Medical/Surgical Services Manual

Benefits Overview 1
Billing Information 1
- *National Provider Identifier (NPI)* 1
- *Paper Claims* 1
- *Electronic Claims* 1

Paper PAR Instructional Reference 5
Prior Authorization Request Form 10
Procedure/HCPCS Codes Overview 11
Anesthesia Services 11
- *General Benefits* 11
- *Anesthesia by Surgeon* 12
- *Obstetrical Anesthesia* 12
- *Standby Anesthesia* 12

Family Planning Services 12
Foot Care Services 12
Laboratory Services 13
- *General Benefits* 13
- *Interpretation of laboratory testing* 13
- *Handling, collection, and conveyance charges* 13
- *Papanicolaou (Pap) smears* 14

Medical Services 14
- *Consultation* 14
- *Vaccines/Immunizations* 14
- *Medical care and surgery on the same day* 15
- *New Patient Services* 15
- *Nursing Facility Visits* 15
- *Office Visits* 15
- *Supplies Provided by a Physician* 15
- *Non-benefit Medical Services* 16

Psychiatric Services 16
- *General benefits* 16
- *Non-benefit psychiatric services* 16

Behavioral Health Organizations (BHOs) 17
Radiology Services 18
- *General Benefits* 18
- *Home/Nursing Facility Radiology Services* 18

Surgical Services 18
- *General Benefits* 18

Cosmetic Surgery *18*
Abortion *18*
Assistant surgeon *18*
Hysterectomy *19*
Reconstructive surgery *19*
Sterilization *19*
Transplantation *19*
Multiple Surgeries *19*
Bilateral procedures – modifier 50 ..... *19*
Multiple procedures – modifier 51 ..... *19*
Two surgeons – modifier 62 ..... *20*
Vision Care Services *20*
Paper Claim Reference Table *21*
Late Bill Override Date *35*
Sterilizations, Hysterectomies and Abortions *39*
Voluntary sterilizations *39*
General requirements *39*
Hysterectomies *42*
Abortions *43*
Spontaneous Abortion (Miscarriage) *47*
Medical Claim Example ..... ***Error! Bookmark not defined.***
Medical Crossover Claim Example *49*
Medical Claim with CLIA Number Example *49*

Medical/Surgical Services Manual

Benefits Overview

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

The Colorado Medical Assistance Program reimburses providers for medically necessary medical and surgical services furnished to eligible members.

Providers should refer to the Code of Colorado Regulations, Program Rules (10 CCR 2505-10), for specific information when providing medical/surgical services.

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 of Health Care Policy and Financing (the Department). Requests may be sent to Affiliated Computer Services (ACS), 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. 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/ (HIPAA EDI Technical Report 3 (TR3))
- Companion Guides for the 837P, 837I, or 837D are available on the Department’s Web site in the Provider Services Specifications section.
- Web Portal User Guide (within the Web 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.

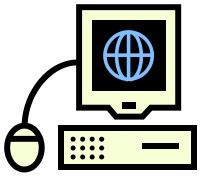
Interactive Claim Submission and Processing

Interactive claim submission through the Web Portal is a real-time exchange of information between the provider and the Colorado Medical Assistance Program. Colorado Medical Assistance Program providers may create and transmit HIPAA compliant 837P (Professional), 837I (Institutional), and 837D (Dental) claims electronically one at a time.

These claims are transmitted through the Colorado Medical Assistance Program OnLine Transaction Processor (OLTP).

The Colorado Medical Assistance Program OLTP reviews the claim information for compliance with Colorado Medical Assistance Program billing policy and returns a response to the provider's personal computer about that single transaction. If the claim is rejected, the OLTP sends a rejection response that identifies the rejection reason.

If the claim is accepted, the provider receives an acceptance message and the OLTP passes accepted claim information to the Colorado Medical Assistance Program claim processing system for final adjudication and reporting on the Colorado Medical Assistance Program Provider Claim Report (PCR).



The Web Portal contains online training, user guides and help that describe claim completion requirements, a mechanism that allows the user to create and maintain a data base of frequently used information, edits that verify the format and validity of the entered information, and edits that assure that required fields are completed.

Because a claim submitter connects to the Web Portal through the Internet, there is no delay for “dialing up” when submitting claims. The Web Portal provides immediate feedback directly to the submitter. All claims are processed to provide a weekly Health Care Claim Payment/Advice (Accredited Standards Committee [ASC] X12N 835) transaction and/or Provider Claim Report to providers. The Web Portal also provides access to reports and transactions generated from claims submitted via paper and through electronic data submission methods other than the Web Portal. The reports and transactions include:

- Accept/Reject Report
- Provider Claim Report
- Health Care Claim Payment/Advice (ASC X12N 835)
- Managed Care Reports such as Primary Care Physician Rosters
- Eligibility Inquiry (interactive and batch)
- Claim Status Inquiry

Claims may be adjusted, edited and resubmitted, and voided in real time through the Web Portal located at colorado.gov/hcpf, Secured Site. For help with claim submission via the Web Portal, please choose the *User Guide* option available for each Web Portal transaction. For additional electronic billing information, please refer to the appropriate Companion Guide in the Specifications section.

Batch Electronic Claim Submission

Batch billing refers to the electronic creation and transmission of several claims in a group. Batch billing systems usually extract information from an automated accounting or patient billing system to create a group of claim transactions. Claims may be transmitted from the provider's office or sent through a billing vendor or clearinghouse.

All batch claim submission software must be tested and approved by the Colorado Medical Assistance Program fiscal agent.

Any entity sending electronic claims to ACS Electronic Data Interchange (EDI) Gateway for processing where reports and responses will be delivered must complete an EDI enrollment package. This provides ACS EDI Gateway the information necessary to assign a Logon Name, Logon ID, and Trading Partner ID, which are required to submit electronic claims. You may obtain an enrollment package by contacting the Colorado Medical Assistance Program fiscal agent or by downloading it from the EDI Support section of the Department's website.

The X12N 837 Professional, Institutional, or Dental transaction data will be submitted to the EDI Gateway, which validates submission of American National Standards Institute (ANSI) X12N format(s). The TA1 Interchange Acknowledgement reports the syntactical analysis of the interchange header and trailer. If the data is corrupt or the trading partner relationship does not exist within the Medicaid Management Information System (MMIS), the interchange will reject and a TA1 along with the data will be forwarded to the ACS State Healthcare Clearinghouse (SHCH) Technical Support for review and follow-up with the sender. An X12N 999 Functional Acknowledgement is generated when a file that has passed the header and trailer check passes through the ACS SHCH.

If the file contains syntactical error(s), the segment(s) and element(s) where the error(s) occurred will be reported. After validation, the ACS SHCH will then return the X12N 835 Remittance Advice containing information related to payees, payers, dollar amount, and payments. These X12N transactions will be returned to the Web Portal for retrieval by the trading partner, following the standard claims processing cycle.

Testing and Vendor Certification

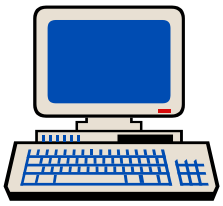
Completion of the testing process must occur prior to submission of electronic batch claims to ACS EDI Gateway. Assistance from ACS EDI business analysts is available throughout this process. Each test transmission is inspected thoroughly to ensure no formatting errors are present. Testing is conducted to verify the integrity of the format, not the integrity of the data; however, in order to simulate a production environment, EDI requests that providers send real transmission data.

The number of required test transmissions depends on the number of format errors on a transmission and the relative severity of these errors. Additional testing may be required in the future to verify any changes made to the MMIS have not affected provider submissions. Also, changes to the ANSI formats may require additional testing.

In order to expedite testing, ACS EDI Gateway requires providers to submit all X12N test transactions to Edifecs prior to submitting them to ACS EDI Gateway. The Edifecs service is free to providers to certify X12N readiness. Edifecs offers submission and rapid result turnaround 24 hours a day, 7 days a week. For more information, go to edifecs.com (Edifecs).

Prior Authorization

Although most procedures can be processed without prior review and approval, certain procedures require prior authorization. A list of authorizing agencies, addresses, and telephone numbers is located in Appendices C and D in the Appendices of the Provider Services Billing Manuals section of Department's Web site. Selected surgical procedures and all services provided outside of Colorado, with the exception of emergency services, require prior authorization. Providers must complete, submit, and receive approval of the Prior Authorization Request (PAR) **before** rendering the service or supply. Surgical procedure codes requiring prior authorization are listed in Appendix M.



Providers are encouraged to submit PARs electronically using the 278 Transaction. Electronically submitted PARs without the minimally required information are rejected. Instructions for completing and submitting electronic PARs are available through the 278 Transaction Companion Guide found on the Department's Web site in the Specifications section.

Electronic PAR submission offers the provider:

- Immediate system assignment of a PAR number
- Faster PAR processing

Only Dental Care, Medical Care, and Supply PARs may be submitted electronically through the Web Portal, but *all* PAR type responses are available for inquiry.

PARs submitted to the fiscal agent by paper must be submitted on the correct PAR form using the national Centers for Medicare and Medicaid Services (CMS) and Current Procedural Terminology (CPT) codes described in this manual. PARs submitted to the fiscal agent without utilizing the Healthcare Common Procedural Coding System (HCPCS) codes or on the incorrect form will not be accepted. Paper PAR forms and completion instructions are located in the Provider Services Forms section.

Approval of a PAR does not guarantee Colorado Medical Assistance Program payment and does not serve as a timely filing waiver. Prior authorization only assures that the service 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.

After a PAR has been reviewed, a PAR letter is sent to the provider and the member. For approved services, allow sufficient time for the fiscal agent to enter the PAR data into the Colorado Medical Assistance Program processing system before submitting a claim for the authorized service.

PAR Revisions

Please print "REVISION" in bold letters at the top and enter the PAR number being revised in box # 7. Do not enter the PAR number being revised anywhere else on the PAR.

Paper PAR Instructional Reference

Field Label	Completion Format	Instructions
The upper margin of the PAR form must be left blank. This area is for authorizing agency's use only.		
Invoice/Pat Account Number	Text	Optional Enter up to 12 characters (numbers, letters, hyphens) to identify the claim or member.
1. Client Name	Text	Required Enter the member's last name, first name and middle initial. Example: Adams, Mary A.
2. Client Identification Number	7 characters, a letter prefix followed by six numbers	Required Enter the member's state identification number. This number consists of a letter prefix followed by six numbers. Example: A123456
3. Sex	Check box ☐ M ☐ F	Required Enter an "X" in the appropriate box.
4. Date of Birth	6 numbers	Required Enter the member's birth date using MMDDYY format. Example: January 1, 2010 = 010110.
5. Client Address	Characters: numbers and letters	Required Enter the member's full address: Street, city, state, and zip code.
6. Client Telephone Number	10 numbers	Optional Enter the member's telephone number.
7. Prior Authorization Number		System Assigned Do not write in this area. The authorizing agency reviews the PAR, and approves or denies the services. Enter the assigned PAR number in the appropriate field on the claim form when billing for prior authorized services

Field Label	Completion Format	Instructions
8. Dates Covered by This Request	6 numbers for from date and 6 digits for through date (MMDDYY)	Enter the date(s) within which service(s) will be provided. If left blank, dates are entered by the authorizing agency. Authorized services must be provided within these dates. If retroactive authorization is requested, enter the date(s) of service and provide justification in field 11 (Diagnosis).
9. Does Client Reside in a Nursing Facility?	Check Box ☐Yes ☐No	Required Check the appropriate box.
10. Group Home Name - if Patient Resides in a Group Home	Text	Conditional Enter the name of the group home if the member resides in a group home.
11. Diagnosis	Text	Required Enter the diagnosis and/or sufficient relevant information to justify the request. If ICD-9-CM diagnosis codes are used, the written description of the diagnosis is also required. Document that certificate of medical necessity is on file. Approval of the PAR is based on documented medical necessity. Attach documents as required. For Over-The-Cap (OTC) requests - include beginning location and destination address. Justify medical necessity of the trip and why member is unable to receive treatment closer to home. Specify type of transportation and that less costly means are unavailable. Provide mileage per unit and dollar amount requested per unit.
12. Requesting Authorization for Repairs	None	Not Required
13. Indicate Length of Necessity	None	Not Required
14. Group Home Name if Patient Resides in a Group Home	None	Conditional Enter the name of the Group Home if the member lives in a group home.

Field Label	Completion Format	Instructions
15. Line No. Preprinted	None	Required Do not alter preprinted lines. No more than five items can be requested on one form.
16. Describe Procedure, Supply, or Drug to be Provided	Text	Required Enter the description of the service to be provided. Example: Over-The-Cap Wheelchair van Example: Over-The-Cap Mobility van
17. Procedure, Supply or Drug Code	5 digits	Required Enter the HCPCS code for each service that will be billed on the claim form. The authorizing agency may change any code. The approved code(s) on the PAR form must be used on the claim form.
18. Requested Number of Services	Numbers	Required Enter the number of visits, services, procedures requested. If this field is blank, the authorizing agency will complete it.
19. Authorized No. of Services	None	Leave Blank The authorizing agency indicates the number of services authorized which may or may not equal number requested in Field 18 (Number Of Services).
20. A=Approved D=Denied	None	Leave Blank *No longer used. Providers should check the PAR on-line or refer to the PAR letter*.
21. Primary Care Physician (PCP) Name	Text	Not Required
Telephone Number		Not Required
22. Primary Care Physician Address	Text	Not Required
23. PCP Provider Number	8 digits	Not Required

Field Label	Completion Format	Instructions
24. Name and Address of Provider Requesting Prior Authorization	Text	Required Enter the complete name and address of the provider requesting the PAR. If the clinic is requesting a PAR, enter the provider's complete name and address
25. Name and Address of Provider Who will Render Service **Telephone Number**	Text	Required Enter the name and address of the provider who will receive reimbursement. Required Enter the telephone number of rendering provider.
26. Requesting Physician Signature **Telephone Number**	Text	Required The physician requesting the service must sign the PAR. A rubber stamp facsimile signature is not acceptable on the PAR. Required Enter the telephone number of the physician requesting the service.
27. Date Signed	6 numbers MMDDYY	Required Enter the date the PAR form is signed by the requesting physician.
28. Requesting Physician Provider Number	8 digits	Required Enter the eight-digit Colorado Medical Assistance Program provider number of the requesting provider.
29. Service Provider Number	8 digits	Required Enter the eight-digit Colorado Medical Assistance Program provider number of the State designated entity. The rendering provider must be enrolled in the Colorado Medical
30. Comments or Reasons For Denial of Benefits	Completed by Authorizing Agent	Leave Blank Refer to the PAR response for comments submitted by the authorizing agency.

Field Label	Completion Format	Instructions
31. PA Number Being Revised	Text	Leave Blank This field is completed by the authorizing agency

The authorizing agency reviews all completed PARs. The authorizing agency approves or denies, by individual line item, each requested service or supply listed on the PAR. **Read the response carefully as some line items may be approved and others denied.**

Do not render or bill for services until the PAR has been approved. The claim **must** contain the PAR number for payment.

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

Prior Authorization Request Form

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND FINANCING

INVOICE/PAT. ACCOUNT NUMBER

MEDICAID PRIOR AUTHORIZATION REQUEST (PAR)

To avoid delay, please answer all questions completely.

1. CLIENT NAME (Last, First, Middle Initial)	2. CLIENT IDENTIFICATION NUMBER	3. SEX ☐ M ☐ F	4. DATE OF BIRTH (MMDDYY)
5. CLIENT ADDRESS (Street, City, State, ZIP Code)			6. CLIENT TELEPHONE NUMBER ( )

7. PRIOR AUTHORIZATION NUMBER * SYSTEM ASSIGNED	8. DATES COVERED BY THIS REQUEST FROM (MMDDYY) THROUGH (MMDDYY)	9. DOES CLIENT RESIDE IN A NURSING FACILITY? ☐ YES ☐ NO	10. GROUP HOME NAME - IF PATIENT RESIDES IN A GROUP HOME

11. ICD-9-CM DIAGNOSIS CODE and DESCRIPTION (Must include Diagnosis Code and Description, Prognosis, Clinical Information and Other Medications presently prescribed)

12. REQUESTING AUTHORIZATION FOR REPAIRS EQUIPMENT MUST BE OWNED BY THE CLIENT - THE SERIAL NUMBER MUST BE ENTERED

13. INDICATE LENGTH OF NECESSITY (IN MONTHS AND YEARS) I.E., HOW LONG WILL THIS EQUIPMENT BE NEEDED?

14. ESTIMATED COST OF EQUIPMENT

SERVICES TO BE AUTHORIZED

15. LINE NO.	16. DESCRIBE THE PROCEDURE OR SUPPLY TO BE PROVIDED — INCLUDE MODEL NUMBER FOR DME PURCHASE OR SERIAL NUMBER FOR REPAIR	17. PROCEDURE OR SUPPLY CODE	18. REQUESTED NUMBER OF SERVICES	19. AUTHORIZED NO. OF SERVICES (LEAVE BLANK **)	20. APPROVED/DENIED (LEAVE BLANK **)
01					
02					
03					
04					
05					

21. PRIMARY CARE PHYSICIAN (PCP) NAME		22. PRIMARY CARE PHYSICIAN ADDRESS (Street, City, State, ZIP code)
TELEPHONE NUMBER ( )	23. PCP PROVIDER NUMBER	
24. NAME AND ADDRESS OF PHYSICIAN REQUESTING PRIOR AUTHORIZATION		25. NAME AND ADDRESS OF PROVIDER WHO WILL RENDER SERVICE
26. REQUESTING PHYSICIAN SIGNATURE	27. DATE SIGNED	

TELEPHONE NUMBER ( )	28. REQUESTING PHYSICIAN PROVIDER NUMBER	TELEPHONE NUMBER ( )	29. SERVICE PROVIDER NUMBER

If services are provided according to the manner prescribed by State of Colorado Laws and Regulations, reimbursement will be provided for authorized services following submission of an appropriately completed Medicaid claim.

30. COMMENTS **

☐ ATTACH COPY OF THIS PAR TO CLAIM(S) **

SIGNATURE OF STATE AGENCY REPRESENTATIVE **	DATE **	31. PA NUMBER BEING REVISED **

* THE ASSIGNED PAR NUMBER APPEARS ON THE PAR LETTER. ENTER THE PAR NUMBER FROM THE LETTER ON THE CLAIM WHEN BILLING FOR THE SERVICES. ** THESE FIELDS ARE COMPLETED BY THE AUTHORIZING AGENT

FORM NO. 10013 (REV. 12/98)
COL — 105

White - AUTHORIZING AGENT Yellow - ORIGINATOR

Procedure/HCPCS Codes Overview

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

The Healthcare Common Procedural Coding System (HCPCS) is divided into two principal subsystems, referred to as level I and level II of the HCPCS. Level I of the HCPCS is comprised of 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. Providers should regularly consult monthly bulletins located in the Provider Bulletins section. 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 completing and submitting a Publication Email Preference Form in the Provider Services Forms section. Bulletins include updates on approved procedures codes as well as the maximum allowable units billed per procedure.

Anesthesia Services

General Benefits

Anesthesia benefits are provided for medical, surgical, and radiological procedures. Anesthesia reimbursement is based on actual anesthesia time. One unit of service equals fifteen minutes, or any fraction thereof, of anesthesia time. Anesthesia time begins when the anesthetist starts patient preparation for induction in the operating room or an equivalent area and ends when the patient may be safely placed under post operative care. No additional benefits are provided for emergency conditions or the patient's physical status.

Reimbursement for anesthesia includes all of the following:

- Preoperative evaluation
- Postoperative visits
- Anesthesia care during the procedure
- Fluid and/or blood administration
- Interpretation of blood gases
- Any necessary non-invasive monitoring procedures (e.g., EKG)

Nerve blocks for anesthetic purposes are processed as general anesthesia. Nerve blocks for diagnostic or therapeutic purposes are processed as surgical procedures.

The following services are considered incidental to the anesthesia service and no separate benefit is allowed:

- Total body hypothermia in combination with or in addition to procedure codes described as "open" or "bypass"
- Endotracheal intubation or extubation
- Unusual circumstances or exceptions to allow additional benefits for these procedures must be fully documented, reviewed, and authorized.

Anesthesia by Surgeon

Local infiltration, digital block, or topical anesthesia administered by the operating surgeon is included in the surgical reimbursement and no additional benefit is available. IV valium or IV pentothal is a benefit when administered by the surgeon. For obstetrical deliveries, local pudendal and paracervical block anesthesia is included in the obstetrical payment and no additional benefits are allowed for the delivering physician.

Obstetrical Anesthesia

Use modifier 47 with surgical procedure codes to report general or regional anesthesia by the surgeon. Enter units of service as one.

General or regional anesthesia by the delivering physician or an anesthesiologist is reimbursable. Use modifier 47 with delivery procedure codes to report general or regional anesthesia by the delivering surgeon. Enter units of service as one.

Epidural anesthesia by a provider other than the delivering practitioner is a covered benefit. Patient contact time must be documented on the claim. Paper claims for more than 120 minutes (eight or more time units) of direct patient contact epidural time require an attached copy of the anesthesia record. Claims may be submitted (no attachments) but documents verifying extended direct patient contact must be maintained and produced upon request.

Standby Anesthesia

Standby anesthesia is a benefit in conjunction with obstetrical deliveries, subdural hematomas, femoral or brachial artery embolectomies, patients with a physical status of 4 or 5, insertion of a cardiac pacemaker, cataract extraction and/or lens implant, percutaneous transluminal angioplasty, and corneal transplant. Unusual circumstances or exceptions to allow a benefit for standby anesthesia for other procedures must be fully documented. Documentation must be submitted with claim.

Family Planning Services

Family planning services including intrauterine devices, implants, diaphragms, and contraceptive drugs are benefits of the Colorado Medical Assistance Program.

Foot Care Services

Foot care services are benefits of the Colorado Medical Assistance Program whether provided by a physician or licensed podiatrist. Claims for services provided to dually eligible (i.e., Colorado Medical Assistance and Medicare eligible) members are submitted directly to the fiscal agent.

If the billed service is routine foot care and is identified by the Medicare program as non-reimbursable, use the GY modifier to identify routine podiatric foot care services that are not covered by Medicare. The Medicare non-covered services field on the claim record must also be completed.

Laboratory Services

General Benefits

Medically necessary, physician-ordered laboratory services are benefits of the Colorado Medical Assistance Program when provided by a Clinical Laboratory Improvement Act (CLIA)-certified laboratory.

The physician may only bill for laboratory services performed in the office under his/her direct and personal supervision. A physician may not bill for services performed by an independent or hospital laboratory.

Clinical Laboratory Improvement Amendments (CLIA) Claims

Providers submitting procedures covered by CLIA must have a CLIA number of the laboratory where the procedure was done on the claim or claim line.

- Providers billing on the 837P format should refer to the 837P Companion Guide which is posted in the Provider Services Specifications section of the Department's Web site. Providers billing on the 837P format and billing agents should update their billing systems for 837P transactions.
- Providers billing an 837P through the Web Portal are able to enter CLIA numbers on the Detail Line Item tab (claim line). Entry on the Member's Info tab (header level) is also available. Further information on Web Portal functionality for CLIA is available in the February 2011 provider bulletin (B1100296) located in the Provider Bulletin section of the Department's website.
- Providers billing on the CMS 1500 paper claim form should enter their valid CLIA number in the REMARKS field (# 30). Enter "CLIA" before the CLIA number.

  Please note: Only one CLIA number can be included on each paper claim form. It is applied to all CLIA covered procedures on the claim. Procedures covered by different CLIA numbers need to be submitted on separate claims. Enter the CLIA number in the REMARKS field only.

The Tax ID (TID) on record with the CMS for the CLIA number must correspond to the TID on record with the Department. Questions regarding claims processing or responses should be directed to ACS Provider Services at 1-800-237-0757 or 1-800-237-0044.

Interpretation of laboratory testing

CMS has determined that clinical diagnostic laboratory services, including cytogenetic studies, are totally technical in nature and do not contain a professional component. No additional benefits for physician interpretation or reporting are available for clinical diagnostic laboratory tests, except for limited procedures identified by Medicare.

Handling, collection, and conveyance charges

Venipuncture, for the purpose of specimen collection, is a benefit of the Colorado Medical Assistance program when performed in the physician's office. Charges related to other forms of specimen collection, preparation, and handling (e.g., collection and handling of urine specimens, preparation of smears, etc.) are reimbursed as part of the fee for medical services.

No additional or separate benefit is available for specimen handling and conveyance from a physician's office to an independent or outpatient hospital laboratory.

Specimen collection (including venipuncture) is considered to be an integral part of the laboratory testing procedure when performed by an independent/hospital laboratory and is not reimbursable as a separate or additional charge.

Transfer of a specimen from one independent clinical laboratory to another is a benefit **only** if the first laboratory's equipment is not functioning or the laboratory is not certified to perform the ordered tests.

Use modifier KX with laboratory codes to certify that the laboratory's equipment is not functioning or the laboratory is not certified to perform the ordered test.

Specimen collection, handling, and conveyance from the patient's home, a nursing facility, or facility other than the physician's office or place of service is a benefit only if the patient is homebound, bedfast, or otherwise non-ambulatory, and the specimen cannot reasonably be transported by mail. A physician's statement explaining the circumstances and medical necessity is required.

Papanicolaou (Pap) smears

One Pap smear screening/examination is allowed per 12 month period in women less than 40 years of age. More than one Pap smear in a 12 month period is allowed for women ages 40 and over, women with a history of diethylstilbestrol exposure in utero, women with malignancy of the cervix, vagina, uterus, fallopian tubes or ovaries, cervical polyps, cervicitis, neoplastic disease of the pelvic organs, vaginal discharge or bleeding of unknown origin, post menopausal bleeding, vaginitis, or if the physician determines that more frequent testing is medically necessary. The diagnosis code entered on the claim must support the testing frequency.

- Preparation, collection, and handling charges are not provided for Pap smears. These services are considered to be an integral part of the examination. The physician's services are identified by the appropriate evaluation and management service code. Laboratory services must be billed by the facility actually processing the specimen. Use the following diagnosis codes:

  - V72.31 - Routine Gynecological examination - papanicolaou smear as part of general gynecological examination or pelvic examination (annual or periodic)

    or

  - V76.2 - Special screening for malignant neoplasms, cervix.

Medical Services

Consultation

Effective April 1, 2010, CPT consultation codes (ranges 99241-99245 for office/outpatient consultations and 99251-99255 for inpatient consultations) will no longer be recognized for payment. This change was implemented to be consistent with Medicare policy.

Please submit claims for consultation services using another Evaluation and Management (E/M) code that most appropriately represents where the visit occurred and that identifies the complexity of the visit performed.

Vaccines/Immunizations

Children

Immunizations for children are provided through The Colorado Medical Assistance Program's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit for children, newborn through age 20.

The Colorado Department of Public Health and Environment (CDPHE) furnishes some vaccines to medical providers at no cost through two programs, the federal Vaccines for Children (VFC) Program and the Colorado Infant Immunization Program.Providers who wish to participate in these immunization programs must enroll with CDPHE by calling (303) 692-2798 or (303) 692-2363.

Adults

Immunizations for adults (age 21 and older) are a Colorado Medical Assistance Program benefit when medically necessary or when needed to enter the work force or to attend school.

Reimbursement

The Colorado Medical Assistance Program pays providers an Administration, Record keeping and Tracking (ART) fee for immunizations that are available through the VFC or Infant Immunization programs. Because vaccine is available at no cost through these programs, providers who elect to obtain vaccine from other suppliers may not request nor receive reimbursement above the ART payment level.

Medically necessary immunizations that are not provided to practitioners at no cost by the VFC or Infant Immunization program, as well as immunizations provided to adults, are reimbursed using the following formula:

Average Wholesale Price (AWP) + 10 percent + $2.00 for administration.

When an immunization is administered by a practitioner, an Evaluation/Management (E/M) service reflecting the level of medical service provided may be billed in addition to the charges for the immunization. If an immunization is the only service rendered, providers may not submit charges for an Evaluation/Management (E/M) service. Please refer to the most recent Immunization Benefit Update bulletin located in the Provider Services Provider Bulletins section of the Department's Web site.

*Note: Immunizations for the sole purpose of overseas travel are **not** a benefit.*

Medical care and surgery on the same day

Both medical care and surgery are allowed when performed on the same day by the physician when the surgical procedure is minor in nature. Follow up care requirements are determined by the Department and are related to those assigned by Medicare and other sources.

Procedure code 99025 (i.e., initial visit when starred surgical procedure constitutes major service at that visit) is not a benefit.

New Patient Services

New patient medical care visits are limited to one per patient per provider. A medical records administrative fee is included in the Colorado Medical Assistance Program reimbursement.

Nursing Facility Visits

Nursing facility visits are limited to one visit per day per patient by the same provider for the same diagnosis or condition.

Office Visits

Office visits are limited to one visit per day per patient by the same provider for the same diagnosis or condition.

Supplies Provided by a Physician

Providers may bill for non-routine supplies following the instructions in the current CMS bulletin for practitioners.

Billable non-routine supplies are listed in the CMS publication under separate categories. Providers should always refer to the most current publications when billing the Colorado Medical Assistance Program as some supplies are considered inclusive in the medical or surgical service.

Non-benefit Medical Services

Services for which Colorado Medical Assistance is not available include, but are not limited to:

- Cosmetic surgery solely for improvement of physical appearance
- Telephone call charges for prescriptions
- Immunizations for the sole purpose of overseas travel
- Missed appointments
- Telephone consultation
- Medical testimony
- Chiropractic services (except crossover claims for QMB members)
- Homeopathic services
- Report preparation
- Acupuncture

Psychiatric Services

General benefits

Psychiatric services refer to services described in CPT under the heading "Psychiatry". Colorado Medical Assistance Program benefits are available for face to face patient contact services only. Benefits are not available for report preparation, telephone consultation, case presentations, or staff consultation.

Non-benefit psychiatric services

Psychotherapy services provided for the following specific primary diagnoses are not benefits of the Colorado Medical Assistance Program.

290	Dementias
290.0	Senile dementia, uncomplicated
290.20	Senile dementia with delusional features
290.21	Senile dementia with depressive features
290.3	Senile dementia with delirium
290.4	Vascular dementia
290.40	Vascular dementia, uncomplicated
290.41	Vascular dementia with delirium
290.42	Vascular dementia with delusions
290.43	Vascular dementia with depressed mood
290.8	Other specified senile psychotic conditions
290.9	Unspecified senile psychotic condition
310	Specific nonpsychotic mental disorders due to brain damage
310.0	Frontal lobe syndrome

310.1	Personality change due to conditions classified elsewhere
310.2	Post concussion syndrome
310.8	Other specified nonpsychotic mental disorders following organic brain damage
310.9	Unspecified nonpsychotic mental disorder following organic brain damage
317	Mild mental retardation
318	Other specified mental retardation
318.0	Moderate mental retardation
318.1	Severe mental retardation
318.2	Profound mental retardation
319	Unspecified mental retardation
797	Senility without mention of psychosis

The following psychiatric services are not benefits:

- Activity group therapy
- Play therapy
- Family therapy
- Recreational therapy
- Occupational therapy
- Peer relations therapy
- Day care
- Medication check
- Play observation
- Sleep observation
- Music therapy
- Religious counseling
- Group socialization
- Educational activities
- Services directed towards making one's personality more forceful or dynamic
- Consciousness raising
- Vocational counseling
- Primal scream
- Biofeedback
- Marital counseling
- Sex therapy
- Milieu therapy
- Training disability services
- Rolfing or structural integration
- Bioenergetic therapy
- Guided imagery
- Z-therapy
- Obesity control therapy
- Dance therapy
- Tape therapy (recorded psychotherapy)

Unusual circumstances or exceptions to allow benefits for these services must be fully documented, reviewed, and prior authorized.

Behavioral Health Organizations (BHOs)

Behavioral Health Organizations (BHOs) provide all mental health care to members in their geographical area. Non-network practitioners who render emergency mental health services must bill the BHO for payment. The BHO will not pay for non-emergency services provided without BHO prior authorization.

Members who are dually eligible (i.e., Medicaid and Medicare eligible) may obtain services through the BHO or from a non-BHO provider, and the fiscal agent will process submitted Medicare crossover claims. If the mental health service is covered by the Colorado Medical Assistance Program only, the member must obtain services from the BHO.

Radiology Services

General Benefits

Medically necessary, physician ordered radiology services are benefits of the Colorado Medical Assistance Program.

Home/Nursing Facility Radiology Services

The transportation of portable X-ray equipment and personnel to a home or nursing facility is a Colorado Medical Assistance Program benefit only if the provider of services is certified by CMS to provide mobile radiology services. The member must be confined to the home or nursing facility.

Surgical Services

General Benefits

Surgical reimbursement includes payment for the operation, local infiltration, digital block or topical anesthesia when used, and normal, uncomplicated follow-up care. Under most circumstances, the immediate preoperative visit necessary to examine the patient is included in the surgical procedure whether provided in the hospital or elsewhere.

Cosmetic Surgery

Procedures intended solely to improve the physical appearance of an individual but which do not restore bodily function or correct deformity are not benefits of the Colorado Medical Assistance Program.

Abortion

Therapeutic legally induced abortions are benefits 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. Specific instructions for submitting claims for abortions performed for maternal life endangering circumstances, sexual assault or incest are described in the Sterilizations, Hysterectomies, and Abortions Billing Instructions section.

Assistant surgeon

CPT codes for the listing of assistant surgeon are the same as for surgical procedures. Assistant surgeon services may be reported by adding the modifier code 80 to the surgical procedure code. Surgical procedures for which an assistant surgeon is allowed are individually reviewed as they become reimbursable under Medicaid. The source for procedures appropriate for assistant surgery benefit is Medicare guidelines. This information is entered on the procedure file for those procedures for which Medicare allows assistant surgeon benefits.

Payment allowed is up to 20 percent of the surgeon's maximum allowable reimbursement for the first procedure and 5 percent of the surgeon's maximum allowable reimbursement for second or subsequent procedures.

Surgical procedures for which an assistant surgeon is allowed are determined by the Department.

- Assistant surgery services are not paid when the same physician is reimbursed for primary surgical services performed concurrently or consecutively on the same day.
- Benefits for assistant surgeons are not allowed for non-physician assistants at surgery.

Hysterectomy

A hysterectomy is a benefit of the Colorado Medical Assistance program when performed solely for medical reasons. A hysterectomy is **not** a benefit when:

- The procedure is performed solely for the purpose of sterilization.
- There is more than one purpose for the procedure and it would not been performed except for the purpose of sterilization.

Refer to the Sterilizations, Hysterectomies, and Abortions Billing Instructions section for billing requirements.

Reconstructive surgery

Surgical procedures intended to improve function and appearance of any body area altered by disease, trauma, congenital or developmental anomalies, or previous surgical processes may be benefits of the program if services are prior authorized. Physician documentation on the PAR form is the basis for determining the benefit for reconstructive surgery.

Sterilization

Voluntary sterilization is a benefit when appropriately documented on the Med-178 form. Refer to the Sterilizations, Hysterectomies, and Abortions Billing Instructions section for sterilization billing requirements.

Transplantation

Organ procurement and transplantation are benefits only when prior authorized. Corneal and kidney transplants are benefits and do not require prior authorization.

Important: Organ transplants are <u>not</u> a covered benefit for non-citizens.

Multiple Surgeries

Colorado Medicaid utilizes the general surgical guidelines, subsection instructions, and procedure code modifiers found in each year's CPT code book published by the AMA. The following information is in addition to the CPT guidelines, and should be utilized for billing the Colorado Medical Assistance Program and reimbursement purposes.

Bilateral procedures – modifier 50

Unless otherwise identified in the CPT-4 listings, bilateral procedures requiring a separate incision that are performed at the same operative session, should be identified by the appropriate five digit code describing the first procedure. The second (bilateral) procedure is identified by adding modifier 50 to the procedure code. Use of this modifier should be limited to procedures for which no "bilateral" code is listed in CPT-4.

Bilateral procedures performed by one surgeon will be reimbursed at 100 percent for the procedure commanding the greatest value and 80 percent for the second or subsequent procedures.

Bilateral procedures performed by two surgeons will be reimbursed at 100 percent for the first procedure and 100 percent for the second procedure.

Multiple procedures – modifier 51

When multiple procedures are performed during the same operative session, report the major procedure as listed. In order to ensure appropriate processing and correct payment, providers billing multiple procedures must bill the procedure with the highest allowed amount on the first line of the claim.

For pricing information, please refer to the Medicaid Fee Schedules located in the Rates & Fee Schedules section of the Department's web site.

The provider should bill for the most costly or most complex procedure on the first line of the claim. The secondary, additional, or lesser procedure(s) may be listed and identified by adding the modifier 51 to the secondary procedure code(s). This modifier should not be appended to designated "add-on" codes.

Single surgical field or single surgical incision – Multiple procedures performed by one or two surgeons, regardless of how many organ systems are involved, will be reimbursed at 100 percent for the procedure commanding the greatest value and 50 percent for the second or subsequent procedures.

Two surgical fields or two surgical incisions – Multiple procedures performed by one surgeon, involving separate organ systems or different anatomical locations, will be reimbursed at 100 percent for the procedure commanding the greatest value and 50 percent for the second or subsequent procedures. Multiple procedures performed by two surgeons, involving separate organ systems or different anatomical locations, will be reimbursed at 100 percent for the procedure commanding the greatest value and 100 percent for the second procedure.

Foot surgery – single surgical field/incision or two surgical fields/incisions on the same foot will be reimbursed at 100 percent for the procedure commanding the greatest value, 50 percent for the second procedure, and 25 percent for each subsequent procedure.

Bilateral procedures (left and right foot), or two surgical procedures performed on both feet (one procedure on the left foot and one procedure on the right foot) will be reimbursed at 100 percent for the procedure commanding the greatest valued and 80 percent for the second procedure.

Two surgeons – modifier 62

When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) including add-on procedure(s) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. Note: if a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

The total reimbursement for the surgical procedure will be increased to 125 percent and will be apportioned (50-50) between the two surgeons.

Vision Care Services

Medically necessary vision exams are a benefit for all age groups. Medically necessary vision exams include those required due to physical symptoms such as headache, visual disturbances, etc.

Medically necessary vision care services are benefits of the Colorado Medical Assistance Program under the following conditions:

- Eyeglasses and contact lenses are benefits following eye surgery and do not require prior authorization. Use modifier 55. The surgery may have been performed at any time during the patient's life.
- Vision care services and eyeglasses are benefits for members under the age of 21 through the provisions of the Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Medically necessary contact lenses for members ages 20 and under may be a benefit if prior

authorized or for a member with a history of eye surgery. Refer to the EPSDT manual for details.

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 claim form.

CMS Field #	Field Label	Field is?	Instructions
1	**Insurance Type**	Required	Place an "X" in the box marked as Medicaid.
1a	**Insured's ID Number**	Required	Enter the member's Colorado Medical Assistance Program seven-digit Medicaid ID number as it appears on the Medicaid Identification card. Example: A123456.
2	**Patient's Name**	Required	Enter the member's last name, first name, and middle initial.
3	**Patient's Date of Birth / Sex**	Required	Enter the patient's birth date using two digits for the month, two digits for the date, and two digits for the year. Example: 070114 for July 1, 2014. Place an "X" in the appropriate box to indicate the sex of the member.
4	**Insured's Name**	Conditional	Complete if the member is covered by a **Medicare** 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.
5	**Patient's Address**	Not Required	
6	**Patient's Relationship to Insured**	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.
7	**Insured's Address**	Not Required	
8	**Reserved for NUCC Use**		

CMS Field #	Field Label	Field is?	Instructions
9	**Other Insured's Name**	Conditional	If field 11d is marked "yes", enter the insured's last name, first name and middle initial.
9a	**Other Insured's Policy or Group Number**	Conditional	If field 11d is marked "yes", enter the policy or group number.
9b	**Reserved for NUCC Use**		
9c	**Reserved for NUCC Use**		
9d	**Insurance Plan or Program Name**	Conditional	If field 11d is marked "yes", enter the insurance plan or program name.
10a-c	**Is Patient's Condition Related to?**	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	**Reserved for Local Use**		
11	**Insured's Policy, Group or FECA Number**	Conditional	Complete if the member is covered by a **Medicare** health insurance policy. Enter the insured's policy number as it appears on the ID card. Only complete if field 4 is completed.
11a	**Insured's Date of Birth, Sex**	Conditional	Complete if the member is covered by a **Medicare** 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: 070114 for July 1, 2014. Place an "X" in the appropriate box to indicate the sex of the insured.
11b	**Other Claim ID**	Not Required	

CMS Field #	Field Label	Field is?	Instructions
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	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: 070114 for July 1, 2014. Enter the applicable qualifier to identify which date is being reported 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period
15	**Other Date**	Not Required	
16	**Date Patient Unable to Work in Current Occupation**	Not Required	
17	**Name of Referring Physician**	Not Required	
18	**Hospitalization Dates Related to Current Service**	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: 070114 for July 1, 2014. If the member is still hospitalized, the discharge date may be omitted. This information is not edited.

CMS Field #	Field Label	Field is?	Instructions
19	**Additional Claim Information**	Conditional	**LBOD** Use to document the Late Bill Override Date for timely filing.
20	**Outside Lab?** **$ Charges**	Conditional	Complete if all 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 any laboratory work was performed in the office. Practitioners may not request payment for services performed by an independent or hospital laboratory.
21	**Diagnosis or Nature of Illness or Injury**	Required	Enter at least one but no more than twelve diagnosis codes based on the member's diagnosis/condition. Enter applicable ICD indicator to identify which version of ICD codes is being reported. 9 ICD-9-CM 0 ICD-10-CM
22	**Medicaid Resubmission Code**	Conditional	List the original reference number for resubmitted claims. When resubmitting a claim, enter the appropriate bill frequency code in the left-hand side of the field. 7 Replacement of prior claim 8 Void/Cancel of prior claim This field is not intended for use for original claim submissions.
23	**Prior Authorization**	Conditional	**CLIA** When applicable, enter the word "CLIA" followed by the number. **Prior Authorization** Enter the six character prior authorization number from the approved Prior Authorization Request (PAR). Do not combine services from more than one approved PAR on a single claim form. Do not attach a copy of the approved PAR unless advised to do so by the authorizing agent or the fiscal agent..
24	**Claim Line Detail**	Information	The paper claim form allows entry of up to six detailed billing lines. Fields 24A through 24J apply to each billed line. **Do not enter more than six lines of information** on the paper claim. If more than

CMS Field #	Field Label	Field is?	Instructions
			six lines of information are entered, the additional lines will not be entered for processing. Each claim form must be fully completed (totaled). **Do not file continuation claims** (e.g., Page 1 of 2).
24A	**Dates of Service**	Required	The field accommodates the entry of two dates: a "From" date of services and a "To" date of service. Enter the date of service using two digits for the month, two digits for the date and two digits for the year. Example: 010114 for January 1, 2014 From To 01 01 14 | | | Or From To 01 01 14 01 01 14 Span dates of service From To 01 01 14 01 31 14 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. **Supplemental Qualifier** To enter supplemental information, begin at 24A by entering the qualifier and then the information. ZZ Narrative description of unspecified code N4 National Drug Codes 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

CMS Field #	Field Label	Field is?	Instructions
24B	**Place of Service**	Required	Enter the Place of Service (POS) code that describes the location where services were rendered. The Colorado Medical Assistance Program accepts the CMS place of service codes. 04 Homeless Shelter 11 Office 12 Home 15 Mobile Unit 20 Urgent Care Facility 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room Hospital 25 Birthing Center 26 Military Treatment Center 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Transportation – Land 51 Inpatient Psychiatric Facility 52 Psychiatric Facility Partial Hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility – MR 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 99 Other Unlisted
24C	**EMG**	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.

CMS Field #	Field Label	Field is?	Instructions
			If a "Y" for YES is entered, the service on this detail line is exempt from co-payment requirements.
24D	**Procedures, Services, or Supplies**	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.
24D	**Modifier**	Conditional	Enter the appropriate procedure-related modifier that applies to the billed service. Up to four modifiers may be entered when using the paper claim form. 24 **Unrelated Evaluation/Management (E/M) service by the same physician during a postoperative period** Use with E/M codes to report unrelated services by the same physician during the postoperative period. Claim diagnosis code(s) must identify a condition unrelated to the surgical procedure. 26 **Professional component** Use with diagnostic codes to report professional component services (reading and interpretation) billed separately from technical component services. Report separate professional and technical component services <u>only</u> if different providers perform the professional and technical portions of the procedure. Read CPT descriptors carefully. Do not use modifiers if the descriptor specifies professional or technical components. 47 **Anesthesia by surgeon**

CMS Field #	Field Label	Field is?	Instructions
			Use with surgical procedure codes to report general or regional anesthesia by the surgeon. Local anesthesia is included in the surgical reimpursement. 50 **Bilateral procedures** Use to identify the bilateral (second) surgical procedure performed at the same operative session. Read CPT descriptions carefully. Do not use modifier 50 if the procedure descriptor states “Unilateral or bilateral” services. 51 **Multiple procedures** Use to identify additional procedures that are performed on the same day or at the same session by the same provider. Do not use to designate “add-on” codes. 55 **Postoperative Management only** Use with eyewear codes (lenses, lens dispensing, frames, etc.) to identify eyewear provided after eye surgery. Benefit for eyewear, including contact lenses, for members over age 20 must be related to surgery. Modifier 55 takes the place of the required claim comment that identifies the type and date of eye surgery. The provider must retain and, upon request, furnish records that identify the type and date of surgery. 59 **Distinct Procedural Service** Use to indicate a service that is distinct or independent from other services that are performed on the same day. These services are not usually reported together but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system or separate lesion or injury. 62 **Two surgeons** Use when two surgeons work together as primary surgeons

			performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons.
			76 **Repeat procedure or service by <u>same</u> physician/provider/other qualified health care professional** Use to identify subsequent occurrences of the same service on the same day by the same provider. Not valid with E/M codes.
			77 **Repeat procedure by <u>another</u> physician/provider/other qualified health care professional** Use to identify subsequent occurrences of the same service on the same day by different rendering providers.
			79 **Unrelated procedure or service by the same surgeon during the postoperative period** Unrelated procedures or services (other than E/M services) by the surgeon during the postoperative period. Use to identify unrelated services by the operating surgeon during the postoperative period. Claim diagnosis code(s) must identify a condition unrelated to the surgical procedure.
			80 **Assistant surgeon** Use with surgical procedure codes to identify assistant surgeon services. Note: Assistant surgeon services by non-physician practitioners, physician assistants, perfusionists, etc. are not reimbursable.
			GY **Item or services statutorily excluded or does not meet the Medicare benefit.** Use with podiatric procedure codes to identify routine, non-Medicare covered podiatric foot care. Modifier -GY takes the place of the required provider certification that the services are not covered by Medicare. The

CMS Field #	Field Label	Field is?	Instructions
			Medicare non-covered services field on the claim record must also be completed. KX **Specific required documentation on file** Use with laboratory codes to certify that the laboratory's equipment is not functioning or the laboratory is not certified to perform the ordered test. The -KX modifier takes the place of the provider's certification, "I certify that the necessary laboratory equipment was not functioning to perform the requested test ", or "I certify that this laboratory is not certified to perform the requested test." TC **Technical component** Use with diagnostic codes to report technical component services or procedures and includes the cost of equipment and supplies to perform that service or procedure. This modifier corresponds to the equipment/facility part of a given service or procedure. Report separate professional and technical component services only if different providers perform the professional and technical portions of the procedure. Read CPT descriptors carefully. Do not use modifiers if the descriptor specifies professional or technical components.
24E	**Diagnosis Pointer**	Required	Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis. At least one diagnosis code reference letter must be entered. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. This field allows for the entry of 4 characters in the unshaded area.

CMS Field #	Field Label	Field is?	Instructions
24F	**$ Charges**	Required	Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number. Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one procedure from the same group is billed, special multiple pricing rules apply. The base procedure is the procedure with the highest allowable amount. The base code is used to determine the allowable amounts for additional CPT surgical procedures when more than one procedure from the same grouping is performed. Submitted charges cannot be more than charges made to non-Colorado Medical Assistance Program covered individuals for the same service. Do not deduct Colorado Medical Assistance Program co-payment or commercial insurance payments from the usual and customary charges.
24G	**Days or Units**	Required	Enter the number of services provided for each procedure code. Enter whole numbers only- do not enter fractions or decimals.
24G	**Days or Units**	General Instructions	A unit represents the number of times the described procedure or service was rendered. Except as instructed in this manual or in Colorado Medical Assistance Program bulletins, the billed unit must correspond to procedure code descriptions. The following examples show the relationship between the procedure description and the entry of units.

Anesthesia Services

Anesthesia services must be reported as minutes. Units may only be reported for anesthesia services when the code description includes a time period.

Anesthesia time begins when the anesthetist begins patient preparation for induction in the operating room or an equivalent area and ends when the anesthetist is no longer in constant attendance. No additional benefit or additional units are added for emergency conditions or the member's physical status.

The fiscal agent converts reported anesthesia time into fifteen minute units. Any fractional unit of service is rounded up to the next fifteen minute increment.

CMS Field #	Field Label	Field is?	Instructions
Psychiatric Services The following information applies only to codes identified under the Psychiatry heading in the CPT code book. These instructions do not apply to any other procedure code (hospital services, consultations, etc.) that might be billed by a psychiatric or psychological services provider. Except for electroconvulsive therapy (ECT), one unit of service for psychiatric or mental health services represents fifteen minutes of face-to-face patient contact. A fractional unit of services gets rounded up to the next fifteen minute unit. Examples: 15 minutes = 1 unit 16 mnutes = 2 units 30 minutes = 2 units 31 minutes = 3 units Psychiatric providers may not bill for: ➤ Test scoring or evaluation time unless the member is present ➤ Conferences with the member, family members, or other health care providers unless the member is present ➤ Telephone calls ➤ Prescription refill calls ➤ Missed appointments			
24H	**EPSDT/Family Plan**	Conditional	**EPSDT** (shaded area) For Early & Periodic Screening, Diagnosis, and Treatment related services, enter the response in the shaded portion of the field as follows: AV Available- Not Used S2 Under Treatment ST New Service Requested NU Not Used **Family Planning** (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 Medical Assistance Program provider number assigned to the individual 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.

CMS Field #	Field Label	Field is?	Instructions
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.
30	**Rsvd for NUCC Use**		
31	**Signature of Physician or Supplier Including Degrees or Credentials**	Required	Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent. A holographic signature stamp may be used <u>if</u> authorization for the stamp is on file with the fiscal agent. 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. Each claim must have the date the enrolled provider or registered authorized agent signed the claim form. Enter the date the claim was signed using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. **Unacceptable signature alternatives:** Claim preparation personnel may not sign the enrolled provider's name. Initials are not acceptable as a signature.

CMS Field #	Field Label	Field is?	Instructions
			Typed or computer printed names are not acceptable as a signature. "Signature on file" notation is not acceptable in place of an authorized signature.
32	**32- Service Facility Location Information** **32a- NPI Number** **32b- Other ID #**	Conditional	Complete for services provided in a hospital or nursing facility in the following format: 1st Line Name 2nd Line Address 3rd Line City, State and ZIP Code 32a- NPI Number Enter the NPI of the service facility (if known). 32b- Other ID # Enter the eight-digit Colorado Medical Assistance Program provider number of the service facility (if known). The information in field 32, 32a and 32b is not edited.
33	**33- Billing Provider Info & Ph #** **33a- NPI Number** **33b- Other ID #**	Required	Enter the name of the individual or organization that will receive payment for the billed services in the following format: 1st Line Name 2nd Line Address 3rd Line City, State and ZIP Code 33a- NPI Number Enter the NPI of the billing provider 33b- Other ID # Enter the eight-digit Colorado Medical Assistance Program provider number of the individual or organization.

Late Bill Override Date

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

Valid Delay Reason Codes

1 Proof of Eligibility Unknown or Unavailable

3 Authorization Delays

7 Third Party Processing Delay

8 Delay in Eligibility Determination

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

11 Other

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

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

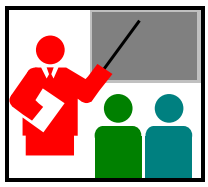
Billing Instruction Detail	Instructions
LBOD Completion Requirements	• Electronic claim formats provide specific fields for documenting the LBOD. • Supporting documentation must be kept on file for 6 years. • For paper claims, follow the instructions appropriate for the claim form you are using. ➢ *UB-04*: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

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

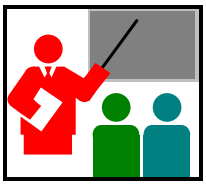
Billing Instruction Detail	Instructions
	(see Certification & Request for Timely Filing Extension in the Provider Services Forms section) that identifies the member, indicates the effort made to identify eligibility, and shows the date of eligibility notification. • Claims must be filed within 365 days 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 Standard Paper Remit (SPR) or Electronic Remittance Advice (ERA). Maintain a copy of the SPR/ERA on file. **LBOD** = the Medicare processing date shown on the SPR /ERA.
Medicare Denied Services	The claim is for Medicare denied services (Medicare non-benefit services, benefits exhausted services, or the member does not have Medicare coverage) being submitted within 60 days of the date of Medicare processing/denial. *Note: This becomes a regular Colorado Medical Assistance Program claim, not a Medicare crossover claim.* **File the claim within 60 days** of the Medicare processing date shown on the Standard Paper Remit (SPR) or Electronic Remittance Advice (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.

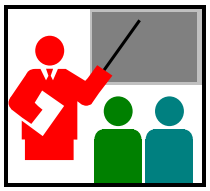
Billing Instruction Detail	Instructions
Correspondence LBOD Authorization	The claim is being submitted in accordance with instructions (authorization) from the Colorado Medical Assistance Program for a 60 day filing extension for a specific member, claim, services, or circumstances. **File the claim 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.

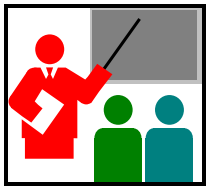
Sterilizations, Hysterectomies and Abortions

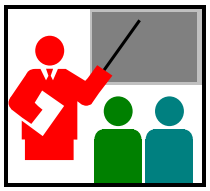
Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions 	**Voluntary sterilizations** Sterilization for the purpose of family planning is a benefit of the Colorado Medical Assistance Program in accordance with the following procedures: **General requirements** The following 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.

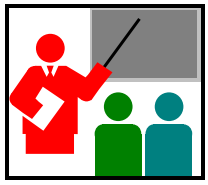
Billing Instruction Detail	Instructions

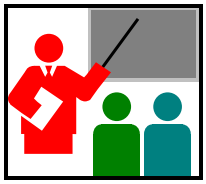
Sterilizations, Hysterectomies, and Abortions
(continued)
 
	The person may not be an "institutionalized individual".
	Institutionalized includes:
	• Involuntarily confinement or detention, under a civil or criminal statute, in a correctional or rehabilitative facility including a mental hospital or 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.

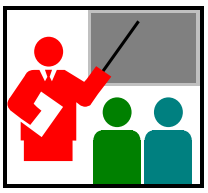
Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions (continued) 	• A full description of the benefits or advantages that may be expected as a result of the sterilization • Advice that the sterilization will not be performed for at least 30 days except in the case of 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 Services→Forms→Sterilization Consent 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.

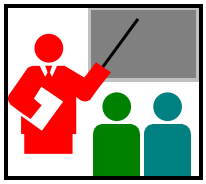
Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions (continued) 	**Completion of the MED-178 consent form** Please refer to the MED-178 Instructions on the Department's website (colorado.gov/hcpf)→Provider Services→Forms→Sterilization Consent Forms. Information entered 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 Appendix J. 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 (decimals 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 Appendix K**. 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 Appendix L**. 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 an ICD-9-CM 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.

CMS 1500 Medical Claim Example

HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

3. PATIENT'S BIRTH DATE MM 10 DD 16 YY 45 SEX M F X

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

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

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

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? 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 X NO If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED Signature on File DATE 1/1/15

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

SIGNED

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

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. 17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

A. 824X B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER			E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	01	15	01	01	15	11		99211				A	60 00	128		NPI	12345678 / 0123456789
2																	NPI	
3																	NPI	
4																	NPI	
5																	NPI	
6																	NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. Optional

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

28. TOTAL CHARGE $ 60 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED Signature DATE 1/1/15

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

ABC Center
100 Any Street
Any City

a. 1234567890 b. 04567890

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

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

CMS 1500 Medical Crossover Claim Example

HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

3. PATIENT'S BIRTH DATE MM 10 DD 16 YY 45 SEX M [ ] F [X]

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

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

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

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: Medicare Policy Number

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM 10 DD 15 YY 45 SEX M [ ] F [X]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED Signature on File DATE 1/1/15

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

SIGNED

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

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. 17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

A. 824X B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	01	15	01	01	15	11		99211		A	60 00	1		NPI	12345678 0123456789
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: Optional

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

28. TOTAL CHARGE $ 60 00

29. AMOUNT PAID $ 40 00

30. Rsvd for NUCC Use

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

SIGNED Signature DATE 1/1/15

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

ABC Center
100 Any Street
Any City

a. 1234567890 b. 04567890

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

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

CMS 1500 Medical Claim with CLIA Number Example

HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

3. PATIENT'S BIRTH DATE MM 10 DD 16 YY 45 SEX M F X

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

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

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

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

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED Signature on File DATE 1/1/15

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

SIGNED

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

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. | 17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

A. 824X B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: CLIA 01D1000000

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	01	15	01	01	15	11		G0307		A	100 00	1		NPI	12345678 0123456789
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: Optional

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

28. TOTAL CHARGE $ 100 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED Signature DATE 1/1/15

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

ABC Center
100 Any Street
Any City

a. 1234567890 b. 04567890

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

Medical Surgical Services Revisions Log

Revision Date	*Additions/Changes*	*Pages*	*Made by*
04/20/2009	*Drafted Manual*	*All*	*jg*
02/01/2010	*General updates*	*Throughout*	*jg*
02/05/2010	*Changed EOMB to SPR*	*34 & 39*	*vr*
03/04/2010	*Added link to Program Rules*	*3*	*jg*
03/10/2010	*Added SPR to Special Instructions for Medicare SPR Date field*	*34*	*jg*
07/09/2010	*Corrected PAR instructions for fields 18,24,25 26 & 27* *Updated date examples for field 19A* *Updated claim examples*	*8 & 9* *26* *55 & 56*	*jg*
07/14/2010	*Added Electronic Remittance Advice (ERA) to Special Instructions for Medicare SPR Date field and* *to Electronic Medicare Crossover Claims & to Medicare Denied Services in Late Bill Override Date section.*	*34* *39*	*vr*
09/24/2010	*Added statement about billing most costly or most complex procedure on the first line of the claim*	*20*	*jg*
05/13/2011	*Updated TOC* *Added CLIA claim information* *Added CLIA instructions to Remarks field 30* *Updated service dates on claim examples* *Added claim example with CLIA information* *Updated Diagnosis & Procedure codes and descriptions*	*1 & 2* *14* *36* *55 & 56* *57* *15, 17, 28, 30, 31, 51, 55*	*jg*
06/23/2011	*Updated TOC* *Added NPI Information under Paper Claims* *Deleted "and inquiries"* *Changed wording for Date of Birth field in PAR instructions* *Added CLIA information* *Changed wording under PAP smears* *Changed wording under Consultations* *Changed example in Client Date of Birth field* *Updated code in ICD-9-CM field* *Updated codes in Diagnosis field* *Added CLIA instructions in Remarks field* *Changed wording for Electronic Medicare Crossover Claims* *Updated Claim examples*	*1* *3* *6* *7* *14* *15* *21* *23* *26* *33* *37* *40* *56, 57 & 58*	*jg*
12/05/2011	*Replaced 997 with 999* *Replaced wpc-edi.com/hipaa with wpc-edi.com/* *Replaced Implementation Guide with Technical Report 3 (TR3)*	*3* *1* *1*	*ss*
01/27/2012	*Changed authorizing agent to authorizing agency*	*Throughout*	*jg*

Revision Date	*Additions/Changes*	*Pages*	*Made by*
10/02/2013	*Removed MED-178 instructions and example. Referenced location of form and instructions on p 41*	*41-48*	*cc*
10/03'2013	*Reformated Sterilizations, Hysterectomies, and Abortions secton* *Updated TOC*	*39-47* *i-ii*	*jg*
02/03/2014	*Updated abortion information*	*44*	*jg*
05/14/2014	*Updated information to remove references to the Primary Care Physician Program*	*29, 32, 32*	*Mm*
8/1/14	*Replaced all CO 1500 references with CMS 1500*	*Throughout*	*Zs*
8/1/14	*Updated Professional Claim Billing Instructions section with CMS 1500 information.*		*Zs*
8/1/14	*Changed all references of client to member*	*Throughout*	*Zs*
8/1/14	*Updated all claim examples to the cms 1500*		*Zs*
8/4/14	*Updated all web links to reflect new Department web site*	*Throughout*	*mm*
12/8/14	*Removed Appendix H information, added Timely Filing document information*	*36, 37*	*mc*

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.