colorado Medical Assistance Program fee schedule.

In-State Billing Providers:

- Reimbursement Amount = Line Item Submitted Charges * Hospital Cost to Charge Ratio * Colorado Medicaid Cost Ratio

Out-of-State Billing Providers:

- Reimbursement Amount = Line Item Submitted Charges * Hospital Cost to Charge Ratio * Colorado Medicaid Cost Ratio Out-of-State

Bundling

"Bundling" describes a single reimbursement package for related services. Colorado Medical Assistance Program reimbursement for inpatient hospital care includes associated outpatient, laboratory, and supply services provided in a 24-hour period immediately prior to the hospital admission, during the hospital stay and 24 hours immediately after discharge.

For example, prenatal services provided within 24 hours of an inpatient delivery are related and should be bundled.

Outpatient, clinical laboratory, and supply claims are bundled. Transportation services are not bundled. Inpatient payment bundling assures that all services associated with the inpatient stay are included in the hospital's APR-DRG or per diem payment.

During claim processing, outpatient, laboratory, and supply claim service dates are compared to previously processed and in process inpatient claims. Payment for "unbundled" outpatient, laboratory, or supply claims may be denied.

Clinical Laboratory Improvement Amendments (CLIA)

To comply with the Federal Clinical Laboratory Improvement Amendments of 1988 (CLIA 88), the Colorado Medical Assistance Program requires that all providers of clinical laboratory services obtain a CLIA certificate of waiver or certificate of registration to perform and receive payment for laboratory testing services. A copy of the CLIA registration and a completed information form must be submitted to Colorado Medical Assistance Program Provider Enrollment in order for providers to receive payment. Claims for laboratory services must be provided and billed by an appropriately registered CLIA certified laboratory. These requirements apply to any facility or practitioner who provides clinical laboratory services or performs laboratory testing. CLIA registration is not required for providers who only collect or prepare specimens.

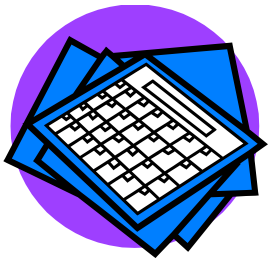
Span Billing

Span billing is used for outpatient hospital, rural health clinics and dialysis centers. Enter the beginning and ending dates of service in FL 6. FL 45 must be completed with the correct date of service using MMDDYY format for each line item submitted. Each date of service must be shown on a separate detail line with a corresponding description, revenue code, units and charge.

Providers not wishing to span bill under these guidelines must submit one claim per date of service.

Split Bills

For any specified date or date span, billed services must appear on a single UB-04. A claim cannot be submitted as a two or more part claim.



Outpatient claims that span the end of one calendar year and the beginning of the following year should be split billed by year. The member co-payment responsibility is renewed January 1st of each calendar year and cannot be calculated when claim dates of service span two calendar years.

Providers reimbursed an encounter rate or per diem must split bill to accommodate the date of the rate change.

Medical records or ancillary service records are not required as claim attachments unless they are requested.

Third Party Payment Pro-rate

When a provider receives a third party lump sum payment for multiple services billed to Colorado Medical Assistance Program on separate UB-04 claim forms, i.e., hospital accommodations, lab and transportation, the provider should pro-rate the third party payment to the multiple services/claims.

Each claim must include a copy of the insurance company's explanation of benefits (EOB) or check with a notation that the payment has been applied to multiple claims.

Example (for outpatient, outpatient laboratory and transportation services)

Services incurred were:	Outpatient	$ 720.00
	Outpatient Lab	215.00
	Transportation	173.00
	Total Billed To Third Party Payer	$1,108.00
Lump sum payment received from Third Party Payer		$ 830.00

To pro-rate third party payment for multiple Colorado Medical Assistance Program UB-04 claims, determine what percentage of the total charge is represented by each claim amount. Divide each individual claim charge by the total charge.

Outpatient Services	$720.00 ÷ $1,108.00 = 65%
Outpatient Lab Services	$215.00 ÷ $1,108.00 = 19%
Transportation Services	$173.00 ÷ $1,108.00 = 16%

To determine the correct Third Party payment amount to enter on each claim, multiply each percentage from the previous calculation times the total amount received from the third party payer. These amounts should be entered on the Third Party payer line in FL 54 (Prior Payments).

65% x $830.00 = $539.50 on the Outpatient claim

19% x $830.00 = $157.70 on the Outpatient Lab claim

16% x $830.00 = $132.80 on the Transportation claim

The amount for the Colorado Medical Assistance Program line in FL 55 (Estimated Amount Due) is the difference between the total claim charge and the third party payer pro-rate amount.

Outpatient	$720.00 - $539.50 = $180.50
Outpatient: Lab	$215.00 - $157.70 = $ 57.30
Transportation	$173.00 - $132.80 = $ 40.20

Procedure/HCPCS Codes Overview

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

The Healthcare Common Procedural Coding System (HCPCS) is divided into two principal subsystems, referred to as level I and level II of the HCPCS. Level I of the HCPCS is comprised of Current Procedural Terminology (CPT), a numeric coding system maintained by the American Medical Association (AMA). The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. Level II of the HCPCS is a standardized coding system that is

used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office.

Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter followed by 4 numeric digits, while CPT codes are identified using 5 numeric digits.

HIPAA requires providers to comply with the coding guidelines of the AMA CPT Procedure Codes and the International Classification of Disease, Clinical Modification Diagnosis Codes. If there is no time designated in the official descriptor, the code represents one unit or session.

The Department updates and revises HCPCS code listings through the billing manuals and bulletins. Providers should regularly consult the billing manuals and monthly bulletins in the Provider Services Billing Manuals and Bulletins section of the Department's website.

To receive electronic provider bulletin notifications, an email address can be entered into the Web Portal in the *(MMIS) Provider Data Maintenance* area or by filling out a publication preference form. Bulletins include updates on approved codes as well as the maximum allowable units billed per procedure.

All outpatient laboratory, occupational therapy, physical therapy, x-ray and hospital based transportation claims must be billed using both HCPCS and revenue codes. Outpatient laboratory, occupational therapy, physical therapy, and hospital based transportation claims are reimbursed based on the Colorado Medical Assistance Program fee schedule. Outpatient hospital x-ray claims are reimbursed based on the hospital cost to charge ratio.

When submitting claims for transportation, outpatient laboratory, occupational therapy, physical therapy, and radiology to the Colorado Medical Assistance Program, observe the following guidelines:

Always use the most current CPT revision. The Colorado Medical Assistance Program adds and deletes codes as they are published in annual revisions of the CPT.

Use CMS codes only when CPT codes are not available or are not as specific as the CMS codes.

Not all codes listed in the annual Colorado Medical Assistance Program HCPCS code publications are benefits of the Colorado Medical Assistance Program. Read the entire entry to determine the benefit status of the item.

The CPT can be purchased at local university bookstores and from the American Medical Association at the following address:

Book & Pamphlet Fulfillment: OP-341/9
American Medical Association
P.O. Box 10946
Chicago, Illinois 60610

UB-04 Revenue Codes

The Colorado Medical Assistance Program Revenue Code Table located in Appendix Q contains revenue codes for billing services to the Colorado Medical Assistance Program. Not all of the revenue codes listed are Colorado Medical Assistance Program benefits. When non-benefit revenue codes are used, the claim must be completed according to the billing instructions for non-covered charges. Claims submitted with revenue codes that are not listed are denied.

UB-04 Paper Claim Reference Table

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

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

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

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

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

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

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

Form Locator and Label	Completion Format	Instructions
		6 Intermediate Care Level II 7 Sub-Acute Inpatient (revenue code 019X required with this bill type) 8 Swing Beds 9 Other Digit 2 Bill Classification (Clinics Only): 1 Rural Health/FQHC 2 Hospital Based or Independent Renal Dialysis Center 3 Freestanding 4 Outpatient Rehabilitation Facility (ORF) 5 Comprehensive Outpatient Rehabilitation Facilities (CORFs) 6 Community Mental Health Center Digit 2 Bill Classification (Special Facilities Only): 1 Hospice (Non-Hospital Based) 2 Hospice (Hospital Based) 3 Ambulatory Surgery Center 4 Freestanding Birthing Center 5 Critical Access Hospital 6 Residential Facility Digit 3 Frequency: 0 Non-Payment/Zero Claim 1 Admit through discharge claim 2 Interim - First claim 3 Interim - Continuous claim 4 Interim - Last claim 7 Replacement of prior claim 8 Void of prior claim
5. Federal Tax Number	None	Submitted information is not entered into the claim processing system.
6. Statement Covers Period –	From: 6 digits MMDDYY	Inpatient/ Outpatient - Required (Note: OP claims cannot span over a month's end) Enter the From (beginning) date and Through (ending) date of service covered by this bill using

Form Locator and Label	Completion Format	Instructions
From/Through	Through: 6 digits MMDDYY	MMDDYY format. *For Example:* January 1, 2013 = 0101013 **Inpatient** "From" date is the actual admission date, or first date of an interim bill. "From" date cannot be prior to the date reported in FL 12 (Admission Date). "Through" date is the actual discharge date, or final date of an interim bill. If patient is admitted and discharged the same date, that date must appear in both form locators. Interim bills may be submitted for Prospective Payment System (PPS)- APR-DRG claims, but must meet specific billing requirements **Outpatient** This form locator must reflect the beginning and ending dates of service. When span billing for multiple dates of service and multiple procedures, complete FL 45 (Service Date). Providers not wishing to span bill following these guidelines, must submit one claim per date of service. "From" and "Through" dates must be the same. All line item entries must represent the same date of service.
8a. Patient Identifier		Submitted information is not entered into the claim processing system.
8b. Patient Name	Up to 25 characters: Letters & spaces	Inpatient/ Outpatient - Required Enter the member's last name, first name and middle initial.
9a. Patient Address – Street	Characters Letters & numbers	Inpatient/ Outpatient - Required Enter the member's street/post office box as determined at the time of admission.
9b. Patient Address – City	Text	Inpatient/ Outpatient - Required Enter the member's city as determined at the time of admission.
9c. Patient Address – State	Text	Inpatient/ Outpatient - Required Enter the member's state as determined at the time of admission.

Form Locator and Label	Completion Format	Instructions
9d. Patient Address – Zip	Digits	Inpatient/ Outpatient - Required Enter the member's zip code as determined at the time of admission.
9e. Patient Address – Country Code	Digits	Inpatient/ Outpatient – Optional
10. Birthdate	8 digits (MMDDCCYY)	Inpatient/ Outpatient - Required Enter the member's birthdate using two digits for the month, two digits for the date, and four digits for the year (MMDDCCYY format). Example: 01012010 for January 1, 2010.
11. Patient Sex	1 letter	Inpatient/ Outpatient - Required Enter an M (male) or F (female) to indicate the member's sex.
12. Admission Date	6 digits	Inpatient - Required Outpatient - Conditional **Inpatient** Enter the date member was admitted to the hospital. Use MMDDYY format for inpatient hospital claims. **Outpatient** Required for observation holding beds only
13. Admission Hour	6 digits	Inpatient - Required Outpatient - Conditional **Inpatient** Enter the hour the member was admitted for inpatient care. Code — Time 00 — 12:00-12:59 am 01 — 1:00-1:59 am 02 — 2:00-2:59 am 03 — 3:00-3:59 am 04 — 4:00-4:59 am 05 — 5:00-5:59 am 06 — 6:00-6:59 am 07 — 7:00-7:59 am 08 — 8:00-8:59 am

Form Locator and Label	Completion Format	Instructions
		09 9:00-9:59 am 10 10:00-10:59 am 11 11:00-11:59 am 12 12:00-12:59 pm 13 1:00-1:59 pm 14 2:00-2:59 pm 15 3:00-3:59 pm 16 4:00-4:59 pm 17 5:00-5:59 pm 18 6:00-6:59 pm 19 7:00-7:59 pm 20 8:00-8:59 pm 21 9:00-9:59 pm 22 10:00-10:59 pm 23 11:00-11:59 pm 99 Unknown **Outpatient** Required for observation holding beds only
14. Admission Type	1 digit	Inpatient/ Outpatient - Required Enter the following to identify the admission priority: 1 – Emergency Member requires immediate intervention as a result of severe, life threatening or potentially disabling conditions. Exempts inpatient hospital & clinic claims from co-payment and PCP referral. Exempts outpatient hospital claims from co-payment and PCP only if revenue code 0450 or 0459 is present. This is the only benefit service for an undocumented alien. If span billing, emergency services cannot be included in the span bill and must be billed separately from other outpatient services. 2 - Urgent The member requires immediate attention for the care and treatment of a physical or mental disorder.

Form Locator and Label	Completion Format	Instructions
		3 - Elective The member's condition permits adequate time to schedule the availability of accommodations. 4 - Newborn Required for inpatient and outpatient hospital. 5 - Trauma Center Visit to a trauma center/hospital as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons and involving trauma activation. **Clinics** Required only for emergency visit.
15. Source of Admission	1 digit	Inpatient/ Outpatient - Required Enter the appropriate code for co-payment exceptions on claims submitted for outpatient services. (To be used in conjunction with FL 14, Type of Admission). 1 Non-HC Facility Point of Origin 2 Clinic or Physician's Office referral 4 Transfer from a different hospital 5 Transfer from a skilled nursing facility (SNF, ICF, ALF) 6 Transfer from another health care facility 8 Court/Law Enforcement 9 Information not available E Transfer from Ambulatory Surgery Center F Transfer from a Hospice Facility **Newborns** 5 Baby born inside this hospital 6 Baby born outside this hospital
16. Discharge Hour	2 digits	Inpatient - Required Enter the hour the member was discharged from inpatient hospital care. Use the same coding used in FL 13 (Admission Hr.)
17. Patient Discharge Status	2 digits	Inpatient - Required Outpatient – Conditional **Inpatient/Outpatient**

Form Locator and Label	Completion Format	Instructions
		Enter patient status as of discharge date. 01 Discharged to Home or Self Care (Dialysis is limited to code 01) 02 Discharged/transferred to another short term hospital 03 Discharged/transferred to a Skilled Nursing Facility (SNF) 04 Discharged/transferred to an Intermediate Care Facility (ICF) 05 Discharged/transferred to another type institution 06 Discharged/transferred to home under care of organized Home and Community Based Services Program (HCBS) 07 Left against medical advice or discontinued care 08 Discharged/transferred to home under care of a Home Health provider 09 Admitted as an inpatient to this hospital 20 Expired 30** Still a patient or expected to return for outpatient services 31 Still a patient - Awaiting transfer to long term psychiatric hospital 32 Still a Patient - Awaiting placement by Colorado Medical Assistance Program 50 Hospice – Home 51 Hospice - Medical Facility 61 Discharged/transferred within this institution to hospital based Medicare approved swing bed 62 Discharged/transferred to an inpatient rehabilitation hospital. 63 Discharged/transferred to a Medicare certified long term care hospital. 65 Discharge/Transfered to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital (effective 1/1/14) 66 Transfered/Discharged to Critical Access Hospital CAH (effective 1/1/14) 70 Discharged/Transferd to Other HC Insitution (effective 1/1/14)

Form Locator and Label	Completion Format	Instructions
		71 Discharged/transferred/referred to another institution for outpatient services 72 Discharged/transferred/referred to this institution for outpatient services Use code 02 for a PPS hospital transferring a patient to another PPS hospital. Code 05, Discharged to Another Type Institution, is the most appropriate code to use for a PPS hospital transferring a patient to an exempt hospital. **A PPS hospital cannot use Patient Status codes 30, 31 or 32 on any claim submitted for APR-DRG reimbursement. The code(s) are valid for use on exempt hospital claims only. Interim bills may be submitted for Prospective Payment System (PPS)-APR-DRG claims, but must meet specific billing requirements. For exempt hospitals use the appropriate code from the codes listed. Note: Refer to the "Interim" billing instruction in this section of the manual.
18-28.Condition Codes	2 Digits	Inpatient/Outpatient - Conditional Complete with as many codes necessary to identify conditions related to this bill that may affect payer processing. Condition Codes 01 Military service related 02 Employment related 04 HMO enrollee 05 Lien has been filed 06 ESRD patient - First 18 months entitlement 07 Treatment of non-terminal condition/hospice patient 17 Patient is homeless 25 Patient is a non-US resident 39 Private room medically necessary 42 Outpatient Continued Care not related to Inpatient 44 Inpatient CHANGED TO Outpatient 51 Outpatient Non-diagnostic Service unrelated to Inpatinet admit 60 APR-DRG (Day outlier) Renal dialysis settings

Form Locator and Label	Completion Format	Instructions
		71 Full care unit 72 Self care unit 73 Self care training 74 Home care 75 Home care - 100 percent reimbursement 76 Back-up facility <u>Special Program Indicator Codes</u> A1 EPSDT/CHAP A2 Physically Handicapped Children's Program A4 Family Planning A6 PPV/Medicare A9 Second Opinion Surgery AA Abortion Due to Rape AB Abortion Done Due to Incest AD Abortion Due to Life Endangerment AI Sterilization B3 Pregnancy Indicator B4 Admission Unrelated to Discharge Inpatient/Outpatient - Conditional Complete with as many codes necessary to identify conditions related to this bill that may affect payer processing. <u>PRO Approval Codes</u> C1 Approved as billed C2 Automatic approval as billed - Based on focused review C3 Partial approval C4 Admission/Services denied C5 Post payment review applicable C6 Admission preauthorization C7 Extended authorization <u>Claim Change Reason Codes</u> D3 Second/Subesequent interim PPS bill
29. Accident State	2 digits	Inpatient/Outpatient – Optional State's abbreviation where accident occurred

Form Locator and Label	Completion Format	Instructions
31-34. Occurrence Code/Date	2 digits and 6 digits	Inpatient/Outpatient - Conditional Complete both the code and date of occurrence. Enter the appropriate code and the date on which it occurred. Enter the date using MMDDYY format. <u>Occurrence Codes</u>: 01 Accident/Medical Coverage 02 Auto Accident - No Fault Liability 03 Accident/Tort Liability 04 Accident/Employment Related 05 Other Accident/No Medical Coverage or Liability Coverage 06 Crime Victim 20 Date Guarantee of Payment Began 24* Date Insurance Denied 25* Date Benefits Terminated by Primary Payer 26 Date Skilled Nursing Facility Bed Available 27 Date of Hospice Certification or Re-certification 40 Scheduled Date of Admission (RTD) 50 Medicare Pay Date 51 Medicare Denial Date 53 Late Bill Override Date 55 Insurance Pay Date A3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer A indicated in FL 50 B3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer B indicated in FL 50 C3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer C indicated in FL 50 **Other Payer occurrence codes 24 and 25 must be used when applicable. The claim must be submitted with the third party information*
35-36. Occurrence Span Code From/ Through	2 digits and 6 digits	75 SNF Level of Care during Inpatient

Form Locator and Label	Completion Format	Instructions
38. Responsible Party Name/ Address	None	Submitted information is not entered into the claim processing system.
39-41. Value Code- Code Value Code- Amount	2 characters and 9 digits	Inpatient/Outpatient - Conditional Enter appropriate codes and related dollar amounts to identify monetary data or number of days using whole numbers, necessary for the processing of this claim. Never enter negative amounts. If a value code is entered, a dollar amount or numeric value related to the code <u>must</u> always be entered. 01 Most common semiprivate rate (Accommodation Rate) 06 Medicare blood deductible 14 No fault including auto/other 15 Worker's Compensation 30 Preadmission testing 31 Patient Liability Amount 32 Multiple Patient Ambulance Transport 37 Pints of Blood Furnished 38 Blood Deductible Pints 40 New Coverage Not Implemented by HMO 45 Accident Hour Enter the hour when the accident occurred that necessitated medical treatment. Use the same coding used in FL 18 (Admission Hour). 49 Hematocrit Reading - EPO Related 58 Arterial Blood Gas (PO2/PA2) 68 EPO-Drug 80 Covered Days 81 Non-Covered Days *Enter the deductible amount applied by indicated payer:* A1 Deductible Payer A B1 Deductible Payer B C1 Deductible Payer C *Enter the amount applied to* member's *co-insurance by indicated payer:* A2 Coinsurance Payer A B2 Coinsurance Payer B C2 Coinsurance Payer C *Enter the amount paid by indicated payer:*

Form Locator and Label	Completion Format	Instructions
		A3 Estimated Responsibility Payer A B3 Estimated Responsibility Payer B C3 Estimated Responsibility Payer C For Rancho Coma Score bill with appropriate diagnosis for head injury. Medicare & TPL - See A1-A3, B1-B3, & C1-C3 above
42. Revenue Code	4 digits	Inpatient/Outpatient - Required Enter the revenue code which identifies the specific accommodation or ancillary service provided. List revenue codes in ascending order. A revenue code must appear only once per date of service. If more than one of the same service is provided on the same day, combine the units and charges on one line accordingly. When billing outpatient hospital radiology, the radiology revenue code may be repeated, but the corresponding HCPCS code cannot be repeated for the same date of service. Refer to instructions under FL 44 (HCPCS/Rates). Psychiatric step down Use the following revenue codes: 0114 Psychiatric Step Down 1 0124 Psychiatric Step Down 2
43. Revenue Code Description	Text	Inpatient/Outpatient – Required Enter the revenue code description or abbreviated description. **When reporting an NDC** • Enter the NDC qualifier of "N4" in the first two positions on the left side of the field. • Enter the 11-digit NDC numeric code • Enter the NDC unit of measure qualifier (examples include): ➤ F2 – International Unit ➤ GR – Gram ➤ ML – Milliliter ➤ UN – Units • Enter the NDC unit of measure quantity Refer to the claim example included in this billing manual.

Form Locator and Label	Completion Format	Instructions
44. **HCPCS/Rates / HIPPS Rate Codes**	5 digits	Inpatient - Not required Outpatient - Conditional Enter only the HCPCS code for each detail line. Use approved modifiers listed in this section for hospital based transportation services. Complete for laboratory, radiology, physical therapy, occupational therapy, and hospital based transportation. When billing HCPCS codes, the appropriate revenue code must also be billed. Services Requiring HCPCS • Anatomical Laboratory: Bill with TC modifier • Hospital Based Transportation • Outpatient Laboratory: Use only HCPCS 80000s - 89000s. • Outpatient Radiology Services Enter HCPCS and revenue codes for each radiology line. The only valid modifier for OP radiology is TC. Refer to the appropriate billing manual and/or annual HCPCS bulletin in the Provider Services Billing Manuals or Bulletins section of the Department's website. With the exception of outpatient lab and hospital-based transportation, outpatient radiology services can be billed with other outpatient services. HCPCS codes must be identified for the following revenue codes: • 030X Laboratory • 032X Radiology – Diagnostic • 033X Radiology – Therapeutic • 034X Nuclear Medicine • 035X CT Scan • 040X Other Imaging Services • 042X Physical Therapy • 043X Occupational Therapy • 054X Ambulance • 061X MRI and MRA HCPCS codes cannot be repeated for the same date of service. Combine the units in FL 46 (Service Units) to report multiple services. Inpatient - Not required Outpatient - Conditional Enter only the HCPCS code for each detail line. The following revenue codes always require a HCPCS code. Please reference the Provider Services Bulletins or

Form Locator and Label	Completion Format	Instructions
		Billing Manuals section of the Department's website for a list of physician-administered drugs that also require an NDC code. When a HCPCS code is repeated more than once per day and billed on separate lines, use modifier 76 to indicate this is a repeat procedure and not a duplicate. 0252 Non-Generic Drugs 0253 Take Home Drugs 0255 Drugs Incident to Radiology 0257 Non-Prescription 0258 IV Solutions 0259 Other Pharmacy 0260 IV Therapy General Classification 0261 Infusion Pump 0262 IV Therapy/Pharmacy Services 0263 IV Therapy/Drug/Supply Delivery 0264 IV Therapy/Supplies 0269 Other IV Therapy 0631 Single Source Drug 0632 Multiple Source Drug 0633 Restrictive Prescription 0634 Erythropoietin (EPO) <10,000 0635 Erythropoietin (EPO) >10,000 0636 Drugs Requiring Detailed Coding 0637 Pharmacy – Self Administrable Dugs
45. Service Date	6 digits	Inpatient – Leave blank Outpatient – Required For span bills only Enter the date of service using MMDDYY format for each detail line completed. Each date of service must fall within the date span entered in the "Statement Covers Period" (FL 6). Not required for single date of service claims.
46. Service Units	3 digits	Inpatient/Outpatient - Required Enter a unit value on each line completed. Use whole numbers only. Do not enter fractions or decimals and do not show a decimal point followed by a 0 to designate whole numbers (e.g., Do not enter 1.0 to signify one unit) The grand total line (Line 23) does not require a unit value.

Form Locator and Label	Completion Format	Instructions
		For span bills, the units of service reflect only those visits, miles or treatments provided on dates of service in FL 45.
47. Total Charges	9 digits	Inpatient/Outpatient - Required Enter the total charge for each line item. Calculate the total charge as the number of units multiplied by the unit charge. Do not subtract Medicare or third party payments from line charge entries. Do not enter negative amounts. A grand total in line 23 is required for all charges.
48. Non-Covered Charges	9 digits	Inpatient/Outpatient - Conditional Enter incurred charges that are not payable by the Colorado Medical Assistance Program. Non-covered charges must be entered in both FL 47 (Total Charges) and FL 48 (Non-Covered Charges). Each column requires a grand total. Non-covered charges cannot be billed for outpatient hospital laboratory or hospital based transportation services.
50. Payer Name	1 letter and text	Inpatient/Outpatient - Required Enter the payment source code followed by name of each payer organization from which the provider might expect payment. At least one line must indicate The Colorado Medical Assistance Program. Source Payment Codes B Workmen's Compensation C Medicare D Colorado Medical Assistance Program E Other Federal Program F Insurance Company G Blue Cross, including Federal Employee Program H Other - Inpatient (Part B Only) I Other Line A Primary Payer Line B Secondary Payer Line C Tertiary Payer
51. Health Plan ID	8 digits	Inpatient/Outpatient - Required Enter the provider's Health Plan ID for each payer name.

Form Locator and Label	Completion Format	Instructions
		Enter the eight digit Colorado Medical Assistance Program provider number assigned to the **billing provider**. Payment is made to the enrolled provider or agency that is assigned this number.
52. Release of Information		Submitted information is not entered into the claim processing system.
53. Assignment of Benefits		Submitted information is not entered into the claim processing system.
54. Prior Payments	Up to 9 digits	Inpatient/Outpatient – Conditional Complete when there are Medicare or third party payments. Enter third party and/or Medicare payments.
55. Estimated Amount Due	Up to 9 digits	Inpatient/Outpatient – Conditional Complete when there are Medicare or third party payments. Enter the net amount due from The Colorado Medical Assistance Program after provider has received other third party, Medicare or patient liability amount. **Medicare Crossovers** Enter the sum of the Medicare coinsurance plus Medicare deductible less third party payments and patient payments.
56. National Provider Identifier (NPI)	10 digits	Inpatient/Outpatient – Optional Enter the billing provider's 10-digit National Provider Identifier (NPI).
57. Other Provider ID		Submitted information is not entered into the claim processing system.
58. Insured's Name	Up to 30 characters	Inpatient/Outpatient - Required Required Enter the member's name on the Colorado Medical Assistance Program line. **Other Insurance/Medicare** Complete additional lines when there is third party coverage. Enter the policyholder's last name, first name, and middle initial.

Form Locator and Label	Completion Format	Instructions
60. Insured's Unique ID	Up to 20 characters	Inpatient/Outpatient - Required Enter the insured's unique identification number assigned by the payer organization exactly as it appears on the health insurance card. Include letter prefixes or suffixes shown on the card.
61. Insurance Group Name	14 letters	Inpatient/Outpatient – Conditional Complete when there is third party coverage. Enter the name of the group or plan providing the insurance to the insured exactly as it appears on the health insurance card.
62. Insurance Group Number	17 digits	Inpatient/Outpatient – Conditional Complete when there is third party coverage. Enter the identification number, control number, or code assigned by the carrier or fund administrator identifying the group under which the individual is carried.
63. Treatment Authorization Code	Up to 18 characters	Inpatient/Outpatient – Conditional Complete when the service requires a PAR. Enter the authorization number in this FL if a PAR is required and has been approved for services.
64. Document Control Number		Submitted information is not entered into the claim processing system.
65. Employer Name	Text	Inpatient/Outpatient – Conditional Complete when there is third party coverage. Enter the name of the employer that provides health care coverage for the individual identified in FL 58 (Insured Name).
66. Diagnosis Version Qualifier		Submitted information is not entered into the claim processing system.
67. Principal Diagnosis Code	Up to 6 digits	Inpatient/Outpatient – Required Enter the exact diagnosis code describing the principal diagnosis that exists at the time of admission or develops subsequently and affects the length of stay. Do not add extra zeros to the diagnosis code. The Present on Admission (POA) indicator is required for inpatient claims. Document the POA in the gray area to the right side of the principal diagnosis code.

Form Locator and Label	Completion Format	Instructions
		Allowed responses are limited to: ✓ Y = Yes – present at the time of inpatient admission ✓ N = No – not present at the time of inpatient admission ✓ U = Unknown – the documentation is insufficient to determine if the condition was present at the time of inpatient admission ✓ W = Clinically Undetermined – the provider is unable to clinically determined whether the condition was present at the time of inpatient admission or not ✓ "1" on UB-04 ("Blank" on the 837I) = Unreported/Not used – diagnosis is exempt from POA reporting **Outpatient Hospital Laboratory** May use diagnosis code V71(may require 4th or 5th digit) **Hospital Based Transportation** May use diagnosis code 780 (may require 4th or 5th digit)
67A- Other 67Q.Diagnosis	Up to 6 digits	Inpatient/Outpatient – Conditional Enter the exact diagnosis code corresponding to additional conditions that co-exist at the time of admission or develop subsequently and which effect the treatment received or the length of stay. Do not add extra zeros to the diagnosis code.0 The Present on Admission (POA) indicator is required for inpatient claims. Document the POA in the gray area to the right side of the "other" diagnosis code(s). Allowed responses are limited to: ✓ Y = Yes – present at the time of inpatient admission ✓ N = No – not present at the time of inpatient admission ✓ U = Unknown – the documentation is insufficient to determine if the condition was present at the time of inpatient admission ✓ W = Clinically Undetermined – the provider is unable to clinically determined whether the condition was present at the time of inpatient admission or not

Form Locator and Label	Completion Format	Instructions
		"1" on UB-04 ("Blank" on the 837I) = Unreported/Not used – diagnosis is exempt from POA reporting
69. Admitting Diagnosis Code	Up to 6 digits	Inpatient – Required Outpatient - Optional Enter the diagnosis code as stated by the physician at the time of admission.
70. Patient Reason Diagnosis	Up to 6 digits	Submitted information is not entered into the claim processing system. Outpatient – Required for all unscheduled outpatient visits. Enter the ICD-CM diagnosis codes describing the patient's reason for visit at the time of outpatient registration.
71. PPS Code		Submitted information is not entered into the claim processing system.
72. External Cause of Injury Code (E-code)	Up to 6 digits	Inpatient/Outpatient – Optional Enter the diagnosis code for the external cause of an injury, poisoning, or adverse effect. This code must begin with an "E".
74. Principal Procedure Code/ Date	Up to 7 characters or Up to 6 digits	Inpatient/Outpatient - Conditional Enter the procedure code for the principal procedure performed during this billing period and the date on which procedure was performed. Enter the date using MMDDYY format. Apply the following criteria to determine the principle procedure: The principal procedure is not performed for diagnostic or exploratory purposes. This code is related to definitive treatment; and The principal procedure is most related to the primary diagnosis.
74A. Other Procedure Code/Date	Up to 7 characters or Up to 6 digits	Inpatient/Outpatient – Conditional Complete when there are additional significant procedure codes. Enter the procedure codes identifying all significant procedures other than the principle procedure and the dates on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures

Form Locator and Label	Completion Format	Instructions
		closely related to the principle diagnosis. Enter the date using MMDDYY format.
75. Unlabeled Field	N/A	N/A
76. Attending **NPI – Conditional** **QUAL - Conditional** **ID - (Colorado Medical Assistance Provider #) – Required** **Attending-Last/ First Name**	NPI - 10 digits QUAL – Text Medicaid ID - 8 digits Text	Inpatient/Outpatient – Colorado Medical Assistance Program ID Required NPI - Enter the 10-digit NPI and eight-digit Colorado Medical Assistance Program provider number assigned to the physician having primary responsibility for the patient's medical care and treatment. This number is obtained from the physician, and cannot be a clinic or group number. (If the attending physician is not enrolled in the Colorado Medical Assistance Program or if the member leaves the ER before being seen by a physician, the hospital may enter their individual numbers.) Hospitals may enter the member's regular physician's 10-digit NPI and Medical Assistance Program provider ID in the Attending Physician ID form locator if the locum tenens physician is not enrolled in the Colorado Medical Assistance Program. QUAL – Enter "1D " for Medicaid Enter the attending physician's last and first name. This form locator must be completed for all services.
77. Operating-NPI/QUAL/ID		Submitted information is not entered into the claim processing system.
78-79. Other ID **NPI – Conditional** **QUAL - Conditional** **ID - (Colorado Medical Assistance**	NPI - 10 digits QUAL – Text Medicaid ID - 8 digits	Inpatient/Outpatient – Colorado Medical Assistance Program ID Conditional (see below) Complete when attending physician is not the PCP or to identify additional physicians. NPI - Enter up to two 10-digit NPI and eight digit physician Colorado Medical Assistance Program provider numbers, when applicable. This form locator identifies physicians other than the attending physician. If the attending physician is not the PCP or if a clinic is a PCP agent, enter the PCP eight digit Colorado Medical Assistance Program provider number as the referring physician. The name of the

Form Locator and Label	Completion Format	Instructions
Provider #) – Conditional		Colorado Medical Assistance Program member's PCP appears on the eligibility verification. Review either for eligibility and PCP. The Colorado Medical Assistance Program does not require that the PCP number appear more than once on each claim submitted. The attending physician's last and first name are optional.
80. Remarks	Text	Enter specific additional information necessary to process the claim or fulfill reporting requirements.
81. Code-Code **QUAL/CODE/ VALUE** **(a-d)**		Submitted information is not entered into the claim processing system

Late Bill Override Date

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

Valid Delay Reason Codes

1 Proof of Eligibility Unknown or Unavailable

3 Authorization Delays

7 Third Party Processing Delay

8 Delay in Eligibility Determination

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

11 Other

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

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

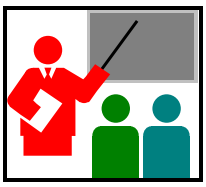
Billing Instruction Detail	Instructions
LBOD Completion Requirements	• Electronic claim formats provide specific fields for documenting the LBOD. • Supporting documentation must be kept on file for 6 years. • For paper claims, follow the instructions appropriate for the claim form you are using. ➢ *UB-04*: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

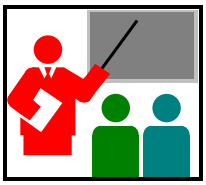
Billing Instruction Detail	Instructions
	LBOD = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the payment.
Denied Paper Claims	If the initial timely filing period has expired and a previously submitted paper claim that was filed within the original Colorado Medical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

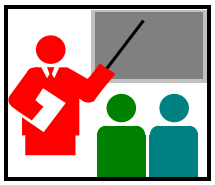
Billing Instruction Detail	Instructions
	• Identifies the patient by name • States that eligibility was backdated or retroactive • Identifies the date that eligibility was added to the state eligibility system. **LBOD** = the date shown on the county letter that eligibility was added to or first appeared on the state eligibility system.
Delayed Notification of Eligibility	The provider was unable to determine that the patient had Colorado Medical Assistance Program coverage until after the timely filing period expired. **File the claim within 60 days** of the date of notification that the individual had Colorado Medical Assistance Program coverage. Retain correspondence, phone logs, or a signed Delayed Eligibility Certification form (see Certification & Request for Timely Filing Extension in the Provider Services Forms section) that identifies the member, indicates the effort made to identify eligibility, and shows the date of eligibility notification. • Claims must be filed within 365 days of the date of service. No exceptions are allowed. • This extension is available only if the provider had no way of knowing that the individual had Colorado Medical Assistance Program coverage. • Providers who render services in a hospital or nursing facility are expected to get benefit coverage information from the institution. • The extension does not give additional time to obtain Colorado Medical Assistance Program billing information. • If the provider has previously submitted claims for the member, it is improper to claim that eligibility notification was delayed. **LBOD** = the date the provider was advised the individual had Colorado Medical Assistance Program benefits.
Electronic Medicare Crossover Claims	An electronic claim is being submitted for Medicare crossover benefits within 120 days of the date of Medicare processing/ payment. (Note: On the paper claim form (only), the Medicare SPR/ERA date field documents crossover timely filing and completion of the LBOD is not required.) **File the claim within 120 days** of the Medicare processing/ payment date shown on the SPR/ERA. Maintain the original SPR/ERA on file. **LBOD** = the Medicare processing date shown on the SPR/ERA.
Medicare Denied Services	The claim is for Medicare denied services (Medicare non-benefit services, benefits exhausted services, or the member does not have Medicare coverage) being submitted within 60 days of the date of Medicare processing/denial.

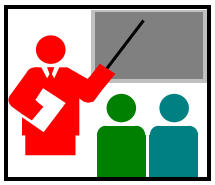
Billing Instruction Detail	Instructions
	Note: This becomes a regular Colorado Medical Assistance Program claim, not a Medicare crossover claim. **File the claim within 60 days** of the Medicare processing date shown on the SPR/ERA. Attach a copy of the SPR/ERA if submitting a paper claim and maintain the original SPR/ERA on file. **LBOD** = the Medicare processing date shown on the SPR/ERA.
Commercial Insurance Processing	The claim has been paid or denied by commercial insurance. **File the claim within 60 days** of the insurance payment or denial. Retain the commercial insurance payment or denial notice that identifies the patient, rendered services, and shows the payment or denial date. Claims must be filed within 365 days of the date of service. No exceptions are allowed. If the claim is nearing the 365-day limit and the commercial insurance company has not completed processing, file the claim, receive a denial or rejection, and continue filing in compliance with the 60-day rule until insurance processing information is available. **LBOD** = the date commercial insurance paid or denied.
Correspondence LBOD Authorization	The claim is being submitted in accordance with instructions (authorization) from the Colorado Medical Assistance Program for a 60 day filing extension for a specific member, claim, services, or circumstances. **File the claim within 60 days** of the date on the authorization letter. Retain the authorization letter. **LBOD** = the date on the authorization letter.
Member Changes Providers during Obstetrical Care	The claim is for obstetrical care where the patient transferred to another provider for continuation of OB care. The prenatal visits must be billed using individual visit codes but the service dates are outside the initial timely filing period. **File the claim within 60 days** of the last OB visit. Maintain information in the medical record showing the date of the last prenatal visit and a notation that the patient transferred to another provider for continuation of OB care. **LBOD** = the last date of OB care by the billing provider.

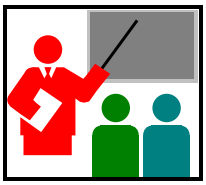
Sterilizations, Hysterectomies, and Abortions

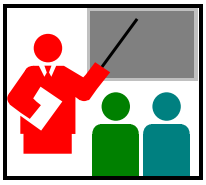
Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions 	**Voluntary sterilizations** Sterilization for the purpose of family planning is a benefit of the Colorado Medical Assistance Program in accordance with the following procedures: **General requirements** The following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

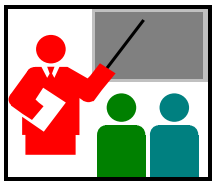
Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions 	The person may not be an "institutionalized individual". Institutionalized includes: • Involuntarily confinement or detention, under a civil or criminal statute, in a correctional or rehabilitative facility including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

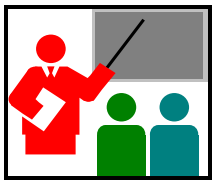
Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions 	➤ A full description of the benefits or advantages that may be expected as a result of the sterilization ➤ Advice that the sterilization will not be performed for at least 30 days except in the case of premature delivery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

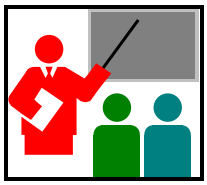
Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions 	**Completion of the MED-178 consent form** Please refer to the MED-178 Instructions on the Department's website (colorado.gov/hcpf/provider-forms). Information entered on the consent form must correspond directly to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

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

Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions (continued) 	Diagnosis code ranges: (decimal not required when billing) 635.00-635.92 637.00-637.92 Surgical diagnosis codes: 69.01 69.51 69.93 74.91 75.0 **Providers billing on the CMS 1500 claim form** Use the appropriate procedure/diagnosis code from the list above **and** the most appropriate modifier from the list below: G7 - Termination of pregnancy resulting from rape, incest, or certified by physian as life-threatening. In addition to the required coding, all claims must be submitted with the required documentation. Claims submitted for induced abortion-related services submitted without the required documentation will be denied. **Providers billing on the UB-04 claim form** Use the appropriate procedure/diagnosis code from those listed previously **and** the most appropriate condition code from the list below: AA Abortion Due to Rape AB Abortion Due to Incest AD Abortion Due to Life Endangerment In addition to the required coding, all claims must be submitted with the required documentation Claims submitted for induced abortion-related services submitted without the required documentation will be denied. **Induced abortions to save the life of the mother** Every reasonable effort to preserve the lives of the mother and unborn child must be made before performing an induced abortion. The services must be performed in a licensed health care facility by a licensed practitioner, unless, in the judgment of the attending practitioner, a transfer to a licensed health care facility endangers the life of the pregnant woman and there is no licensed health care facility within a 30 mile radius of the place where the medical services are performed. "**To save the life of the mother**" means: The presence of a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, as determined by the attending practitioner, which represents a serious and substantial threat to the life of the pregnant woman if the pregnancy is allowed to continue to term.

Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions (continued) 	The presence of a psychiatric condition which represents a serious and substantial threat to the life of the pregnant woman if the pregnancy continues to term. All claims for services related to induced abortions to save the life of the mother must be submitted with the following documentation: • Name, address, and age of the pregnant woman • Gestational age of the unborn child • Description of the medical condition which necessitated the performance of the abortion • Description of services performed • Name of the facility in which services were performed • Date services were rendered And, at least one of the following forms with additional supporting documentation that confirms life-endangering circumstances: • Hospital admission summary • Hospital discharge summary • Consultant findings and reports • Laboratory results and findings • Office visit notes • Hospital progress notes **A suggested form on which to report the required information is in Claim Forms and Attachments** in the Provider Services Forms section of the Department's website. Providers may copy this form, as needed, for attachment to claim(s). Providers may substitute any form that includes the required information. The submitted form or case summary documentation must be signed and dated by the practitioner performing the abortion service. For psychiatric conditions lethal to the mother if the pregnancy is carried to term, the attending practitioner must: • Obtain consultation with a physician specializing in psychiatry. • Submit a report of the findings of the consultation unless the pregnant woman has been receiving prolonged psychiatric care.

Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions (continued) 	**The practitioner performing the abortion is responsible for providing the required documentation to other providers (facility, anesthetist, etc.) for billing purposes.** **Induced abortions when pregnancy is the result of sexual assault (rape) or incest** Sexual assault (including rape) is defined in the Colorado Revised Statutes (C.R.S.) 18-3-402 through 405, 405.3, or 405.5. Incest is defined in C.R.S. 18-6-301. Providers interested in the legal basis for the following abortion policies should refer to these statutes. All claims for services related to induced abortions resulting from sexual assault (rape) or incest **must** be submitted with the "Certification Statement for abortion for sexual assault (rape) or incest". **A suggested form is located in Claim Forms and Attachments** in the Provider Services Forms section of the Department's website. This form **must**: • Be signed and dated by the patient or guardian **and** by the practitioner performing the induced abortion AND • Indicate if the pregnancy resulted from sexual assault (rape) or incest. Reporting the incident to a law enforcement or human services agency is not mandated. If the pregnant woman did report the incident, that information should be included on the Certification form. No additional documentation is required. The practitioner performing the abortion is responsible for providing the required documentation to other providers (facility, anesthetist, etc.) for billing purposes.

Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions (continued) 	**Spontaneous Abortion (Miscarriage)** **Ectopic and molar pregnancies** Surgical and/or medical treatment of pregnancies that have terminated spontaneously (miscarriages) and treatment of ectopic and molar pregnancies are routine benefits of the Colorado Medical Assistance Program. Claims for treatment of these conditions do not require additional documentation. The claim must indicate a diagnosis code that specifically demonstrates that the termination of the pregnancy was not performed as a therapeutic legally induced abortion. The following diagnosis codes are appropriate for identifying conditions that may properly be billed for Colorado Medical Assistance Program reimbursement. 630 Hydatidiform Mole 631 Other Abnormal Products of Conception 632 Missed Abortion 633-633.91 Ectopic Pregnancy 634-639.9 Spontaneous Abortion 656.4 Intrauterine Death The following HCPCS (CPT) procedure codes may be submitted for covered abortion and abortion related services. 58120 D & C For Hydatidiform Mole 59100 Hysterectomy For Removal of Hydatidiform Mole 59812-59830 Medical and Surgical Treatment of Abortion **Fetal anomalies incompatible with life outside the womb** Therapeutic abortions performed due to fetal anomalies incompatible with life outside the womb are not a Colorado Medical Assistance Program benefit.

Institutional Provider Certification

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

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

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

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

Inpatient Hospital Claim Example

1 City Hospital
100 Saginaw Street
Anytown, CO 80201
303-333-3333

2

3a PAT. CNTL # PCN0123456789
b. MED. REC. #
4 TYPE OF BILL 111
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 07/15/11 THROUGH 07/19/11
7

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

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
02/13/1980	F	07/15/11	9	2	1	10	01													

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

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	01	250:00				
b	80	4:00				
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	120	Room and Board/Semi			4	1000:00		1
2	250	Pharmacy			16	1500:00		2
3	270	Med-Sur			10	980:00		3
4	300	Laboratory			8	850:00		4
5	360	OR Supplies			8	520:00		5
6	370	Anesthesia			4	250:00		6
7	710	Recovery Room			16	35:00		7
8	993	Telephone			6	11:00	11:00	8
23		PAGE 1 OF 1	CREATION DATE		TOTALS	5146:00	11:00	23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
A	D - Medicaid	12345678				5135:00	57 OTHER PRV ID
B							
C							

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

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

66 DX: I 585, J 7533, K 3574, L 420, M, N, O, P, Q 68

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

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75

c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE

	NPI	QUAL	
76 ATTENDING LAST Provider FIRST Ima		1D	87654321
77 OPERATING LAST Surgeon FIRST Ima		1D	01234567
78 OTHER LAST FIRST			
79 OTHER LAST FIRST			

80 REMARKS

81CC		
a		
b		
c		
d		

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

Inpatient for Combined Stay Under 48-Hour Readmission Policy Claim Example

Print Form

1 City Hospital
100 Main Street
Anytown, CO 80201
303-333-1111

2

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

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

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
02/17/1980	F	01/19/12	14	1	1	9	01													

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

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	01	228 00				
b	80	7 00				
c	81	2 [illegible]				
d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
120	Room and Board/Semi			7	2052 00		
180	Leave of absence-General			2		00 01	
210	Coronary Car			5	3000 00		
250	Pharmacy			30	2170 00		
270	Med-Sur Supplies			20	2120 00		
300	Laboratory			12	1600 00		
320	Dx-X-ray			10	1170 00		
360	OR supplies			8	1090 00		
370	Anesthesia			8	410 00		
410	Respiratory Services			1	90 00		
710	Recovery Room			1	60 00		
730	EKG/ECG			1	40 00		
993	Telephone			9		18 65	
	PAGE 1 OF 1	CREATION DATE		TOTALS	13820 65	18 66	

50 PAYER NAME: D- Medicaid
51 HEALTH PLAN ID: 12345678
52 REL. INFO
53 ASG. BEN
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE: 13820 65
56 NPI
57 OTHER PRV ID

58 INSURED'S NAME
59 P REL
60 INSURED'S UNIQUE ID
61 GROUP NAME
62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX: 5849 5939 5859 Button 587
67
68
69 ADMIT DX
70 PATIENT REASON DX
71 PPS CODE
72 ECI
73

74 PRINCIPAL PROCEDURE CODE DATE: 2765
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI QUAL LAST Provider FIRST Ima
77 OPERATING NPI QUAL LAST Surgeon FIRST Ima
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

80 REMARKS
81 CC a b c d

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

Outpatient Hospital Claim Example

1 City Hospital
100 Saginaw Street
Anytown, CO 80201
303-333-3333

2

3a PAT. CNTL. # PCN0123456789
b. MED. REC. #
4 TYPE OF BILL 131
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 07/15/11 THROUGH 07/19/11
7

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

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
02/13/1980	F			3	3		01													

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

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a						
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	430	Physical Therapy	97110 GO	07/15/11	2	60:00		1
2	430	Physical Therapy	97110 GO	07/16/11	2	40:00		2
3	430	Physical Therapy	97110 GO	07/17/11	2	40:00		3
4	430	Physical Therapy	97110 GO	07/18/11	2	40:00		4
5	430	Physical Therapy	97110 GO	07/19/11	2	20:00		5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23		PAGE 1 OF 1	CREATION DATE		TOTALS	200:00		23

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

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

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

66 DX	2509	648	2504	2507	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

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

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75

c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE

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

80 REMARKS

81CC		
a		
b		
c		
d		

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

Outpatient Hospital Lab and X-Ray Claim Example

1 City Hospital
100 Saginaw Street
Anytown, CO 80201
303-333-3333

2

3a PAT. CNTL. # PCN01312008
b. MED. REC. #
4 TYPE OF BILL 131
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 07/15/11 THROUGH 07/15/11
7

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

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
02/13/1980	F			1	7		01													

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

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a						
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	450	General Emergency Room		07/15/11	1	450 00		
2	300	General Diagnostic and Clinical	81000	07/15/11	1	67 50		
3	320	General X-Ray	73070	07/15/11	2	250 00		
23		PAGE 1 OF 1	CREATION DATE		TOTALS	767 50		

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

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

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

66 DX: 2509 (I) 648 (J) 2504 (K) 2507 (L) D (M) E (N) F (O) G (P) H (Q) 68

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

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

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

80 REMARKS
81CC a
b
c
d

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

Outpatient Hospital Crossover Claim Example

1 City Hospital
100 Saginaw Street
Anytown, CO 80201
303-333-3333

2

3a PAT. CNTL # PCN01312008
b. MED. REC. #
4 TYPE OF BILL 131
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 07/15/11 THROUGH 07/15/11
7

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

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
02/13/1980	F			1	7		01													

	31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a	50	1/30/08													a
b															b

38

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a	A2	153:50				
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	450	General Emergency Room		07/15/11	1	450:00		1
2	300	General Diagnostic and Clinical	81000	07/15/11	1	67:50		2
3	320	General X-Ray	73070	07/15/11	2	250:00		3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23		PAGE 1 OF 1	CREATION DATE		TOTALS	767:50		23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A	C - Medicare				614:00		57	A
B	D - Medicaid	12345678				153:50	OTHER	B
C							PRV ID	C

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

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

66 DX: 2509 | 648 | 2504 | 2507 | D | E | F | G | H | 68
I | J | K | L | M | N | O | P | Q

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

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

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

80 REMARKS

81CC		
a		
b		
c		
d		

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

Inpatient Hospital Part A Claim Example

1 City Hospital
100 Saginaw Street
Anytown, CO 80201
303-333-3333

2

3a PAT. CNTL. # SM000123
b. MED. REC. #
4 TYPE OF BILL 111
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 07/17/11 THROUGH 07/18/11
7

8 PATIENT NAME
a
b Client, Ima D.

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

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
03/09/1920	F	07/17/11	02	1	7	09	01	C5												

	31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a	50	05/12/09													
b															

38

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a	A1	1068.00				
b	80	1.00				
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	121			07/17/11	1	2941.64		
2	250			07/17/11	385	100.00		
3	259			07/17/11	27	164.81		
4	270			07/17/11	2	381.94		
5	271			07/17/11	1	4.22		
6	300			07/17/11	1	58.39		
7	301			07/17/11	8	1062.54		
8	305			07/17/11	2	104.22		
9	307			07/17/11	1	37.08		
10	320			07/17/11	2	743.29		
11	324			07/17/11	1	471.70		
12	352			07/17/11	1	2699.70		
13	424			07/17/11	1	332.69		
14	450			07/17/11	1	3763.66		
15	460			07/17/11	1	282.34		
16	730			07/17/11	1	304.58		
17								
18								
19								
20								
21								
22								
23		PAGE 1 OF 1	CREATION DATE		TOTALS	13452.80		

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
A	C - Medicare				626.79		57
B	D - Medicaid	12345678				7187.01	OTHER
C							PRV ID

	58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Client, Ima D.		987654321A		
B	Client, Ima D.		A123456		
C					

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

66 DX: 427.89 | 276.1 | 733.13 | E942.9 | 426.11 | 733.00 | 250.00 | 401.9 | 564.00 | 68

I J K L M N O P Q

69 ADMIT DX: 427.89
70 PATIENT REASON DX: a b c
71 PPS CODE
72 ECI: a b c
73

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75

c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE

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

80 REMARKS
81CC a
b
c
d

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

Inpatient Part B Only Claim Example

1 City Hospital
100 Saginaw Street
Anytown, CO 80201
303-333-3333

3a PAT. CNTL. # PCN0123456789
b MED. REC. #
4 TYPE OF BILL 111
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 07/15/11 THROUGH 07/24/11
7

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

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18–28 CONDITION CODES	29 ACDT STATE	30
02/13/1980	F	07/15/11	14	1	1	9	01			

31–37 OCCURRENCE CODE DATE; OCCURRENCE SPAN CODE FROM THROUGH

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	01	228:00				
b	80	9:00				
c						
d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
120	Room and Board/Semi			9	2052:00		
210	Coronary Care			5	3000:00		
250	Pharmacy			30	2170:00		
270	Med-Sur Supplies			20	2120:00		
300	Laboratory			12	1600:00		
320	Dx X-Ray			10	1170:00		
360	OR Supplies			8	1090:00		
370	Anesthesia			8	410:00		
410	Respiratory Services			1	90:00		
710	Recovery Room			2	60:00		
730	EKG/ECG			1	40:00		
993	Telephone			9	18:65	18:65	
	PAGE 1 OF 1	CREATION DATE		TOTALS	13820:65	18:65	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
a H - Medicare Part B Only				1156:00		57
b D - Medicaid	12345678				12646:00	OTHER
c						PRV ID

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

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
a		
b		
c		

66 DX: 5849 5939 5859 587 D E F G H 68
I J K L M N O P Q

69 ADMIT DX 2765 70 PATIENT REASON DX a b c 71 PPS CODE 72 ECI a b c 73

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

76 ATTENDING NPI QUAL 1D 87654321
LAST Provider FIRST Ima
77 OPERATING NPI QUAL 1D 01234567
LAST Surgeon FIRST Ima
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS
81 CC a b c d

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

Outpatient Hospital with NDC Claim Example

1 City Hospital
100 Saginaw Street
Anytown, CO 80201
303-333-3333

2

3a PAT. CNTL. #
b. MED. REC. #
5 FED. TAX NO.
4 TYPE OF BILL: 131
6 STATEMENT COVERS PERIOD FROM 07/15/11 THROUGH 07/15/11
7

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

10 BIRTHDATE: 02/13/1980
11 SEX: F
12 DATE
13 HR
14 TYPE: 1
15 SRC: 1
16 DHR
17 STAT: 01
18 19 20 21 22 23 24 25 26 27 28
29 ACDT STATE
30

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

38

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

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	250	Pharmacy General Classification		07/15/11	2	500 00		
2	251	N4 54569304000 ML 10	J1100	07/15/11	10	200 00		
3	258	N4 54569572200 GR 1	J0696	07/15/11	1	200 00		
4	258	N4 54569572500 GR 1	J0696 76	07/15/11	1	200 00		
5	258	N4 68030713901 GR 1	J0696 76	07/15/11	1	100 00		
6	450	Emergency Room		07/15/11	1	600 00		
23		PAGE 1 OF 1	CREATION DATE		TOTALS	1800 00		

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

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

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX: 2509
A B C D E F G H I J K L M N O P Q
68

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

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

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

80 REMARKS
81CC a b c d

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

State Mental Hospital Claim Example

1 Psychiatric Hospital
100 Saginaw Street
Anytown, CO 88888
303-123-4567

4 TYPE OF BILL: 114

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM: 10/01/2011 THROUGH: 10/11/2011

8 PATIENT NAME: b Client, Ima D

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

10 BIRTHDATE: 05/27/1997 | 11 SEX: M | 12 ADMISSION DATE: 10/01/11 | 13 HR: 11 | 14 TYPE: 2 | 15 SRC: 8 | 16 DHR: 15 | 17 STAT: 01

Note: Member must be under 21 or over 64 years old.

39 VALUE CODES AMOUNT: a 80 10

42 REV. CD. | 43 DESCRIPTION | 46 SERV. UNITS | 47 TOTAL CHARGES

42 REV. CD.	43 DESCRIPTION	46 SERV. UNITS	47 TOTAL CHARGES
124	Psychiatric Step Down 2	10	1053000
001		0	1053000

PAGE 1 OF 1 CREATION DATE TOTALS 1053000

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

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

66 DIAG. CODE: 31401 | 3129 | 3159 | 317 | 78340

69 ADMIT DX: 7999

74 PRINCIPAL PROCEDURE CODE/DATE

76 ATTENDING NPI: 1234567890 QUAL: 12345678 LAST FIRST

77 OPERATING NPI QUAL LAST FIRST

78 OTHER NPI QUAL LAST FIRST

79 OTHER NPI QUAL LAST FIRST

80 REMARKS

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

IP/OP Revisions Log

Revision Date	Additions/Changes	Pages	Made by
02/13/2008	*Electronic Claims – Updated first two paragraphs with bullets*	*1*	*pr-z*
05/28/2008	*Addition of NDC instructions and NDC claim example*	*30 & 63*	*vr*
06/05/2008	*Updated Psychiatric/Psychological Services*	*11*	*vr*
11/05/2008	*Updated web addresses*	*Throughout*	*jg*
03/23/2009	*General updates*	*Throughout*	*jg*
05/29/2009	*Information and Web site updates*	*Throughout*	*vr/jg*
06/09/2009	*Addition of Inpatient Part A Claim Example*	*64*	*jg*
10/28/2009	*Inserted Serious Reportable Events table*	*14*	*vr*
11/02/2009	*Updated Web site links*	*Throughout*	*jg*
04/07/2010	*Update to "Readmission w/in 24 hours of discharge" section*	*13*	*vr*
07/27/2011	*Update to "Readmission w/in 48 hours of discharge"* *Updated claim examples*	*15* *65-71*	*vr* *jg*
08/29/2011	*Corrected TOB for Part B only to 12X*	*14 & 70*	*jg*
12/06/2011	*Replaced 997 with 999* *Replaced wpc-edi.com/hipaa with wpc-edi.com/* *Replaced Implementation Guide with Technical Report 3 (TR3)*	*5* *4* *4*	*ss*
01/27/2012	*Changed authorizing agent to authorizing agency*	*Throughout*	*jg*
08/24/2012	*Updated information, language and reformatted* *Added Electronic PAR form* *Added State Mental Hospital Claim Example*	*Throughout*	*vr/jg*
09/17/2012	*Removed duplicate list for Digit 2, Bill Classification (Clinics Only)*	*27*	*jg*
08/21/2013	*Removed electronic billing information, referencing General Billing Information manual* *Updated Claim Reference table- 15. Source of Admission*	*2* *27*	*Cc*
08/27/2013	*In POA Indicator on Hospital Claims Section updated with HCAC and OPPC information* *Updated HCAC and OPPC conditions and ICD-9-CM Codes*	*16-19*	*Ca*
09/03/2013	*Updated General PAR Section with mandatory electronic PAR submission info.*	*2*	*Cc*
12/26/2013	*APR-DRG updated* *Added depth to PAR Revisons* *Removed paper PAR Reference Table*	*Throughout* *3* *3-7*	*cc*

Revision Date	Additions/Changes	Pages	Made by
	Removed Example of paper and electronic PAR forms *IP expanded to add Discharge Date info.* *Added value codes to Readmission within 48 hrs of discharge* *Paper claim reference table update:* *17- Added discharge status of 65, 66, 70* *18-28- Added condition codes 42, 44, 51;* *Added special program indicator AA, AB, AD, AI* *Removed A7 and A8* *35-63- Removed IP/OP- Leave blank* *Added 74 and 75* *39-41- Added value code/amount 30* *Added FC to enter amount paid by client* *42- Removed 0134 from psychiatric step down* *44- Added zero to HCPCS* *70- Added OP Required status* *Added Billing for Combine Stays Under the 48 hour Readmission Policy and claim example*	*9-10* *11* *16* *34* *36* *36* *36* *39* *39* *40* *41* *42* *44* *49* *73-74*	
02/03/2014	*Updated abortion information*	*48*	*Jg*
8/29/14	*Replaced CO 1500 with CMS 1500*	*Throughout*	*ZS*
8/29/14	*Replaced all references of client with member*	*Throughout*	*ZS*
9/4/14	*Updated all web links for the Department's new website*	*Throughout*	*MM*
12/08/14	*Removed Appendix H information, added Timely Filing document information*	*41*	*Mc*
5/6/15	*Added Rates language, added effective dates, removed value FC*	*14, 29, 34*	*AL*
5/6/15	*Updated information for Outpatient services, removed blank page 20, page 54, page 64,*	*18, 20, 54, 64*	*AL*
5/6/15	*Added language around Psychiatric and Psychological Services / Rehab for Alcohol and Drug Dependence*	*11*	*AL*
5/08/15	*Changed font to Tahoma, repositioned images.*	*Throughout*	*JH*
05/11/2015	*TOC updates and formatting*	*Throughout*	*bl*

Note: In many instances when specific pages are updated, the page numbers change for the entire section. Page numbers listed above, are the page numbers on which the updates/changes occur.