

Outpatient Physical and Occupational Therapy Fee-For-Service Policy and Billing Manual

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Physical and Occupational Therapy Outpatient – Fee-For-Service Provider Qualifications

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

Licensed physical therapists (PT) and registered occupational therapists (OT) who meet the qualifications prescribed by federal regulations for participation at 42 CFR 484.4 and who meet all the requirements under state law are eligible to become Colorado Medical Assistance providers.

Physical therapists must be licensed by the Colorado Department of Regulatory Agencies ([DORA](#)) pursuant to Title 12 Article 41.106 and may supervise up to four individuals at one time who are not physical therapists, including certified nurse aides, to assist in the therapist's clinical practice. Supervision authority extends to the limits stated in the Physical Therapists Practice Act per section [C.R.S. §12-41-113\(1\)](#).

Physical therapist assistants (PTA) must be certified by DORA pursuant to Title 12 Article 41.204 and must work under the supervision of a licensed physical therapist as defined in the Colorado Physical Therapy Practice Act (§12-41-203(2) C.R.S.) and accompanying rules as promulgated by the State Board of Physical Therapy.

Occupational therapists must be registered by DORA pursuant to Title 12 Article 40.5.

Occupational therapy assistants (OTA) must practice under the general supervision of a Colorado registered occupational therapist.

All physical and occupational therapists must submit a completed provider enrollment packet to become a Colorado Medical Assistance Program eligible provider. Providers will find enrollment information in the [Provider Services Enrollment](#) section of the Department's website (colorado.gov/hcpf). Enrollment documents may be downloaded and mailed to:

Xerox State Healthcare
Colorado Medical Assistance Program Provider Enrollment
PO Box 1100
Denver, CO 80201-1100

General Benefit Policies

Physical and occupational therapists not employed by an agency, clinic, hospital, or physician may bill the Colorado Medical Assistance Program directly. Providers should refer to the Code of Colorado Regulations, Qualified Non-Physician Practitioners Eligible to Provide Physician's Services (10 CCR 2505-10, Section 8.200.2.C), for further regulatory information when providing physical and occupational therapy.

1. All PT/OT services must have a written order, referral, or prescription by any of the following:
 - a. Physician (M.D. or D.O.)
 - b. Physician's assistant
 - c. Nurse practitioner
 - d. Individualized Family Service Plan (IFSP) for Early Intervention PT/OT
2. Pursuant to the Affordable Care Act's requirements that State Medicaid Agencies ensure correct ordering, prescribing, and referring (OPR) National Provider Identification (NPI) numbers be on the claim form (42 CFR §455.440):
 - a. All Outpatient PT/OT claims must contain the valid NPI number of the OPR physician, physician assistant, nurse practitioner, or provider associated with an Individualized Family Service Plan (IFSP), in accordance with Program Rule 8.125.8.A.
 - b. All physicians, physician assistants, nurse practitioners, or providers associated with an IFSP who order, prescribe, or refer Outpatient PT/OT services for Medicaid members must be enrolled in Colorado Medicaid (42 CFR §455.410), in accordance with Program Rule 8.125.7.D. OPR Providers can begin enrollment on Colorado Medicaid's website.
 - i. The new enrollment requirement for OPR providers does not include a requirement to see Medicaid members or to be listed as a Medicaid provider for patient assignments or referrals.
 - ii. Physicians or other eligible professionals who are already enrolled in Colorado Medicaid as participating providers and who submit claims to Colorado Medicaid are not required to enroll separately as OPR providers.
3. The term "valid OPR NPI number" means the registered NPI number of the provider that legitimately orders, prescribes, or refers the Outpatient PT/OT service being rendered, as indicated by the procedure code on the claim.
 - a. Claims without a valid OPR NPI number which are paid will then be subject to recovery.
 - b. Medical documentation must be kept on file to substantiate the order, prescription, or referral for Outpatient PT/OT. Claims lacking such documentation on file will be subject to recovery.
4. Colorado Medicaid recognizes that Outpatient PT/OT ordered in conjunction with an approved IFSP for Early Intervention may not necessarily have an ordering provider. Under this circumstance alone the rendering provider must use their own NPI number as the OPR NPI number.

- a. Early Intervention Outpatient PT/OT claims must have modifier 'TL' attached on the procedure line item for Colorado Medicaid to identify that the services rendered were associated with an approved IFSP.
 - i. Any claim with modifier 'TL' attached must be for a service ordered by an approved IFSP and delivered within the time span noted in the IFSP.
 - ii. If the OPR NPI on the claim is that of the rendering provider, and the claim does not have modifier 'TL' attached, the claim is subject to recovery.
5. Educational, personal need, and comfort therapies are not covered PT/OT therapy benefits for any member regardless of age.

Payment for Covered Services

Regardless of whether Colorado Medicaid has actually reimbursed the provider, billing members for covered services 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 services not covered by Colorado Medicaid.

- Members may be billed for non-covered services 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 Prior Authorization Requests (PAR) for services are required, the following policy applies:
 - Technical/lack of information (LOI) denial does not mean those services are not covered. Members may not be billed for services denied for LOI.
 - Services partially approved are still considered covered services. Members may not be billed for the denied portion of the request.
 - Services totally denied for not meeting medical necessity criteria are considered non-covered services.
- Members ages 20 and under who reach the initial 48 unit limit for physical and occupational therapy (PT/OT) require a PAR to obtain further coverage. Refusal, failure, or negligence by the provider to request a PAR for services beyond the first 48 units of PT/OT does not mean that those further services are non-covered.

Medically Necessary

Physical and Occupational Therapy services must be medically necessary to qualify for Medicaid reimbursement. Medical necessity, as defined under program rule 8.200.1, physician services, means:

A covered service that will, or is reasonably expected to prevent, diagnose, cure, correct, reduce or ameliorate the pain and suffering, or the physical, mental, cognitive or developmental effects of an illness, injury or disability; and for which there is no other equally effective or substantially less costly course of treatment suitable for the member's needs.

Non-Covered Services

- Educational, personal need, and comfort therapies are not covered benefits of fee-for-service for any member regardless of age
- Duplicated services (in general, and those overlapped between PTs and OTs)
- Art and craft activities for the purpose of recreation
- Hippotherapy/equine therapy
- Vocational or educational 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.

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.

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.

Paper Claims

Electronic claims format shall be required unless hard copy claims submittals are specifically authorized by the Department. Requests 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 and processed for payment:

- Claims from providers who consistently submit five claims or fewer per month (requires 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 [Specifications](#) section of the Department's Web site.
- 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.

Interactive Claim Submission and Processing

Interactive claim submission through the Web Portal is a real-time exchange of information between the submitter and the Colorado Medicaid Management Information System (MMIS). Colorado Medical Assistance Program providers may create and transmit HIPAA compliant 837P (Professional), 837I (Institutional), and 837D (Dental) claims electronically one at a time. These claims are transmitted through the Colorado Medical Assistance Program OnLine Transaction Processor (OLTP).

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

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

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

Because a claim submitter connects to the Web Portal through the Internet, there is no delay for "dialing up" when submitting claims. The Web Portal provides immediate feedback directly to the submitter. All claims are processed to provide a weekly Health Care Claim Payment/Advice (Accredited Standards Committee [ASC] X12N 835) transaction and/or a PCR containing information related to submitted claims. The Web Portal provides access to the following reports through the File and Report Service (FRS):

- Accept/Reject Report
- Provider Claim Report
- Health Care Claim Payment/Advice (ASC X12N 835)
- Managed Care Reports such as Primary Care Physician Rosters
- Prior Authorization Letters

Users may also inquire about information generated from claims submitted via paper and through electronic data submission methods other than the Web Portal. Other inquiry options include:

- Eligibility Inquiry (interactive and batch)
- Claim Status Inquiry
- PAR Status Inquiry

Claims may be adjusted, edited and resubmitted, and voided in real time through the Web Portal. Access the Web Portal at colorado.gov/hcpf → For Our Providers → Provider Services → [Web Portal](#). For help with claim submission via the Web Portal, please choose the *User Guide* option available for each Web Portal transaction. For additional electronic billing information, please refer to the appropriate Companion Guide located in the Provider Services [Specifications](#) section.

Batch Electronic Claim Submission

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

All batch claim submission software must be tested and approved by the Department's fiscal agent.

Any entity sending electronic transactions through the fiscal agent's Electronic Data Interchange (EDI) Gateway for processing where reports and responses will be delivered must complete an EDI enrollment package. This provides EDI Gateway the information necessary to assign a Logon Name, Logon ID, and Trading Partner ID, which are required to submit electronic transactions, including claims.

An enrollment package may be obtained by contacting the Department's fiscal agent or by downloading it from the Provider Services [EDI Support](#) section.

The X12N 837 Professional (837P), Institutional (837I), or Dental (837D) transaction data will be submitted to the EDI Gateway, which validates submission of American National Standards Institute (ANSI) X12N format(s).

The TA1 Interchange Acknowledgement reports the syntactical analysis of the interchange header and trailer. If the data is corrupt or the trading partner relationship does not exist within the MMIS, the interchange will reject and a TA1 along with the data will be forwarded to the State Healthcare Clearinghouse (SHCH) Technical Support for review and follow-up with the sender. An X12N 999 Functional Acknowledgement is generated when a file that has passed the header and trailer check passes through the SHCH.

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

Testing and Vendor Certification

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

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

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

Procedure/HCPCS Code Overview

The codes used for submitting claims for services provided to Colorado Medical Assistance Program s 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 principal subsystems, referred to as level I and level II of the HCPCS. Level I of the HCPCS is comprised of CPT (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA). The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter followed by 4 numeric digits, while CPT codes are identified using 5 numeric digits.

HIPAA requires providers to comply with the coding guidelines of the AMA CPT Procedure Codes and the International Classification of Disease, Clinical Modification Diagnosis Codes. If there is no time designated in the official descriptor, the code represents one unit or session. Providers should regularly consult monthly bulletins located in the Provider Services [Bulletins](#) section. To receive electronic provider bulletin notifications, an email address can be entered into the Web Portal in the *(MMIS) Provider Data Maintenance* area or by filling out a publication preference

form. Bulletins include updates on approved procedure codes as well as the maximum allowable units billed per procedure.

Rehabilitative and Habilitative Therapy Definitions

The Colorado Division of Insurance defined Habilitative services as:

Services that help a person retain, learn, or improve skills and functioning for daily living that are offered in parity with, and in addition to, any rehabilitative services offered in Colorado's Essential Health Benefits (EHB) benchmark plan. Parity in this context means of like type and substantially equivalent in scope, amount, and duration.

Habilitative therapy is a covered physical, occupational, and speech therapy benefit for children of any eligibility type, and for adults ages 19 through 64 who receive benefits through the ACA Adult Medicaid Plan (Alternative Benefits Plan).

When running a member's ID through the provider web portal for member eligibility checks, adult expansion members will have the eligibility response message "this EXPANSION MEMBER receives the ACA ADULT MEDICAID BENEFIT PLAN." Eligible members may receive outpatient PT, OT, and ST for the purpose of habilitation **in addition to** rehabilitation.

Rehabilitative therapies are those meant to assist a member with recovery from an acute injury, illness, or surgical recovery. Habilitative therapies are those meant to help the member retain, learn, or improve skills and functions for daily living. This includes the treatment of long-term chronic conditions and meeting developmental milestones.

Additional Notes

- Habilitative therapies are not an Inpatient or Home Health benefit.
- Habilitative therapies are not a benefit if provided in nursing facilities; Rehabilitative PT, OT, ST remain so.
- Habilitative therapies are not to be confused with Habilitation services found within Home and Community Based Services (HCBS) waivers.

Assistive Technology Assessments

The following billing policies are effective for CPT procedure code 97755 to accommodate HB14-1211. HB14-1211 requires that all Medicaid members seeking complex rehabilitation technology must have an initial Assistive Technology Assessment (complex rehabilitative technology evaluation/assessment) prior to receiving complex rehabilitation technology, and follow-up assessments, as needed. Only licensed speech, physical, and occupational therapists may render this specialty evaluation.

All providers using procedure code 97755 must follow these guidelines. The Department recognizes that only a portion of Assistive Technology Assessments will be used for complex rehabilitation technology evaluation/assessment. Providers will be asked upon PAR submission if the service is for a complex rehabilitation technology assessment.

Policy	Notes
Complex rehabilitation technology evaluations / assessments are billed using only 97755.	Combinations of procedure codes, including procedure code 97542, for the purposes of complex rehabilitation technology evaluation / assessment are not allowed.
97755 always requires a Prior Authorization Request (PAR).	PARs must be submitted electronically using ColoradoPAR. Details are found here .
Member daily limit of 97755 is 20 units.	Up to five hours of assessment is allowed per date of service.
Member yearly limit of 97755 is 60 units.	Members may have up to 60 units of procedure code 97755 per State Fiscal Year (July 1 – June 30). This limit will reset with the start of each new State Fiscal Year.

PARs for 97755 must comply with the following policies:

- Must have a current prescription/referral for an Assistive Technology Assessment from the member’s primary care physician.
- May indicate up to one year duration.
- May indicate initial/new assessments or follow-up assessment visits.
- Only one active PAR for 97755 is allowed per member, per span of time. Overlapping 97755 PAR requests will be denied.
- Initial PT/OT evaluation services, such as 97001, are not required prior to requesting 97755.
- 97755 is **separate** from PT/OT and is not part of the PT/OT benefit limitation.
- PARs for 97755 should be submitted independently from other services. The Medical PAR type should be selected for 97755 at ColoradoPAR.com.

If a member requires further assessment by a different provider not indicated on the original PAR, and that PAR is still active, then it must be closed by the original requesting provider. Once closed a new PAR can be submitted. Members may request a ‘change of provider’ on their PAR by contacting the vender directly. Please see the Prior Authorization Request section of this manual.

Benefit Limitations

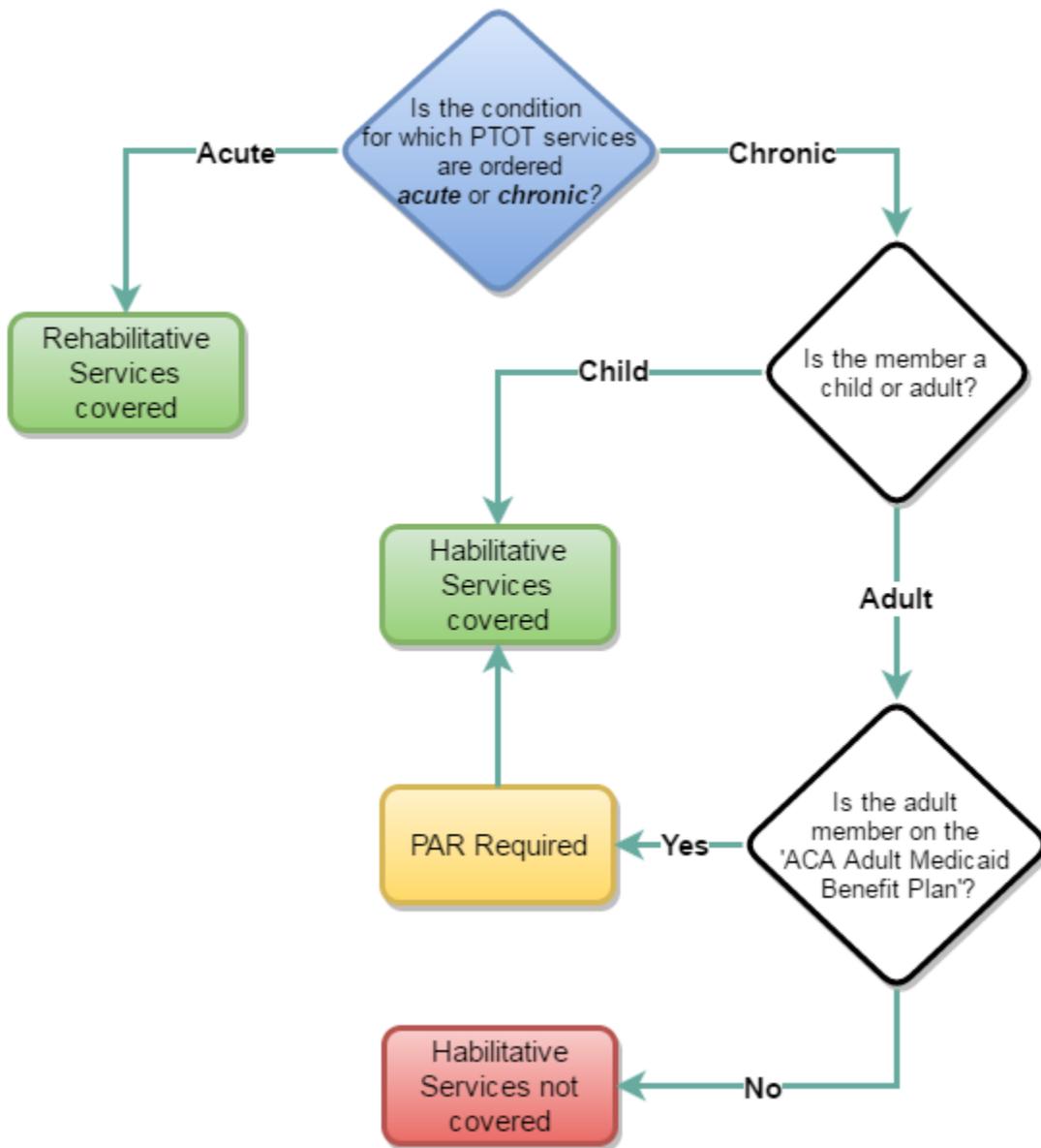
Members may receive up to 48 units of any combination of PT/OT services per 12 month period before a Prior Authorization Request (PAR) is required. Evaluation and orthotic services are not included in this limit (97001, 97002, 97003, 97004). This equates to roughly twelve hours of therapy services (each unit of service being equal to 15 minutes). This unit limit will be automatically enforced by the claims payment system by denying claims that exceed the limit.

Units of service exceeding the initial 48 units will not be reimbursed without an approved PAR. Only children may obtain a PAR for further services; adults are limited to 48 units. Adults therefore do not require a PAR unless it is for Habilitative therapy. Only some adults qualify to receive an additional 48 units of Habilitative therapy. See the coverage table and diagram that follows.

	Children (ages 0 – 20)	Adults (ages 21+)
Rehabilitative Benefit Limit	No limit	48 units per 12 month period
Habilitative Benefit Limit	No limit	48 units per 12 month period covered for certain adult members only
Prior Authorization Required	Required to exceed the initial 48 units per 12 months, which do not require prior authorization. Habilitative services always require prior authorization.	Not required for Rehabilitative services. Always required for Habilitative services.
Billing Cycle	Claims for services beyond 48 units per 12 months that do not have prior authorization will be denied.	Claims for services beyond 48 units per 12 months will be automatically denied. Claims for Habilitative services which do not have prior authorization will be denied.

Members will have their benefit limit renewed on the 366th day since their first date of PT/OT service. The 48 units accumulate from paid units for a specific member, regardless of provider, for each treatment modality, beginning on the first date of service. A unit equals either 1) a timed increment or 2) one treatment session as described in the specific CPT procedure codes.

Coverage Diagram



Daily Limits and Coding Modifiers

A daily limit of five units of physical therapy services and five units of occupational therapy services is allowed, whether it is Rehabilitative or Habilitative. All PT/OT PARs and claims must have the correct modifiers attached. Correct modifier use indicates the precise nature of the procedure being rendered and is mandatory.

- All PT claims must have modifier 'GP' attached to each procedure code line.
- All OT claims must have the modifier 'GO' attached to each procedure code line.
- All Habilitative PT/OT claims must have the second modifier "HB" attached in addition to "GP" or "GO" to each procedure code line.
- All Early Intervention PT/OT claims must have the second modifier "TL" attached in addition to "GP" or "GO" to each procedure code line. Services rendered via Early Intervention are not distinguished as either rehabilitative or Habilitative for billing modifier purposes

Benefit	Rehabilitative Modifiers	Habilitative Modifiers
Physical Therapy	GP	GP + HB
Occupational Therapy	GO	GO + HB
Early Intervention PT	GP + TL	
Early Intervention OT	GO + TL	

National Correct Coding Initiative (NCCI)

National Correct Coding Initiative Procedure-To-Procedure (PTP) and Medically Unlikely Edits (MUE) edits apply to certain combinations of PT and OT procedure codes. Please refer to the [Medicaid.gov](http://www.Medicaid.gov) website for NCCI edits, for a complete list of impacted codes, guidance on bypass modifier use, and general information.

Prior Authorization Requests (PARs)

Independent Physical and Occupational Therapists and hospital based therapy clinics providing outpatient therapy services must submit PARs for medically necessary services when:

- The member is a child (age 20 and under) and has exceeded 48 units of PT/OT service per 12 month period, or
- When Habilitative PT/OT is being sought.

PARs are approved for up to a twelve (12) month period (depending on medical necessity determined by the reviewer).

- Retroactive PAR request forms will not be accepted.

- Overlapping PAR request dates for same provider types will not be accepted, with the exception of Early Intervention PAR requests which may have overlapping dates of service and multiple provider types. All Early Intervention PT/OT PARs must additionally indicate that the member has an Individual Family Service Plan (IFSP) and that it is current and approved.
- Incomplete, incorrect or insufficient member information on a PAR request form will not be accepted.

Submit PARs for the number of units for each specific procedure code requested, not for the number of services. Modifier codes must be included. The same modifiers used on the PAR must be used on the claim, in the same order.

- When submitting Rehabilitative Therapy PARs, and subsequent claims, CPT codes for PT services must have the GP modifier (e.g. 97001+GP). CPT codes for OT services must have the GO modifier (e.g. 97003+GO).
- When submitting Habilitative Therapy PARs, and subsequent claims, CPT codes for PT services must have the GP modifier and HB modifier (e.g. 97001+GP+HB). CPT codes for OT services must have the GO modifier and HB modifier (e.g. 97003+GO+HB).
- Early Intervention PARs, and subsequent claims, must have the GP or GO modifier plus the TL modifier (e.g. 97110+GP+TL).

Additional Limitations:

- Members may receive PT and OT services during the same time period and service dates. However, duplicative therapies (the same therapy performed by both an OT and PT) may not be performed on the same date of service.
- Members may not receive both Rehabilitative and Habilitative therapies of the same type (e.g. Rehabilitative PT and Habilitative PT) on the same date of service.
- Members may have one active PAR for each type of therapy (Rehabilitative PT, Rehabilitative OT, Habilitative PT, and Habilitative OT) with independent time spans. These PARs may not overlap in time span unless one of them is for Early Intervention.
- Evaluation and orthotic services do not require a PAR.

PAR Requirements:

- Legibly written and signed ordering practitioner prescription, to include diagnosis (preferably with ICD-10 code) and reason for therapy, the number of requested therapy sessions per week and total duration of therapy.
- The member's Physical or Occupational treatment history, including current assessment and treatment. Include duration of previous treatment and treating diagnosis.
- Documentation indicating if the member has received PT or OT under the Home Health Program or inpatient hospital treatment.
- Current treatment diagnosis.
- Course of treatment, measurable goals and reasonable expectation of completed treatment.
- Documentation supporting medical (physical NOT developmental) necessity for the course and duration of treatment being requested.

- Assessment or progress notes submitted for documentation, must not be more than sixty (60) days prior to submission of PAR request.
- If the PAR is submitted for services delivered by an independent therapist, the name and address of the individual therapist providing the treatment must be present in field #24 of the PAR.
- The billing provider name and address needs to be present in field #25 on the PAR.
- The Colorado Medical Assistance Program provider number of the independent therapist must be present in PAR field #28.
- The billing provider's Colorado Medical Assistance Program number must be present in field #29 of the PAR.
- Early Intervention PT/OT PARs must additionally indicate that the member has an Individual Family Service Plan (IFSP) and that it is current and approved.
- DME products **cannot** be requested on the same PAR as therapy services.

The authorizing agency reviews all completed PARs and approves or denies, by individual line item, each requested service or supply listed on the PAR. PAR status inquiries can be made through the Web Portal and results are included in PAR letters sent to both the provider and the member. **Read the results carefully as some line items may be approved and others denied. Do not render or bill for services until the PAR has been processed.**

The claim must contain the PAR number for reimbursement.

Approval of a PAR does not guarantee Colorado Medical Assistance Program reimbursement and does not serve as a timely filing waiver. Prior authorization only assures that the service is considered a benefit of the Colorado Medical Assistance Program. All claims, including those for prior authorized services, must meet eligibility and claim submission requirements (e.g. timely filing, third party resources payment pursued, required attachments included, etc.) before reimbursement can be made.

If the PAR is denied, providers should direct inquiries to the authorizing agency:

[ColoradoPAR Program](#)

Provider Prior Authorization (PAR) Vendor for the Colorado Medical Assistance Program

Provider PAR Request Line: 888-801-9355

PAR Fax Line: 866-940-4288

The Colorado Medical Assistance Program PAR forms are available in the Provider Services [Forms](#) section or by contacting the ColoradoPAR Program at 1-888-801-9355 (toll free).

Providers can fax documents to the ColoradoPAR Program at 866-940-4288 Documents that may be compromised by faxing can be mailed to:

PAR Revisions

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

PT/OT Allowed Procedure Codes

Physical and Occupational Therapists are indicated as rendering providers for the following procedures. Reference the current [Fee Schedule](#) for rates. Evaluation and orthotic services are not subject to the 48 unit limit.

Note: this table serves only as a reference guide and not a guarantee of payment or coverage. Definitive coverage of a specific procedure code is found on the Fee Schedule.

Last table update: 06/02/2016

Procedure Code	Short Description	Provider Type	Max Daily Units	Prior Authorization Required
92526	Treatment of swallowing dysfunction and/or oral function for feeding	OT	1	Sometimes
97001	Physical therapy evaluation	PT	1	No
97002	Physical therapy re-evaluation	PT	1	No
97003	Occupational therapy evaluation	OT	1	No
97004	Occupational therapy re-evaluation	OT	1	No
97010	Application of modality; hot or cold packs	PT, OT	1	Sometimes
97012	Application of modality; mechanical traction	PT, OT	1	Sometimes
97014	Application of modality; electrical stimulation	PT, OT	1	Sometimes
97016	Application of modality; vasopneumatic devices	PT, OT	1	Sometimes
97018	Application of modality; paraffin bath	PT, OT	1	Sometimes
97022	Application of modality; whirlpool	PT, OT	1	Sometimes
97024	Application of modality; diathermy (microwave)	PT, OT	1	Sometimes
97026	Application of modality: infrared	PT, OT	1	Sometimes
97028	Application of modality; ultraviolet	PT, OT	1	Sometimes
97032	Application of modality; electrical stimulation, each unit 15 mins	PT, OT	2	Sometimes
97033	Application of modality; iontophoresis, each unit 15 mins	PT, OT	4	Sometimes
97034	Application of modality; contrast baths, each unit 15 mins	PT, OT	4	Sometimes
97035	Application of modality; ultrasound, each unit 15 mins	PT, OT	4	Sometimes
97036	Application of modality; hubbard tank, each unit 15 mins	PT, OT	4	Sometimes

97110	Therapeutic exercises, each unit 15 mins	PT, OT	4	Sometimes
97112	Neuromuscular reeducation, each unit 15 mins	PT, OT	4	Sometimes
97113	Aquatic therapy with therapeutic exercises, each unit 15 mins	PT, OT	2	Sometimes
97116	Gait training, each unit 15 mins	PT, OT	3	Sometimes
97124	Massage (effleurage, petrissage, tapotement), each unit 15 mins	PT, OT	4	Sometimes
97140	Manual therapy, each unit 15 mins	PT, OT	2	Sometimes
97150	Therapeutic procedures, group (two or more individuals)	PT, OT	1	Sometimes
97530	Therapeutic activities, direct one-on-one contact, each unit 15 mins	PT, OT	3	Sometimes
97532	Cognitive skills development, each unit 15 mins	PT, OT	3	Sometimes
97533	Sensory integration, each unit 15 mins	PT, OT	4	Sometimes
97535	Self care / home management training (activities of daily living, including instruction on the use of assistive technology devices), each unit 15 mins	PT, OT	4	Sometimes
97537	Community/work reintegration training, each unit 15 mins	PT, OT	4	Sometimes
97542	Wheelchair management training and fitting, each unit 15 mins	PT, OT	4	Sometimes
97545	Work hardening/conditioning, each unit initial 2 hours	PT, OT	1	Sometimes
97546	Work hardening, additional 1 hour	PT, OT	1	Sometimes
97597	Debridement, open wound, and wound assessment, first 20 square centimeters or less of wound surface area, per session	PT, OT	1	No
97598	Debridement, open wound, and wound assessment, each additional 20 square centimeters of wound surface area, per sessions	PT, OT	1	No
97602	Wound(s) care including non-selective debridement, and instruction, per sessions	PT, OT	1	No
97750	Physical performance test or measurement, each unit 15 mins	PT, OT	2	No
97755	Assistive technology assessment, each unit 15 mins	PT, OT	20	Always

97760	Orthotic management and training, each unit 15 mins	PT, OT	4	Sometimes
97761	Prosthetic training, each unit 15 mins	PT, OT	4	Sometimes
97762	Checkout for orthotic/prosthetic use, each unit 15 mins	PT, OT	4	Sometimes
97799	Unlisted physical medicine/rehab (specify)	PT, OT	1	Sometimes
L1902	Ankle foot orthotic, gauntlet, prefabricated, OTS	PT, OT	2	No
L1960	Ankle foot orthotic, posterior solid ankle, plastic, CF	PT, OT	2	No
L3730	Elbow orthotic, double upright with forearm/arm cuffs, extension/ flexion assist, CF	PT, OT	2	No
L3763	Elbow-wrist-hand orthotic, rigid, without joints, includes fitting and adjustment, CF	PT, OT	2	No
L3764	Elbow-wrist-hand orthotic, includes fitting and adjustment, CF	PT, OT	2	No
L3808	Wrist-hand-finger orthotic, rigid without joints, includes fitting and adjustment, CF	PT, OT	2	No
L3900	Wrist-hand-finger orthotic, dynamic flexor hinge, CF	PT, OT	2	No
L3906	Wrist-hand orthosis, without joints, includes fitting and adjustment, CF	PT, OT	2	No
L3908	Wrist hand orthosis, cock-up, non-molded, prefabricated, OTS	PT, OT	2	No
L3912	Hand finger orthosis, flexion glove with elastic finger control, prefabricated, OTS	PT, OT	2	No
L3919	Hand orthotic, includes fitting and adjustment, CF	PT, OT	2	No
L3923	Hand finger orthosis, customized prefabricated item	PT, OT	2	No
L3925	Finger orthosis, proximal interphalangeal/distal interphalangeal, prefabricated, OTS	PT, OT	10	No
L3929	Hand finger orthosis, customized prefabricated item	PT, OT	2	No
L3933	Finger orthotic, without joints, includes fitting and adjustment, CF	PT, OT	10	No
L3982	Upper extremity fracture orthotic, prefabricated, includes fitting and adjustment	PT, OT	2	No

Q4040	Short leg cast, pediatric (0-10 years), fiberglass	PT, OT	2	No
Q4048	Short leg splint, pediatric (0-10 years), fiberglass	PT, OT	2	No

For further billing information on the above orthotic/prosthetic codes, please refer to the Durable Medical Equipment (DME) and Supplies Provider Reference Manual which can be found in the Provider Services [Billing Manuals](#) section.

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 use only.		
Invoice/Pat Account Number	Text	Optional Enter up to 12 characters (numbers, letters, hyphens) that help identify the claim or member.
Does the Member Have Primary Insurance?	Check box <input type="checkbox"/> Y <input type="checkbox"/> N	Optional Enter an "X" in the appropriate box.
1. Member Name	Text	Required Enter the member's last name, first name, and middle initial.
2. Member Identification Number	1 letter followed by 6 numbers	Required Enter the member's state identification number. This number consists of a letter prefix followed by six numbers. Example: A123456.
3. Sex	Check box <input type="checkbox"/> Y <input type="checkbox"/> N	Required Enter an "X" in the appropriate box.
4. Date of Birth	6 digits (MMDDYY)	Required Enter the member's birth date using MMDDYY format. Example: January 1, 2009 = 010109.
5. Member Address	Characters: numbers and letters	Required Enter the member's full address: Street, City, State, and Zip code.
6. Member Telephone Number	Text	Optional Enter the member's telephone number.
7. Prior Authorization Number		System assigned Leave blank
8. Dates Covered by this Request	6 digits for From date and 6 digits for Through date (MMDDYY)	Optional Enter the date(s) within which service(s) will be provided. If left blank, dates are entered by the authorizing agency.

Field Label	Completion Format	Instructions
		Authorized services must be provided within these dates.
9. Does Member Reside in a Nursing Facility?	Check box <input type="checkbox"/> Y <input type="checkbox"/> N	Required Check the appropriate box.
10. Group Home Name if Patient Resides in a Group Home	Text	Not applicable.
11. Diagnosis	Text	Required Enter the medical/physiological diagnosis code and sufficient relevant diagnostic information to justify the request. Include the prognosis. Provide relevant clinical information, other drugs or alternative therapies tried to treating the condition, results of tests, etc. to justify a Colorado Medical Assistance Program determination of medical necessity. Approval of necessity. Attach documents as required.
12. Requesting Authorization for Repairs	Text	Not applicable
13. Indicate Length of Necessity	Text	Not applicable
14. Estimated Cost of Equipment	Digits	Not applicable
15. Services to be Authorized	None	Preprinted Do not alter preprinted lines. No more than five items can be requested on one form.
16. Describe Procedure, Supply, or Drug to be Provided	Text	Required Enter the description of the service/procedure to be provided.
17. Procedure, Supply or Drug Code Required	HCPCS code	Enter the procedural code for each item that will be billed on the claim form. The authorized agency may change any code.

Field Label	Completion Format	Instructions
		The approved code(s) on the PAR form must be used on the claim form.
18. Requested Number of Services	Digits	Required Enter the number of units for supplies, services or equipment requested. If this field is blank, the authorizing agency will complete with one unit.
19. Authorized No. of Services	None	Leave blank The authorizing agency indicates the number of services authorized which may be more not equal number of requested in Field 18 (Number of Services).
20. A = Approved D = Denied	None	Leave blank Check the PAR on-line or refer to the PAR letter.
21. Primary Care Physician (PCP) Name	Text	Conditional Complete if member has a PCP.
Telephone Number	Text	Optional Enter the PCP's telephone number.
22. Primary Care Physician Address	Text	Conditional Complete if member has a PCP. Enter the PCP's complete address.
23. PCP Provider Number	8 Digits	Conditional Complete if member has a PCP. Enter the PCP's eight-digit Colorado Medical Assistance provider number. This number must be obtained by contacting the PCP for the necessary authorization.
24. Name and Address of Physician Referring for Prior Authorization	Text	Required Enter the complete name and address of the physician requesting prior authorization (the physician ordering/writing the prescription).
25. Name and Address of Provider Who will Bill Service	Text	Required

Field Label	Completion Format	Instructions
		Enter the name and telephone number of the provider who will be billing for the service.
26. Requesting Physician Signature	Text	<p>Required</p> <p>The requesting provider must sign the PAR and must be the physician ordering the service. Under unusual circumstances, when the prescribing physician is not available, a legible copy of a signed prescription may be attached in place of the signature of the requesting provider. The written diagnosis must be entered in Field 11 (Diagnosis), even if a prescription form is attached. Do not send the original prescription; send a photocopy on an 8 ½ x 11 sheet.</p> <p>A rubber stamp facsimile signature is not acceptable on the PAR.</p>
27. Date Signed	6 Digits	<p>Required</p> <p>Enter the date the PAR form is signed by the requesting provider.</p>
Telephone Number	Text	<p>Required</p> <p>Enter the telephone number of the requesting provider.</p>
28. Requesting Physician Provider Number	8 Digits	<p>Required</p> <p>Enter the eight-digit Colorado Medical Assistance Program provider number of the requesting provider.</p>
29. Billing Provider Number	8 Digits	<p>Required</p> <p>Enter the eight-digit Colorado Medical Assistance Program provider number of the billing provider.</p> <p>All rendering and billing providers must be Colorado Medical Assistance program providers.</p>
30. Comments	Text	<p>Leave Blank</p> <p>This field is completed by the authorizing agency.</p>

Field Label	Completion Format	Instructions
		Refer to the PAR response for comments submitted by the authorizing agent.
31. PA Number Being Revised	Text	Leave Blank This field is completed by the authorizing agency.

Physical Therapy PAR Form Example

*** Required Field**

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) * Doe, Jane A	2. CLIENT IDENTIFICATION NUMBER * Y123456	3. SEX * M <input type="checkbox"/> F <input checked="" type="checkbox"/>	4. DATE OF BIRTH (MMDDYYYY) * 01/04/2006
--	---	---	--

5. CLIENT ADDRESS (Street, City, State, ZIP Code) * 1234 Any St. Denver, CO 88888	6. CLIENT TELEPHONE NUMBER * (123) 456-7890
---	---

7. PRIOR AUTHORIZATION NUMBER * SYSTEM ASSIGNED * 3	8. DATES COVERED BY THIS REQUEST FROM (MMDDYYYY) * 02/06/2013	THROUGH (MMDDYYYY) * 02/06/2014	9. DOES CLIENT RESIDE IN A NURSING FACILITY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	10. GROUP HOME NAME - IF PATIENT RESIDES IN A GROUP HOME Leave blank – Not applicable
---	--	--	---	---

11. ICD-9-CM DIAGNOSIS CODE and DESCRIPTION (Must include Diagnosis Code and Description, Prognosis, Clinical Information and Other Medications presently prescribed) * 3 4 3 9 Cerebral Palsy	12. REQUESTING AUTHORIZATION FOR REPAIRS EQUIPMENT MUST BE OWNED BY THE CLIENT - THE SERIAL NUMBER MUST BE ENTERED Leave blank – Not applicable
--	---

13. INDICATE LENGTH OF NECESSITY (IN MONTHS AND YEARS) I.E., HOW LONG WILL THIS EQUIPMENT BE NEEDED? Leave blank – Not applicable	14. ESTIMATED COST OF EQUIPMENT Leave blank – Not applicable
---	--

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	PT Evaluation	97001-GT	1		
02	PT Treatment	97032-GT	90		
03					
04					
05					

21. PRIMARY CARE PHYSICIAN (PCP) NAME * Enter the PCP's name	22. PRIMARY CARE PHYSICIAN ADDRESS (Street, City, State, ZIP code) Enter the PCP's address
TELEPHONE NUMBER	23. PCP PROVIDER NUMBER

24. NAME AND ADDRESS OF PHYSICIAN REFERRING FOR PRIOR AUTHORIZATION * Enter the Requesting Physician's name & address	25. NAME AND ADDRESS OF PROVIDER WHO WILL BILL SERVICE
---	--

26. REQUESTING PHYSICIAN SIGNATURE * Enter the Requesting Physician's Signature	27. DATE SIGNED	28. REQUESTING PHYSICIAN PROVIDER NUMBER * Enter the Requesting Physician's Provider Number	29. BILLING PROVIDER NUMBER *
TELEPHONE NUMBER		TELEPHONE 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

Occupational Therapy PAR Form Example

*** Required Field**

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND FINANCING

MEDICAID PRIOR AUTHORIZATION REQUEST (PAR)

INVOICE/PAT. ACCOUNT NUMBER
DOES CLIENT HAVE PRIMARY INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO

To avoid delay, please answer all questions completely.

1. CLIENT NAME (Last, First, Middle Initial) *Doe, Jane A	2. CLIENT IDENTIFICATION NUMBER * Y123456	3. SEX *M <input type="checkbox"/> F <input type="checkbox"/>	4. DATE OF BIRTH (MMDDYYYY) * 01/04/2006
5. CLIENT ADDRESS (Street, City, State, ZIP Code) * 1234 Any St. Denver, CO 88888			6. CLIENT TELEPHONE NUMBER * (123) 456-7890

7. PRIOR AUTHORIZATION NUMBER * SYSTEM ASSIGNED	8. DATES COVERED BY THIS REQUEST FROM (MMDDYYYY) * 02/06/2013	* THROUGH (MMDDYYYY) 02/06/2014	9. DOES CLIENT RESIDE IN A NURSING FACILITY? * <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	10. GROUP HOME NAME - IF PATIENT RESIDES IN A GROUP HOME Leave blank - Not applicable
---	--	--	--	---

11. ICD-9-CM DIAGNOSIS CODE and DESCRIPTION (Must include Diagnosis Code and Description, Prognosis, Clinical Information and Other Medications presently prescribed) * 3 4 3 9 Cerebral Palsy	12. REQUESTING AUTHORIZATION FOR REPAIRS EQUIPMENT MUST BE OWNED BY THE CLIENT - THE SERIAL NUMBER MUST BE ENTERED Leave blank - Not applicable
13. INDICATE LENGTH OF NECESSITY (IN MONTHS AND YEARS) I.E., HOW LONG WILL THIS EQUIPMENT BE NEEDED? Leave blank - Not applicable	14. ESTIMATED COST OF EQUIPMENT Leave blank - Not applicable

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	OT Evaluation	97003-GO	1		
02	OT Treatment	97033-GO	140		
03					
04					
05					

21. PRIMARY CARE PHYSICIAN (PCP) NAME Enter the PCP's name	22. PRIMARY CARE PHYSICIAN ADDRESS (Street, City, State, ZIP code) Enter the PCP's address
TELEPHONE NUMBER	23. PCP PROVIDER NUMBER
24. NAME AND ADDRESS OF PHYSICIAN REFERRING FOR PRIOR AUTHORIZATION * Enter the Requesting Physician's name & address	25. NAME AND ADDRESS OF PROVIDER WHO WILL BILL SERVICE *
26. REQUESTING PHYSICIAN SIGNATURE * Enter the Requesting Physician's Signature	27. DATE SIGNED
TELEPHONE NUMBER	28. REQUESTING PHYSICIAN PROVIDER NUMBER * Enter the Requesting Physician's 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

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.

Instructions for completing and submitting electronic claims are available through the X12N Technical Report 3 (TR3) for the 837P (wpc-edi.com), 837P Companion Guide (in the Provider Services [Specifications](#) section of the Department’s Web site), and in the Web Portal User Guide (via within the portal).

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.

CMS Field #	Field Label	Field is?	Instructions
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.
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 client is covered by a Medicare health insurance policy.

CMS Field #	Field Label	Field is?	Instructions
			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 client is covered by a Medicare health insurance policy. Enter the insured's birth date using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. Place an "X" in the appropriate box to indicate the sex of the insured.
11b	Other Claim ID	Not Required	
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	

CMS Field #	Field Label	Field is?	Instructions
14	Date of Current Illness Injury or Pregnancy	Conditional	<p>Complete if information is known. Enter the date of illness, injury or pregnancy, (date of the last menstrual period) using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014.</p> <p>Enter the applicable qualifier to identify which date is being reported</p> <p>431 Onset of Current Symptoms or Illness</p> <p>484 Last Menstrual Period</p>
15	Other Date	Not Required	
16	Date Patient Unable to Work in Current Occupation	Not Required	
17	Name of Referring Physician or other source	Not Required	
17.b.	NPI of Referring Physician or other source	Required	<p>Per Program Rule 8.125.8, all outpatient physical and occupational therapy services require a referring provider NPI. Services rendered in accordance with an ISFP may not always have a referring physician. In this circumstance alone the rendering provider’s NPI must be entered in this field.</p>
18	Hospitalization Dates Related to Current Service	Conditional	<p>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 client is still hospitalized, the discharge date may be omitted. This information is not edited.</p>

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

CMS Field #	Field Label	Field is?	Instructions												
			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 (totalled). 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: 010116 for January 1, 2016 <table style="margin-left: auto; margin-right: auto; border-collapse: collapse;"> <tr> <td style="text-align: center; padding: 0 10px;">From</td> <td style="text-align: center; padding: 0 10px;">To</td> </tr> <tr> <td style="border: 1px solid black; padding: 2px;">01 01 16</td> <td style="border: 1px solid black; padding: 2px;"> </td> </tr> </table> Or <table style="margin-left: auto; margin-right: auto; border-collapse: collapse;"> <tr> <td style="text-align: center; padding: 0 10px;">From</td> <td style="text-align: center; padding: 0 10px;">To</td> </tr> <tr> <td style="border: 1px solid black; padding: 2px;">01 01 16</td> <td style="border: 1px solid black; padding: 2px;">01 01 16</td> </tr> </table> Span dates of service <table style="margin-left: auto; margin-right: auto; border-collapse: collapse;"> <tr> <td style="text-align: center; padding: 0 10px;">From</td> <td style="text-align: center; padding: 0 10px;">To</td> </tr> <tr> <td style="border: 1px solid black; padding: 2px;">01 01 16</td> <td style="border: 1px solid black; padding: 2px;">01 31 16</td> </tr> </table> <u>Single Date of Service:</u> Enter the six digit date of service in the "From" field. Completion of the "To" field is not	From	To	01 01 16		From	To	01 01 16	01 01 16	From	To	01 01 16	01 31 16
From	To														
01 01 16															
From	To														
01 01 16	01 01 16														
From	To														
01 01 16	01 31 16														

CMS Field #	Field Label	Field is?	Instructions
			<p>required. Do not spread the date entry across the two fields.</p> <p><u>Span billing</u>: permissible if the same service (same procedure code) is provided on consecutive dates.</p> <p>Supplemental Qualifier</p> <p>To enter supplemental information, begin at 24A by entering the qualifier and then the information.</p> <ul style="list-style-type: none"> 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	<p>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.</p> <ul style="list-style-type: none"> 04 Homeless Shelter 11 Office 12 Home 15 Mobile Unit 20 Urgent Care Facility 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room Hospital 25 Birthing Center 26 Military Treatment Center 31 Skilled Nursing Facility

CMS Field #	Field Label	Field is?	Instructions
			32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Transportation – Land 51 Inpatient Psychiatric Facility 52 Psychiatric Facility Partial Hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility – MR 60 Mass Immunization Center 61 Comprehensive IP Rehab Facility 62 Comprehensive OP Rehab Facility 65 End Stage Renal Dialysis Trtmt Facility 71 State-Local Public Health Clinic 99 Other Unlisted
24C	EMG	Conditional	Enter a "Y" for YES or leave blank for NO in the bottom, unshaded area of the field to indicate the service is rendered for a life-threatening condition or one that requires immediate medical intervention. 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).

CMS Field #	Field Label	Field is?	Instructions
			Only approved codes from the current CPT or HCPCS publications will be accepted.
24D	Modifier	Conditional	<p>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.</p> <p>GO Occupational Therapy</p> <p>GP Physical Therapy</p> <p>HB Habilitative Therapy (must be in addition to GO/GP)</p> <p>TL Early Intervention service (must be in addition to GO/GP)</p>
24E	Diagnosis Pointer	Required	<p>Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis.</p> <p>At least one diagnosis code reference letter must be entered.</p> <p>When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow.</p> <p>This field allows for the entry of 4 characters in the unshaded area.</p>
24F	\$ Charges	Required	<p>Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.</p> <p>Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one procedure from the same group is billed, special multiple pricing rules apply.</p> <p>The base procedure is the procedure with the highest allowable amount. The base code is used to determine the</p>

CMS Field #	Field Label	Field is?	Instructions
			<p>allowable amounts for additional CPT surgical procedures when more than one procedure from the same grouping is performed.</p> <p>Submitted charges cannot be more than charges made to non-Colorado Medical Assistance Program covered individuals for the same service.</p> <p>Do not deduct Colorado Medical Assistance Program co-payment or commercial insurance payments from the usual and customary charges.</p>
24G	Days or Units	Required	<p>Enter the number of services provided for each procedure code.</p> <p>Enter whole numbers only- do not enter fractions or decimals.</p>
24H	EPSDT/Family Plan	Conditional	<p>EPSDT (shaded area) For Early & Periodic Screening, Diagnosis, and Treatment related services, enter the response in the shaded portion of the field as follows:</p> <p>AV Available- Not Used S2 Under Treatment ST New Service Requested NU Not Used</p> <p>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.</p>
24I	ID Qualifier	Not Required	
24J	Rendering Provider ID #	Required	<p>In the shaded portion of the field, enter the eight-digit Colorado Medical Assistance Program provider number assigned to the <u>individual</u> who actually performed or rendered the billed service. This number cannot be assigned to a group or clinic.</p>

CMS Field #	Field Label	Field is?	Instructions
			NOTE: When billing a paper claim form, do not use the individual's NPI.
25	Federal Tax ID Number	Not Required	
26	Patient's Account Number	Optional	Enter information that identifies the patient or claim in the provider's billing system. Submitted information appears on the Provider Claim Report (PCR).
27	Accept Assignment?	Required	The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.
28	Total Charge	Required	Enter the sum of all charges listed in field 24F. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
29	Amount Paid	Conditional	Enter the total amount paid by Medicare or any other commercial health insurance that has made payment on the billed services. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
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.

CMS Field #	Field Label	Field is?	Instructions
			<p>Each claim must have the date the enrolled provider or registered authorized agent signed the claim form. Enter the date the claim was signed using two digits for the month, two digits for the date and two digits for the year. Example: 070116 for July 1, 2016.</p> <p>Unacceptable signature alternatives:</p> <p>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.</p>
<p>32</p>	<p>32- Service Facility Location Information 32a- NPI Number 32b- Other ID #</p>	<p>Conditional</p>	<p>Complete for services provided in a hospital or nursing facility in the following format:</p> <p>1st Line Name 2nd Line Address 3rd Line City, State and ZIP Code</p> <p>32a- NPI Number Enter the NPI of the service facility (if known).</p> <p>32b- Other ID # Enter the eight-digit Colorado Medical Assistance Program provider number of the service facility (if known).</p> <p>The information in field 32, 32a and 32b is not edited.</p>
<p>33</p>	<p>33- Billing Provider Info & Ph # 33a- NPI Number 33b- Other ID #</p>	<p>Required</p>	<p>Enter the name of the individual or organization that will receive payment for the billed services in the following format:</p> <p>1st Line Name 2nd Line Address</p>

CMS Field #	Field Label	Field is?	Instructions
			3 rd 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.

UB-04 Paper Claim Reference Table

PT and OT outpatient hospital paper claims must be submitted on the UB-04 claim form.

The information in the following Paper Claim Reference Table lists the required, optional and/or conditional form locators for submitting the UB-04 paper claim form to the Colorado Medical Assistance Program for PT and OT services. It also provides instructions for completing Form Locators (FL) as they appear on the paper UB-04 claim form. Instructions for completing the UB-04 claim form are based on the current *National Uniform Billing Committee (NUBC) UB-04 Reference Manual*. Unless otherwise noted, all data FLs on the UB-04 have the same attributes (specifications) for the Colorado Medical Assistance Program as those indicated in the *NUBC UB-04 Reference Manual*.

All code values listed in the *NUBC UB-04 Reference Manual* for each FL **may not** be used for submitting paper claims to the Colorado Medical Assistance Program. The appropriate code values listed in this manual must be used when billing the Colorado Medical Assistance Program.

The UB-04 certification must be completed and attached to all claims submitted on the UB-04 paper claim form. A copy of the certification form is included with this manual. Completed UB-04 paper Colorado Medical Assistance Program claims, including hardcopy Medicare claims, should be mailed to the correct fiscal agent address located in Appendix A of the Appendices section in Provider Services [Billing Manuals](#).

Do not submit "continuation" claims. Each claim form has a set number of billing lines available for completion. Do not crowd more lines on the form. Billing lines in excess of the designated number are not processed or acknowledged. Claims with more than one page may be submitted electronically.

Form Locator and Label	Completion Format	Instructions
1. Billing Provider Name, Address, Telephone Number	Text	Required Enter the provider or agency name and complete mailing address of the provider who is billing for the services: Street/Post Office box City State

Form Locator and Label	Completion Format	Instructions														
		<p>Zip Code</p> <p>Abbreviate the state using standard post office abbreviations. Enter the telephone number.</p>														
<p>2. Pay-to Name, Address, City, State</p>	<p>Text</p>	<p>Required if different from FL 1.</p> <p>Enter the provider or agency name and complete mailing address of the provider who will receive payment for the services:</p> <p style="padding-left: 40px;">Street/Post Office box</p> <p style="padding-left: 40px;">City</p> <p style="padding-left: 40px;">State</p> <p style="padding-left: 40px;">Zip Code</p> <p>Abbreviate the state using standard post office abbreviations. Enter the telephone number.</p>														
<p>3a. Patient Control Number</p>	<p>Up to 20 characters: Letters, numbers or hyphens</p>	<p>Optional</p> <p>Enter information that identifies the client or claim in the provider’s billing system. Submitted information appears on the Provider Claim Report.</p>														
<p>3b. Medical Record Number</p>	<p>17 digits</p>	<p>Optional</p> <p>Enter the number assigned to the patient to assist in retrieval of medical records.</p>														
<p>4. Type of Bill</p>	<p>3 digits</p>	<p>Required</p> <p>Enter the three-digit number indicating the specific type of bill. The three-digit code requires one digit each in the following sequences (Type of facility, Bill classification, and Frequency):</p> <table border="0" style="margin-left: 20px;"> <thead> <tr> <th style="text-align: left;"><u>Digit</u></th> <th style="text-align: left;"><u>Type of Facility</u></th> </tr> </thead> <tbody> <tr> <td><u>1</u></td> <td></td> </tr> <tr> <td>1</td> <td>Hospital</td> </tr> <tr> <td>2</td> <td>Skilled Nursing Facility</td> </tr> <tr> <td>3</td> <td>Home Health</td> </tr> <tr> <td>4</td> <td>Religious Non-Medical Health Care Institution Hospital Inpatient</td> </tr> <tr> <td>5</td> <td>Religious Non-Medical Health Care Institution Post-Hospital Extended Care Services</td> </tr> </tbody> </table>	<u>Digit</u>	<u>Type of Facility</u>	<u>1</u>		1	Hospital	2	Skilled Nursing Facility	3	Home Health	4	Religious Non-Medical Health Care Institution Hospital Inpatient	5	Religious Non-Medical Health Care Institution Post-Hospital Extended Care Services
<u>Digit</u>	<u>Type of Facility</u>															
<u>1</u>																
1	Hospital															
2	Skilled Nursing Facility															
3	Home Health															
4	Religious Non-Medical Health Care Institution Hospital Inpatient															
5	Religious Non-Medical Health Care Institution Post-Hospital Extended Care Services															

Form Locator and Label	Completion Format	Instructions
		<p>6 Intermediate Care</p> <p>7 Clinic (Rural Health/FQHC/Dialysis Center)</p> <p>8 Special Facility (Hospice, RTCs)</p> <p><u>Digit</u> <u>Bill Classification (Except clinics & special facilities):</u></p> <p>2</p> <p>1 Inpatient (Including Medicare Part A)</p> <p>2 Inpatient (Medicare Part B only)</p> <p>3 Outpatient</p> <p>4 Other (for hospital referenced diagnostic services or home health not under a plan of treatment)</p> <p>5 Intermediate Care Level I</p> <p>6 Intermediate Care Level II</p> <p>7 Sub-Acute Inpatient (revenue code 19X required with this bill type)</p>
<p>4. Type of Bill (continued)</p>	<p>3 digits</p>	<p>Required</p> <p>Enter the three-digit number indicating the specific type of bill. The three-digit code requires one digit each in the following sequences (Type of facility, Bill classification, and Frequency):</p> <p><u>Digit</u> <u>Bill Classification (Except clinics & special facilities):</u></p> <p>2</p> <p>8 Swing Beds</p> <p>9 Other</p>

Form Locator and Label	Completion Format	Instructions
		<p><u>Digit 2</u> <u>Bill Classification (Clinics Only):</u></p> <p>1 Rural Health/FQHC</p> <p>2 Hospital Based or Independent Renal Dialysis Center</p> <p>3 Freestanding</p> <p>4 Outpatient Rehabilitation Facility (ORF)</p> <p>5 Comprehensive Outpatient Rehabilitation Facilities (CORFs)</p> <p>6 Community Mental Health Center</p> <p><u>Digit 2</u> <u>Bill Classification (Special Facilities Only):</u></p> <p>1 Hospice (Non-Hospital Based)</p> <p>2 Hospice (Hospital Based)</p> <p>3 Ambulatory Surgery Center</p> <p>4 Freestanding Birthing Center</p> <p>5 Critical Access Hospital</p> <p>6 Residential Facility</p> <p><u>Digit 3</u> <u>Frequency:</u></p> <p>0 Non-Payment/Zero Claim</p> <p>1 Admit through discharge claim</p> <p>2 Interim - First claim</p> <p>3 Interim - Continuous claim</p> <p>4 Interim - Last claim</p> <p>7 Replacement of prior claim</p> <p>8 Void of prior claim</p>
5. Federal Tax Number	None	Not required Submitted information is not entered into the claim processing system.

Form Locator and Label	Completion Format	Instructions
<p>6. Statement Covers Period – From/Through</p>	<p>From: 6 digits MMDDYY</p> <p>Through: 6 digits MMDDYY</p>	<p>Required</p> <p>(Note: OP claims cannot span over a month’s end)</p> <p>Enter the From (beginning) date and Through (ending) date of service covered by this bill using MMDDYY format. <i>For Example:</i> January 1, 2016 = 0101016</p> <p>This form locator must reflect the beginning and ending dates of service. When span billing for multiple dates of service and multiple procedures, complete FL 45 (Service Date). Providers not wishing to span bill following these guidelines, must submit one claim per date of service. "From" and "Through" dates must be the same. All line item entries must represent the same date of service.</p>
<p>8a. Patient Identifier</p>		<p>Not required</p> <p>Submitted information is not entered into the claim processing system.</p>
<p>8b. Patient Name</p>	<p>Up to 25 characters: Letters & spaces</p>	<p>Required</p> <p>Enter the client’s last name, first name and middle initial.</p>
<p>9a. Patient Address – Street</p>	<p>Characters Letters & numbers</p>	<p>Required</p> <p>Enter the client’s street/post office box as determined at the time of admission.</p>
<p>9b. Patient Address – City</p>	<p>Text</p>	<p>Required</p> <p>Enter the client’s city as determined at the time of admission.</p>
<p>9c. Patient Address – State</p>	<p>Text</p>	<p>Required</p> <p>Enter the client’s state as determined at the time of admission.</p>
<p>9d. Patient Address – Zip</p>	<p>Digits</p>	<p>Required</p> <p>Enter the client’s zip code as determined at the time of admission.</p>
<p>9e. Patient Address – Country Code</p>	<p>Digits</p>	<p>Optional</p>

Form Locator and Label	Completion Format	Instructions
<p>10. Birthdate</p>	<p>8 digits (MMDDCCYY)</p>	<p>Required Enter the client’s birthdate using two digits for the month, two digits for the date, and four digits for the year (MMDDCCYY format). Example: 01012010 for January 1, 2010.</p>
<p>11. Patient Sex</p>	<p>1 letter</p>	<p>Required Enter an M (male) or F (female) to indicate the client’s sex.</p>
<p>12. Admission Date</p>	<p>6 digits</p>	<p>Conditional Required for observation holding beds only</p>
<p>13. Admission Hour</p>	<p>6 digits</p>	<p>Conditional Required for observation holding beds only</p>
<p>14. Admission Type</p>	<p>1 digit</p>	<p>Required Enter the following to identify the admission priority: <u>1 – Emergency</u> Client requires immediate intervention as a result of severe, life threatening or potentially disabling conditions. Exempts inpatient hospital & clinic claims from co-payment and PCP referral. Exempts outpatient hospital claims from co-payment and PCP only if revenue code 450 or 459 is present. This is the only benefit service for an undocumented alien. If span billing, emergency services cannot be included in the span bill and must be billed separately from other outpatient services. <u>2 - Urgent</u> The client requires immediate attention for the care and treatment of a physical or mental disorder. <u>3 - Elective</u> The client’s condition permits adequate time to schedule the availability of accommodations. <u>4 - Newborn</u></p>

Form Locator and Label	Completion Format	Instructions
		<p>Required for inpatient and outpatient hospital.</p> <p>5 - Trauma Center Visit to a trauma center/hospital as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons <u>and</u> involving trauma activation.</p> <p>Clinics Required only for emergency visit.</p>
<p>15. Source of Admission</p>	<p>1 digit</p>	<p>Required</p> <p>Enter the appropriate code for co-payment exceptions on claims submitted for outpatient services. (To be used in conjunction with FL 14, Type of Admission).</p> <ul style="list-style-type: none"> 1 Physician referral 2 Clinic referral 3 Referred from HMO 4 Transfer from a hospital 5 Transfer from a skilled nursing facility (SNF) 6 Transfer from another health care facility 7 Emergency Room 8 Court/Law Enforcement 9 Information not available A Transfer from a Critical Access Hospital B Transfer from another Home Health Agency C Readmission to Same Home Health Agency <p>Newborns</p> <ul style="list-style-type: none"> 1 Normal Delivery 2 Premature Delivery 3 Sick Baby

Form Locator and Label	Completion Format	Instructions
		<p>4 Extramural Birth (Birth in a non-sterile environment)</p>
<p>16. Discharge Hour</p>	<p>2 digits</p>	<p>Not Required Enter the hour the client was discharged from inpatient hospital care. Use the same coding used in FL 13 (Admission Hr.)</p>
<p>17. Patient Discharge Status</p>	<p>2 digits</p>	<p>Conditional Enter patient status as of discharge date.</p> <ul style="list-style-type: none"> 01 Discharged to Home or Self Care (Dialysis is limited to code 01) 02 Discharged/transferred to another short term hospital

Form Locator and Label	Completion Format	Instructions
<p>17. Patient Discharge Status (continued)</p>	<p>2 digits</p>	<p>70 Discharged/Transferred to Other HC Institution</p> <p>71 Discharged/transferred/referred to another institution for outpatient services</p> <p>72 Discharged/transferred/referred to this institution for outpatient services</p> <p>Use code <u>02</u> for a PPS hospital transferring a patient <u>to</u> another PPS hospital.</p> <p>Code <u>05</u>, Discharged to Another Type Institution, is the most appropriate code to use for a PPS hospital transferring a patient to an exempt hospital.</p> <p>**A PPS hospital cannot use Patient Status codes 30, 31 or 32 on any claim submitted for DRG reimbursement. The code(s) are valid for use on exempt hospital claims only.</p> <p>Interim bills may be submitted for Prospective Payment System (PPS)-DRG claims, but must meet specific billing requirements.</p> <p>For exempt hospitals use the appropriate code from the codes listed. Note: Refer to the "Interim" billing instruction in this section of the manual.</p>
<p>18-28. Condition Codes</p>	<p>2 Digits</p>	<p>Conditional</p> <p>Complete with as many codes necessary to identify conditions related to this bill that may affect payer processing.</p> <p><u>Condition Codes</u></p> <ul style="list-style-type: none"> 01 Military service related 02 Employment related 04 HMO enrollee 05 Lien has been filed 06 ESRD patient - First 18 months entitlement

Form Locator and Label	Completion Format	Instructions
		07 Treatment of non-terminal condition/hospice patient 17 Patient is homeless 25 Patient is a non-US resident 39 Private room medically necessary 42 Outpatient Continued Care not related to Inpatient
18-28. Condition Codes (continued)	2 Digits	44 Inpatient CHANGED TO Outpatient 51 Outpatient Non-diagnostic Service unrelated to Inpatient admit 60 DRG (Day outlier) <u>Renal dialysis settings</u> 71 Full care unit 72 Self care unit 73 Self care training 74 Home care 75 Home care - 100 percent reimbursement 76 Back-up facility <u>Special Program Indicator Codes</u> A1 EPSDT/CHAP A2 Physically Handicapped Children's Program A4 Family Planning A6 PPV/Medicare A9 Second Opinion Surgery AA Abortion Due to Rape AB Abortion Done Due to Incest AD Abortion Due to Life Endangerment AI Sterilization B3 Pregnancy Indicator

Form Locator and Label	Completion Format	Instructions
		B4 Admission Unrelated to Discharge <u>PRO Approval Codes</u> C1 Approved as billed C2 Automatic approval as billed - Based on focused review C3 Partial approval C4 Admission/Services denied C5 Post payment review applicable C6 Admission preauthorization C7 Extended authorization
29. Accident State		Optional

Form Locator and Label	Completion Format	Instructions
<p>31-34. Occurrence Code/Date</p>	<p>2 digits and 6 digits</p>	<p>Conditional</p> <p>Complete both the code and date of occurrence. Enter the appropriate code and the date on which it occurred. Enter the date using MMDDYY format.</p> <p>Occurrence Codes:</p> <ul style="list-style-type: none"> 01 Accident/Medical Coverage 02 Auto Accident - No Fault Liability 03 Accident/Tort Liability 04 Accident/Employment Related 05 Other Accident/No Medical Coverage or Liability Coverage 06 Crime Victim 20 Date Guarantee of Payment Began 24* Date Insurance Denied 25* Date Benefits Terminated by Primary Payer 26 Date Skilled Nursing Facility Bed Available 27 Date of Hospice Certification or Re-certification 40 Scheduled Date of Admission (RTD) 50 Medicare Pay Date 51 Medicare Denial Date 53 Late Bill Override Date 55 Insurance Pay Date A3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer A indicated in FL 50 B3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer B indicated in FL 50

Form Locator and Label	Completion Format	Instructions
		<p>C3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer C indicated in FL 50</p> <p>*Other Payer occurrence codes 24 and 25 must be used when applicable. The claim must be submitted with the third party information</p>

Form Locator and Label	Completion Format	Instructions
35-36. Occurrence Span Code From/ Through	2 digits and 6 digits	Leave blank
38. Responsible Party Name/ Address	None	Not required Submitted information is not entered into the claim processing system.
39-41. Value Code- Code Value Code- Amount	2 characters and 9 digits	<p>Conditional</p> <p>Enter appropriate codes and related dollar amounts to identify monetary data or number of days using whole numbers, necessary for the processing of this claim.</p> <p>Never enter negative amounts.</p> <p>If a value code is entered, a dollar amount or numeric value related to the code <u>must</u> always be entered.</p> <ul style="list-style-type: none"> 01 Most common semiprivate rate (Accommodation Rate) 06 Medicare blood deductible 14 No fault including auto/other 15 Worker's Compensation 30 Preadmission testing 31 Patient Liability Amount 32 Multiple Patient Ambulance Transport 37 Pints of Blood Furnished 38 Blood Deductible Pints 40 New Coverage Not Implemented by HMO 45 Accident Hour Enter the hour when the accident occurred that necessitated medical treatment. Use the same coding used in FL 18 (Admission Hour). 49 Hematocrit Reading - EPO Related 58 Arterial Blood Gas (PO2/PA2)

Form Locator and Label	Completion Format	Instructions
		68 EPO-Drug 80 Covered Days 81 Non-Covered Days
39-41. Value Code-Code Value Code-Amount (continued)	2 characters and 9 digits	Enter the deductible amount applied by indicated payer: A1 Deductible Payer A B1 Deductible Payer B C1 Deductible Payer C Enter the amount applied to client’s co-insurance by indicated payer: A2 Coinsurance Payer A B2 Coinsurance Payer B C2 Coinsurance Payer C Enter the amount paid by indicated payer: A3 Estimated Responsibility Payer A B3 Estimated Responsibility Payer B C3 Estimated Responsibility Payer C Enter the amount paid by client: FC Patient Paid Amount For Rancho Coma Score bill with appropriate diagnosis for head injury. Medicare & TPL - See A1-A3, B1-B3, & C1-C3 above
42. Revenue Code	3 digits	Required Enter the revenue code which identifies the specific accommodation or ancillary service provided. List revenue codes in ascending order. A <u>revenue code</u> must appear only <u>once</u> per date of <u>service</u> . If more than one of the same service is provided on the same day, combine the <u>units</u> and charges on one line accordingly. When billing outpatient hospital radiology, the radiology revenue code may be repeated, but the corresponding HCPCS code cannot be repeated

Form Locator and Label	Completion Format	Instructions
		for the same date of service. Refer to instructions under FL 44 (HCPCS/Rates). Psychiatric step down Use the following revenue codes: 011 Psychiatric Step Down 1 4 012 Psychiatric Step Down 2 4

Form Locator and Label	Completion Format	Instructions
<p>43. Revenue Code Description</p>	<p>Text</p>	<p>Required</p> <p>Enter the revenue code description or abbreviated description.</p> <p>When reporting an NDC</p> <ul style="list-style-type: none"> ▪ Enter the NDC qualifier of "N4" in the first two positions on the left side of the field. ▪ Enter the 11-digit NDC numeric code ▪ Enter the NDC unit of measure qualifier (examples include): <ul style="list-style-type: none"> ✓ F2 – International Unit ✓ GR – Gram ✓ ML – Milliliter ✓ UN – Units ▪ Enter the NDC unit of measure quantity
<p>44. HCPCS/Rates/ HIPPS Rate Codes</p>	<p>5 digits</p>	<p>Conditional</p> <p>Enter only the HCPCS code for each detail line. Use approved modifiers listed in this section for hospital based transportation services.</p> <p>Complete for laboratory, radiology, physical therapy, occupational therapy, and hospital based transportation. When billing HCPCS codes, the appropriate revenue code must also be billed. HCPCS codes must be identified for the following revenue codes:</p> <ul style="list-style-type: none"> ▪ 030X Laboratory ▪ 032X Radiology – Diagnostic ▪ 033X Radiology – Therapeutic ▪ 034X Nuclear Medicine ▪ 035X CT Scan ▪ 040X Other Imaging Services ▪ 042X Physical Therapy ▪ 043X Occupational Therapy ▪ 054X Ambulance ▪ 061X MRI <p>HCPCS codes cannot be repeated for the same date of service. Combine the units in FL 46 (Service Units) to report multiple services.</p>

Form Locator and Label	Completion Format	Instructions
		<p>The following revenue codes always require a HCPCS code. Please reference the Provider Services Bulletins section of the Department’s Web site for a list of physician-administered drugs that also require an NDC code.</p> <p>When a HCPCS code is repeated more than once per day and billed on separate lines, use modifier 76 to indicate this is a repeat procedure and not a duplicate.</p> <ul style="list-style-type: none"> 0252 Non-Generic Drugs 0253 Take Home Drugs 0255 Drugs Incident to Radiology 0257 Non-Prescription 0258 IV Solutions 0259 Other Pharmacy 0260 IV Therapy General Classification 0261 Infusion Pump 0262 IV Therapy/Pharmacy Services 0263 IV Therapy/Drug/Supply Delivery 0264 IV Therapy/Supplies 0269 Other IV Therapy 0631 Single Source Drug 0632 Multiple Source Drug 0633 Restrictive Prescription 0634 Erythropoietin (EPO) <10,000 0635 Erythropoietin (EPO) >10,000 0636 Drugs Requiring Detailed Coding
45. Service Date	6 digits	<p>Required</p> <p>For span bills only</p> <p>Enter the date of service using MMDDYY format for each detail line completed.</p> <p>Each date of service must fall within the date span entered in the "Statement Covers Period" (FL 6).</p> <p>Not required for single date of service claims.</p>

Form Locator and Label	Completion Format	Instructions
46. Service Units	3 digits	<p>Required</p> <p>Enter a unit value on each line completed. Use whole numbers only. Do not enter fractions or decimals and do not show a decimal point followed by a 0 to designate whole numbers (e.g., Do not enter 1.0 to signify one unit)</p> <p>The grand total line (Line 23) does not require a unit value.</p> <p>For span bills, the units of service reflect only those visits, miles or treatments provided on dates of service in FL 45.</p>

Form Locator and Label	Completion Format	Instructions
<p>47. Total Charges</p>	<p>9 digits</p>	<p>Required Enter the total charge for each line item. Calculate the total charge as the number of units multiplied by the unit charge. Do not subtract Medicare or third party payments from line charge entries. Do not enter negative amounts. A grand total in line 23 is required for all charges.</p>
<p>48. Non-Covered Charges</p>	<p>9 digits</p>	<p>Conditional Enter incurred charges that are not payable by the Colorado Medical Assistance Program. Non-covered charges must be entered in both FL 47 (Total Charges) and FL 48 (Non-Covered Charges). Each column requires a grand total. Non-covered charges cannot be billed for outpatient hospital laboratory or hospital based transportation services.</p>
<p>50. Payer Name</p>	<p>1 letter and text</p>	<p>Required Enter the payment source code followed by name of each payer organization from which the provider might expect payment. At least one line must indicate The Colorado Medical Assistance Program.</p> <p><u>Source Payment Codes</u></p> <ul style="list-style-type: none"> B Workmen's Compensation C Medicare D Colorado Medical Assistance Program E Other Federal Program F Insurance Company G Blue Cross, including Federal Employee Program H Other - Inpatient (Part B Only) I Other <p>Line A Primary Payer Line B Secondary Payer Line C Tertiary Payer</p>

Form Locator and Label	Completion Format	Instructions
<p>51. Health Plan ID</p>	<p>8 digits</p>	<p>Required Enter the provider’s Health Plan ID for each payer name. Enter the eight digit Colorado Medical Assistance Program provider number assigned to the billing provider. Payment is made to the enrolled provider or agency that is assigned this number.</p>
<p>52. Release of Information</p>		<p>Not required Submitted information is not entered into the claim processing system.</p>
<p>53. Assignment of Benefits</p>		<p>Not required Submitted information is not entered into the claim processing system.</p>
<p>54. Prior Payments</p>	<p>Up to 9 digits</p>	<p>Conditional Complete when there are Medicare or third party payments. Enter third party and/or Medicare payments.</p>
<p>55. Estimated Amount Due</p>	<p>Up to 9 digits</p>	<p>Conditional Complete when there are Medicare or third party payments. Enter the net amount due from The Colorado Medical Assistance Program after provider has received other third party, Medicare or patient liability amount. Medicare Crossovers Enter the sum of the Medicare coinsurance plus Medicare deductible less third party payments and patient payments.</p>
<p>56. National Provider Identifier (NPI)</p>	<p>10 digits</p>	<p>Required Enter the billing provider’s 10-digit National Provider Identifier (NPI).</p>
<p>57. Other Provider ID</p>		<p>Not required Submitted information is not entered into the claim processing system.</p>
<p>58. Insured’s Name</p>	<p>Up to 30 characters</p>	<p>Required</p>

Form Locator and Label	Completion Format	Instructions
		Enter the member’s name on the Colorado Medical Assistance Program line. Other Insurance/Medicare Complete additional lines when there is third party coverage. Enter the policyholder's last name, first name, and middle initial.
60. Insured’s Unique ID	Up to 20 characters	Required Enter the insured's unique identification number assigned by the payer organization exactly as it appears on the health insurance card. Include letter prefixes or suffixes shown on the card.
61. Insurance Group Name	14 letters	Conditional Complete when there is third party coverage. Enter the name of the group or plan providing the insurance to the insured exactly as it appears on the health insurance card.
62. Insurance Group Number	17 digits	Conditional Complete when there is third party coverage. Enter the identification number, control number, or code assigned by the carrier or fund administrator identifying the group under which the individual is carried.
63. Treatment Authorization Code	Up to 18 characters	Conditional Complete when the service requires a PAR. Enter the authorization number in this FL if a PAR is required and has been approved for services.
64. Document Control Number		Not required Submitted information is not entered into the claim processing system.
65. Employer Name	Text	Conditional Complete when there is third party coverage. Enter the name of the employer that provides health care coverage for the individual identified in FL 58 (Insured Name).
66. Diagnosis Version Qualifier		Not required Submitted information is not entered into the claim processing system.

Form Locator and Label	Completion Format	Instructions
67. Principal Diagnosis Code	Up to 6 digits	Required Enter the exact diagnosis code describing the principal diagnosis that exists at the time of admission or develops subsequently and affects the length of stay. Do not add extra zeros to the diagnosis code.
67A- 67Q. Other Diagnosis	Up to 6 digits	Conditional Enter the exact diagnosis code corresponding to additional conditions that co-exist at the time of admission or develop subsequently and which effect the treatment received or the length of stay. Do not add
69. Admitting Diagnosis Code	Up to 6 digits	Optional Enter the diagnosis code as stated by the physician at the time of admission.
70. Patient Reason Diagnosis		Not required Submitted information is not entered into the claim processing system.
71. PPS Code		Not required Submitted information is not entered into the claim processing system.
72. External Cause of Injury Code (E-code)	Up to 6 digits	Optional Enter the diagnosis code for the external cause of an injury, poisoning, or adverse effect. This code must begin with an "E".
74. Principal Procedure Code/ Date	Up to 7 characters or Up to 6 digits	Conditional Enter the procedure code for the principal procedure performed during this billing period and the date on which procedure was performed. Enter the date using MMDDYY format. Apply the following criteria to determine the principle procedure: The principal procedure is not performed for diagnostic or exploratory purposes. This code is related to definitive treatment; and The principal procedure is most related to the primary diagnosis.

Form Locator and Label	Completion Format	Instructions
74A. Other Procedure Code/Date	Up to 7 characters or Up to 6 digits	<p>Conditional</p> <p>Complete when there are additional significant procedure codes.</p> <p>Enter the procedure codes identifying all significant procedures other than the principle procedure and the dates on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principle diagnosis. Enter the date using MMDDYY format.</p>
<p>76.Attending NPI – Conditional QUAL - Conditional ID - (Colorado Medical Assistance Provider #) – Required</p> <p>Attending-Last/First Name</p>	<p>NPI - 10 digits</p> <p>QUAL – Text</p> <p>Medicaid ID - 8 digits</p> <p>Text</p>	<p>Colorado Medical Assistance Program ID Required</p> <p>NPI - Enter the 10-digit NPI and eight-digit Colorado Medical Assistance Program provider number assigned to the physician having primary responsibility for the patient's medical care and treatment. This number is obtained from the physician, and <u>cannot</u> be a clinic or group number. (If the attending physician is not enrolled in the Colorado Medical Assistance Program or if the client leaves the ER before being seen by a physician, the hospital may enter their individual numbers.)</p> <p>Hospitals may enter the client's regular physician's 10-digit NPI and Medical Assistance Program provider ID in the Attending Physician ID form locator if the locum tenens physician is not enrolled in the Colorado Medical Assistance Program.</p> <p>QUAL – Enter "1D " for Medicaid</p> <p>Enter the attending physician's last and first name.</p> <p>This form locator must be completed for all services.</p>
77. Operating-NPI/QUAL/ID		<p>Not required</p> <p>Submitted information is not entered into the claim processing system.</p>

Form Locator and Label	Completion Format	Instructions
<p>78-79. Other ID NPI – Conditional QUAL - Conditional ID - (Colorado Medical Assistance Provider #) – Conditional</p>	<p>NPI - 10 digits QUAL – Text Medicaid ID - 8 digits</p>	<p>Conditional – Colorado Medical Assistance Program ID (see below) Complete when attending physician is not the PCP or to identify additional physicians. NPI - Enter up to two 10-digit NPI and eight digit physician Colorado Medical Assistance Program provider numbers, when applicable. This form locator identifies physicians other than the attending physician. If the attending physician is not the PCP or if a clinic is a PCP agent, enter the PCP eight digit Colorado Medical Assistance Program provider number as the referring physician. The name of the Colorado Medical Assistance Program client’s PCP appears on the eligibility verification. Review either for eligibility and PCP. The Colorado Medical Assistance Program does not require that the PCP number appear more than once on each claim submitted. The attending physician’s last and first name are optional.</p>
<p>80. Remarks</p>	<p>Text</p>	<p>Optional Enter specific additional information necessary to process the claim or fulfill reporting requirements.</p>
<p>81. Code-Code QUAL/CODE /VALUE (a-d)</p>		<p>Optional Submitted information is not entered into the claim processing system</p>



Institutional Provider Certification

This is to certify that the foregoing information is true, accurate and complete.

This is to certify that I understand that payment of this claim will be from Federal and State funds and that any falsification, or concealment of material fact, may be prosecuted under Federal and State Laws.

Signature: _____

Date: _____

This document is an addendum to the UB-04 claim form and is required per 42 C.F.R. 445.18 (a)(1-2) to be attached to paper claims submitted on the UB-04.

CMS 1500 OT/PT Claim Example



HEALTH INSURANCE CLAIM FORM

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

1. MEDICARE (Medicare #) <input checked="" type="checkbox"/> MEDICAID (Medicaid #) (ID#DcD#) TRICARE (ID#DcD#) 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 M F <input checked="" type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial)													
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (include Area Code)					6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse Child Other			7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (include Area Code)													
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? PLACE (State) YES NO c. OTHER ACCIDENT? YES NO			11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M F b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME													
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED Signature on File DATE 10/1/15					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 MM DD YY 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? \$ CHARGES YES NO 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD-10: G80.9 A. 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. REFERRAL PARTY I. ID. QUAL. J. RENDERING PROVIDER ID. #										25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO. Optional		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES NO		28. TOTAL CHARGE \$ 80.00		29. AMOUNT PAID \$		30. Revd for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Signature DATE 10/15										32. SERVICE FACILITY LOCATION INFORMATION ABC Therapy Clinic 100 Any Street Any City					33. BILLING PROVIDER INFO & PH # () a. 1234567890 b. 04567890						

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

UB-04 Outpatient PT Claim Example

1 City Hospital 100 Saginaw St. Anytown, CO 80000 333-333-3333		2		3a PAT. CNTL. # 3b MED. REC. #		4 TYPE OF BILL 131	
5 PATIENT NAME Client, Ima				6 PATIENT ADDRESS 123 Main Street Anytown CO 80000			
10 BIRTHDATE 01/04/2006		11 SEX F		12 DATE OF ADMISSION 02/06/14		13 HPI 3	
14 TYPE 3		15 SRC 3		16 DHR		17 STAT	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACCT STATE	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42 REV. CD.		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1 440		Speech therapy		92502		02/06/14	
2 440		Speech Therapy		92507		02/06/14	
3							
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Late Bill Override Date

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

Valid Delay Reason Codes

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



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

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

Billing Instruction Detail	Instructions
LBOD Completion Requirements	<ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> ➤ <i>UB-04</i>: Occurrence code 53 and the date are required in FL 31-34. ➤ <i>CMS 1500</i>: Indicate "LBOD" and the date in box 19 – Additional Claim Information. ➤ <i>2006 ADA Dental</i>: 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

Billing Instruction Detail	Instructions
	<p>follow-up period was paid and now needs to be adjusted, resulting in additional payment to the provider.</p> <p>Adjust the claim within 60 days of the claim payment. Retain all documents that prove compliance with timely filing requirements.</p> <p><i>Note: There is no time limit for providers to adjust paid claims that would result in repayment to the Colorado Medical Assistance Program.</i></p> <p>LBOD = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the payment.</p>
Denied Paper Claims	<p>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.</p> <p>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.</p> <p>LBOD = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the denial.</p>
Returned Paper Claims	<p>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.</p> <p>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.</p> <p>LBOD = the stamped fiscal agent date on the returned claim.</p>
Rejected Electronic Claims	<p>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.</p> <p>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.</p> <p>LBOD = the date shown on the claim rejection report.</p>

Billing Instruction Detail	Instructions
<p>Denied/Rejected Due to Client Eligibility</p>	<p>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.</p> <p>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 client and date of eligibility rejection.</p> <p>LBOD = the date shown on the eligibility rejection report.</p>
<p>Retroactive Client Eligibility</p>	<p>The claim is for services provided to an individual whose Colorado Medical Assistance Program eligibility was backdated or made retroactive.</p> <p>File the claim within 120 days of the date that the individual’s eligibility information appeared on state eligibility files. Obtain and maintain a letter or form from the county departments of social services that:</p> <ul style="list-style-type: none"> • Identifies the patient by name • States that eligibility was backdated or retroactive • Identifies the date that eligibility was added to the state eligibility system. <p>LBOD = the date shown on the county letter that eligibility was added to or first appeared on the state eligibility system.</p>
<p>Delayed Notification of Eligibility</p>	<p>The provider was unable to determine that the patient had Colorado Medical Assistance Program coverage until after the timely filing period expired.</p> <p>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 client, indicates the effort made to identify eligibility, and shows the date of eligibility notification.</p> <ul style="list-style-type: none"> • 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.

Billing Instruction Detail	Instructions
	<ul style="list-style-type: none"> • 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. <p>LBOD = the date the provider was advised the individual had Colorado Medical Assistance Program benefits.</p>
<p>Electronic Medicare Crossover Claims</p>	<p>An electronic claim is being submitted for Medicare crossover benefits within 120 days of the date of Medicare processing/ payment. (Note: On the paper claim form (only), the Medicare SPR/ERA date field documents crossover timely filing and completion of the LBOD is not required.)</p> <p>File the claim within 120 days of the Medicare processing/ payment date shown on the SPR/ERA. Maintain the original SPR/ERA on file.</p> <p>LBOD = the Medicare processing date shown on the SPR/ERA.</p>
<p>Medicare Denied Services</p>	<p>The claim is for Medicare denied services (Medicare non-benefit services, benefits exhausted services, or the member does not have Medicare coverage) being submitted within 60 days of the date of Medicare processing/denial.</p> <p><i>Note: This becomes a regular Colorado Medical Assistance Program claim, not a Medicare crossover claim.</i></p> <p>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.</p> <p>LBOD = the Medicare processing date shown on the SPR/ERA.</p>
<p>Commercial Insurance Processing</p>	<p>The claim has been paid or denied by commercial insurance.</p> <p>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.</p> <p>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</p>

Billing Instruction Detail	Instructions
	<p>compliance with the 60-day rule until insurance processing information is available.</p> <p>LBOD = the date commercial insurance paid or denied.</p>
Correspondence LBOD Authorization	<p>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.</p> <p>File the claim within 60 days of the date on the authorization letter. Retain the authorization letter.</p> <p>LBOD = the date on the authorization letter.</p>
Member Changes Providers during Obstetrical Care	<p>The claim is for obstetrical care where the patient transferred to another provider for continuation of OB care. The prenatal visits must be billed using individual visit codes but the service dates are outside the initial timely filing period.</p> <p>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.</p> <p>LBOD = the last date of OB care by the billing provider.</p>

PT and OT Therapy Revisions Log

Revision Date	Additions/Changes	Pages	Made by
<i>04/22/2009</i>	<i>Drafted Manual</i>	<i>All</i>	<i>jg</i>
<i>09/14/2009</i>	<i>Updates and formatting</i>	<i>Throughout</i>	<i>jg</i>
<i>10/19/2009</i>	<i>LBOD</i>	<i>44</i>	<i>jg</i>
<i>01/12/2010</i>	<i>Updated Web site links</i>	<i>Throughout</i>	<i>jg</i>
<i>02/10/2010</i>	<i>Changed EOMB to SPR</i>	<i>23 & 46</i>	<i>jg</i>
<i>03/04/2010</i>	<i>Added link to Program Rules</i>	<i>2</i>	<i>jg</i>
<i>07/14/2010</i>	<i>Updated date examples for field 19A Updated Colorado 1500 claim example UB-04 claim example</i>	<i>19 49 & 50</i>	<i>jg</i>
<i>07/15/2010</i>	<i>Added Electronic Remittance Advice (ERA) to Special Instructions for Medicare SPR Date field, to Electronic Medicare Crossover Claims and to Medicare Denied Services in Late Bill Override Date section</i>	<i>23 46</i>	<i>jg</i>
<i>08/30/2011</i>	<i>Deleted CFMC information and added ColoradoPAR fax number and address</i>	<i>8</i>	<i>crc</i>
<i>09/13/2011</i>	<i>Updated Par Reference Table to reflect changes to PAR form</i>		<i>vr</i>
<i>09/15/2011</i>	<i>Updated PAR Form Examples</i>		<i>jg</i>
<i>12/06/2011</i>	<i>Replaced 997 and 999 Replaced wpc-edi.com/hipaa with wpc-edi.com/Replaced Implementation Guide with Technical Report 3 (TR3)</i>	<i>5 3 3</i>	<i>ss</i>
<i>05/18/2012</i>	<i>Redrafted Manual Removed all Speech Therapy references Added in contact information, etc for ColoradoPAR</i>	<i>Throughout</i>	<i>akb</i>
<i>10/01/2012</i>	<i>Updated Global information such as Electronic Claim Submission and LBOD</i>	<i>3 54</i>	<i>vr</i>
<i>10/01/2012</i>	<i>Reformatted Updated TOC</i>	<i>All i</i>	<i>jg</i>
<i>10/03/2012</i>	<i>Reformatted</i>	<i>All</i>	<i>jg</i>

Revision Date	Additions/Changes	Pages	Made by
	<i>Updated TOC</i>	<i>i</i>	
<i>02/7/2014</i>	<i>Significant changes throughout. Added Habilitation Therapy content.</i>	<i>All</i>	<i>as</i>
<i>02/27/2014</i>	<i>UB-04 Paper Claim Reference Table Update: 17- Added discharge status of 65, 66, 70 18-28- Added condition codes 42, 44, 51; Added special program indicator AA, AB, AD, AI Removed A7 and A8 35-63- Added 74 and 75 39-41- Added value code/amount 30 Added FC to enter amount paid by client 42- Removed 0134 from psychiatric step down 44- Added zero to HCPCS</i>	<i>34-35 36 37 37 39 40 40 40 42-43</i>	<i>cc</i>
<i>02/07/2014</i>	<i>Updated TOC Formatted Updated PAR Examples Updated Claim Examples</i>	<i>i Throughout 12 & 13 46 & 47</i>	<i>jg</i>
<i>5/21/2014</i>	<i>Added modifier language to service limitations and PARs</i>	<i>6 & 7</i>	<i>As</i>
<i>8/22/14</i>	<i>Replaced all CO 1500 references with CMS 1500</i>	<i>Throughout</i>	<i>ZS</i>
<i>8/22/14</i>	<i>Updated Professional Claim Billing Instructions section with CMS 1500 information.</i>		<i>ZS</i>
<i>8/22/14</i>	<i>Replaced all CO 1500 references with CMS 1500</i>	<i>Throughout</i>	<i>ZS</i>
<i>8/25/14</i>	<i>Updated all weblinks for the Department's new website</i>	<i>Throughout</i>	<i>MM</i>
<i>8/29/14</i>	<i>Add Early Intervention PT/OT information per policy</i>	<i>1, 7 - 9</i>	<i>MM</i>
<i>12/08/14</i>	<i>Removed Appendix H information, added Timely Filing document information</i>	<i>51</i>	<i>mc</i>
<i>12/29/14</i>	<i>Added 2015 HCPCS: 97607 and 97608</i>	<i>7</i>	<i>mc</i>
<i>12/29/14</i>	<i>Changed "client" to "member"</i>	<i>throughout</i>	<i>mc</i>

Revision Date	Additions/Changes	Pages	Made by
<i>12/29/14</i>	<i>Updated TOC</i>	<i>1</i>	<i>bl</i>
<i>7/20/15</i>	<i>Thorough revision and addition of content, added proc code table</i>	<i>throughout</i>	<i>AW</i>
<i>8/3/15</i>	<i>Reviewed for publications formatting, changed client to member, changed to Tahoma font.</i>	<i>Throughout</i>	<i>JH</i>
<i>08/05/2015</i>	<i>Accepted changes, removed blank spacing, minor formatting</i>	<i>Throughout</i>	<i>Bl</i>
<i>8/31/15</i>	<i>Reviewed for ICD-10, removed ICD-9. Reviewed for mentions of CareWebQI and replaced with ColoradoPAR.com. Removed APS and changed the phone numbers for eQH.</i>	<i>Throughout Throughout 11</i>	<i>JH</i>
<i>09/09/2015</i>	<i>Accepted changes and updated TOC</i>	<i>Throughout</i>	<i>bl</i>
<i>9/22/2015</i>	<i>Clarified PT supervision authority</i>	<i>2</i>	<i>AW</i>
<i>09/28/2015</i>	<i>Accepted changes and updated TOC</i>	<i>Throughout</i>	<i>Bl</i>
<i>2/4/2016</i>	<i>Updated assistive technology assessment policy to indicate speech therapists can provide it; included guidance on OPR regulations</i>	<i>4, 11</i>	<i>AW</i>
<i>5/11/2016</i>	<i>Updated info on coverage and benefit limitations</i>	<i>12-16</i>	<i>AW</i>
<i>07/12/2016</i>	<i>Clarified which eval codes do not hit against the 48 unit limit</i>	<i>12</i>	<i>AW</i>

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.