Obstetrical Care

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Obstetrical Care

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 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

Colorado Medical Assistance Program 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.

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 Xerox State Healthcare, P.O. Box 90, Denver, CO 80201-0090. The following claims can be submitted on paper and processed for payment:

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

Paper claims do not require an NPI, but do require the Colorado Medical Assistance Program provider number. Electronically mandated claims submitted on paper are processed, denied, and marked with the message "Electronic Filing Required".

Electronic Claims

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

- X12N Technical Report 3 (TR3) for the 837P, 837I, or 837D (wpc-edi.com/)
- Companion Guides for the 837P, 837I, or 837D in the Provider Services
- Web Portal User Guide (via 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.

For additional electronic information, please refer to the Medicaid Provider Information manual located on the Department's website (Colorado.gov/hcpf) · For Our Providers · Provider Services · Billing Manuals.

Presumptive Eligibility (PE)

Presumptive Eligibility (PE) provides medical assistance benefits to low income pregnant women and their children prior to receiving approval for full Medicaid benefits. This program improves benefit accessibility for pregnant women through the process known as PE.

PE allows a woman temporary Colorado Medical Assistance Program 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, Colorado Medical Assistance eligible members receive a Medical Identification Card (MIC).

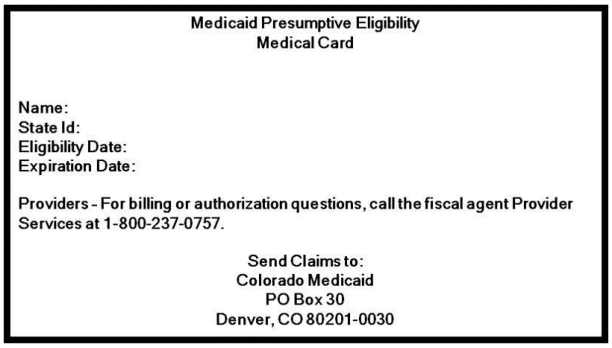
Colorado Medical Assistance eligible pregnant women have continuous eligibility. The woman remains eligible throughout her pregnancy and until the end of the month in which the 60th day following the end of her pregnancy occurs. Income changes during pregnancy do not affect eligibility. The infant has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

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

Diagnosis Code	Description	Diagnosis Code	Description
V22	Normal pregnancy	630-634.99 & 639-676.94	Complications of pregnancy, childbirth, and puerperium
V23	Supervision of high-risk pregnancy		
V24	Postpartum care and examination		
V25	Contraceptive management		

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
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
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
99201-99215 w/modifier TH	Antepartum care, per visit Each visit must be billed on a separate detail line.	1
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
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

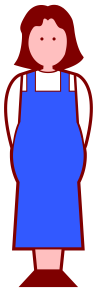
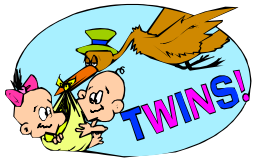
Global OB code	Description	Units
59410	Vaginal delivery including postpartum care Includes (with or without episiotomy, and/or forceps) Bill when the delivering practitioner provides postpartum care for a period of 45 days after birth. Use delivery date as date of service	1
59409	Vaginal delivery without postpartum care Includes,(with or without episiotomy, and/or forceps)	1
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
59514	Cesarean delivery without postpartum care	1
59430	Postpartum care (separate procedure) Bill when the postpartum care provider does not deliver the baby, but does provide follow-up postpartum care.	1
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and /or forceps) and postpartum care, after previous cesarean delivery.	1
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and /or forceps); including postpartum care.	1
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery.	1
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care.	1

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

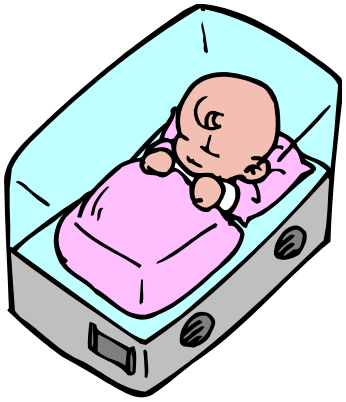
Separate Procedures

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	Colorado Medicaid covers a maximum of three (3) ultrasounds for an uncomplicated or low-risk pregnancy. If the patient'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. Use one of the following diagnosis codes: V22.X-V23.9 — Confirmed pregnancy (No PCP referral required) V72.4X — Pregnancy examination/test, pregnancy unconfirmed (If member has a PCP, referral is required.) 626.X — Absence of menstruation (If member has a PCP, referral is required.)
Conditions requiring additional management 	59610-59614 Single vaginal delivery of multiple infants Multiple Infants: Use the appropriate vaginal or Cesarean delivery procedure code and bill one unit of service. The additional infants may be billed using 59409 or 59514 with modifier 22 and indicating the number of additional infants in unit field of the claim form. Use the appropriate diagnosis code to indicate multiple infants. The date of service must be the delivery date.

Service	Instructions
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 delivering practitioner must be billed by the rendering provider.
Epidural anesthesia	Epidural anesthesia by a provider other than the delivering practitioner is a covered benefit. Document patient contact time on the claim. Paper claims for more than 120 minutes (8 or more time units) of direct patient contact epidural time require an attached copy of the anesthesia record. Electronic claims may be submitted (no attachments) but documents verifying extended direct patient contact must be maintained and produced upon request.
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 	Colorado Medical Assistance Program enrolled women may receive family planning services during and after pregnancy. Colorado Medical Assistance Program generally covers most methods of birth control. Prior authorization is not required for family planning.

Service	Instructions
Surgical sterilization	Voluntary sterilization requires strict compliance with Federal informed consent regulations. All sterilization or sterilization-related claims must be submitted on paper with an attached MED-178 consent form, 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 30 days in advance of the procedure 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 must be billed on paper using the appropriate sterilization code 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.
Treatment of HIV-infected persons	Treatment of HIV-infected persons with antiretroviral medications prescribed by a doctor is a Colorado Medical Assistance Program 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 Colorado Medical Assistance Program Provider Services.
Treatment for substance abusing pregnant women	Substance abusing pregnant women may be eligible for involvement in Special Connections, a Colorado Medical Assistance Program 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.

Service	Instructions
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 Colorado Medical Assistance Program State ID number and date of birth. Any services provided after mother's discharge must be submitted using the child's Colorado Medical Assistance Program State ID number. Under continuous eligibility, babies born to women enrolled in the Colorado Medical Assistance Program 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 Colorado Medical Assistance Program 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. If the infant is transferred to a different hospital or remains hospitalized after mother's discharge, claims must be submitted using the child's Colorado Medical Assistance Program 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 V30.00-V39.21 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. Nurse Midwives submit claims in the same manner as physicians. Certified nurse midwives may act as assistant surgeon at cesarean.
Certified Family Nurse Practitioners or Certified Pediatric Nurse Practitioners	Must be specifically identified and enrolled according to The Colorado Medical Assistance Program provider enrollment policy. These non-physician practitioners do not require direct and personal supervision of an on-premises, licensed, Colorado Medical Assistance Program-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 is only available to licensed freestanding birth centers that enroll with the Colorado Medical Assistance Program as a Medicaid provider for services rendered to Medicaid-eligible members. Practitioners, such as certified nurse midwives, providing services at birth centers must also be enrolled as Medicaid providers and affiliated with the birth center under which claims are submitted. Currently, licensed freestanding birth centers enroll as non-physician practitioner groups in Colorado Medicaid, and affiliated certified nurse midwives enroll as certified nurse midwives.

Billing Requirements

All claims are submitted through Colorado Medicaid's web 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

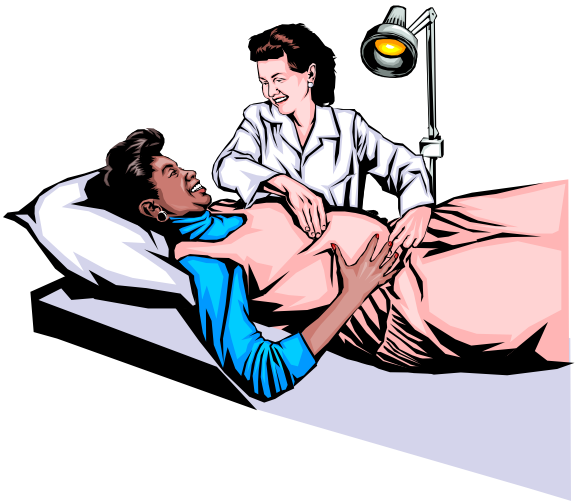
The modifier included in the tables above and below are required for the claim to pay correctly. If 'HD' (women's program/service) is not included in the 1st position, the claim will pay incorrectly.

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 Colorado Medicaid's fee schedule.
Office or outpatient visit; 41 minute to 121 minutes (99354)	99215 + 99354	Payment is based upon Colorado Medicaid'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 Colorado Medicaid'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 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.

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**	Not Required	

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: 070114 for July 1, 2014. If the member is still hospitalized, the discharge date may be omitted. This information is not edited.
19	**Additional Claim Information**	Conditional	**LBOD** Use to document the Late Bill Override Date for timely filing. **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 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

CMS Field #	Field Label	Field is?	Instructions
			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 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**

CMS Field #	Field Label	Field is?	Instructions
			Practitioner claims must be consecutive days. Single Date of Service: 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. 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 Colorado Medical Assistance Program 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

CMS Field #	Field Label	Field is?	Instructions
			12 Home 15 Mobile Unit 20 Urgent Care Facility 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room Hospital 24 ASC 25 Birthing Center 26 Military Treatment Center 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Transportation – Land 42 Transportation – Air or Water 50 Federally Qualified Health Center 51 Inpatient Psychiatric Facility 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-

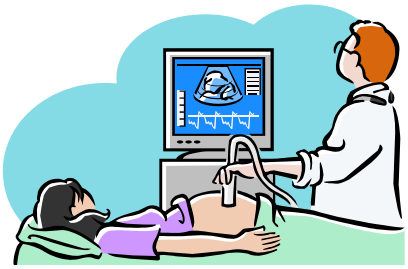
CMS Field #	Field Label	Field is?	Instructions
			threatening condition or one that requires immediate medical intervention. If a "Y" for YES is entered, the service on this detail line is exempt from co-payment requirements.
24D	**Procedures, Services, or Supplies**	Required	Enter the HCPCS procedure 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. 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** TC **Technical component** TH **Obstetrical Treatment/Services, Prenatal or Postpartum** UK **Services provided while mother and baby were hospitalized**
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.

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

CMS Field #	Field Label	Field is?	Instructions
			Claim preparation personnel may not sign the enrolled provider's name. Initials are not acceptable as a signature. Typed or computer printed names are not acceptable as a signature. "Signature on file" notation is not acceptable in place of an authorized signature.
32	**32- Service Facility Location Information** **32a- NPI Number** **32b- Other ID #**	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.



OB Claim Example

HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

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

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

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

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

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

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: Signature on File DATE: 1/1/15

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

SIGNED

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

15. OTHER DATE MM DD YY QUAL.

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. 17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

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

A. V22X 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		59400		A	1200 00	1			12345678
															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) YES [X] 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: 1/1/15

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

ABC OB 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)

Late Bill Override Date

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

Valid Delay Reason Codes

1 Proof of Eligibility Unknown or Unavailable

3 Authorization Delays

7 Third Party Processing Delay

8 Delay in Eligibility Determination

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

11 Other

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

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

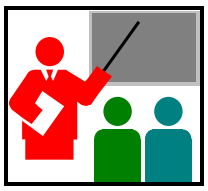
Billing Instruction Detail	Instructions
LBOD Completion Requirements	• Electronic claim formats provide specific fields for documenting the LBOD. • Supporting documentation must be kept on file for 6 years. • For paper claims, follow the instructions appropriate for the claim form you are using. ➢ *UB-04*: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

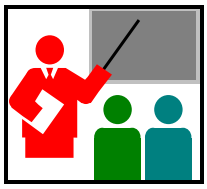
Billing Instruction Detail	Instructions
	LBOD = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the payment.
Denied Paper Claims	If the initial timely filing period has expired and a previously submitted paper claim that was filed within the original Colorado Medical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

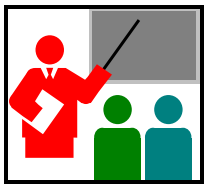
Billing Instruction Detail	Instructions
	• States that eligibility was backdated or retroactive • Identifies the date that eligibility was added to the state eligibility system. **LBOD** = the date shown on the county letter that eligibility was added to or first appeared on the state eligibility system.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

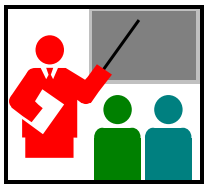
Billing Instruction Detail	Instructions
	File the claim within 60 days of the Medicare processing date shown on the SPR/ERA. Attach a copy of the SPR/ERA if submitting a paper claim and maintain the original SPR/ERA on file. **LBOD** = the Medicare processing date shown on the SPR/ERA.
Commercial Insurance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

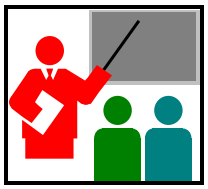
Sterilizations, Hysterectomies, and Abortions

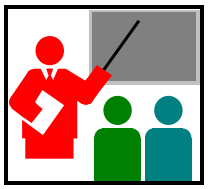
Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions 	**Voluntary sterilizations** Sterilization for the purpose of family planning is a benefit of the Colorado Medical Assistance Program in accordance with the following procedures: **General requirements** The following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

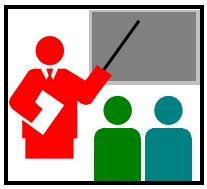
Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions 	The person may not be an "institutionalized individual". Institutionalized includes: ▪ Involuntarily confinement or detention, under a civil or criminal statute, in a correctional or rehabilitative facility including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

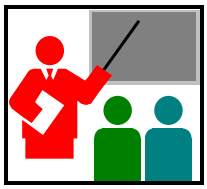
Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions 	➤ A full description of the benefits or advantages that may be expected as a result of the sterilization ➤ Advice that the sterilization will not be performed for at least 30 days except in the case of premature delivery or emergency abdominal surgery ➤ Suitable arrangements have been made to ensure that the preceding information was effectively communicated to an individual who is blind, deaf, or otherwise handicapped. ➤ The individual to be sterilized was permitted to have a witness of his or her choice present when consent was obtained. ➤ The consent form requirements (noted below) were met. ➤ Any additional requirement of the state or local law for obtaining consent was followed. ➤ Informed consent may <u>not</u> be obtained while the individual to be sterilized is: ✓ In labor or childbirth; ✓ Seeking to obtain or is obtaining an abortion; and/or ✓ Under the influence of alcohol or other substances that may affect the individual's sense of awareness. **MED-178 consent form requirements** Evidence of informed consent must be provided on the MED-178 consent form. The MED-178 form is available on the the Department's website (colorado.gov/hcpf)→Provider 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.

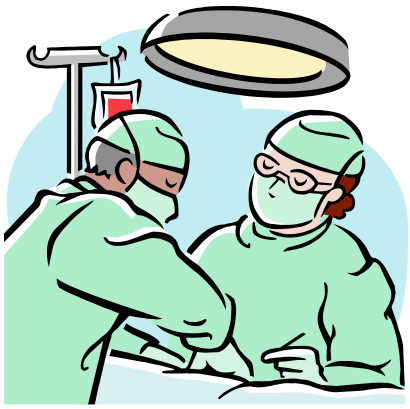
Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions 	**Completion of the MED-178 consent form** Please refer to the MED-178 Instructions on the Department's website (colorado.gov/hcpf)→Provider Services→Forms→Sterilization Consent Forms. Information entered on the consent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

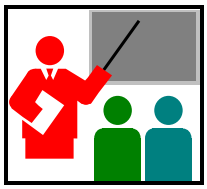
Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions (continued) 	If the patient's acknowledgment is not required because of the one of the above noted exceptions, the practitioner who performs the hysterectomy **must certify in writing**, as applicable, one of the following: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

Billing Instruction Detail	Instructions
Sterilizations, Hysterectomies, and Abortions (continued) 	Diagnosis code ranges: (decimal not required when billing) 635.00-635.92 637.00-637.92 Surgical diagnosis codes: • 69.01 • 69.51 • 69.93 • 74.91 • 75.0 **Providers billing on the CMS 1500 claim form** Use the appropriate procedure/diagnosis code from the list above **and** the most appropriate modifier from the list below: • G7 - Termination of pregnancy resulting from rape, incest, or certified by 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. "**To save the life of the mother**" means: The presence of a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, as determined by the attending practitioner, which represents a serious and substantial threat to the life of the pregnant woman if the pregnancy is allowed to continue to term.

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

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



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

Obstetrical Care Revisions Log

Revision Date	Additions/Changes	Pages	Made by
01/20/2014	*Created*	*All*	*jg*
01/14/2014	*Edited*	*Throughout*	*km*
01/23/2014	*Edited*	*Throughout*	*cc*
01/23/2014	*Formatted and updated TOC*	*Throughout*	*jg*
01/30/2014	*Removed condition codes A7 & A8. Added condition codes AA, AB, & AD*	*34*	*cc*
05/21/2014	*Updated ultrasound language to allow 3 ultrasounds with documentation.*	*4*	*Km*
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*
8/11/2014	*Updated all web links to reflect new Department website*	*Throughout*	*MM*
12/08/2014	*Removed Appendix H information, added Timely Filing document information*	*28*	*Mc*
3/4/2015	*Updated wording for clients to members, added section for Freestanding Birth Centers (Provider Enrollment & Billing Requirements) per policy analyst.*	*Throughout*	*JH, CC, KM*
03/04/2015	*Format and TOC Updates*	*Throughout*	*bl*
04/28/2015	*Changed the word unshaded to shaded*	*24J*	*bl*