

# Immunization Benefit Billing Manual

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# Immunization Benefit Billing Manual

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This Immunization Benefit Billing Manual provides a summary of benefits and billing guidelines for Colorado Medicaid providers who administer vaccines to adults and children. The Colorado Department of Health Care Policy and Financing (the Department) periodically reviews and modifies the immunization benefits and services. Therefore, the information in this manual is subject to change, and the manual is updated as new policies are implemented.

To access the most recent fee schedule, please refer to the Provider Rates and Fee Schedules located on Department's [website](#) → For Our Providers → Provider Services → [Rates and Fee Schedules](#).

The Colorado Medicaid immunization benefit works to promote and facilitate the prevention of vaccine-preventable diseases. Colorado Medicaid maintains an inter-agency agreement with the [Colorado Department of Public Health and Environment](#) (CDPHE) to implement immunization recommendations by the [Advisory Committee on Immunization Practices](#) (ACIP) of the U.S. Department of Health and Human Services.

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## Covered Services

Immunizations for all Colorado Medicaid members are a benefit when recommended by the ACIP.

**Medicaid members ages 18 and under** are eligible to receive all immunizations available from the federal Vaccines for Children (VFC) Program, at VFC-enrolled provider offices.

- For more information about the VFC Program, please see the “Vaccines for Children Program” section in Appendix C of this manual.
- Immunizations may be given during an Early Periodic Screening Diagnosis and Treatment (EPSDT) periodic screening visit, an EPSDT inter-periodic visit, or any other medical appointment.
- Covered CPT codes are listed in **Appendix B** of this manual.
- The CDPHE Immunization Branch administers the VFC Program in Colorado, which provides all ACIP-recommended vaccines to medical providers at no cost to the provider for eligible members.

**Medicaid members ages 19 and 20** can receive immunizations with no co-pay. **Members ages 21 and older** may have an office visit co-pay at the time of service.

- Vaccines for Children vaccines cannot be used for anyone 19 and older.
- The influenza vaccine is covered for members ages 19 and older one time per year.

Members enrolled in a Colorado Medicaid Health Maintenance Organization (HMO) or Prepaid Inpatient Health Plan (PIHP) must receive immunization services through the plan's providers, not Medicaid fee-for-service providers.

Members enrolled in the Accountable Care Collaborative (ACC) must access immunization services through their assigned primary care physician.

Vaccines available from the VFC Program are updated annually and listed in this manual.

Refer to [www.colorado.gov/pacific/cdphe/immunization-schedules](http://www.colorado.gov/pacific/cdphe/immunization-schedules) for the current ACIP recommended schedules for children, teens and adults.

## Prior Authorization

There are no prior authorization requirements for any vaccine recommended by the ACIP. Please refer to the **Synagis®** section of this manual for more information about prior authorization of Synagis.

## **Non-Covered Services and General Limitations**

Colorado Medicaid will not reimburse providers for the cost of vaccines that are available through the VFC Program.

Immunizations for the sole purpose of international travel are not a benefit for Colorado Medicaid members.

School District providers participating in the School Health Services (SHS) Program may not bill for immunizations.

## **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 30, Denver, CO 80201-0090.

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

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

Paper claims do not require an NPI, but do require Colorado Medicaid provider number. 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/](http://wpc-edi.com/)) (HIPAA EDI Technical Report 3 (TR3))
- Companion Guides for the 837P, 837I, or 837D in the Provider Services [Specifications](#) section of the Department's website.
- Web Portal User Guide (via the portal)

Colorado Medicaid collects electronic claim information interactively through the Colorado Medicaid Secure Web Portal ([Web Portal](#)) or via batch submission through a host system. For additional electronic submission information, please refer to the General Provider Information manual located on the Department's website ([Colorado.gov/hcpf](http://Colorado.gov/hcpf)) → For Our Providers → Provider Services → [Billing Manuals](#).

**Billing for Members Ages 18 and Under**

Members ages 0-18 may receive vaccines at no cost through the VFC Program, a CDPHE-managed, federally-funded program. For providers to receive federally-funded vaccines to administer to their Medicaid members (ages 0-18), they must be enrolled in the VFC Program. Vaccines available through the VFC Program are not reimbursed by Colorado Medicaid. However, Colorado Medicaid reimburses providers for each administration of a VFC vaccine.

- If immunizations are given during an EPSDT periodic screening appointment or during any other medical care appointment (also called an “EPSDT inter-periodic visit”), claims must be submitted on the CMS 1500 paper claim form or as an 837 Professional (837P) electronic transaction using the appropriate procedure and diagnosis codes. For an example of the CMS 1500 paper claim form, please see the claim example at the end of this manual. Practitioners must maintain records that document the full nature and extent of the services rendered during this visit.
- If an immunization is the only service provided to a Colorado Medicaid member ages 18 and under, the administration fee must be billed on the CMS 1500 paper claim form or as an 837P electronic transaction with the appropriate procedure and diagnosis codes.

**Billing for Members Ages 19 and Over**

Colorado Medicaid reimburses for both vaccine administration and the vaccine product itself for members ages 19 and over. Administration codes **90471-90474** must be billed as one line item and the vaccine product should be billed as a separate line item. Providers must bill both an administration code and the product code in order to be reimbursed.

Providers must submit claims for adult immunization services on the CMS 1500 paper claim form or as an 837P electronic transaction. Please refer to bottom of the [Provider Services](#) home page on the Department’s website for the current fee schedule.

If an immunization is the only service rendered, providers may not submit charges for an Evaluation/Management (E&M) service.

If E&M services are rendered in addition to the immunization administration by an appropriate provider, enter the diagnosis and appropriate procedure codes on the claim.

**Vaccine Administration Codes and Reimbursement Rates**

The following codes should be used for all vaccine administration, including VFC vaccine administration for members 18 years old and younger. Report these codes in addition to the vaccine and toxoid code(s).

CPT Code	Description	Rate
Use the following codes for VFC vaccine administration, to patients 18 and under, with face-to-face counseling of the patient/family during the vaccine administration:		
<b>90460</b>	Through 18 years, via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered	\$21.68
+ <b>90461</b>	Each additional vaccine or toxoid component administered (list separately in addition to <b>90460</b> ; use to indicate multi-component vaccinations)	\$0

Use the following codes for vaccine administration to patients of any age when the administration is not accompanied by any face-to-face counseling, or for administration to patients over 18 with or without counseling:		
<b>90471</b>	(Including percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccines/toxoid) (do not report in conjunction with <b>90473</b> )	\$21.68
<b>+ 90472</b>	Each additional vaccine/toxoid (List separately in addition to <b>90471, 90473</b> )	\$12.59
<b>90473</b>	By intranasal or oral route; one vaccine (single or combination vaccine/toxoid) (do not report in conjunction with <b>90471</b> )	\$21.68
<b>+ 90474</b>	Each additional vaccine/toxoid administered by intranasal or oral route (List separately in addition to <b>90471, 90473</b> )	\$12.59

Please always refer to the [fee schedule](#) in the Provider Services section of the Department’s website for the most up-to-date rate information.

### Using Pediatric Immunization Codes 90460 and 90461

The following chart identifies the number of components in some of the common pediatric vaccines, and how to report the pediatric immunization administration codes for each vaccine:

**Table 1**

Vaccine	# of Components	Which Administration Codes to Report?
HPV	1	<b>90460</b>
Influenza	1	<b>90460</b>
Meningococcal	1	<b>90460</b>
Pneumococcal	1	<b>90460</b>
Td	2	<b>90460, 90461</b>
DTaP or Tdap	3	<b>90460, 90461, 90461</b>
MMR	3	<b>90460, 90461, 90461</b>
DTaP-Hib-IPV	5	<b>90460, 90461, 90461, 90461, 90461</b>
DTaP-HepB-IPV	5	<b>90460, 90461, 90461, 90461, 90461</b>
DTaP-IPV	4	<b>90460, 90461, 90461, 90461</b>
MMRV	4	<b>90460, 90461, 90461, 90461</b>
DTaP-Hib	4	<b>90460, 90461, 90461, 90461</b>
HepB-Hib	2	<b>90460, 90461</b>
Rotavirus	1	<b>90473</b>
IPV	1	<b>90460</b>

**Table 1**

Vaccine	# of Components	Which Administration Codes to Report?
Hib	1	<b>90460</b>

**Source:** American Academy of Pediatrics "[FAQ Fact Sheet for the 2011 Pediatric Immunization Administration Codes](#)"

**To submit claims for immunization services, providers must "roll up/bundle" the total unit count of the immunization administration codes.**

- If an immunization administration code is billed for each vaccine that was given during the visit as its own line item, each subsequent line item billed using **90460** after the initial **90460** line item will be denied as a duplicate claim.

**Example 1:**

The following example demonstrates how to bill for the administration of Hep A, DTaP-HIB-IPV, and MMR vaccines.

**Component Calculation and which codes to report (Using Table 1):**

**Table 2**

Vaccine	# of Components	Which Codes to Report?
Hep A	1	<b>90460</b>
DTaP-HIB-IPV	5	<b>90460, 90461, 90461, 90461, 90461</b>
MMR	3	<b>90460, 90461, 90461</b>

**How to Bill:**

**Table 3**

Line #	CPT Descriptor	CPT Code	Units
Line 1	First Vaccine Component	<b>90460</b>	3
Line 2	Additional Vaccine Component	<b>90461</b>	6
Line 3	Hep A	<b>90633</b>	1
Line 4	DTaP-HIB-IPV	<b>90698</b>	1
Line 5	MMR	<b>90707</b>	1

- CPT code **90460** is billed for three (3) units because it was reported once for each vaccine that was administered.
- CPT code **90461** is billed for six (6) units because it was reported six (6) times (four (4) times for the DTaP-HIB-IPV vaccine and two (2) times the MMR vaccine).

For further clarification on billing pediatric immunization codes, please refer to the [American Academy of Pediatrics \(AAP\) practice guidelines](#).

For billing questions, please contact the Department's fiscal agent, Xerox State Healthcare at 800-237-0757 or 800-237-0044.

## Using Vaccine Administration Codes 90471-90474

The immunization administration codes **90471-90474** need to be billed as one (1) line item, and the vaccine product should be billed as a separate line item. In order for an immunization claim to be reimbursed both an administration code and the vaccine product must be billed. If an immunization is the only service rendered, providers may not submit charges for an E&M service.

Adult immunizations are reimbursed at the lower of: billed charges, or the Medicaid fee schedule amount for each immunization.

Note: Providers are not to bill CPT codes **90471-90474** for children ages 0-18 for whom counseling was given (see section "Using Pediatric Immunization Codes **90460** and **90461**" in this manual). CPT Codes **90471-90474** must only be billed for members (ages 19 and older) or members ages 18 and under for whom no counseling was given.

## Preventive Medicine Counseling Codes 99401, 99402, and 99211

If a member receives only immunization-related counseling during the visit, the provider may not bill a preventive medicine counseling code, and may only bill the vaccine administration fee. However, if the member receives other prevention counseling (besides the immunizations) such as child health, developmental milestones, sexually transmitted infection safety, etc., the provider may bill the following codes:

- **99401** – Approximately 15 minutes of counseling
- **99402** – Approximately 30 minutes of counseling
- **99211** – Approximately five (5) minutes of counseling (for examples, please see Appendix B – Clinical Examples in the AMA CPT billing manual)
- **99420** - administration and interpretation of a health risk assessment instrument – used for adolescent depression screening.

Keep documentation in the member's chart that shows the duration of counseling and a list of the prevention topics covered during counseling.

When using a modifier is appropriate, refer to the [CMS NCCI Policy Manual](#), Chapter 1, Section E for specific guidance on proper use of modifiers.

## Billing Instructions for Specific Providers

### Managed Care Programs

Colorado Medicaid members enrolled in an HMO or PIHP must receive immunization services from the HMO or PIHP, and providers may not bill Colorado Medicaid directly for vaccines provided to these members.

### Outpatient, Emergency Room, or Inpatient Hospital

Immunization administration may be billed as part of an outpatient or emergency room visit when the visit is for medical reasons.

Outpatient or emergency room visits cannot be billed for the sole purpose of immunization administration. Administration of an immunization at the time of an inpatient stay is included in the APR-DRG.

## **Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC)**

Federally Qualified Health Centers and Rural Health Centers may bill an encounter fee even if the only service provided is administering an immunization. If an immunization is administered in addition to a routine office visit, then an additional encounter fee may not be billed.

## **Nursing Facilities**

Nursing facility residents may receive immunizations if ordered by their physician. The skilled nursing component for immunization administration is included in the facility's rate. The vaccine itself may be billed directly to Colorado Medicaid by a Colorado Medicaid enrolled pharmacy. The pharmacy must bill the appropriate National Drug Code (NDC) for the individual vaccine dose under the member's Colorado Medicaid ID.

## **Home Health**

A member receiving home health services may receive immunizations if the administration is part of a normally scheduled home health visit. A home health visit for the sole purpose of immunization administration is not a benefit.

The pharmacy bills the vaccine as an individual dose under the member's Colorado Medicaid ID. The home health agency may not bill for the vaccine.

## **Alternative Health Care Facilities (ACFs)/Group Homes**

Residents of an ACF may receive immunizations from their own physician. They may also receive vaccines under home health as stated above in the home health guideline.

Colorado Medicaid does not pay for home health agencies, physicians, or other non-physician practitioners to go to nursing facilities, group homes, or residential treatment centers to administer immunizations (for example: flu vaccines) to groups of members.

## **Medicare Crossover Claims (Medicare/Medicaid Claims)**

For Medicare crossover claims, Colorado Medicaid pays the Medicare deductible and coinsurance or Colorado Medicaid allowable reimbursement minus the Medicare payment, whichever amount is less. If Medicare's payment for immunization services is the same or greater than the Colorado Medicaid allowable benefit, no additional payment is made.

If Medicare pays 100% of the Medicare allowable, Colorado Medicaid makes no additional payment.

## **Immunization Billing Codes**

Please see **Appendix B** of this manual.

## **National Correct Coding Initiative (NCCI) Impacts on Immunization and Evaluation & Management (E&M) Codes**

Effective April 1, 2014, the Department will no longer reimburse NCCI procedure-to-procedure (PTP) edits when immunization administration procedure codes (CPT **90460-90474**) are paired with preventative medicine E&M service procedure codes (CPT **99381-99397**).

If a significant separately identifiable E&M service (e.g. new or established patient office or other outpatient services [**99201-99215**], office or other outpatient consultation [**99241-99245**], emergency department service [**99281-99285**], preventative medicine service [**99381-99429**] is performed), the appropriate E&M service code should be reported in addition to the vaccine and toxoid administration codes.

Each NCCI PTP edit has an assigned modifier indicator. A modifier indicator of "0" indicates that NCCI PTP-associated modifiers cannot be used to bypass the edit. A modifier indicator of "1" indicates that

NCCI PTP-associated modifiers may be used to bypass an edit under appropriate circumstances. A modifier indicator of "9" indicates that the edit has been deleted, and the modifier indicator is not relevant. The Correct Coding Modifier Indicator can be found in the files containing Medicaid NCCI PTP edits on the [CMS website](#).

A modifier should not be added to a HCPCS/CPT code solely to bypass an NCCI PTP edit, if the clinical circumstances do not justify its use. If the E&M service is significant and separately identifiable and performed on the same day, the E&M code should be billed with the vaccine and toxoid administration codes using PTP associated modifier '25'. Modifier '25' is only valid when appended to the E&M codes. Do not append to the immunization administration procedure codes **90460-90474**.

## Synagis® (palivizumab) Vaccine

Synagis® (Palivizumab) is used to prevent serious lower respiratory tract disease caused by Respiratory Syncytial Virus (RSV) in certain high risk pediatric members. The Department uses coverage criteria based on the American Academy of Pediatrics (AAP) 2014 and the Colorado Chapter of the AAP recommendations for RSV prophylactic therapy. Synagis® (Palivizumab) is not provided by the VFC program.

### Limitations on Synagis®

Synagis® is administered by intramuscular injections, at 15 mg per kg of body weight, once a month during expected periods of RSV frequency in the community. Providers should be aware that the Colorado RSV season typically has a later onset, starting closer to December, and should schedule their Synagis® doses accordingly. Synagis® administration must be prior authorized.

The 2015-2016 Synagis® season begins December 1, 2015 and ends April 30, 2015. For more information, please see the October 2015 Synagis® and Influenza Vaccines provider bulletin on the [Provider Bulletin](#) website.

### Billing for Synagis®

- The Department will provide pricing information during each Synagis® season.
- Providers may not ask members to obtain Synagis® from a pharmacy and bring it to the practitioner's office for administration.
- Synagis® given in a doctor's office, hospital, or dialysis unit is to be billed directly by those facilities as a medical benefit. **Synagis® may only be a pharmacy benefit if the medication is administered in the member's home or long-term care facility.**

**Note:** A separate Synagis® PAR process exists for the CHP+ State Managed Care Network members. Any questions regarding this process should be directed to Colorado Access at 303-751-9005 or 800-511-5010, or US Bioservices at 303-706-0053.

## Seasonal Influenza Vaccine

Seasonal influenza vaccine is a benefit for children and adults, and is recommended for individuals who are six (6) months of age or older. Influenza vaccine is available through the VFC Program for providers enrolled in the program to administer to Colorado Medicaid enrolled children/adolescents (aged 18 and under). (See Appendix B).

For more Colorado Medicaid information on the seasonal influenza vaccine for both children and adults, please see the October 2015 Synagis® and Influenza Vaccines Provider Bulletin on the [Provider Bulletin](#) website.

## **Colorado Department of Public Health and Environment (CDPHE) Vaccines for Children (VFC) Program**

The VFC Program, administered by CDPHE, partners with Colorado Medicaid to provide free vaccines for providers to administer to Medicaid-enrolled children.

Participation in the VFC Program is strongly encouraged by the Department. Providers, including but not limited to: private practitioners, managed care providers, local public health agencies, Rural Health Centers (RHCs), hospital outpatient clinics, school-based health centers, and Federally Qualified Health Centers (FQHCs), who wish to participate in the immunization program must enroll with CDPHE. Providers can get information on the CDPHE VFC program at [the program website found here](#), or by calling 303-692-2650.

## **CMS 1500 Paper Claim Reference Table**

The following paper form reference table shows required, optional, and conditional fields and detailed field completion instructions for the CMS 1500 paper claim form.

<b>CMS Field #</b>	<b>Field Label</b>	<b>Field is?</b>	<b>Instructions</b>
<b>1</b>	<b>Insurance Type</b>	Required	Place an "X" in the box marked as Medicaid.
<b>1a</b>	<b>Insured's ID Number</b>	Required	Enter the member's Colorado Medicaid seven-digit Medicaid ID number as it appears on the Medicaid Identification card. Example: A123456.
<b>2</b>	<b>Patient's Name</b>	Required	Enter the member's last name, first name, and middle initial.
<b>3</b>	<b>Patient's Date of Birth / Sex</b>	Required	Enter the patient's birth date using two digits for the month, two digits for the date, and two digits for the year. Example: 070115 for July 1, 2015.  Place an "X" in the appropriate box to indicate the sex of the member.
<b>4</b>	<b>Insured's Name</b>	Conditional	Complete if the member is covered by a <b>Medicare</b> health insurance policy. Enter the insured's full last name, first name, and middle initial. If the insured used a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name.
<b>5</b>	<b>Patient's Address</b>	Not Required	
<b>6</b>	<b>Patient's Relationship to Insured</b>	Conditional	Complete if the member is covered by a commercial health insurance policy. Place an "X" in the box that identifies the member's relationship to the policyholder.
<b>7</b>	<b>Insured's Address</b>	Not Required	
<b>8</b>	<b>Reserved for NUCC Use</b>		

CMS Field #	Field Label	Field is?	Instructions
9	<b>Other Insured's Name</b>	Conditional	If field 11d is marked "YES", enter the insured's last name, first name and middle initial.
9a	<b>Other Insured's Policy or Group Number</b>	Conditional	If field 11d is marked "YES", enter the policy or group number.
9b	<b>Reserved for NUCC Use</b>		
9c	<b>Reserved for NUCC Use</b>		
9d	<b>Insurance Plan or Program Name</b>	Conditional	If field 11d is marked "YES", enter the insurance plan or program name.
10a-c	<b>Is Patient's Condition Related to?</b>	Conditional	When appropriate, place an "X" in the correct box to indicate whether one or more of the services described in field 24 are for a condition or injury that occurred on the job, as a result of an auto accident or other.
10d	<b>Reserved for Local Use</b>		
11	<b>Insured's Policy, Group or FECA Number</b>	Conditional	Complete if the member is covered by a <b>Medicare</b> health insurance policy. Enter the insured's policy number as it appears on the ID card. Only complete if field 4 is completed.
11a	<b>Insured's Date of Birth, Sex</b>	Conditional	Complete if the member is covered by a <b>Medicare</b> health insurance policy. Enter the insured's birth date using two digits for the month, two digits for the date and two digits for the year. Example: 070115 for July 1, 2015. Place an "X" in the appropriate box to indicate the sex of the insured.

CMS Field #	Field Label	Field is?	Instructions
11b	Other Claim ID	Not Required	
11c	Insurance Plan Name or Program Name	Not Required	
11d	Is there another Health Benefit Plan?	Conditional	When appropriate, place an "X" in the correct box. If marked "YES", complete 9, 9a and 9d.
12	Patient's or Authorized Person's signature	Required	Enter "Signature on File", "SOF", or legal signature. If there is no signature on file, leave blank or enter "No Signature on File". Enter the date the claim form was signed.
13	Insured's or Authorized Person's Signature	Not Required	
14	Date of Current Illness Injury or Pregnancy	Conditional	<p>Complete if information is known. Enter the date of illness, injury or pregnancy, (date of the last menstrual period) using two digits for the month, two digits for the date and two digits for the year. Example: 070115 for July 1, 2015.</p> <p>Enter the applicable qualifier to identify which date is being reported</p> <p>431 Onset of Current Symptoms or Illness</p> <p>484 Last Menstrual Period</p>
15	Other Date	Not Required	
16	Date Patient Unable to Work in Current Occupation	Not Required	
17	Name of Referring Physician	Not Required	

CMS Field #	Field Label	Field is?	Instructions
18	<b>Hospitalization Dates Related to Current Service</b>	Conditional	Complete for services provided in an inpatient hospital setting. Enter the date of hospital admission and the date of discharge using two digits for the month, two digits for the date and two digits for the year. Example: 070115 for July 1, 2015. If the member is still hospitalized, the discharge date may be omitted. This information is not edited.
19	<b>Additional Claim Information</b>	Conditional	<b>LBOD</b> Use to document the Late Bill Override Date for timely filing.
20	<b>Outside Lab? \$ Charges</b>	Conditional	Complete if <u>all</u> laboratory work was referred to and performed by an outside laboratory. If this box is checked, no payment will be made to the physician for lab services. Do not complete this field if <u>any</u> laboratory work was performed in the office.  Practitioners may not request payment for services performed by an independent or hospital laboratory.
21	<b>Diagnosis or Nature of Illness or Injury</b>	Required	Enter at least one but no more than twelve diagnosis codes based on the member's diagnosis/condition.  Enter applicable ICD indicator to identify which version of ICD codes is being reported.  0 ICD-10-CM (DOS 10/1/15 and after) 9 ICD-9 CM (DOS 9/30/15 and before)
22	<b>Medicaid Resubmission Code</b>	Conditional	List the original reference number for adjusted claims.  When resubmitting a claim as a replacement or a void, enter the appropriate bill frequency code in the left-hand side of the field.  7 Replacement of prior claim 8 Void/Cancel of prior claim  This field is not intended for use for original claim submissions.
23	<b>Prior Authorization</b>	Not Required	

CMS Field #	Field Label	Field is?	Instructions																																				
24	Claim Line Detail	Information	<p>The paper claim form allows entry of up to six detailed billing lines. Fields 24A through 24J apply to each billed line.</p> <p><b>Do not enter more than six lines of information</b> on the paper claim. If more than six lines of information are entered, the additional lines will not be entered for processing.</p> <p>Each claim form must be fully completed (totaled).</p> <p><b>Do not file continuation claims</b> (e.g., Page 1 of 2).</p>																																				
24A	Dates of Service	Required	<p>The field accommodates the entry of two dates: a "From" date of services and a "To" date of service. Enter the date of service using two digits for the month, two digits for the date and two digits for the year. Example: 010116 for January 1, 2016</p> <table border="1" data-bbox="911 947 1247 1031"> <tr> <td colspan="3">From</td> <td colspan="3">To</td> </tr> <tr> <td>01</td><td>01</td><td>16</td> <td></td><td></td><td></td> </tr> </table> <p>Or</p> <table border="1" data-bbox="911 1087 1247 1171"> <tr> <td colspan="3">From</td> <td colspan="3">To</td> </tr> <tr> <td>01</td><td>01</td><td>16</td> <td>01</td><td>01</td><td>16</td> </tr> </table> <p>Span dates of service</p> <table border="1" data-bbox="911 1228 1247 1312"> <tr> <td colspan="3">From</td> <td colspan="3">To</td> </tr> <tr> <td>01</td><td>01</td><td>16</td> <td>01</td><td>31</td><td>16</td> </tr> </table> <p>Practitioner claims must be consecutive days. <u>Single Date of Service</u>: Enter the six digit date of service in the "From" field. Completion of the "To" field is not required. Do not spread the date entry across the two fields. <u>Span billing</u>: permissible if the same service (same procedure code) is provided on consecutive dates.</p> <p><b>Supplemental Qualifier</b> To enter supplemental information, begin at 24A by entering the qualifier and then the information.</p> <p>ZZ Narrative description of unspecified code N4 National Drug Codes</p>	From			To			01	01	16				From			To			01	01	16	01	01	16	From			To			01	01	16	01	31	16
From			To																																				
01	01	16																																					
From			To																																				
01	01	16	01	01	16																																		
From			To																																				
01	01	16	01	31	16																																		

CMS Field #	Field Label	Field is?	Instructions
			VP Vendor Product Number OZ Product Number CTR Contract Rate JP Universal/National Tooth Designation JO Dentistry Designation System for Tooth & Areas of Oral Cavity
<b>24B</b>	<b>Place of Service</b>	Required	Enter the Place of Service (POS) code that describes the location where services were rendered. Colorado Medicaid accepts the CMS place of service codes.  03 School 04 Homeless Shelter 05 IHS Free-Standing Facility 06 Provider-Based Facility 07 Tribal 638 Free-Standing 08 Tribal 638 Provider-Based 11 Office 12 Home 15 Mobile Unit 20 Urgent Care Facility 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room Hospital 24 ASC 25 Birthing Center 26 Military Treatment Center 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Transportation – Land 42 Transportation – Air or Water 50 Federally Qualified Health Center 51 Inpatient Psychiatric Facility

CMS Field #	Field Label	Field is?	Instructions
			52 Psychiatric Facility Partial Hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility – MR 55 Residential Treatment Facility 60 Mass Immunization Center 61 Comprehensive IP Rehab Facility 62 Comprehensive OP Rehab Facility 65 End Stage Renal Dialysis Trtmt Facility 71 State-Local Public Health Clinic 72 Rural Health Clinic 81 Independent Lab 99 Other Unlisted
<b>24C</b>	<b>EMG</b>	Conditional	Enter a "Y" for YES or leave blank for NO in the bottom, unshaded area of the field to indicate the service is rendered for a life-threatening condition or one that requires immediate medical intervention.  If a "Y" for YES is entered, the service on this detail line is exempt from co-payment requirements.
<b>24D</b>	<b>Procedures, Services, or Supplies</b>	Required	Enter the HCPCS procedure code that specifically describes the service for which payment is requested.  All procedures must be identified with codes in the current edition of Physicians Current Procedural Terminology (CPT). CPT is updated annually.  HCPCS Level II Codes  The current Medicare coding publication (for Medicare crossover claims only).  Only approved codes from the current CPT or HCPCS publications will be accepted.
<b>24D</b>	<b>Modifier</b>	Not Required	

CMS Field #	Field Label	Field is?	Instructions
24E	<b>Diagnosis Pointer</b>	Required	<p>Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis.</p> <p>At least one diagnosis code reference letter must be entered.</p> <p>When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow.</p> <p>This field allows for the entry of four (4) characters in the unshaded area.</p>
24F	<b>\$ Charges</b>	Required	<p>Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.</p> <p>Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one procedure from the same group is billed, special multiple pricing rules apply.</p> <p>The base procedure is the procedure with the highest allowable amount. The base code is used to determine the allowable amounts for additional CPT surgical procedures when more than one procedure from the same grouping is performed.</p> <p>Submitted charges cannot be more than charges made to non-Colorado Medicaid covered individuals for the same service.</p> <p>Do not deduct Colorado Medicaid co-payment or commercial insurance payments from the usual and customary charges.</p>
24G	<b>Days or Units</b>	Required	<p>Enter the number of services provided for each procedure code.</p> <p>Enter whole numbers only- do not enter fractions or decimals.</p>
24H	<b>EPSDT/Family Plan</b>	Conditional	<p><b>EPSDT</b> (shaded area)</p> <p>For Early &amp; Periodic Screening, Diagnosis, and Treatment related services, enter the response in the shaded portion of the field as follows:</p> <p>AV Available- Not Used</p>

CMS Field #	Field Label	Field is?	Instructions
			S2 Under Treatment ST New Service Requested NU Not Used <b>Family Planning</b> (unshaded area) If the service is Family Planning, enter "Y" for YES or "N" for NO in the bottom, unshaded area of the field.
24I	ID Qualifier	Not Required	
24J	Rendering Provider ID #	Required	In the shaded portion of the field, enter the eight-digit Colorado Medicaid provider number assigned to the <u>individual</u> who actually performed or rendered the billed service. This number cannot be assigned to a group or clinic. NOTE: When billing a paper claim form, do not use the individual's NPI.
25	Federal Tax ID Number	Not Required	
26	Patient's Account Number	Optional	Enter information that identifies the patient or claim in the provider's billing system. Submitted information appears on the Provider Claim Report (PCR).
27	Accept Assignment?	Required	The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.
28	Total Charge	Required	Enter the sum of all charges listed in field 24F. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
29	Amount Paid	Conditional	Enter the total amount paid by Medicare or any other commercial health insurance that has made payment on the billed services. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.

CMS Field #	Field Label	Field is?	Instructions
30	Rsvd for NUCC Use		
31	<b>Signature of Physician or Supplier Including Degrees or Credentials</b>	Required	<p>Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent.</p> <p>A holographic signature stamp may be used <u>if</u> authorization for the stamp is on file with the fiscal agent.</p> <p>An authorized agent or representative may sign the claim for the enrolled provider <u>if</u> the name and signature of the agent is on file with the fiscal agent.</p> <p>Each claim must have the date the enrolled provider or registered authorized agent signed the claim form. Enter the date the claim was signed using two digits for the month, two digits for the date and two digits for the year. Example: 070115 for July 1, 2015.</p> <p><b>Unacceptable signature alternatives:</b></p> <p>Claim preparation personnel may not sign the enrolled provider’s name.</p> <p>Initials are not acceptable as a signature.</p> <p>Typed or computer printed names are not acceptable as a signature.</p> <p>“Signature on file” notation is not acceptable in place of an authorized signature.</p>
32	<b>32- Service Facility Location Information</b> <b>32a- NPI Number</b> <b>32b- Other ID #</b>	Conditional	<p>Complete for services provided in a hospital or nursing facility in the following format:</p> <p>1<sup>st</sup> Line Facility Name</p> <p>2<sup>nd</sup> Line Address</p> <p>3<sup>rd</sup> Line City, State and ZIP Code</p> <p>32a- NPI Number</p> <p>Enter the NPI of the service facility (if known).</p> <p>32b- Other ID #</p> <p>Enter the eight-digit Colorado Medicaid provider number of the service facility (if known).</p> <p>The information in field 32, 32a and 32b is not edited.</p>

CMS Field #	Field Label	Field is?	Instructions
33	<b>33- Billing Provider Info &amp; Ph #</b> <b>33a- NPI Number</b> <b>33b- Other ID #</b>	Required	Enter the name of the individual or organization that will receive payment for the billed services in the following format: 1 <sup>st</sup> Line    Name 2 <sup>nd</sup> Line    Address 3 <sup>rd</sup> Line    City, State and ZIP Code 33a- NPI Number Enter the NPI of the billing provider 33b- Other ID # Enter the eight-digit Colorado Medicaid provider number of the individual or organization.

# CMS 1500 Immunization Claim Example



## HEALTH INSURANCE CLAIM FORM

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

PICA										PICA																			
1. MEDICARE (Medicare #) <input checked="" type="checkbox"/> MEDICAID (Medicaid #) <input checked="" type="checkbox"/> TRICARE (ID#/DoDR#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>D444444</b>																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Client, Ima A</b>										3. PATIENT'S BIRTH DATE (MM   DD   YY) <b>10   16   45</b> SEX <b>M</b> <input checked="" type="checkbox"/> <b>F</b> <input checked="" type="checkbox"/>																			
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse Child Other																			
CITY					STATE					7. INSURED'S ADDRESS (No., Street)					8. RESERVED FOR NUCC USE														
ZIP CODE					TELEPHONE (Include Area Code)					CITY					STATE														
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) YES NO										a. INSURED'S DATE OF BIRTH (MM   DD   YY) SEX <b>M</b> <input checked="" type="checkbox"/> <b>F</b> <input checked="" type="checkbox"/>									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? PLACE (State) YES NO										b. OTHER CLAIM ID (Designated by NUCC)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? YES NO										c. INSURANCE PLAN NAME OR PROGRAM NAME									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> <i>If yes, complete items 9, 9a and 9d.</i>									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.  SIGNED <b>Signature on File</b> DATE <b>1/1/16</b>										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  SIGNED																			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM   DD   YY QUAL										15. OTHER DATE MM   DD   YY QUAL										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM   DD   YY TO MM   DD   YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. NPI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM   DD   YY TO MM   DD   YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES YES NO										22. RESUBMISSION CODE ORIGINAL REF. NO.									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. <b>0</b>										23. PRIOR AUTHORIZATION NUMBER										24. A. DATE(S) OF SERVICE From MM   DD   YY To MM   DD   YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSSIT Family Plan I. ID QUAL J. RENDERING PROVIDER ID #									
A. <b>Z 139</b>										B. _____ C. _____ D. _____										E. _____ F. _____ G. _____ H. _____									
I. _____ J. _____ K. _____ L. _____										F. <b>18   15</b> G. <b>1</b> H. <b>12345678</b> I. <b>NPI</b> J. <b>0123456789</b>										F. <b>21   68</b> G. <b>1</b> H. <b>12345678</b> I. <b>NPI</b> J. <b>0123456789</b>									
1										2										3									
4										5										6									
25. FEDERAL TAX I.D. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO. <b>Optional</b>										27. ACCEPT ASSIGNMENT? (For govt. claims, see task) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									
28. TOTAL CHARGE \$ <b>39   83</b>										29. AMOUNT PAID \$										30. Rsvd for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH# ( ) <b>ABC Clinic</b> <b>100 Any Street</b> <b>Any City</b>									
SIGNED <b>Signature</b> DATE <b>1/1/16</b>										a. <b>1234567890</b> b. <b>04567890</b>										a. <b>1234567890</b> b. <b>04567890</b>									

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

## Late Bill Override Date

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

### Valid Delay Reason Codes

- 1 Proof of Eligibility Unknown or Unavailable
- 3 Authorization Delays
- 7 Third Party Processing Delay
- 8 Delay in Eligibility Determination
- 9 Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules
- 11 Other



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

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

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

Billing Instruction Detail	Instructions
<p><b>Commercial Insurance Processing</b></p>	<p>The claim has been paid or denied by commercial insurance.  <b>File the claim within 60 days</b> of the insurance payment or denial. Retain the commercial insurance payment or denial notice that identifies the patient, rendered services, and shows the payment or denial date.                      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.  <b>LBOD</b> = the date commercial insurance paid or denied.</p>
<p><b>Correspondence LBOD Authorization</b></p>	<p>The claim is being submitted in accordance with instructions (authorization) from Colorado Medicaid for a 60 day filing extension for a specific member, claim, services, or circumstances.  <b>File the claim within 60 days</b> of the date on the authorization letter. Retain the authorization letter.  <b>LBOD</b> = the date on the authorization letter.</p>
<p><b>Member Changes Providers during Obstetrical Care</b></p>	<p>The claim is for obstetrical care where the patient transferred to another provider for continuation of OB care. The prenatal visits must be billed using individual visit codes but the service dates are outside the initial timely filing period.  <b>File the claim within 60 days</b> of the last OB visit. Maintain information in the medical record showing the date of the last prenatal visit and a notation that the patient transferred to another provider for continuation of OB care.  <b>LBOD</b> = the last date of OB care by the billing provider.</p>

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# Appendices

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## **Appendix A - Immunization Schedules**

- Recommended [Immunization schedule](#) for persons aged 0 through 18 years.
- Recommended [Immunization schedule](#) for adults aged 19 and older.

## Appendix B

<b>Immunization Coding Quick Reference</b>		
<p>Practitioners billing for immunizations provided to Colorado Medicaid enrolled children, ages 18 and under when vaccine is available at no cost through the VFC Program, are paid only an administration fee for each immunization using CPT codes 90460 and 90471 – 90474. The immunization administration add-on code for each additional vaccine component in a given vaccine, 90461, is paid an administration fee of \$0.</p> <p>Medically necessary vaccines for members over age 18 are not available through the VFC Program and are reimbursed at the lower of billed charges or Medicaid fee schedule for each immunization. Reimbursement is subject to change. Please refer to the bottom of the <a href="#">Provider Services</a> home page on the Department's website for the current fee schedule.</p> <p>Note: Immune Globulins are not available from the CDPHE Immunization Branch.</p>		
Key		
Ig – immune globulin	INJ – jet injection	SQ – subcutaneous
IM – intramuscular	IV – intravenous	vacc – vaccine

Code	Description	Valid Ages	Maximum Allowable Reimbursement	VFC Program Benefit
<b>Immune Globulins</b>				
<b>90281</b>	Human Ig, IM	All ages	\$15.03	
<b>90283</b>	Human Ig, IV	All ages	\$263.27	
<b>90284</b>	Human Ig, SQ	All ages	\$592.75	
<b>90287</b>	Botulinum antitoxin, equine	All ages	\$196.99	
<b>90288</b>	Botulism Ig, IV	All ages	\$462.64	
<b>90291</b>	CMV Ig, IV	All ages	\$367.24	
<b>90296</b>	Diphtheria antitoxin, equine	All ages	\$41.46	
<b>90371</b>	Hep B Ig, IM	All ages	\$168.88	
<b>90375</b>	Rabies Ig, IM/SQ	All ages	\$97.14	
<b>90376</b>	Rabies Ig, heat-treated, IM/SQ	All ages	\$96.10	
<b>90378</b>	RSV Ig, IM, 50mg (Synagis®)	0-3	\$1,372.74	
<b>90384</b>	Rh Ig, full-dose, IM	All ages	\$115.69	
<b>90385</b>	Rh Ig, mini-dose, IM	All ages	\$52.66	
<b>90386</b>	Rh Ig, IV	All ages	\$131.80	
<b>90389</b>	Tetanus Ig, IM	All ages	\$114.25	

Code	Description	Valid Ages	Maximum Allowable Reimbursement	VFC Program Benefit
90393	Vaccinia Ig, IM	All ages	\$116.49	
90396	Varicella-zoster Ig, IM	All ages	\$110.66	
90399	Unlisted immune globulin	All ages	\$57.26	

Code	Description	Valid Ages	Maximum Allowable Reimbursement	VFC Program Benefit
<b>Vaccines, Toxoids</b>				
90476	Adenovirus vacc, type 4, oral	17+, only given by the military	\$35.08	
90477	Adenovirus vacc, type 7, oral	All ages	\$35.08	
90620	Meningococcal B, 2 dose	0-18	\$0	√
		19+	\$160.75	
90621	Meningococcal B, 3 dose	0-18	\$0	√
		19+	\$115.75	
90632	Hep A vacc, adult, IM	19+	\$79.20	
90633	Hep A vacc, ped/adol, 2 dose, IM	0-18	\$0	√
90636	Hep A & Hep B vacc adult, IM	18+	\$106.11	
90645	Hib vacc HbOC, 4 dose, IM	0-4	\$0	√
90647	Hib vacc, PRP-OMP, 3 dose, IM	0-4	\$0	√
90648	Hib-PRP-T	2-71 months	\$0	√
90649	HPV vacc types 6,11,16,18 quadrivalent 3 dose, IM	9-18	\$0	√
		19-26	\$159.96	
90650	HPV vacc types 16, 18 bivalent 3 dose, IM	19-26, female only	\$159.96	
90651	HPV9 vacc types 6, 11, 16, 18, 31, 33, 45, 52, 58	9-18	\$0	√
		19-26	\$163.09	
90654	Influenza virus vaccine, split virus, preservative free, for intradermal use (IIV3)	19+	\$18.75	

<b>Code</b>	<b>Description</b>	<b>Valid Ages</b>	<b>Maximum Allowable Reimbursement</b>	<b>VFC Program Benefit</b>
<b>90655</b>	Flu vacc, 6-35 mo, preserv free, IM (IIV3)	0-2	\$0	√
<b>90656</b>	Flu vacc, 3 yrs +, preserv free, IM (IIV3)	3-18	\$0	√
		19+	\$18.15	
<b>90657</b>	Flu vacc, 6-35 mo, IM (IIV3)	0-2	\$0	√
<b>90658</b>	Flu vacc, 3 yrs +, IM (IIV3)	3-18	\$0	√
		19+	\$14.29	
<b>90660</b>	Flu vacc, live, intranasal (LAIV3)	No longer produced by manufacturer (see 90672)		
<b>90661</b>	Flu vacc, egg free, preserv free	19+		
			\$14.40	
<b>90669</b>	Pneum conj vacc, polyval, < 5 yrs, IM	0-4	\$0	√
<b>90670</b>	Pneumococcal Conj Vacc, 13 Valent, IM	0-18	\$0	√
		19+, w/ Immune health issue	\$152.01	
<b>90672</b>	Influenza vaccine for nasal administration (LAIV4)	2-18	\$0	√
		21+	\$21.79	
<b>90675</b>	Rabies vacc, IM	All ages	\$234.39	
<b>90680</b>	Rotavirus vacc, pentavalent, oral	8-32 weeks	\$0	√
<b>90681</b>	Rotavirus vacc, attenuated, oral	8-32 weeks	\$0	√
<b>90685</b>	Influenza virus vacc, quadrivalent, split virus, preservative free (single dose syringe)	6-35 months	\$0	√
<b>90686</b>	Influenza virus vacc, quadrivalent, split virus, preservative free, 3 yrs +, IM (single dose syringe)	3-18	\$0	√
		19+	\$15.76	
<b>90687</b>	Influenza virus vacc, quadrivalent, split virus, preservative free ages 6-35 months (Multi-dose vial)	6-35 months	\$0	√
<b>90688</b>		3-18	\$0	√

Code	Description	Valid Ages	Maximum Allowable Reimbursement	VFC Program Benefit
	Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use, IM (multi-dose vial)	19+	\$15.76	
<b>90696</b>	D Tap-IPV vacc, IM	4-6	\$0	√
<b>90698</b>	DTaP – Hib – IPV vacc, IM	0-4	\$0	√
<b>90700</b>	DTaP vacc, < 7 yrs, IM	0-6	\$0	√
<b>90702</b>	DT vacc, < 7 yrs, IM	0-6	\$0	√
<b>90703</b>	Tetanus vacc, IM	All ages	\$53.93	
<b>90704</b>	Mumps vacc, SQ	All ages	\$30.53	
<b>90705</b>	Measles vacc, SQ	All ages	\$24.03	
<b>90706</b>	Rubella vacc, SQ	All ages	\$26.54	
<b>90707</b>	MMR vacc, SQ	0-18	\$0	√
		19+	\$54.49	

Code	Description	Valid Ages	Maximum Allowable Reimbursement	VFC Program Benefit
<b>90708</b>	Measles-rubella vacc, SQ	All ages	\$29.19	
<b>90710</b>	MMRV vacc, SQ	1-12	\$0	√
<b>90713</b>	Poliovirus vacc, IPV, SQ, IM	0-18	\$0	√
		19+	\$65.08	
<b>90714</b>	Td vacc, 7 yrs +, preserv free, IM	7-18	\$0	√
		19+	\$52.57	
<b>90715</b>	Tdap vacc, 7 yrs +, IM	7-18	\$0	√
		19+	\$99.21	
<b>90716</b>	Varicella (chicken pox) vacc, SQ	0-18	\$0	√
		19+	\$104.52	
<b>90718</b>	Td vacc, 7 yrs +, IM (code deleted from CPT 1/1/13)	7-18	\$0	
		19+	\$29.40	
<b>90719</b>	Diphtheria vacc, IM	All ages	\$10.67	

<b>Code</b>	<b>Description</b>	<b>Valid Ages</b>	<b>Maximum Allowable Reimbursement</b>	<b>VFC Program Benefit</b>
<b>90721</b>	DTaP/Hib vacc, IM	0-6	\$0	√
<b>90723</b>	DTaP-Hep B-IPV vacc, IM	0-6	\$0	√
<b>90732</b>	Pneum polysacc vacc, 23 valent, adult or ill pat, SQ/IM	2-18	\$0	√
		19+	\$77.86	
<b>90733</b>	Meningococcal polysacc vacc, SQ	All ages	\$120.91	
<b>90734</b>	Meningococcal conj vacc, serogrp A, C, Y, W-135, IM	10-18	\$0	√
		19-25	\$112.11	
<b>90735</b>	Encephalitis vacc, SQ	All ages	\$118.93	
<b>90736</b>	Zoster vacc, SQ	60+	\$179.53	
<b>90740</b>	Hep B vacc, ill pat, 3 dose, IM	0-18	\$0	√
		19-20	\$121.08	
<b>90743</b>	Hep B vacc, adol, 2 dose, IM	11-15	\$0	√
<b>90744</b>	Hep B vacc, ped/adol, 3 dose, IM	0-18	\$0	√
<b>90746</b>	Hep B vacc, adult, IM	0-18	\$0	
		19+	\$74.25	
<b>90747</b>	Hep B vacc, ill pat, 4 dose, IM	0-18	\$0	√
		19+	\$74.26	
<b>90749</b>	Unlisted vaccine/toxoid	All ages	Manually priced	
<b>S0195</b>	Pneum conj, polyvalent, IM, 5-9 yrs with no previous dose	5-9	\$0	√

## **Appendix C - Vaccines for Children Program**

### **Vaccines for Children Program (VCF) Information**

Updated information about the VFC program can be found at the following website:

[www.colorado.gov/pacific/cdphe/vaccines-children](http://www.colorado.gov/pacific/cdphe/vaccines-children)

### ***Immunization Manual Revisions Log***

<b>Revision Date</b>	<b>Additions/Changes</b>	<b>Pages</b>	<b>Made by</b>
07/02/2012	Manual Published	All	akb
12/07/2012	Updated Immunizations for ages 19 and 20 Information	All	akb
12/12/2012	Removed ACS and replaced with Xerox State Healthcare	All	cc
12/17/2012	Reviewed, formatted and updated TOC	All	jg
04/23/2013	Consolidated Electronic Billing information by referring to the General Colorado 1500 Billing Manual Added 2013 newly covered HCPC: 90672& 90686	5 39	cc
05/14/2013	Updated TOC Reformatted	i-ii Throughout	jg
08/30/2013	Added NCCI PTP info Removed CIP Removed comments from Current Vaccines Provided to the VFC Program Enrolled Providers Updated Synagis pricing in Appendix B Added "female only" to HPV in Appendix B Changed age for influenza virus vac in Appendix B	8 11 15 36 37 38	mh
09/05/2013	Updated dates	Throughout	cc
09/20/2013	Reformatted Updated TOC Replaced "dually eligible" with "Medicare-Medicaid enrollees"	Throughout i-ii 18	jg
02/06/2014	Added 2% price increase in Appendix B Updated Synagis Bulletin to 2013 Added NCCI Impacts on Immunizations & E&M codes	Appendix B 2 8	mh
02/10/2014	Removed reference to deleted codes 90470 & 90663 Removed reference to added code 90654 Revised children, adolescent, and adult immunization schedule Rates added for procedure codes: 90735, 90736, and 90654 Updated FAQs	11 12 32 39 46-51	cc
02/10/2014	Formatted Revised claim example Updated TOC	Throughout 27 i-ii	jg
03/04/2014	Updated 90636 to \$106.11; 90707 to \$53.42 & 90734 to \$109.91	34, 35 & 36	jg

05/14/2014	Updated Billing Manual for removal of the Primary Care Physician Program	Throughout	Mm
08/11/2014	Updated all web links for the Department's new website	Throughout	Mm
08/29/2014	Updated additional rate information per policy	7	MM
11/19/14	Changed the \$6.33 & \$6.46 immunization administration reimbursement rate to \$6.59 per Meredith Henry's request	2, 6, 7	Mc
12/8/14	Removed Appendix H information, added Timely Filing document information	32	Mc
12/11/14	Added CPT code 90661 and 90670 and its descriptions. Added by Jeremy Oat	7, 35, 36	Mc
12/11/14	Updated hyperlinks	throughout	Mc
04/28/2015	Changed the word unshaded to shaded	24J	Bl
8/25/15	Reviewed for ICD-9 changes but no diagnoses codes are utilized. There are no PAR'd procedures per the billing manual other than Synagis.	Throughout	JH
9/8/15	Updated to reflect changes in VFC policy, vaccination information, rate changes, Synagis and flu season information. Added by Elizabeth Freudenthal	Throughout	EF
10/08/15	Updated claim example image for ICD-10	20	JH
10/20/15	Minor format updating.	Throughout	JH
10/20/15	TOC updates, formatting throughout, removal of blank space	Throughout	bl
3/30/16	Corrected rate for 90461	3	EF

**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.