Obstetrical Care

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

Providers must be enrolled as a Health First Colorado provider in order to:

- Treat a Health First Colorado member
- Submit claims for payment to the Health First Colorado

Health First Colorado benefits are available for pregnant women and infants meeting Federal income guidelines. Eligibility is determined by the County Department of Human/Social Services in the applicant's county of residence.

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

Paper Claims

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

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

Paper claims require an NPI for those provider types that can obtain one. Providers that cannot obtain an NPI are required to use an assigned Health First Colorado provider number on their claims. Electronically mandated claims submitted on paper are processed, denied, and marked with the message "Electronic Filing Required".

Electronic Claims

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

- X12N Technical Report 3 (TR3) for the 837P, 837I, or 837D (wpc-edi.com/)
- Companion Guides for the 837P, 837I, or 837D in the EDI support section of the Department's website (edi-support)
- Online Portal User Guide (via within the Online Portal)

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

Interactive Claim Submission and Processing

Interactive claim submission through the Online Portal is a real-time exchange of information between the provider and the Health First Colorado. Health First Colorado providers may create and transmit HIPAA compliant 837P (Professional), 837I (Institutional), and 837D (Dental) claims electronically one at a time. These claims are transmitted through the Health First Colorado Online Portal (OP).

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

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

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

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

The Online Portal provides immediate feedback directly to the submitter. All claims are processed to provide a weekly Health Care Claim Payment/Advice (Accredited Standards Committee [ASC] X12N 835) transaction and/or Remittance Advice to providers. The Online Portal also provides access to reports and transactions generated from claims submitted via paper and through electronic data submission methods other than the Online Portal. The reports and transactions include:

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

Claims may be adjusted, edited and resubmitted, and voided in real time through the Online Portal. Access the Online Portal through Secured Site at colorado.gov/hcpf. For help with claim submission via the Online Portal, please choose the *User Guide* option available for each Online Portal transaction.

For additional electronic billing information, please refer to the appropriate Companion Guide located in the Provider Services Specifications section of the Department's website.

Presumptive Eligibility (PE)

Presumptive Eligibility (PE) provides medical assistance benefits to low income pregnant women and their children prior to receiving approval for full Health First Colorado (Colorado's Medicaid Program)

benefits. This program improves benefit accessibility for pregnant women through the process known as PE.

PE allows a woman temporary Health First Colorado coverage for 60 days. PE members receive a PE card that identifies them as eligible for ambulatory medical services. Inpatient hospital (e.g., delivery) services are not a PE benefit. After the full eligibility determination process, Health First Colorado eligible members receive a Medical Identification Card (MIC).

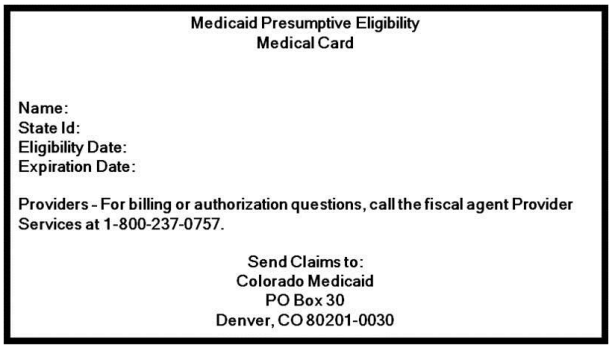
Health First Colorado eligible pregnant women have continuous eligibility. The woman remains eligible throughout her pregnancy and until the end of the month in which the 60th day following the end of her pregnancy occurs. Income changes during pregnancy do not affect eligibility. The infant has continuous eligibility until his or her first birthday.

Pregnant women are eligible for all Health First Colorado benefit services determined by their physician to be medically necessary. Pregnant women under age 21 are also eligible for Early and Periodic Screening Diagnosis and Treatment (EPSDT) services, including dental, vision care and EPSDT health checkups.

Woman in the maternity cycle are exempt from co-payment. The provider must mark the co-payment indicator on the paper claim form or on the electronic format.

- Providers must be a CHP+ site to offer services
- Providers must verify CHP+ PE member eligibility through Colorado Access

Presumptive Eligibility (PE) Card


Medicaid Presumptive Eligibility
Medical Card

Name:
State Id:
Eligibility Date:
Expiration Date:

Providers - For billing or authorization questions, call the fiscal agent Provider Services at 1-800-237-0757.

Send Claims to:
Colorado Medicaid
PO Box 30
Denver, CO 80201-0030

Diagnosis Coding

The Health First Colorado recognizes the *International Classification of Diseases, 9th Revision, Clinical Modification (ICD-10-CM)* diagnostic coding reference. The following diagnoses are for reference only. See the ICD-10-CM for a full list of diagnosis codes. When required, use additional digits as indicated.

Diagnosis Code	Description	Diagnosis Code	Description
Z32.00-Z32.02	Encounter for pregnancy test	O00.0-O00.9	Ectopic pregnancies
Z34.00-Z34.93	Encounter for supervision of normal pregnancy	O01.0-O02.0	Hydatidiform mole and other abnormal products of conception
		O02.1	Missed abortion (incomplete miscarriage)

Diagnosis Code	Description	Diagnosis Code	Description
O09.00-O09.93 O30.00-O30.93	Supervision of high risk pregnancy Multiple gestation	O03.0-O03.9	Spontaneous abortion (miscarriage)
Z37.0 - Z37.9 Z39.0 – Z39.2	Outcome of delivery Encounter for care and examination of mother immediately after delivery		

Procedure Coding

Whenever possible, medical care provided during pregnancy, labor and delivery, and the postpartum period should be billed using the global OB codes. The following CPT codes do not represent an exhaustive list of codes. Medical providers should consult the CPT codebook to ensure correct coding.

Global Procedure Codes

Global OB code	Description	Units	NCCI edits Require Modifier (XU) when billing for Multiple Gestation	Prior Authorization Required
59400-59410	**Vaginal Delivery:** Comprehensive and Component Services			
59400	Global OB care - Vaginal delivery Includes routine antepartum care, labor and vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care. (Requires a minimum of four antepartum visits.) Bill using delivery date as date of service.	1		No
59410	Vaginal delivery including postpartum care Includes (with or without episiotomy, and/or forceps) Bill when the delivering practitioner provides postpartum care for a period of 45 days after birth. Use delivery date as date of service	1	59410 with 59409 use XU	No

Global OB code	Description	Units	NCCI edits Require Modifier (XU) when billing for Multiple Gestation	Prior Authorization Required
59409	Vaginal delivery only without postpartum care. Includes,(with or without episiotomy, and/or forceps)	1		No
59510-59515	**Cesarean Section Delivery**: Comprehensive and Component Services			
59510	Global OB care - Cesarean delivery Includes routine antepartum care, and postpartum care. (Requires a minimum of four antepartum visits.) Bill using delivery date as date of service.	1		No
59515	Cesarean delivery including postpartum care Bill when the delivering practitioner provides postpartum care for a period of 45 days after birth. Use delivery date as date of service	1	59515 with 59514 use XU	No
59514	Cesarean delivery only, without postpartum care	1		No
59610-59614	**Vaginal Delivery after Prior Cesarean Section:** Comprehensive and Component Services			
59610	Vaginal Delivery, after prior cesarean delivery, including routine obstetric antepartum care, vaginal delivery (with or without episiotomy, and /or forceps) and postpartum care.	1	59610 with 59612 use XU	No
59614	Vaginal delivery, after previous cesarean delivery (with or without episiotomy and /or forceps); including postpartum care.	1	59614 with 59612 use XU	No
59612	Vaginal delivery only, after previous cesarean delivery.	1		No
59618-59622	**Cesarean Section after attempted Vaginal birth/Prior C-Section:** Comprehensive and Component Services			

Global OB code	Description	Units	NCCI edits Require Modifier (XU) when billing for Multiple Gestation	Prior Authorization Required
59618	Cesarean delivery, following attempted vaginal delivery after previous cesarean delivery including routine obstetric antepartum care, cesarean delivery, and postpartum care.	1	59618 with 59620 use XU	No
59622	Cesarean delivery, following attempted vaginal delivery after previous cesarean delivery; including postpartum care.	1	59622 with 59620 use XU	No
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery.	1		No
99201-99215 w/modifier TH	Antepartum care, per visit Each visit must be billed on a separate detail line.	1		No
59425	Antepartum care, 4-6 visits Bill on one detail line; date of service is the last antepartum visit. Delivery and postpartum care must be billed separately.	1		No
59426	Antepartum care, 7 or more visits Bill on one detail line; date of service is the last antepartum visit. Delivery and postpartum care must be billed separately.	1		No
59430	Postpartum care (separate procedure) Bill when the postpartum care provider does not deliver the baby, but does provide follow-up postpartum care.	1		No

Services not Included in Global Reimbursement:

- Unusual circumstances
- Conditions which are unrelated to the pregnancy or delivery
- Complications of pregnancy
- Certain adjunctive services
- Medical/Surgical services unrelated to the pregnancy
- Depression screens for pregnant and postpartum women

Separate Procedures

These services should be billed separately from (in addition to) global obstetrical care charges.

Service	Instructions
Prenatal testing	Bill only for the testing or the portion of the testing performed by the provider Use modifier -TC for technical component services only Use modifier - 26 for professional services only Use no modifier if professional and technical testing services are performed by the same provider
Invasive or non-invasive prenatal testing, including ultrasound	Health First Colorado covers a maximum of two (2) ultrasounds for an uncomplicated or low-risk pregnancy. If the member's medical condition requires additional ultrasonography, medical records must be documented.
Clinical laboratory testing	Providers must be CLIA certified Tests performed by an outside lab, must be billed by the lab. Laboratory testing other than routine chemical urinalysis and finger stick hematocrit. Pap smear during pregnancy and a second pap smear during the postpartum period. (This is in addition to the routine annual pap smear.) *NOTE: Lab tests **must** be marked "Emergency" for all non-citizens. If the claim is not marked "Emergency", **the claim will not be paid.***
Adjunctive services	For example, Tracheloplasty/trachelorrhaphy, etc.
Initial antepartum visit	Use CPT E&M codes 99201-99215 for initial visit. Initial visit may involve additional time and attention. The following represents possible diagnosis codes: Z34.00-Z34.03 Encounter for supervision of normal first pregnancy Z34.80-Z34.83 Encounter for supervision of other normal pregnancy Z34.90-Z34.93 Encounter for supervision of normal pregnancy, unspecified Z33.1 Pregnant state, incidental O09.00-O09.03 Supervision of high risk pregnancy with history of infertility O09.10-O09.13 Supervision of high risk pregnancy with history of ectopic or molar pregnancy O09.211-O09.219

Service	Instructions	
	O09.291-O09.299	Supervision of pregnancy with history of pre-term labor
	O09.30-O09.32	Supervision of high risk pregnancy with other poor reproductive or obstetric history
	O09.40-O09.43	Supervision of pregnancy with insufficient antenatal care
	O09.511-O09.529	Supervision of pregnancy with grand multiparity
	O09.611-O09.629	Supervision of elderly primigravida and multiogravida
	O09.70-O09.73	Supervision of young primigravida and multiogravida
	O09.821-O09.829	Supervision of high risk pregnancy due to social problems
	O09.891- O09.899	Supervision of pregnancy with history of in utero procedure during previous pregnancy
	O09.90-O09.93	Supervision of other high risk pregnancies
		Supervision of high risk pregnancy, unspecified
	Z32.00	Encounter for pregnancy test, result unknown
	Z32.01	Encounter for pregnancy test, result positive
	Z32.02	Encounter for pregnancy test, result negative
	N89.7	Hematocolpos
	N91.0-N91.5	Absent, scanty and rare menstruation
	N92.0- N92.6	Excessive frequent and irregular menstruation
	N93.0- N93.9	Other abnormal uterine and vaginal bleeding

Service	Instructions
Conditions requiring additional management	Billing for Multiple Infants: To avoid claim denials and National Correct Coding Initiative (NCCI) edits on claims involving the delivery of multiple infants, additional information is required. **For Cesarean Deliveries:** Bill ONLY one CPT code and only ONE unit for the complete cesarean delivery, regardless of the number of babies delivered. Whether reporting for a: global delivery (59510 or 59618), delivery only (59514 or 59620), or delivery including post-partum care (59515 or 59622) only one cesarean procedure (with one incision) is being performed. Use the most accurate/complete procedure code which describes the antenatal care, delivery history, current delivery type, and any postnatal care provided for the current pregnancy. **For Vaginal Deliveries**: bill multiple infants using the guidelines outlined below: For the first infant (Baby A), use the most accurate and complete vaginal delivery diagnostic and procedure code. Choose the procedure code which best describes all services provided and considers delivery history, current delivery type, prenatal care and postnatal care. Bill one unit of service for Baby A. For the additional infant (Baby B), bill this infant on a separate line using one of the following delivery **only** codes: 59409 or 59612. Choose the code associated with the delivery history and delivery type you used for Baby A. Include modifier '22' in the first position for Baby B. Use the delivery date as the date of service. **For Vaginal Deliveries followed by a Cesarean Delivery:** For a Vaginal Delivery of the first infant (Baby A): Use either code 59409 or 59612 "vaginal delivery only" for Baby A. Include modifier '22' in the first position for Baby A. Bill only one (1) unit of service. For Cesarean Delivery of the second infant (Baby B): Use the most accurate/complete global cesarean procedure code that describes the antenatal and/or postnatal care or delivery only care provided for the current pregnancy. Use one of the following codes for Baby B: global delivery (59510 or 59618), delivery only (59514 or 59620), or delivery including post-partum care (59515 or 59622). Choose the Cesarean code associated with the same delivery history you used for Baby A: (59510 or 59515 with 59409) OR (59618, 59620 or 59622 with 59612). Bill one (1) unit of service for Baby B. Each infant

Service	Instructions
	should be listed on a separate line. Use the delivery date as the date of service. **NCCI Edit Requirements:** A second modifier 'XU' is required for NCCI edits when the following code combinations are billed: 59410 with 59409, 59610 with 59612 or 59614 with 59612. NCCI edits do not allow procedure code 59514 to be combined or billed with codes: 59400, 59409 or 50410. **Delivery Procedure Codes:** For vaginal delivery codes use: 59400, 59410 or 59409 For vaginal deliveries (after a previous cesarean delivery) use: 59610, 59614 or 59612 For cesarean delivery codes use: 59510, 59515 or 59514 For cesarean deliveries (with attempted vaginal delivery, with a previous cesarean delivery) use: 59618, 59622 or 59620.
Medical or surgical complications	Bill on an ongoing basis using the appropriate procedure code(s). The diagnosis code must identify the complication or condition.
Conditions unrelated to pregnancy	Medical or surgical services for conditions that are not related to pregnancy should be billed separately. Identify the condition requiring additional care. Services are subject to PCP referral.
Anesthesia	The delivery fee includes local, pudendal, and paracervical blocks by the delivering practitioner. If the delivering practitioner begins block anesthesia for a vaginal delivery that subsequently requires a cesarean, separate charges may be submitted using the appropriate block code. If the delivering practitioner provides general or regional anesthesia (epidural, caudal, spinal, or saddle), bill the service separately using the appropriate delivery code (59409 or 59410) plus modifier -47. Enter units of service as one. Anesthesia by a practitioner, other than the practitioner delivering the infant(s), must be billed by the provider who renders the service.
Epidural anesthesia	Epidural anesthesia by a provider other than the delivering practitioner is a covered benefit. Document member contact time on the claim. Paper claims for more than 120 minutes (8 or more time units) of direct member contact epidural time require an attached copy of the anesthesia record. Electronic claims may be submitted (no attachments) but documents verifying extended direct member contact must be maintained and produced upon request.

Service	Instructions
Assistant surgeon at cesarean delivery	Modifier - 80 identifies assistant surgeon services. A family practitioner or certified nurse midwife may bill as assistant surgeon at cesarean. Physician assistants, surgical assistants, and nurse practitioners may not bill as assistant surgeon. An assistant surgeon is not allowed on vaginal deliveries.
Family planning	Health First Colorado enrolled women may receive family planning services during and after pregnancy. Health First Colorado covers all FDA approved methods of birth control. Prior authorization is not required for family planning services. When billing for family planning services, such as, contraception provision or sterilization procedures, always include the family planning (FP) modifier next to the appropriate procedure code on the claims form.
Surgical sterilization	Voluntary sterilization is considered a family planning service (requiring the FP modifier with billing) and requires strict compliance with Federal informed consent regulations. These sterilization claims can now be submitted electronically. A copy of the CO Medicaid sterilization consent form (MED 178, website link: Sterilization Consent Forms) must be attached to each related claim and completed according to the provider manual. The woman must be at least 21 years old on the date she signs the MED-178 and the form must be completed at least 30 days in advance of the procedure, but fewer than 180 days, unless emergency surgery or premature delivery occurs. The **surgeon must provide copies** of the properly completed MED-178 to the assistant surgeon, anesthetist, and hospital. Claims without MED-178 documentation are denied. Sterilization performed at the time of vaginal or cesarean delivery can be submitted electronically using the appropriate sterilization code and FP modifier with the required MED-178 form attached. If laparoscopic tubal ligation is performed, bill the base diagnostic laparoscopy on one detail line and the appropriate tubal ligation procedure code on a second detail line. Refer to the MED-178 Instructions for completion and form on the Department's website (colorado.gov/hcpf/ProviderServices) → Forms→ Sterilization Consent Forms.

Service	Instructions
Treatment of HIV-infected persons	Treatment of HIV-infected persons with antiretroviral medications prescribed by a doctor is a Health First Colorado benefit. Medications include, but are not limited to, zidovudine (AZT), didanosine (ddI), and stavudine. Medications to treat HIV related diseases must be FDA approved, listed on the drug formulary, and not classified as experimental. Most drugs do not require prior authorization. For questions on the status of drugs as a covered benefit, call your local pharmacy or Health First Colorado Provider Services.
Treatment for high risk pregnant women	Women who would be high risk given physical health, psychosocial history, and current life stressors may be eligible for involvement in the Prenatal Plus (PN+) Program, a Health First Colorado that provides a care team for women at higher risk of adverse birth outcomes. The service package includes: a care coordinator, a dietitian, and a mental health professional. If you think the mother would be eligible, please visit the website to find a provider near you: https://www.colorado.gov/pacific/hcpf/prenatal-plus
Treatment for substance abusing pregnant women	Substance abusing pregnant women may be eligible for involvement in Special Connections, a Health First Colorado funded program for substance abuse treatment. The service package includes: Risk assessment, case management, individual counseling, group counseling and health maintenance. Substance abusing pregnant women can refer themselves to Special Connections or be referred by a provider.
Newborn Care in the Hospital	Practitioner services provided to newborns in the hospital while the mother is also hospitalized may be billed using the mother's Health First Colorado State ID number and date of birth. Any services provided after mother's discharge must be submitted using the child's Health First Colorado State ID number. Under continuous eligibility, babies born to women enrolled in the Health First Colorado are eligible for program benefits until their first birthday as long as the baby remains in the mother's home. The mother or the provider must notify the local county department of human/social services of the infant's birth date, name and sex. Prompt notification avoids billing delays. Upon notification, the county will enroll the infant in the Health First Colorado and assign a State ID number. When billing newborn care under mother's State ID number, complete the claim with mother's name, mother's State ID number, mother's date of birth, and use modifier UK with each procedure code to identify that services were provided while mother and baby were hospitalized.

Service	Instructions
	If the infant is transferred to a different hospital or remains hospitalized after mother's discharge, claims must be submitted using the child's Health First Colorado State ID number. Claims for newborn care using the mother's State ID number after the mother's hospital discharge are denied.
Examination and evaluation of the healthy newborn	Use diagnosis code Z38.0-Z38.8 and a procedure code in the range 99460-99463. Use modifier UK with each submitted code as appropriate. EPSDT Periodicity Guidelines recommend initial newborn screenings at 3-5 days and 2 weeks.
Routine or ritual circumcision	As of July, 1, 2011 circumcision is no longer a benefit of the program. The following CPT codes are no longer being reimbursed 54150, 54160 or 54161. This change does not affect the CHP+ Program.
Newborn resuscitation or care of the high risk newborn at delivery	Includes, for example, inhalation therapy, aspiration, and administration of medication for initial stabilization. Bill using procedure code 99465-UK.

Special Provider Considerations

Provider	Service
Enrolled Certified Nurse Midwives	May provide OB care in accordance with the Colorado Medical Practice Act. Certified Nurse Midwives submit claims in the same manner as physicians. Certified nurse midwives may act as assistant surgeon at cesarean deliveries.
Certified Family Nurse Practitioners or Certified Pediatric Nurse Practitioners	Must be specifically identified and enrolled according to The Health First Colorado provider enrollment policy. These non-physician practitioners do not require direct and personal supervision of an on-premises, licensed, Health First Colorado-enrolled physician and may receive direct reimbursement.
Physician assistants other nurse practitioners	These providers do not qualify for direct reimbursement. The provider number of the supervising physician must appear in the supervising provider field on the claim record. Physician assistants, surgical assistants, and nurse practitioners may not serve as assistant surgeons.

Freestanding Birth Centers

Provider Enrollment

Reimbursement for birth centers for services rendered to Health First Colorado-eligible members is only available to licensed (through CDPHE) freestanding birth centers (FSBC) that enroll with the Health First Colorado as a Health First Colorado provider with a birth center specialty designation. Include a copy of your CDPHE license with your Health First Colorado provider enrollment application and request the

specialty designation for FSBCs. Practitioners, such as certified nurse midwives, providing services at birth centers must also be enrolled as Health First Colorado providers and affiliated with the birth center under which claims are submitted. Currently, licensed freestanding birth centers enroll as non-physician practitioner groups in Health First Colorado, and affiliated certified nurse midwives enroll as certified nurse midwives.

Billing Requirements

All claims are submitted through Health First Colorado's Online portal. Freestanding birth centers should submit usual and customary charges for all services rendered. Claims will be submitted using the 837 Professional (837P) electronic transaction. The following table illustrates the coding that must be used for the facility payment.

Birth centers in Colorado must notify the Department prior to beginning the submission of birth center payment claims for the first time to ensure correct payment. In addition to the submission of claims for antepartum, delivery, and postpartum care, birth centers can also submit claims for a birth center payment and when a member must be transferred to a hospital.

Description	Code(s)	Modifier – 1st position
Birth center payment	59899	HD

The modifier included in the tables above and below are required for the claim to pay correctly. If 'HD' (women's program/service) is not included in the 1st position, the claim will pay incorrectly.

Occasionally, members are unable to deliver at the birth center and need to be transferred to a hospital. In these cases, a reduced birth center payment is available as is reimbursement for time spent with the member.

Description	Code(s)	Modifier – 1st position	Modifier – 2nd position
Transfer payment: Payment for costs incurred prior to transporting a member to a hospital	59899	HD	52

In addition to the payment made for members who transfer, claims can be submitted for the time a midwife spends with the member prior her transfer and for antepartum care.

Description	Code(s)	Reimbursement
Office or outpatient visit; up to 40 minutes of time (99215)	99215	Payment is based upon Health First Colorado's fee schedule.
Office or outpatient visit; 41 minute to 121 minutes (99354)	99215 + 99354	Payment is based upon Health First Colorado's fee schedule.
Office or outpatient visit; each 30 minutes after 121 minutes (99355)	99215 + 99354 + 99355 (1 unit of 99355 per each additional 30 minutes)	Payment is based upon Health First Colorado's fee schedule.

CMS 1500 Paper Claim Reference Table

The following paper claim reference table shows required, optional, and conditional fields with detailed field completion instructions for submitting Obstetrical Care claims on 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 Health First Colorado seven-digit Medicaid ID number as it appears on the Medicaid Identification card. Example: A123456.
2	**Patient's Name**	Required	Enter the member's last name, first name, and middle initial.
3	**Patient's Date of Birth / Sex**	Required	Enter the member's birth date using two digits for the month, two digits for the date, and two digits for the year. Example: 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.

CMS Field #	Field Label	Field is?	Instructions
11b	**Other Claim ID**	Not Required	
11c	**Insurance Plan Name or Program Name**	Not Required	
11d	**Is there another Health Benefit Plan?**	Conditional	When appropriate, place an "X" in the correct box. If marked "YES", complete 9, 9a and 9d.
12	**Patient's or Authorized Person's signature**	Required	Enter "Signature on File", "SOF", or legal signature. If there is no signature on file, leave blank or enter "No Signature on File". Enter the date the claim form was signed.
13	**Insured's or Authorized Person's Signature**	Not Required	
14	**Date of Current Illness Injury or Pregnancy**	Conditional	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**	Conditional	

CMS Field #	Field Label	Field is?	Instructions
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: 070115 for July 1, 2015. If the member is still hospitalized, the discharge date may be omitted. This information is not edited.
19	**Additional Claim Information**	Conditional	**TRANSPORTATION** When applicable, enter the word "TRANSPORT CERT" to certify that you have a transportation certificate or trip sheet on file for this service.
20	**Outside Lab?** **$ Charges**	Conditional	Complete if <u>all</u> laboratory work was referred to and performed by an outside laboratory. If this box is checked, no payment will be made to the physician for lab services. Do not complete this field if <u>any</u> laboratory work was performed in the office. Practitioners may not request payment for services performed by an independent or hospital laboratory.
21	**Diagnosis or Nature of Illness or Injury**	Required	Enter at least one but no more than twelve diagnosis codes based on the member's diagnosis/condition. Enter applicable ICD indicator to identify which version of ICD codes is being reported. 0 ICD-10-CM (DOS 10/1/15 and after) 9 ICD-9-CM (DOS 9/30/15 and before)
22	**Medicaid Resubmission Code**	Conditional	List the original reference number for adjusted claims. When resubmitting a claim as a replacement or a void, enter the appropriate bill frequency code in the left-hand side of the field. 7 Replacement of prior claim 8 Void/Cancel of prior claim This field is not intended for use for original claim submissions.

CMS Field #	Field Label	Field is?	Instructions
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 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 15** | | | | | | Or From To **01 01 15 01 01 15** Span dates of service From To **01 01 15 01 31 15** Practitioner claims must be consecutive days. Single Date of Service: Enter the six digit date of service in the "From" field.

CMS Field #	Field Label	Field is?	Instructions
			Completion of the "To field is not required. Do not spread the date entry across the two fields. Span billing: permissible if the same service (same procedure code) is provided on consecutive dates. **Global Obstetrical care** For global obstetrical care, the "From" and "To" dates of service must be entered as the date of delivery. **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
24B	**Place of Service**	Required	Enter the Place of Service (POS) code that describes the location where services were rendered. The Health First Colorado accepts the CMS place of service codes. 03 School 04 Homeless Shelter 05 IHS Free-Standing Facility 06 Provider-Based Facility 07 Tribal 638 Free-Standing 08 Tribal 638 Provider-Based 11 Office 12 Home 15 Mobile Unit 20 Urgent Care Facility 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room Hospital

CMS Field #	Field Label	Field is?	Instructions
			24 ASC 25 Birthing Center 26 Military Treatment Center 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Transportation – Land 42 Transportation – Air or Water 50 Federally Qualified Health Center 51 Inpatient Psychiatric Facility 52 Psychiatric Facility Partial Hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility – MR 55 Residential Treatment Facility 60 Mass Immunization Center 61 Comprehensive IP Rehab Facility 62 Comprehensive OP Rehab Facility 65 End Stage Renal Dialysis Trtmt Facility 71 State-Local Public Health Clinic 72 Rural Health Clinic 81 Independent Lab 99 Other Unlisted
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. 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.

CMS Field #	Field Label	Field is?	Instructions
			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. 22 Delivery of multiples 26 Professional component 47 Anesthesia by surgeon 80 Assistant surgeon HD Women's program/service for FSBC facility payment TC Technical component TH Obstetrical Treatment/Services, Prenatal or Postpartum UK Services provided while mother and baby were hospitalized XU Delivery of multiple infants when billing CPT codes impact NCCI edits
24E	**Diagnosis Pointer**	Required	Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis. At least one diagnosis code reference letter must be entered. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. This field allows for the entry of 4 characters in the unshaded area.
24F	**$ Charges**	Required	Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.

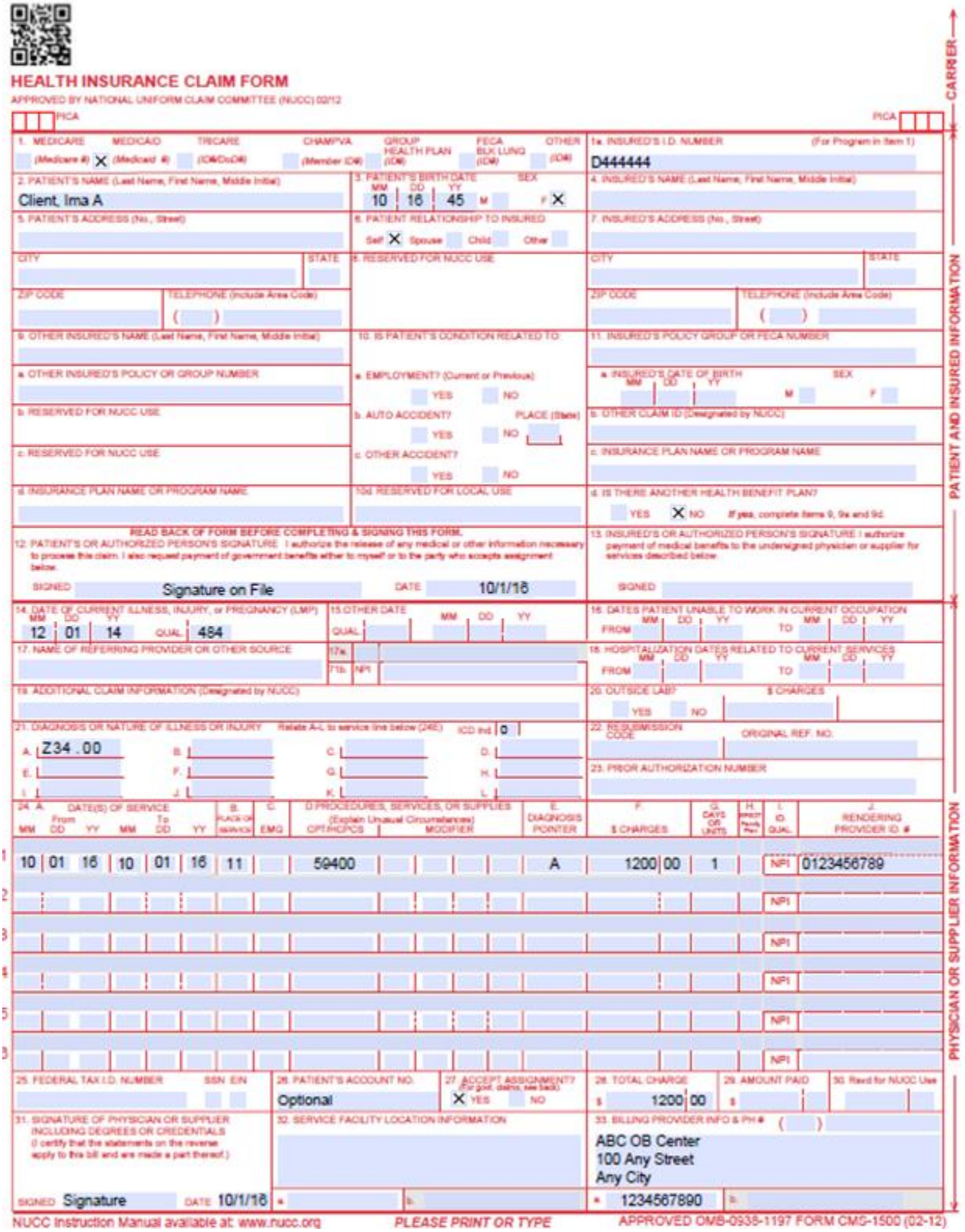
CMS Field #	Field Label	Field is?	Instructions
			Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one procedure from the same group is billed, special multiple pricing rules apply. The base procedure is the procedure with the highest allowable amount. The base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

CMS Field #	Field Label	Field is?	Instructions
			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. **Codes that define units as inclusive numbers** Some services such as allergy testing define units by the number of services as an inclusive number, not as additional services.
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, such as for contraception or sterilization, 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 NPI of the Health First Colorado provider number assigned to the individual who actually performed or rendered the billed service. This number cannot be assigned to a group or clinic.
25	**Federal Tax ID Number**	Not Required	
26	**Patient's Account Number**	Optional	Enter information that identifies the member or claim in the provider's billing system. Submitted information appears on the Remittance Advice (RA).

CMS Field #	Field Label	Field is?	Instructions
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 if authorization for the stamp is on file with the fiscal agent. An authorized agent or representative may sign the claim for the enrolled provider if the name and signature of the agent is on file with the fiscal agent. Each claim must have the date the enrolled provider or registered authorized agent signed the claim form. Enter the date the claim was signed using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. **Unacceptable signature alternatives:** Claim preparation personnel may not sign the enrolled provider's name. Initials are not acceptable as a signature. Typed or computer printed names are not acceptable as a signature. "Signature on file" notation is not acceptable in place of an authorized signature.

CMS Field #	Field Label	Field is?	Instructions
32	**32- Service Facility Location Information** **32a- NPI Number** **32b- Other ID #**	Conditional	Complete for services provided in a hospital or nursing facility in the following format: 1st Line Facility Name 2nd Line Address 3rd Line City, State and ZIP Code 32a- NPI Number Enter the NPI of the service facility (if known).
33	**33- Billing Provider Info & Ph #** **33a- NPI Number** **33b- Other ID #**	Required	Enter the name of the individual or organization that will receive payment for the billed services in the following format: 1st Line Name 2nd Line Address 3rd Line City, State and ZIP Code 33a- NPI Number Enter the NPI of the billing provider

OB 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: 10 16 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 10/1/16

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

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 12 01 14 | QUAL 484

15. OTHER DATE QUAL | MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. | 17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES | NO | $ CHARGES

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

A. Z34.00 | B. | C. | D. | E. | F. | G. | H. | I. | J. | K. | L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 01 16	10 01 16	11		59400		A	1200 00	1		NPI 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 $ 1200 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 10/1/16

32. SERVICE FACILITY LOCATION INFORMATION

a. | b.

33. BILLING PROVIDER INFO & PH # ( )

ABC OB Center
100 Any Street
Any City

a. 1234567890 | b.

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

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

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 Health First Colorado. Sterilization (i.e. tubal ligations, tubal occlusion and vasectomies) is intended to be a permanent, irreversible procedure to prevent consenting individuals from becoming pregnant or fathering a child. Submission of family planning sterilization claims should always include the family planning modifier (FP) and be submitted in accordance with the following procedures: **General requirements** The following requirements must be followed precisely or payment will be denied. These sterilization claims can now be submitted electronically (in the old MMIS system they were only allowed when filed on paper).. A **copy** of the CO Medicaid sterilization consent form (MED-178, website link: Sterilization Consent Forms) must be **attached to <u>each</u> related claim** for service including the hospital, anesthesiologist, surgeon, and assistant surgeon. ▪ The individual must be at least 21 years of age at the time the consent is obtained. ▪ The individual must be mentally competent. An individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose cannot consent to sterilization. The individual can consent if she has been declared competent for purposes that include the ability to consent to sterilization. ▪ The individual must voluntarily give "informed" consent as documented on the MED-178 consent form (see illustration) and specified in the "Informed Consent Requirements" described in these instructions. ▪ At least 30 days but not more than 180 days must pass between the date of informed consent and the date of sterilization with the following exceptions: **Emergency Abdominal Surgery:** An individual may consent to sterilization at the time of emergency abdominal surgery if at least 72 hours have passed since he/she gave informed consent for the sterilization. **Premature Delivery:** A woman may consent to sterilization at the time of a premature delivery if at least 72 hours have passed since she gave informed consent for the sterilization and the consent was obtained at least 30 days prior to the expected date of delivery.

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

Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions	➢ A full description of the benefits or advantages that may be expected as a result of the sterilization ➢ Advice that the sterilization will not be performed for at least 30 days except in the case of premature delivery or emergency abdominal surgery ➢ Suitable arrangements have been made to ensure that the preceding information was effectively communicated to an individual who is blind, deaf, or otherwise handicapped. ➢ The individual to be sterilized was permitted to have a witness of his or her choice present when consent was obtained. ➢ The consent form requirements (noted below) were met. ➢ Any additional requirement of the state or local law for obtaining consent was followed. ➢ Informed consent may not 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 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 Health First Colorado 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 and can be located on the Department's website (colorado.gov/hcpf)→For Our Providers→Provider Services→Forms. A sterilization consent form initiated in another state is acceptable when the text is complete and consistent with the Colorado form.

Sterilizations, Hysterectomies, and Abortions

Completion of the MED-178 consent form

Please refer to the MED-178 Instructions on the Department's website (colorado.gov/hcpf)→Provider Services→Forms→Sterilization Consent Forms. Information entered on the consent form must correspond directly to the information on the submitted Health First Colorado 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 member's portion of the sterilization consent must be approved and initialed by the member.

The following procedure codes for sterilization include:

- 58600
- 58605
- 58611
- 58615
- 58670
- 58671
- 58565
- A4264
- 55250
- 55450
- 00851
- 00921

The Diagnosis code(s) associated:

Z30.2
Z98.51 or Z98.52: Use for follow-up evaluations

Surgical sterilization procedure codes (bilateral examples are listed below. For additional surgical codes, refer to ICD-10-PCS manual.

0U570ZZ, 0U574ZZ, 0UB70ZZ, 0UB74ZZ, 0UL70CZ, 0UL74CZ, 0UL78DZ, 0V5Q0ZZ, 0VBQ3ZZ, 0VBQ4ZZ 0VBQ0ZZ, 0VBQ3ZZ, 0VBQ4ZZ, 0VTQ0ZZ, 0VTQ4ZZ

Providers billing on the CMS 1500 claim form

Use the appropriate procedure/diagnosis code from the recommended list above and the family planning modifier (FP) as previously noted.

In addition to the suggested coding, all claims must be submitted with the required documentation. Claims submitted for sterilization - related services when submitted without the required documentation will be denied.

Providers billing on the UB-04 claim form

Use the appropriate procedure/diagnosis code from those previously listed.

In addition to the suggested coding, all claims must be submitted with the required documentation. Claims submitted for sterilization - related services when submitted without the required documentation will be denied.

Hysterectomies

Billing Instruction Detail	Instructions
	Hysterectomy is a benefit of the Health First Colorado when performed solely for medical reasons. Hysterectomy is not a family planning benefit nor a benefit of the Health First Colorado 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 Health First Colorado**. These claims must be filed electronically. • Prior to the surgery, the person who secures the consent to perform the hysterectomy must inform the member and her representative, if any, verbally and in writing that the hysterectomy will render the member permanently incapable of bearing children. • The member 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 member. A written acknowledgment from the member is not required if: • The member 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 member'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 member was already sterile at the time of hysterectomy and stating the cause of sterility; • A signed and dated statement certifying that the member required hysterectomy under a life-threatening, emergency situation in which the practitioner determined that prior acknowledgment by the member was not possible. The statement must describe the nature of the emergency. A copy of the member's written acknowledgment or the practitioner's certification as described above must be attached to all claims submitted for hysterectomy services. A suggested form on which to report the required information is located in **Claim Forms and Attachments** in the Provider Services Forms section of the Department's website. Providers may copy this form, as needed, for attachment to claim(s). Providers may substitute any form that includes the required information. The submitted form or case summary documentation must be signed and dated by the practitioner performing the hysterectomy. The **surgeon is responsible for providing copies** of the appropriate acknowledgment or certification to the hospital, anesthesiologist, and assistant surgeon for billing purposes. **Claims will be denied if a copy of the written acknowledgment or practitioner's statement is not attached.** **Abortions** **Induced abortions** Therapeutic legally induced abortions are a benefit of the Health First Colorado when performed to save the life of the mother or if the pregnancy is the result of a sexual assault (rape) or incest. A copy of the appropriate certification statement must be attached to all claims for legally induced abortions performed for one of the above three reasons. Because of the attachment requirement, claims for legally induced abortions must be submitted electronically. 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 codes / ranges include: (decimal not required when billing) O04.5, O04.6, O04.7, O04.80 - O04.89 Z33.2 - Encounter for elective termination of pregnancy, uncomplicated Z33.2: is only available for reimbursement when the pregnancy is the result of a rape or incest, and proper supportive documentation is included with the claim. Surgical procedure codes: • 10A07Z6 • 10A07ZW • 10A07ZX • 10A07ZZ • 10A08ZZ **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 physician 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 Done 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.

Billing Instruction Detail	Instructions
	"**To save the life of the mother**" means: The presence of a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, as determined by the attending practitioner, which represents a serious and substantial threat to the life of the pregnant woman if the pregnancy is allowed to continue to term.

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

Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions (continued)	The **practitioner performing the abortion is responsible for providing the required documentation to other providers** (facility, anesthetist, etc.) for billing purposes. Induced abortions when pregnancy is the result of sexual assault (rape) or incest Sexual assault (including rape) is defined in the Colorado Revised Statutes (C.R.S.) 18-3-402 through 405, 405.3, or 405.5. Incest is defined in C.R.S. 18-6-301. Providers interested in the legal basis for the following abortion policies should refer to these statutes. All claims for services related to induced abortions resulting from sexual assault (rape) or incest **must** be submitted with the "Certification Statement for abortion for sexual assault (rape) or incest". **A suggested form is located in Claim Forms and Attachments** in the Provider Services Forms section of the Department's website. This form **must**: Be signed and dated by the member 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.

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 Health First Colorado. Claims for treatment of these conditions **do not** require additional documentation. The claim must indicate a diagnosis code that specifically demonstrates that the termination of the pregnancy was not performed as a therapeutic legally induced abortion.

The following diagnosis codes are appropriate for identifying conditions that may properly be billed for Health First Colorado reimbursement.

O00.0-O00.9	Ectopic Pregnancy
O01.0-O01.9	Hydatidiform mole
O02.0-O02.9	Other abnormal products of conception
O02.1	Missed Abortion (incomplete miscarriage)
O03.0-O03.9	Spontaneous Abortion
O08.0-O08.9	Complications following ectopic and molar pregnancy

The following CPT procedure codes may be submitted for covered abortion and abortion related services.

58120	Dilation & Currettage, diagnostic and/or therapeutic (non-obstetrical)
59100	Hysterotomy, abdominal (For Removal of Hydatidiform Mole, Abortion)
59812-59830	Medical and Surgical Treatment of Miscarriage

Fetal anomalies incompatible with life outside the womb

Billing Instruction Detail	Instructions
	Therapeutic abortions performed due to fetal anomalies incompatible with life outside the womb **are not** a Health First Colorado benefit.

Timely Filing

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

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

Obstetrical Care Revisions Log

Revision Date	Additions/Changes	Pages	Made by
12/01/2016	*Manual revised for interChange implementation. For manual revisions prior to 12/01/2016, please refer to Archive.*	*All*	*HPE (now DXC)*
12/27/2016	*Updates based on Colorado iC Stage II Provider Billing Manuals Comment Log v0_2.xlsx*	*Multiple*	*HPE (now DXC)*
1/10/2017	*Updates based on Colorado iC Stage Provider Billing Manual Comment Log v0_3.xlsx*	*Multiple*	*HPE (now DXC)*
1/19/2017	*Updates based on Colorado iC Stage Provider Billing Manual Comment Log v0_4.xlsx*	*Multiple*	*HPE (now DXC)*
1/26/2017	*Updates based on Department 1/20/2017 approval email*	*Accepted tracked changes throughout*	*HPE (now DXC)*
5/22/2017	*Updates based on Fiscal Agent name change from HPE to DXC*	*1*	*DXC*

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