Outpatient Imaging and Radiology Services

Outpatient Imaging and Radiology Services

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

- Treat a Colorado Medical Assistance Program member; and
- Submit claims for payment to the Colorado Medical Assistance Program (Colorado Medicaid).

Outpatient Imaging and Radiology services are a benefit of Colorado Medicaid, for medical conditions requiring radiology services when supervised by a physician. Imaging and Radiology services are a benefit under the following conditions:

1. The services have been authorized by a licensed physician.
2. The services are performed to diagnose conditions and illnesses with specific symptoms.
3. The services are performed to prevent or treat conditions that are Colorado Medicaid covered benefits.
4. The services are not routine diagnostic tests performed without apparent relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.
5. The radiology services are performed by a provider certified by the Colorado Department of Public Health and Environment (CDPHE) and enrolled as a Colorado Medicaid Provider.

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

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

Billing Information

National Provider Identifier (NPI)

The Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities (i.e., health plans, health care clearinghouses, and health care providers that 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.

Claim Requirements

All claims, including those for prior authorization (PAR) services, must meet eligibility and claim submission requirements (e.g., timely filing, Primary Care Physician [PCP] information completed appropriately, third party resources payments pursued, required attachments included, etc.) before payment can be made.

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

Paper Claims

Electronic claims are required unless hard copy claims are specifically prior authorized by the Department. Requests for paper claim submission may be sent to the Department's fiscal agent, Xerox

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

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

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

Electronic Claims

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

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

The Colorado Medical Assistance Program collects electronic claim information interactively through the Colorado Medical Assistance Program Secure Web Portal (Web Portal) or via batch submission through a host system. For additional electronic billing information, refer to the General Provider Information manual located in the Billing Manuals section of the Department's web site.

General Benefit Policies

Co-payments for Imaging and Radiology Procedures

Co-payment eligible members may be charged a $1 co-payment for each day they receive a radiology procedure. Providers must look up a member's Medicaid eligibility status to determine if that member is eligible for a co-payment. Many members, including children and pregnant women, are exempt from co-payment responsibilities.

- Providers cannot refuse treatment to a member if the member is unable to immediately pay the co-payment. However, the member still remains liable for the co-payment at a later date. Reference Program Rule 8.754 for specific co-payment guidelines

Payment for Covered Services/Procedures

Regardless of whether Colorado Medicaid has actually reimbursed the provider, billing members for covered procedures is strictly prohibited. Balance billing is prohibited. If reimbursement is made, providers must accept this payment as *payment in full* (see Program Rule 8.012). The provider may only bill the member for procedures not covered by Colorado Medicaid.

- Members may be billed for non-covered procedures in accordance with C.R.S. 25.5-4-301(1)(a)(I).
    - *(1) (a) (I) Except as provided in section 25.5-4-302 and subparagraph (III) of this paragraph (a), no recipient or estate of the recipient shall be liable for the cost or the cost remaining after payment by medicaid, medicare, or a private insurer of medical benefits authorized by Title XIX of the social security act, by this title, or by rules promulgated by the state board, which benefits are rendered to the recipient by a provider of medical*

services authorized to render such service in the state of Colorado, except those contributions required pursuant to section 25.5-4-209 (1). However, a recipient may enter into a documented agreement with a provider under which the recipient agrees to pay for items or services that are nonreimbursable under the medical assistance program. Under these circumstances, a recipient is liable for the cost of such services and items.

- If a PAR for procedures are required, the following policy applies:
  - Technical/lack of information (LOI) denial does not mean those procedures are not covered. Members may not be billed for procedures denied for LOI.
  - Procedures partially approved are still considered covered procedures. Members may not be billed for the denied portion of the request.
  - Procedures totally denied for not meeting medical necessity criteria are considered non-covered services.

Billing Edits

The provider's adherence to the application of policies in this manual is monitored through either post-payment review of claims by the Department, or computer audits or edits of claims. When computer audits or edits fail to function properly, the application of policies in this manual remain in effect. Therefore, all claims shall be subject to review by the Department.

Covered Imaging and Radiology Procedures

Colorado Medicaid covered procedures include but are not limited to:

- Angiograms
- Computed Tomography (CT scans)
- Electrocardiograms (ECG)
- Magnetic Resonance Imaging (MRI scans)
- Mammograms
- Positron Emission Tomography (PET scans)
- Radiation treatment for tumors
- Ultrasounds
- X-rays

An exhaustive list of covered procedures may be found on the Department's Fee Schedule.

Preventive Lung Cancer Low Dose Computed Tomography (LDCT) Screening

The United States Preventive Services Task Force recommends annual screening for lung cancer with low-dose computed tomography for adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

Effective July 1, 2015, the following policies must be followed:

1. HCPCS code **S8032** must be used for preventive lung cancer screening procedures
2. ICD-9 diagnosis code V76.0 must be reported for dates of service prior to 10/1/15
3. ICD-10 diagnosis code Z12.2 must be reported for dates of service beginning 10/1/15
4. S8032 always requires Prior Authorization
5. Benefit is limited to one (1) screening (one (1) unit of service) per state fiscal year (July 1 – June 30)

Special eligibility criteria for LDCT lung cancer screening

Member must meet all of the following criteria to be eligible for the benefit:

1. Between 55 and 80 years of age
2. Asymptomatic (no signs of lung cancer)
3. History of cigarette smoking of at least 30 pack-years
4. Current smoker or one who has quit smoking within the last 15 years
5. Receives written order for LDCT lung cancer screening from a qualified physician or non-physician practitioner

Non-Covered Imaging and Radiology Procedures

1. Imaging and Radiology procedures for cosmetic treatment or infertility treatment.
2. Imaging and Radiology procedures considered experimental or not approved by the Food and Drug Administration (FDA).
3. Imaging and Radiology procedures not ordered by the member's attending or treating physician.

Coding Guidelines

General Policies

1. Regardless of billing provider type, component modifiers must be indicated on the claim if reimbursement for the procedure is split between the *professional* and *technical components.*
    a. Professional component – modifier 26
    b. Technical component – modifier TC
2. Claims lacking a component modifier are understood to be inclusive of both components and will be reimbursed as payment in full for the entire procedure. Any separate claim for the same procedure, billed on the same date of service, will be considered an overpayment and may be subject to recovery.
3. Outpatient Hospital claims for Imaging and Radiology must be billed via an 837I (UB-04 paper claim); Practitioner procedure claims must be billed via an 837P (CMS1500 paper claim)

Prior Authorization Requirements and Information

Colorado Medicaid requires all outpatient hospitals and free-standing radiology / X-ray facility centers to obtain a prior authorization (prior authorization request, PAR) for non-emergent CT, non-emergent MRI, and all PET scans. A PAR preceeds the submission of a claim and must be approved in advance of the claim. Procedures which require a PAR cannot be claimed for without an approved PAR on record.

All Imaging and Radiology PARs and revisions are processed by the ColoradoPAR Program and must be submitted using CareWebQI (CWQI). PARs submitted via fax or mail **will not** be processed. These PARs will be returned to providers via mail. This requirement only impacts PARs submitted to the ColoradoPAR Program.

To ensure claims are quickly and accurately processed, all claims for procedures which require a PAR must:

- Contain the correct Billing Provider ID number
- Contain procedure codes which match the corresponding PAR on record
- Contain modifier codes which match the corresponding PAR on record

To request more information Contact:

1-888-454-7686 or refer to the Department's ColoradoPAR Program web page.

PAR Revisions

If a procedure is prior authorized but the desired test was changed just prior to the time of the service, the provider is responsible for submitting a PAR revision with adequate documentation within 48 hours of the date of service for the PAR to be processed by the ColoradoPAR Program. PAR revisions can only be submitted using CWQI. Contact the ColoradoPAR Program at 1-888-454-7686 with questions regarding how to process PAR revisions.

PAR Exceptions

To request a PAR exception contact the ColoradoPAR Program at 888-454-7686 or refer to the Department's ColoradoPAR Program web page.

1. Emergency outpatient imaging and radiology procedures are exempt from PAR requirements. To mark a claim as emergency, check the emergency indicator field.
2. All PET and SPECT scan procedures require prior authorization regardless of whether emergency is indicated.
3. A PAR is not required when Medicare, Medicare Advantage plans, or private insurance has made primary payment on the claim. If third party liability (TPL) carriers have not made payment on the claim, the service must be prior authorized to ensure it meets medical necessity standards of the Medicaid program.
4. PARs are not required of any Imaging and Radiology procedure for the *professional component* if the procedure billing is split between components. The *technical component* still requires prior authorization.

The Department will allow retroactive authorizations when a member's eligibility is determined after the date that the service is performed. When a member's eligibility is determined after the date of service, the member is issued a Load Letter. The Load Letter must be submitted with the supporting clinical documentation for the PAR for a retroactive request to be processed by ColoradoPAR.

PAR Denials

If the PAR is denied, direct inquiries to the ColoradoPAR Program at 888-454-7686 or refer to the Department's ColoradoPAR Program web page.

Other PAR Policies

- It is the provider's responsibility to maintain clinical documentation to support procedures provided in the member's file in the event of an audit or retroactive review. Submitted PARs without minimally required information or with missing or inadequate clinical information will result in a lack of information (LOI) denial.
- All accepted PARs are reviewed by the authorizing agency. The authorizing agency approves or denies, by individual line item, each requested service or supply listed on the PAR.
- Paper PAR forms and completion instructions are located in the Provider Services Forms section of the Department's website. They must be completed and signed by the member's physician and submitted to the authorizing agency for approval.
- Providers should not render procedures or submit claims for procedures that require prior authorization before the PAR is approved. After the authorizing agency has reviewed the request, the PAR status is transmitted to the fiscal agent's prior approval system.
- The status of the requested procedures is available through the Web Portal. In addition, after a PAR has been reviewed, both the provider and the member receive a PAR response letter

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

- Approval of a PAR does **not** guarantee Medicaid reimbursement and does **not** serve as a timely filing waiver. Authorization only assures that the approved service is a medical necessity and is considered a Medicaid covered benefit.

Procedure Codes Requiring Prior Authorization

Positron Emission Tomography (PET) Scans			
Code	**Description**	**Code**	**Description**
78459	Myocardial Imaging, Positron Emission Tomography (PET) Metabolic Eval.	78811	Pet - Limited Area- Chest, Head, Neck
78491	Myocardial Imaging, Positron Emission Tomography (Pet), Perfusion; Single Study At Rest Or Stress	78812	Pet - Skull Base To Mid-Thigh
78492	Myocardial Imaging, Positron Emission Tomography (Pet), Perfusion; Multiple Studies At Rest Or Stress	78813	Pet -Whole Body
78607	Brain Imaging Complete Study Tomograhpic Spect	78814	PET W/CT - Chest, Head, Neck
78608	Brain Imaging, Positron Emission Tomography (PET) Metabolic Evaluation	78815	PET W/CT - Skull Base To Mid-Thigh
78609	Brain Imaging, Positron Emission Tomography (PET), Perfusion Evaluation	78816	PET W/CT - Whole Body

Computerized Tomographic Scans			
Code	**Description**	**Code**	**Description**
70450	CT Head/Brain W/O Contrast	70491	CT Soft Tissue Neck W/ Contrast
70460	CT Head/Brain W/Contrast	70492	CT Soft Tissue Neck W/O & W/ Contrast
70470	CT Head/Brain W/O & W/ Contrast	71250	CT Thorax W/O Contrast
70480	CT Orbit W/O Contrast	71260	CT,Thorax; W/Contrast
70481	CT Orbit W/ Contrast	71270	CT Thorax W/O & W/ Contrast
70482	CT Orbit W/O & W/ Contrast	72125	CT C Spine W/O Contrast
70486	CT Maxllfcl W/O Contrast	73200	CT Upper Extremity W/O Contrast
70487	CT Maxllfcl W/ Contrast	73201	CT Upper Extremity W/ Contrast
72126	CT C Spine W/ Contrast	73202	CT Upper Extremity W/O & W/ Contrast
72127	CT C Spine W/O & W/ Contrast	73700	CT Lower Extremity W/O Contrast
72128	CT T Spine W/O Contrast	73701	CT Lower Extremity W/ Contrast
72129	CT T Spine W/ Contrast	73702	CT Lower Extremity W/O & W/ Contrast
72130	CT T Spine W/O & W/ Contrast	74150	CT Abdomen W/O Contrast
72131	CT L Spine W/O Contrast	74160	CT Abdomen W/ Contrast
72132	CT L Spine W/Contrast	74170	CT Abdomen W/O & W/ Contrast
72133	CT L Spine W/O & W/ Contrast	75571	CT Heart W/O Dye W/CA Test
72192	CT Pelvis W/O Contrast	75572	CT Heart W/ 3d Image
72193	CT Pelvis W/ Contrast	75573	CT Heart W/3d Image Congen
72194	CT Pelvis W/O & W/ Contrast	76380	CT Limited Or Localized Follow-Up Study
70488	CT Maxllfcl W/O & W/ Contrast	77013	CT Guidance For And Monitoring of Tissue Ablation

70490	CT Soft Tissue Neck W/O Contrast	77086	Fracture assessment of spine bones using dedicated X-ray machine for bone density measurement
S8032	Low-dose computed tomography (LDCT) for lung cancer screening		

Computerized Tomographic Angiography (CTA)			
Code	**Description**	**Code**	**Description**
70496	CT Angiography, Head, With Contrast Material(S) Including Noncontrast Images, if performed	73706	CT Angiography Lower Extremity
70498	CT Angiography, Neck With Contrast Material(S) Including Non Contrast Images, if performed	74174	CT Tomographic Angiography, Abdomen, And Pelvis, With Contrast Material(S) Including Non-contrast Images if performed
71275	CT Angiography, Chest(Noncoronary), With Contrast Material(S),Including Non-contrast Images, if performed	74175	CT Tomographic Angiography, Abdomen, With Contrast Material(S) Including Noncontrast Images, if performed
72191	CT Tomographic Angiography, Pelvis, With Contrast Material(S) Including Non-contrast Images, if performed	75574	CT Angiography Heart W/ 3D Image
73206	Ct Tomographic Angiography, Upper Extremity, With Contrast Material(s)		

Magnetic Resonance Angiography (MRA)			
Code	**Description**	**Code**	**Description**
70544	MRA Head ;W/O Contrast Material(s)	71555	MRA Chest (Excluding Myocardium), With Or Without Contrast Material(s)
70545	MRA Head; With Contrast Material(s)	72159	MRA Spinal Canal And Contents With Or Without Contrast Material(s)
70546	MRA Head W/O Contrast Material(S),Followed By Contrast Material(s)	72198	MRA Pelvis,W/& W/O Contrast Material(s)
70547	MRA Neck;W/O Contrast Material(s)	73225	MRA Upper Extremity W/ Or W/O Contrast
70548	MRA Neck With Contrast Material(s)	73725	MRA Lower Extremity,W/ Or W/O Contrast Material(s)
70549	MRA Neck,W/O Contrast Material(s) Followed By Contrast Material(s)	74185	MRA Abdomen W/ Or W/O Contrast Material(s)

Magnetic Resonance Imaging (MRI)			
Code	**Description**	**Code**	**Description**
70336	MRI TMJ	70543	MRI Face, Orbit, Neck W/ & W/O Contrast
70540	MRI Face, Orbit, Neck W/O Contrast	70551	MRI Head W/O Contrast
70542	MRI Face, Orbit, Neck W/Contrast	70552	MRI Head W/Contrast
70553	MRI Brain (Including Brain Stem) W/O Contrast Materials	73223	MRI Upper Extremity Joint W/ & W/O Contrast
71550	MRI Chest W/O Contrast	73718	MRI Lower Extremity W/O Contrast
71551	MRI Chest W/Contrast	73719	MRI Lower Extremity W/Contrast
71552	MRI Chest W/ & W/O Contrast	73720	MRI Lower Extremity W/ & W/O Contrast
72141	MRI Cervical Spine W/O Contrast	73721	MRI Lower Extremity Joint W/O Contrast

Magnetic Resonance Imaging (MRI)			
Code	**Description**	**Code**	**Description**
72142	MRI Cervical Spine W/Contrast	73722	MRI Lower Extremity Joint W/Contrast
72146	MRI Thoracic Spine W/O Contrast	73723	MRI Lower Extremity Joint W/ & W/O Contrast
72147	MRI Thoracic Spine W/Contrast	74181	MRI Abdomen W/O Contrast
72148	MRI Lumbar Spine W/O Contrast	74182	MRI Abdomen / Contrast
72149	MRI Lumbar Spine W/Contrast	74183	MRI Abdomen W/ & W/O Contrast
72156	MRI Spine W/ & W/O Contrast	75557	Cardiac MRI Morphology W/O Contrast
72157	MRI T Spine W/ & W/O Contrast	75559	Cardiac MRI Morphology W/Stress Imaging
72158	MRI Spine W/ & W/O Contrast	75561	Cardiac MRI Morphology W/O Contrast F/U Contrast & Sequences
72195	MRI Pelvis W/O Contrast	75563	Cardiac MRI For Morphology W/O Contrast F/U Contrast & Sequences W/ Stress Imaging
72196	MRI Pelvis W/Contrast	75565	Cardiac MRI Morphology W/Flow /Velocity Quantification & Stress
72197	MRI Pelvis W/ & W/O Contrast	77021	MRI Guidance For Needle Placement
73218	MRI Upper Extremity W/O Contrast	77022	MRI Guidance For And Monitoring of Tissue Ablation
73219	MRI Upper Extremity W/ Contrast	77058	MRI Breast Wi/ And Or W/O Contrast
73220	MRI Upper Extremity Other Than Joint W/O Contrast Followed By Contrast	77059	MRI Breast Bilateral
73221	MRI Upper Extremity Joint W/O Contrast	77084	MRI Bone Marrow Blood Supply
73222	MRI Upper Extremity Joint W/Contrast		
0159T	Cad Breast MRI		

Paper PAR Instructional Reference

Field Label	Completion Format	Instructions
The upper margin of the PAR form must be left blank. This area is for authorizing agency's use only.		
Invoice/Pat Account Number	Text	Optional Enter up to 12 characters, (numbers, letters, hyphens) which helps identify the claim or member.
1. Member Name	Text	Required Enter the member's last name, first name and middle initial. Example: Adams, Mary A.
2. Member Identification Number	7 characters, a letter prefix followed by six (6) numbers	Required Enter the member's state identification number. This number consists of a letter prefix followed by six (6) numbers. Example: A123456
3. Sex	Check box ☐ M ☐ F	Required Enter an "X" in the appropriate box.
4. Date of Birth	6 numbers (MMDDYY)	Required Enter the member's birth date using MMDDYY format. Example: January 1, 2010 = 010110.
5. Member Address	Characters: numbers and letters	Required Enter the member's full address: Street, city, state, and zip code.
6. Member Telephone Number	10 numbers ###-###-####	Optional Enter the member's telephone number.
7. Prior Authorization Number	None	System assigned Do not write in this area unless being revised. The authorizing agency reviews the PAR, and approves or denies the services. Enter the assigned PAR number in the appropriate field on the claim form when billing for prior authorized services.

Field Label	Completion Format	Instructions
8. Dates Covered by This Request	6 numbers for from date and 6 numbers for through date (MMDDYY)	Required Enter the date(s) within which service(s) will be provided. If left blank, dates are entered by the authorizing agency. Authorized services must be provided within these dates. If retroactive authorization is requested, enter the date(s) of service and provide justification in field 11 (Diagnosis).
9. Does Member Reside in a Nursing Facility?	Check box ☐ Yes ☐ No	Required Check the appropriate box.
10. Group Home Name - If Patient Resides in a Group Home	Text	Conditional Enter the name of the Group Home if the member lives in a group home.
11. Diagnosis	Text	Required Enter the diagnosis and sufficient relevant diagnostic information to justify the request and include the prognosis. Provide relevant clinical information, other drugs or alternative therapies tried in treating the condition, results of tests, etc., to justify a Colorado Medical Assistance Program determination of medical necessity. If diagnosis codes are used, the narrative is also required. Approval of the PAR is based on documented medical necessity. Attach documents as required.
12. Requesting Authorization for Repairs	None	Not required
13. Indicate Length of Necessity	None	Not required
14. Estimated Cost of Equipment	None	Not required
15. Services to be Authorized Line Number	None	Preprinted Do not alter preprinted line numbers. No more than five services or items can be requested on one (1) form.
16. Describe Procedure, Supply, or Drug to be Provided	Text	Required Enter a description of the service(s) that will be provided.

Field Label	Completion Format	Instructions
17. Procedure, Supply or Drug Code	Revenue codes - 3 numbers HCPCS codes - 5 Characters	Required Enter the revenue and/or HCPCS code(s) for each service that will be billed on the claim form. The code(s) indicated on the PAR form must be used for billing.
18. Requested Number of Services	Numbers	Required Enter the number of visits, services, procedures requested. If this field is blank, the authorizing agency will complete it.
19. Authorized No. of Services	None	Leave Blank The authorizing agency indicates the number of services authorized. This number may or may not equal the number requested in field 18 (Number of Services).
20. Approved/Denied	None	Leave Blank Providers should check the PAR status on-line or refer to the PAR letter.
21. Primary Care Physician (PCP) Name **Telephone Number**	Text	Conditional If the member has a primary care physician, enter the name of the primary care physician in this field. Optional Enter the primary care physician's phone number.
22. Primary Care Physician Address	Text	Optional Enter the address of the primary care physician.
23. PCP Provider Number	8 numbers	Conditional If the member has a primary care physician, enter the primary care physician's provider number in this field.
24. Name and Address of Physician Requesting Prior Authorization	Text	Required Enter the complete name and address of the provider requesting the prior authorization.
25. Name and Address of Provider Who Will Render Service **Telephone Number**	Text 10 numbers ###-###-####	Required Enter the name of the rendering provider. Required Enter the telephone number of the rendering provider.

Field Label	Completion Format	Instructions
26. Requesting Physician Signature	Text	Required The requesting provider must sign the PAR. A rubber stamp facsimile signature is not acceptable on the PAR.
27. Date Signed	6 numbers (MM/DD/YY)	Required Enter the date the PAR form is signed by the requesting provider.
Telephone Number	10 numbers ###-###-####	Optional Enter the requesting provider's telephone number.
28. Requesting Physician Provider Number	8 numbers	Required Enter the eight-digit Colorado Medical Assistance Program provider number of the requesting provider.
Telephone Number	10 numbers ###-###-####	Optional Enter the telephone number of the rendering provider.
29. Service Provider Number	8 numbers	Required Enter the eight-digit Colorado Medical Assistance Program provider number of the billing provider. The rendering provider must be enrolled in the Colorado Medical Assistance Program.
30. Comments		Leave Blank This field is completed by the authorizing agency. Refer to the PAR response for comments submitted by the authorizing agency.
31. PA Number Being Revised		Leave Blank This field is completed by the authorizing agency.

Prior Authorization Request Form

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND FINANCING

INVOICE/PAT. ACCOUNT NUMBER

MEDICAID PRIOR AUTHORIZATION REQUEST (PAR)

To avoid delay, please answer all questions completely.

1. CLIENT NAME (Last, First, Middle Initial)	2. CLIENT IDENTIFICATION NUMBER	3. SEX ☐M ☐F	4. DATE OF BIRTH (MMDDYY)

5. CLIENT ADDRESS (Street, City, State, ZIP Code)	6. CLIENT TELEPHONE NUMBER
	( )

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

11. ICD-9-CM DIAGNOSIS CODE and DESCRIPTION (Must include Diagnosis Code and Description, Prognosis, Clinical Information and Other Medications presently prescribed)	12. REQUESTING AUTHORIZATION FOR REPAIRS EQUIPMENT MUST BE OWNED BY THE CLIENT - THE SERIAL NUMBER MUST BE ENTERED
	13. INDICATE LENGTH OF NECESSITY (IN MONTHS AND YEARS) I.E., HOW LONG WILL THIS EQUIPMENT BE NEEDED?
	14. ESTIMATED COST OF EQUIPMENT

SERVICES TO BE AUTHORIZED

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

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

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

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

30. COMMENTS **

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

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

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

FORM NO. 10013 (REV. 12/98)
COL — 105

White - AUTHORIZING AGENT Yellow - ORIGINATOR

Electronic Prior Authorization Request Form

Print Form

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND FINANCING

MEDICAID PRIOR AUTHORIZATION REQUEST (PAR)

INVOICE/PAT. ACCOUNT NUMBER

DOES CLIENT HAVE PRIMARY INSURANCE? ☐ YES ☐ NO

To avoid delay, please answer all questions completely.

1. CLIENT NAME (Last, First, Middle Initial)	2. CLIENT IDENTIFICATION NUMBER	3. SEX	4. DATE OF BIRTH (MMDDYYYY)
		☐M ☐F	

5. CLIENT ADDRESS (Street, City, State, ZIP Code)	6. CLIENT TELEPHONE NUMBER

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

11. ICD-9-CM DIAGNOSIS CODE and DESCRIPTION (Must Include Diagnosis Code and Description, Prognosis, Clinical Information and Other Medications presently prescribed)	12. REQUESTING AUTHORIZATION FOR REPAIRS EQUIPMENT MUST BE OWNED BY THE CLIENT - THE SERIAL NUMBER MUST BE ENTERED	13. INDICATE LENGTH OF NECESSITY (IN MONTHS AND YEARS) I.E., HOW LONG WILL THIS EQUIPMENT BE NEEDED?	14. ESTIMATED COST OF EQUIPMENT

SERVICES TO BE AUTHORIZED

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

21. PRIMARY CARE PHYSICIAN (PCP) NAME	22. PRIMARY CARE PHYSICIAN ADDRESS (Street, City, State, ZIP code)

TELEPHONE NUMBER	23. PCP PROVIDER NUMBER

24. NAME AND ADDRESS OF PHYSICIAN REFERRING FOR PRIOR AUTHORIZATION	25. NAME AND ADDRESS OF PROVIDER WHO WILL BILL SERVICE

26. REQUESTING PHYSICIAN SIGNATURE	27. DATE SIGNED

TELEPHONE NUMBER	28. REQUESTING PHYSICIAN PROVIDER NUMBER	TELEPHONE NUMBER	29. BILLING PROVIDER NUMBER

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

30. COMMENTS

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

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

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

FORM NO. 10013
(REV. 0911)
COL — 108

Procedure/HCPCS Codes Overview

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

The Healthcare Common Procedural Coding System (HCPCS) is divided into two (2) principal subsystems, referred to as level I and level II of the HCPCS. Level I of the HCPCS is comprised of Current Procedural Terminology (CPT), a numeric coding system maintained by the American Medical Association (AMA). The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office.

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

HIPAA requires providers to comply with the coding guidelines of the AMA CPT Procedure Codes and the International Classification of Disease, Clinical Modification Diagnosis Codes. If there is no time designated in the official descriptor, the code represents one (1) unit or session.

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

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

All outpatient radiology procedures must be billed using HCPCS codes.

When submitting claims for radiology to the Colorado Medical Assistance Program, observe the following guidelines:

- Always use the most current CPT revision. The Colorado Medical Assistance Program adds and deletes codes as they are published in annual revisions of the CPT.
- Use CMS codes only when CPT codes are not available or are not as specific as the CMS codes.

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

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

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

CMS 1500 Paper Claim Reference Table

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

CMS Field #	Field Label	Field is?	Instructions
1	**Insurance Type**	Required	Place an "X" in the box marked as Medicaid.
1a	**Insured's ID Number**	Required	Enter the member's Colorado Medical Assistance Program seven-digit Medicaid ID number as it appears on the Medicaid Identification card. Example: A123456.
2	**Patient's Name**	Required	Enter the member's last name, first name, and middle initial.
3	**Patient's Date of Birth / Sex**	Required	Enter the patient's birth date using two (2) digits for the month, two (2) digits for the date, and two (2) 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**		
9	**Other Insured's Name**	Conditional	If field 11d is marked "yes", enter the insured's last name, first name and middle initial.

CMS Field #	Field Label	Field is?	Instructions
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 (1) 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 (2) digits for the month, two (2) digits for the date and two (2) digits for the year. Example: 070114 for July 1, 2014. Place an "X" in the appropriate box to indicate the sex of the insured.
11b	**Other Claim ID**	Not Required	
11c	**Insurance Plan Name or Program Name**	Not Required	

CMS Field #	Field Label	Field is?	Instructions
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 (2) digits for the month, two (2) digits for the date and two (2) digits for the year. Example: 070114 for July 1, 2014. Enter the applicable qualifier to identify which date is being reported 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period
15	**Other Date**	Not Required	
16	**Date Patient Unable to Work in Current Occupation**	Not Required	
17	**Name of Referring Physician**	Not Required	
18	**Hospitalization Dates Related to Current Service**	Conditional	Complete for services provided in an inpatient hospital setting. Enter the date of hospital admission and the date of discharge using two (2) digits for the month, two (2) digits for the date and two (2) 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.

CMS Field #	Field Label	Field is?	Instructions
20	**Outside Lab?** **$ Charges**	Not Required	
21	**Diagnosis or Nature of Illness or Injury**	Required	Enter at least one (1) but no more than twelve diagnosis codes based on the member's diagnosis/condition. Enter applicable ICD indicator to identify which version of ICD codes is being reported. 9 ICD-9-CM 0 ICD-10-CM
22	**Medicaid Resubmission Code**	Conditional	List the original reference number for resubmitted claims. When resubmitting a claim, enter the appropriate bill frequency code in the left-hand side of the field. 7 Replacement of prior claim 8 Void/Cancel of prior claim This field is not intended for use for original claim submissions.
23	**Prior Authorization**	Conditional	**CLIA** When applicable, enter the word "CLIA" followed by the number.
24	**Claim Line Detail**	Information	The paper claim form allows entry of up to six (6) detailed billing lines. Fields 24A through 24J apply to each billed line. **Do not enter more than six (6) lines of information** on the paper claim. If more than six (6) 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 (2) dates: a "From" date of services and a "To" date of service. Enter the date of service using two (2) digits for the month, two (2) digits for the date and two (2) digits for the year. Example: 010114 for January 1, 2014 From To 01 01 14

CMS Field #	Field Label	Field is?	Instructions
			Or From To 01 01 14 01 01 14 Span dates of service From To 01 01 14 01 31 14 Practitioner claims must be consecutive days. Single Date of Service: Enter the six (6) 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 (2) fields. Span billing: permissible if the same service (same procedure code) is provided on consecutive dates. **Supplemental Qualifier** To enter supplemental information, begin at 24A by entering the qualifier and then the information. ZZ Narrative description of unspecified code N4 National Drug Codes VP Vendor Product Number OZ Product Number CTR Contract Rate JP Universal/National Tooth Designation JO Dentistry Designation System for Tooth & Areas of Oral Cavity
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. 81 Independent Lab
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 (1) that requires immediate medical intervention. If a "Y" for YES is entered, the service on this detail line is exempt from co-payment requirements.

CMS Field #	Field Label	Field is?	Instructions
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 (4) modifiers may be entered when using the paper claim form. 26 Professional component TC Technical component 76 Repeat procedure, same physician 77 Repeat procedure, different physician 50 Bilateral procedure- Both sides of the body are imaged LT/RT Left side/Right side- Only one (1) side was imaged 59 Indicates that two (2) or more procedures are performed at different anatomic sites or different patient encounters. Only use if no other modifier more appropriately describes the relationships of the two (2) or more procedure codes. 52 Reduces services- Under certain circumstances, a services or procedure is reduced or eliminated at the physician's discretion. 53 Discontinued services- Under certain circumstances, a physician may elect to terminate a diagnostic procedure. 25 Separate procedure during an evaluation and management visit- If a radiologist performs office visits and/or consultations and performs procedures (not 7xxxx codes) that

CMS Field #	Field Label	Field is?	Instructions
			are separately identifiable on the same date of service.
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 (1) 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. Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one (1) 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 (1) 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.

CMS Field #	Field Label	Field is?	Instructions
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.
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) Not Required
24I	**ID Qualifier**	Not Required	
24J	**Rendering Provider ID #**	Not Required	
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.

CMS Field #	Field Label	Field is?	Instructions
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 (2) digits for the month, two (2) digits for the date and two (2) 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.
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 #

CMS Field #	Field Label	Field is?	Instructions
			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.

CMS 1500 Radiology Claim Example

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) X | 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 DD YY: 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 | 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 DD YY | QUAL

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. 9

A. 847 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		70480	26	A	300 00	1		NPI	12345678 0123456789
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER | SSN | EIN

26. PATIENT'S ACCOUNT NO.: Optional

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

28. TOTAL CHARGE: $ 300 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 Radiology Center
100 Any Street
Any City

a. 1234567890 | b. 04567890

PATIENT AND INSURED INFORMATION — CARRIER — 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.* **LBOD** = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the payment.

Billing Instruction Detail	Instructions
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 • 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.

Billing Instruction Detail	Instructions
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.* **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

Billing Instruction Detail	Instructions
	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.

Radiology Revisions Log

Revision Date	Additions/Changes	Pages	Made by
11/25/2013	*Created*	*All*	*jg*
01/26/2014	*Updated for Colorado 1500*	*Throughout*	*jg*
05/22/2014	*Updated manual for removal of Primary Care Physician program*	*20*	*Mm*
8/1/14	*Replaced all CO 1500 references with CMS 1500*	*Throughout*	*ZS*
8/1/14	*Updated Professional Claim Billing Instructions section with CMS 1500 information.*		*ZS*
8/1/14	*Changed all references of client to member*	*Throughout*	*ZS*
8/1/14	*Updated all claim examples to the cms 1500*		*ZS*
8/4/14	*Updated all web links to reflect new Department web site*	*Throughout*	*MM*
12/08/14	*Removed Appendix H information, added Timely Filing document information*	*26*	*mc*
12/23/14	*Alex W. removed code 72292 from the procedure codes that require a PAR.*	*3*	*mc*
12/29/14	*Added 2015 HCPCS: S8032 and 77086*	*3*	*mc*
12/29/14	*Update TOC, minor format change*	*throughout*	*bl*
01/12/15	*Alex W. removed 76390 from procedure codes requiring a PAR.*	*5*	*cc*
01/12/15	*TOC Update*	*throughout*	*bl*
07/06/15	*Clarified TPL exceptions, co-payment policy, preventive lung cancer screening, content revisions/reorganization throughout*	*3, throughout*	*AW*
7/20/15	*Changed client to member, reviewed grammar, corrected proc code descriptions, and content changes.*	*Throughout*	*JH*
07/20/2015	*Accept tracked changes and minor spacing changes*	*Throughout*	*bl*

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