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

Provider Qualifications

Providers must be enrolled as a Health First Colorado (Colorado's Medicaid Program) provider in order to:

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

Licensed physical therapists (PTs) and registered occupational therapists (OTs) 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.

- PTAs cannot enroll with Health First Colorado and cannot place any identifying number on a claim form. Therefore, the supervising therapist's NPI number must be used as the **rendering provider number** on the claim form for services rendered by the assistant. Medical records must still indicate the assistant performed the services.

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.

- OTAs cannot enroll with Health First Colorado and cannot place any identifying number on a claim form. Therefore, the supervising therapist's NPI number must be used as the **rendering provider number** on the claim form for services rendered by the assistant. Medical records must still indicate the assistant performed the services.

Therapy may also be rendered by licensed and enrolled physicians, physician assistants, and advanced practice nurses as allowed by their respective scopes of practice.

All providers must submit a completed provider enrollment to become a Health First Colorado provider. Providers will find enrollment information on the Provider Revalidation & Enrollment web page.

General Benefit Policies

Physical and occupational therapists not employed by an agency, clinic, hospital, or physician may bill Health First Colorado directly, otherwise it is the employer who bills directly for the services. 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. An approved 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.
        i. Community Centered Boards may have their NPI listed as the referring NPI for IFSP-ordered early intervention services.

    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 Health First Colorado (42 CFR §455.410), in accordance with Program Rule 8.125.7.D. OPR Providers can begin enrollment on Health First Colorado'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 Health First Colorado as participating providers and who submit claims to Health First Colorado 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. Health First Colorado 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 Health First Colorado 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. Therapies provided as part of a member's individualized education program (IEP) by a therapist in the school setting are not separately reimbursable. These services are paid for by the school district which is reimbursed by the Department. Providers may not submit claims for services performed in the school setting. Refer to the School Health Services Program web page for details.

Payment for Covered Services

1. 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.
2. Members 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 additional services are non-covered.

Medically Necessary

Outpatient physical and occupational therapy services must be medically necessary to qualify for Health First Colorado reimbursement. Medical necessity (10 CCR 2505-10 8.076.1.8) means a Medical Assistance program good or service:

a. 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, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all.

b. Is provided in accordance with generally accepted professional standards for health care in the United States;

c. Is clinically appropriate in terms of type, frequency, extent, site, and duration;

d. Is not primarily for the economic benefit of the provider or primarily for the convenience of the member, caretaker, or provider;

e. Is delivered in the most appropriate setting(s) required by the member's condition;

f. Is not experimental or investigational; and

g. Is not more costly than other equally effective treatment options.

Documentation Requirements

Rendering providers must document all evaluations, re-evaluations, services provided, member progress, attendance records, and discharge plans. All documentation must be kept in the member's records along with a copy of the referral or prescribing provider's order. Documentation must support both the medical necessity of services and the need for the level of skill provided. Rendering providers must copy the member's primary care provider (PCP), prescribing provider and/or medical home on all relevant records.

All documentation must include the following:

1. The member's name and date of birth
2. The date and type of service provided to the member
3. A description of each service provided during the encounter including procedure codes and time spent on each (including start and stop times)
4. The total duration of the encounter
5. The name or names and titles of the persons providing each service and the name and title of the therapist supervising or directing the services.

Health first Colorado requires the following types of documentation as a record of services provided within an episode of care: initial evaluation, re-evaluation, visit/encounter notes and a discharge summary.

Initial Evaluation

Written documentation of the initial evaluation must include the following:

1. **Referral Information:** Reason for referral and referral source.

2. **History:** Must include diagnoses pertinent to the reason for referral, including date of onset; cognitive, emotional, and/or physical loss necessitating referral, and the date of onset, if different from the onset of the relevant diagnoses; current functional limitation or disability as a result of the above loss, and the onset of the disability; pre-morbid functional status, including any pre-existing loss or disabilities; review of available test results; review of previous therapies/interventions for the presenting diagnoses, and the functional changes (or lack thereof) as a result of previous therapies or interventions.

3. **Assessment:** The assessment section must include a summary of the member's impairments, functional limitations and disabilities, based on a synthesis of all data/findings gathered from the evaluation procedures. Pertinent factors which influence the treatment diagnosis and prognosis must be highlighted, and the inter-relationship between the diagnoses and disabilities for which the referral was made must be discussed.

4. **Plan of Care:** A detailed Plan of Care must be included in the documentation of an initial evaluation. This care plan must include the following:

    a. Specific treatment goals for the entire episode of care which are functionally-based and objectively measured
    b. Proposed interventions/treatments to be provided during the episode of care
    c. Proposed duration and frequency of services to be provided
    d. Estimated duration of episode of care.

- An episode of outpatient therapy is defined as the period of time from the first day the member is under the care of the clinician for the current condition(s) being treated by one therapy discipline until the last date of service for that plan of care for that discipline in that setting.

- The therapist's plan of care must be reviewed, revised if necessary, and signed, as medically necessary by the member's physician, or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law at least once every 90 days.

- The care plan may not cover more than a 90-day period or the time frame documented in the approved IFSP.

- A plan of care must be certified. Certification is the physician's, physician's assistant or nurse practitioner's approval of the plan of care. Certification requires a dated signature on the plan of care or some other document that indicates approval of the plan of care. If the service is a Medicare covered service and is provided to a member who is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare.

Re-Evaluation

A re-evaluation must occur whenever there is an unanticipated change in the member's status, a failure to respond to interventions as expected or there is a need for a new plan of care based on new problems and goals requiring a significant modification of treatment plan. The documentation for a re-evaluation need not be as comprehensive as the initial evaluation, but must include at least the following:

1. Reason for re-evaluation
2. Member's health and functional status reflecting any changes
3. Findings from any repeated or new examination elements
4. Changes to plan of care

Visit/Encounter Notes

Written documentation of each encounter must be in the member's record of service. These visit notes document the implementation of the plan of care established by the therapist at the initial evaluation. Each visit note must include the following:

1. The total duration of the encounter
2. The type and scope of treatment provided, including procedure codes and modifiers used.
3. The time spent providing each service, including start and stop times. The number of units billed/requested must match the documentation.
4. Identification of the short or long-term goals being addressed during the encounter.

Colorado Medicaid requires that documentation follow the Subjective, Objective, Assessment and Plan (SOAP) format. In addition to the above required information, the visit note must include:

1. A subjective element which includes the reason for the visit, the member/caregiver's report of current status relative to treatment goals, and any changes in member's status since the last visit;
2. An objective element which includes the practitioner's findings, including abnormal and pertinent normal findings from any procedures or tests performed;
3. An assessment component which includes the practitioner's assessment of the member's response to interventions provided, specific progress made toward treatment goals, and any factors affecting the intervention or progression of goals, and
4. A plan component which states the plan for next visit(s).

Discharge Summary

At the conclusion of therapy services, a discharge summary must be included in the documentation of the final visit in an episode of care. This must include the following:

1. Highlights of a member's progress or lack of progress towards treatment goals.
2. Summary of the outcome of services provided during the episode of care.

Covered Services

Physical and Occupational Therapy services are covered if they are medically necessary as defined in 10 CCR 2505-10 Section 8.076.1.8 and meet the following criteria:

1. Treatment services must be ordered by an eligible prescribing provider (Physician, Physician Assistant, or Advanced Practice Nurse), and be started within 28 days of the date ordered.

2. Therapy services must be provided under a written treatment plan stating with specificity the member's condition, functional level, treatment objectives, the physicians order, plans for continuing care, modifications to the plan, and the plans for discharge from treatment.
3. In a manner consistent with accepted standards of medical practice, the service is found to be equally effective for a diagnosis or treatment compared to other less conservative or more costly treatment options.
4. The service has a base of evidence (including peer-reviewed literature and/or clinical experience and judgment) to support the clinical reasoning and selection of interventions.
5. The service is consistent with the member's confirmed diagnosis, and not in excess of the member's needs.

Non-Covered Services

1. A member may receive outpatient physical therapy and occupational therapy services during the same period and service dates; however, duplicate therapy (the same therapy performed by both an OT and PT) may not be performed on the same dates of service. Duplicated services (in general, and those overlapped between PTs and OTs) are not covered.
2. Art and craft activities for the purposes of recreation are not covered.
3. Hippotherapy/equine therapy is not covered.
4. Services which are experimental, investigational, or are provided as part of a clinical trial are not covered.
5. Supplies or pre-fabricated supplies that can be obtained from a medical supplier are not covered.
6. Services for conditions of chronic pain that do not interfere with the member's functional status and that can be treated by routine nursing measures are not covered.
7. Services not documented in the member's health care record are not covered.
8. Services not part of the member's plan of care are not covered.
9. Services specified in a plan of care that is **not** reviewed and revised as medically necessary by the member's physician (M.D. or D.O.), physician's assistant, nurse practitioner, or specified in an approved Individualized Family Service Plan (IFSP) for Early Intervention PT/OT are not covered.
10. A therapeutic service that is denied Medicare payment because of the provider's failure to comply with Medicare requirements is not covered.
11. Vocational or educational services, except as provided under IEP-related or waiver services are not covered.
12. Psychosocial services are not covered.
13. Educational, personal need and comfort therapies are not covered.
14. Record keeping documentation and travel time (the transport and waiting time of a member to and from therapy sessions) is not reimbursable.
15. Time spent for preparation, report writing, processing of claims, or documentation regarding billing or service provision is not reimbursable.

Rehabilitative and Habilitative Therapy Definitions

Health First Colorado covers both rehabilitative and habilitative therapies for all age groups in accordance with the Affordable Care Act *Essential Health Benefit* provisions.

The Colorado Division of Insurance defined Habilitative services to be:

> 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 benchmark plan. Parity in this context means of like type and substantially equivalent in scope, amount, and duration.

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 categorized as an Inpatient or Home Health benefit. 'Acute' and 'Long-term' therapies remain benefits per Home Health coverage.
- Habilitative therapies are not a benefit if provided in nursing facilities; Rehabilitative PT/OT remain benefits in that setting.
- Habilitative therapies should 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:

1. Must have a current prescription/referral for an Assistive Technology Assessment from the member's primary care physician.
2. May indicate up to one year duration.
3. May indicate initial/new assessments or follow-up assessment visits.
4. Only one active PAR for 97755 is allowed per member, per span of time. Overlapping 97755 PAR requests will be denied.
5. Initial PT/OT evaluation services, such as 97161, are not required prior to requesting 97755.
6. 97755 is separate from PT/OT and is not part of the PT/OT benefit limitation.
7. 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

1. 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. Some specific daily limits per procedure code apply.
    a. Providers are required to consult the American Medical Association's (AMA) Current Procedural Terminology (CPT) manual for each coded service. Some codes represent a treatment session without regard to its length of time (one unit maximum) while other codes may be billed incrementally as "timed" units.
2. Members may receive up to 48 units of any combination of PT/OT services per rolling 12-month period before a Prior Authorization Request (PAR) is required. **Evaluation and orthotic services are not included in this limit.** This equates to roughly 12 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.
3. Units of service exceeding the initial 48 units are not covered without an approved PAR.
4. The 12-month period begins when therapy is initiated. The unit limit does not roll-over to accumulate more than 48 available units in a 12-month period. Units are continually available until the limit of 48 has been reached in a 12-month period.
5. Units decrement from paid units for a specific member, regardless of provider, 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.

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 website for NCCI edits, for a complete list of impacted codes, guidance on bypass modifier use, and general information.

Coding Tables

Eligible Place of Service Codes

The following place of service codes are allowed:

Place of Service (POS) Code	Description
11	Office
12	Home
62	Comprehensive Outpatient Rehabilitation Facility

- Therapy services provided at an Outpatient Hospital are reported on the institutional claim type and are reimbursed as part of the hospital's EAPG payment. Institutional claim types do not have the POS code field.
- Therapy services provided at a Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) are billed as part of the encounter rate for the center. They must not be billed separately on professional claims.

Required Billing and PAR Modifiers

Outpatient Therapy Type	Modifier 1	Modifier 2 (DOS on/before 12/31/2017)	Modifier 2 (DOS on/after 1/1/2018)
Rehabilitative Physical Therapy	GP	-	97
Rehabilitative Occupational Therapy	GO	-	97
Habilitative Physical Therapy	GP	SZ	96
Habilitative Occupational Therapy	GO	SZ	96
Early Intervention Physical Therapy	GP	TL	TL
Early Intervention Occupational Therapy	GO	TL	TL

Eligible Outpatient PT/OT 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.

- 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.
- Report procedure codes 97001, 97002, 97003, 97004 for evaluation services performed prior to 12/31/2016. Report procedure codes 97161-97168 for evaluation services performed on/after 1/1/2017.
- NCCI MUE edits stipulate maximum daily units for each code. Reference the NCCI website for further information.
- Providers should reference official AMA CPT resources for full descriptions of codes and instruction for proper use.

Table updated: April 2018

Procedure Code	Provider Type	Prior Authorization Required	Comments
92526	OT	Sometimes	
90911	PT	No	Within physical therapist scope of practice
97010	PT, OT	Sometimes	
97012	PT, OT	Sometimes	
97014	PT, OT	Sometimes	
97016	PT, OT	Sometimes	
97018	PT, OT	Sometimes	
97022	PT, OT	Sometimes	
97024	PT, OT	Sometimes	
97026	PT, OT	Sometimes	
97028	PT, OT	Sometimes	
97032	PT, OT	Sometimes	
97033	PT, OT	Sometimes	
97034	PT, OT	Sometimes	
97035	PT, OT	Sometimes	
97036	PT, OT	Sometimes	
97110	PT, OT	Sometimes	
97112	PT, OT	Sometimes	
97113	PT, OT	Sometimes	
97116	PT, OT	Sometimes	
97124	PT, OT	Sometimes	
97127	-	-	Not covered. See G0515.

97140	PT, OT	Sometimes	
97150	PT, OT	Sometimes	
97161	PT	No	
97162	PT	No	
97163	PT	No	
97164	PT	No	
97165	OT	No	
97166	OT	No	
97167	OT	No	
97168	OT	No	
97530	PT, OT	Sometimes	
97532	PT, OT	Sometimes	Closed 12/31/17. Replaced by G0515.
G0515	PT, OT	Sometimes	Effective 1/1/18. Replaced 97532.
97533	PT, OT	Sometimes	
97535	PT, OT	Sometimes	
97537	PT, OT	Sometimes	
97542	PT, OT	Sometimes	
97545	PT, OT	Sometimes	
97546	PT, OT	Sometimes	
97597	PT, OT	No	
97598	PT, OT	No	
97602	PT, OT	No	
97750	PT, OT	No	
97755	PT, OT	Always	
97760	PT, OT	Sometimes	
97761	PT, OT	Sometimes	
97762	PT, OT	Sometimes	
L1902	PT, OT	No	
L1960	PT, OT	No	
L3730	PT, OT	No	
L3763	PT, OT	No	
L3764	PT, OT	No	
L3808	PT, OT	No	
L3900	PT, OT	No	
L3906	PT, OT	No	
L3908	PT, OT	No	
L3912	PT, OT	No	
L3919	PT, OT	No	
L3923	PT, OT	No	
L3925	PT, OT	No	
L3929	PT, OT	No	
L3933	PT, OT	No	

L3982	PT, OT	No	
Q4040	PT, OT	No	
Q4048	PT, OT	No	

For further billing information on the above orthotic/prosthetic codes, please refer to the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) provider billing manual.

Prior Authorization Requests (PARs)

Providers must submit PARs for medically necessary services when services will exceed 48 units of service per 12-month period.

PARs are approved for up to a 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.
- Only one PAR for Early Intervention outpatient PT/OT may be active at a time.
- A maximum of one PAR for Early Intervention outpatient PT/OT and one PAR for non-Early Intervention outpatient PT/OT may be active at any time for children ages 0 – 3.
- Overlapping Early Intervention and non-Early Intervention outpatient PT/OT PARs will only be accepted if the treatment plans associated with each meet different goals and use different treatments.
- 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. 97110+GP). CPT codes for OT services must have the GO modifier (e.g. 97110+GO).
- When submitting Habilitative Therapy PARs, and subsequent claims, CPT codes for PT services must have the GP modifier and HB modifier (e.g. 97110+GP+SZ). CPT codes for OT services must have the GO modifier and HB modifier (e.g. 97110+GO+SZ).
- 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 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 necessity for the course and duration of treatment being requested.
- Assessment or progress notes submitted for documentation, must not be more than 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 Health First Colorado provider number of the independent therapist must be present in PAR field #28.
- The billing provider's Health First Colorado 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 Online Provider 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.

If the PAR is denied, providers should direct inquiries to the authorizing agency, which can be found on the Provider Contacts web page.

Billing Information

Refer to the General Provider Information manual for general billing information.

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.

Occupational Therapy PAR Form Example

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND FINANCING

MEDICAID PRIOR AUTHORIZATION REQUEST (PAR)

To avoid delay, please answer all questions completely.

INVOICE/PAT. ACCOUNT NUMBER

DOES CLIENT HAVE PRIMARY INSURANCE? ☐ YES ☐ NO

1. CLIENT NAME (Last, First, Middle Initial)	2. CLIENT IDENTIFICATION NUMBER	3. SEX	4. DATE OF BIRTH (MMDDYYYY)
Doe, Jane A	Y123456	☐M ☒F	01/04/2006

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

7. PRIOR AUTHORIZATION NUMBER * SYSTEM ASSIGNED	8. DATES COVERED BY THIS REQUEST FROM (MMDDYYYY)	THROUGH (MMDDYYYY)	9. DOES CLIENT RESIDE IN A NURSING FACILITY?	10. GROUP HOME NAME - IF PATIENT RESIDES IN A GROUP HOME
	02/06/2013	02/06/2014	☐ YES ☒ NO	

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

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

14. ESTIMATED COST OF EQUIPMENT

SERVICES TO BE AUTHORIZED

15. LINE NO.	16. DESCRIBE THE PROCEDURE OR SUPPLY TO BE PROVIDED — INCLUDE MODEL NUMBER FOR DME PURCHASE OR SERIAL NUMBER FOR REPAIR	17. PROCEDURE OR SUPPLY CODE	18. REQUESTED NUMBER OF SERVICES	19. AUTHORIZED NO. OF SERVICES (* LEAVE BLANK *)	20. APPROVED/DENIED (* LEAVE BLANK *)
01	OT Evaluation	97003-GO	1		
02	OT Treatment	97033-GO	140		
03					
04					
05					

21. PRIMARY CARE PHYSICIAN (PCP) NAME	22. PRIMARY CARE PHYSICIAN ADDRESS (Street, City, State, ZIP code)
TELEPHONE NUMBER / 23. PCP PROVIDER NUMBER	

24. NAME AND ADDRESS OF PHYSICIAN REFFERRING FOR PRIOR AUTHORIZATION	25. NAME AND ADDRESS OF PROVIDER WHO WILL BILL SERVICE
26. REQUESTING PHYSICIAN SIGNATURE / 27. DATE SIGNED	
TELEPHONE NUMBER / 28. REQUESTING PHYSICIAN PROVIDER NUMBER	TELEPHONE NUMBER / 29. BILLING PROVIDER NUMBER

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

30. COMMENTS

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

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

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

FORM NO. 10013
(REV. 0811)
COL — 106

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.

Reference the Electronic Claims section of the General Provider Information manual for more information on electronic billing.

CMS Field #	Field Label	Field is?	Instructions
1	**Insurance Type**	Required	Place an "X" in the box marked as Medicaid.
1a	**Insured's ID Number**	Required	Enter the member's Health First Colorado seven-digit Medicaid ID number as it appears on the Medicaid Identification card. Example: A123456.
2	**Patient's Name**	Required	Enter the member's last name, first name, and middle initial.
3	**Patient's Date of Birth / Sex**	Required	Enter the 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 member is covered by a **Medicare** health insurance policy. Enter the insured's policy number as it appears on the ID card. Only complete if field 4 is completed.

CMS Field #	Field Label	Field is?	Instructions
11a	**Insured's Date of Birth, Sex**	Conditional	Complete if the member is covered by a **Medicare** health insurance policy. Enter the insured's birth date using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. Place an "X" in the appropriate box to indicate the sex of the insured.
11b	**Other Claim ID**	Not Required	
11c	**Insurance Plan Name or Program Name**	Not Required	
11d	**Is there another Health Benefit Plan?**	Conditional	When appropriate, place an "X" in the correct box. If marked "YES", complete 9, 9a and 9d.
12	**Patient's or Authorized Person's signature**	Required	Enter "Signature on File", "SOF", or legal signature. If there is no signature on file, leave blank or enter "No Signature on File". Enter the date the claim form was signed.
13	**Insured's or Authorized Person's Signature**	Not Required	
14	**Date of Current Illness Injury or Pregnancy**	Conditional	Complete if information is known. Enter the date of illness, injury or pregnancy, (date of the last menstrual period) using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. Enter the applicable qualifier to identify which date is being reported 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period

CMS Field #	Field Label	Field is?	Instructions
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	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.
18	**Hospitalization Dates Related to Current Service**	Conditional	Complete for services provided in an inpatient hospital setting. Enter the date of hospital admission and the date of discharge using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. If the member is still hospitalized, the discharge date may be omitted. This information is not edited.
19	**Additional Claim Information**	Not Required	
20	**Outside Lab?** **$ Charges**	Conditional	Complete if **all** laboratory work was referred to and performed by an outside laboratory. If this box is checked, no payment will be made to the physician for lab services. Do not complete this field if **any** laboratory work was performed in the office.

CMS Field #	Field Label	Field is?	Instructions
			Practitioners may not request payment for services performed by an independent or hospital laboratory.
21	**Diagnosis or Nature of Illness or Injury**	Required	Enter at least one but no more than 12 diagnosis codes based on the member's diagnosis/condition. Enter applicable ICD indicator to identify which version of ICD codes is being reported. 0 ICD-10-CM (DOS 10/1/15 and after) 9 ICD-9-CM (DOS 9/30/15 and before)
22	**Medicaid Resubmission Code**	Conditional	List the original reference number for adjusted claims. When resubmitting a claim as a replacement or a void, enter the appropriate bill frequency code in the left-hand side of the field. 7 Replacement of prior claim 8 Void/Cancel of prior claim This field is not intended for use for original claim submissions.
23	Prior Authorization	Conditional	**CLIA** When applicable, enter the word "CLIA" followed by the number. **Prior Authorization** Enter the six-character prior authorization number from the approved Prior Authorization Request (PAR). Do not combine services from more than one approved PAR on a single claim form. Do not attach a copy of the approved PAR unless advised to do so by the authorizing agent or the fiscal agent.
24	**Claim Line Detail**	Information	The paper claim form allows entry of up to six detailed billing lines. Fields 24A through 24J apply to each billed line.

CMS Field #	Field Label	Field is?	Instructions
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 From To **01 01 16** | | | | | | Or From To **01 01 16 01 01 16** Span dates of service From To **01 01 16 01 31 16** Single Date of Service: Enter the six-digit date of service in the "From" field. Completion of the "To field is not required. Do not spread the date entry across the two fields. Span billing: Permissible if the same service (same procedure code) is provided on consecutive dates. **Supplemental Qualifier** To enter supplemental information, begin at 24A by entering the qualifier and then the information. ZZ Narrative description of unspecified code

CMS Field #	Field Label	Field is?	Instructions
			VP Vendor Product Number OZ Product Number CTR Contract Rate JP Universal/National Tooth Designation JO Dentistry Designation System for Tooth & Areas of Oral Cavity
24B	Place of Service	Required	Enter the Place of Service (POS) code that describes the location where services were rendered. Health First Colorado accepts the CMS place of service codes. *See manual's section on eligible place of service code*

CMS Field #	Field Label	Field is?	Instructions
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). Only approved codes from the current CPT or HCPCS publications will be accepted.
24D	**Modifier**	Conditional	Enter the appropriate procedure-related modifier that applies to the billed service. Up to four modifiers may be entered when using the paper claim form. *See manual's section on required billing modifiers.*

CMS Field #	Field Label	Field is?	Instructions
24E	**Diagnosis Pointer**	Required	Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis. At least one diagnosis code reference letter must be entered. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. This field allows for the entry of 4 characters in the unshaded area.
24F	**$ Charges**	Required	Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number. Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one procedure from the same group is billed, special multiple pricing rules apply. The base procedure is the procedure with the highest allowable amount. The base code is used to determine the allowable amounts for additional CPT surgical procedures when more than one procedure from the same grouping is performed. Submitted charges cannot be more than charges made to non-Health First Colorado covered individuals for the same service. Do not deduct Health First Colorado co-payment or commercial insurance payments from the usual and customary charges.

CMS Field #	Field Label	Field is?	Instructions
24G	**Days or Units**	Required	Enter the number of services provided for each procedure code. Enter whole numbers only- do not enter fractions or decimals.
24H	**EPSDT/Family Plan**	Conditional	**EPSDT** (shaded area) For Early & Periodic Screening, Diagnosis, and Treatment related services, enter the response in the shaded portion of the field as follows: AV Available- Not Used S2 Under Treatment ST New Service Requested NU Not Used **Family Planning** (unshaded area) If the service is Family Planning, enter "Y" for YES or "N" for NO in the bottom, unshaded area of the field**.**
24I	**ID Qualifier**	Not Required	
24J	**Rendering Provider ID #**	Required	In the shaded portion of the field, enter the NPI of the Health First Colorado provider assigned to the **individual** who actually performed or rendered the billed service. This number cannot be assigned to a group or clinic.
25		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 Remittance Advice (RA).
27	**Accept Assignment?**	Required	The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.

CMS Field #	Field Label	Field is?	Instructions
28	**Total Charge**	Required	Enter the sum of all charges listed in field 24F. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
29	**Amount Paid**	Conditional	Enter the total amount paid by Medicare or any other commercial health insurance that has made payment on the billed services. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
30	**Rsvd for NUCC Use**		
31	**Signature of Physician or Supplier Including Degrees or Credentials**	Required	Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent. A holographic signature stamp may be used **if** authorization for the stamp is on file with the fiscal agent. An authorized agent or representative may sign the claim for the enrolled provider **if** the name and signature of the agent is on file with the fiscal agent. Each claim must have the date the enrolled provider or registered authorized agent signed the claim form. Enter the date the claim was signed using two digits for the month, two digits for the date and two digits for the year. Example: 070116 for July 1, 2016. **Unacceptable signature alternatives:** Claim preparation personnel may not sign the enrolled provider's name. Initials are not acceptable as a signature. Typed or computer printed names are not acceptable as a signature.

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

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 Health First Colorado 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 Health First Colorado 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 Health First Colorado. The appropriate code values listed in this manual must be used when billing Health First Colorado.

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 Zip Code Abbreviate the state using standard post office abbreviations. Enter the telephone number.
2. Pay-to Name, Address, City, State	Text	Required if different from FL 1. Enter the provider or agency name and complete mailing address of the provider who will receive payment for the services: Street/Post Office box City State Zip Code Abbreviate the state using standard post office abbreviations. Enter the telephone number.
3a. Patient Control Number	Up to 20 characters: Letters, numbers or hyphens	Optional Enter information that identifies the member or claim in the provider's billing system. Submitted information appears on the Remittance Advice (RA).
3b. Medical Record Number	17 digits	Optional Enter the number assigned to the patient to assist in retrieval of medical records.

Form Locator and Label	Completion Format	Instructions
4. Type of Bill	3 digits	Required 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): Digit 1 — Type of Facility 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 6 — Intermediate Care 7 — Clinic (Rural Health/FQHC/Dialysis Center) 8 — Special Facility (Hospice, RTCs) Digit 2 — Bill Classification (Except clinics & special facilities): 1 — Inpatient (Including Medicare Part A) 2 — Inpatient (Medicare Part B only) 3 — Outpatient 4 — Other (for hospital referenced diagnostic services or home health not under a plan of treatment) 5 — Intermediate Care Level I 6 — Intermediate Care Level II 7 — Sub-Acute Inpatient (revenue code 19X required with this bill type)

Form Locator and Label	Completion Format	Instructions
4. Type of Bill (continued)	3 digits	Required 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): Digit 2 — Bill Classification (Except clinics & special facilities): 8 Swing Beds 9 Other Digit 2 — Bill Classification (Clinics Only): 1 Rural Health/FQHC 2 Hospital Based or Independent Renal Dialysis Center 3 Freestanding 4 Outpatient Rehabilitation Facility (ORF) 5 Comprehensive Outpatient Rehabilitation Facilities (CORFs) 6 Community Mental Health Center Digit 2 — Bill Classification (Special Facilities Only): 1 Hospice (Non-Hospital Based) 2 Hospice (Hospital Based) 3 Ambulatory Surgery Center 4 Freestanding Birthing Center 5 Critical Access Hospital 6 Residential Facility Digit 3 — Frequency: 0 Non-Payment/Zero Claim 1 Admit through discharge claim 2 Interim - First claim

Form Locator and Label	Completion Format	Instructions
		3 Interim - Continuous claim 4 Interim - Last claim 7 Replacement of prior claim 8 Void of prior claim
5. Federal Tax Number	None	Not required Submitted information is not entered into the claim processing system.
6. Statement Covers Period – From / Through	From: 6 digits MMDDYY Through: 6 digits MMDDYY	Required (**Note:** OP claims cannot span over a month's end) Enter the From (beginning) date and Through (ending) date of service covered by this bill using MMDDYY format. Example: January 1, 2016 = 0101016 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.

8a. Patient Identifier		Not required Submitted information is not entered into the claim processing system.
8b. Patient Name	Up to 25 characters: Letters & spaces	Required Enter the member's last name, first name and middle initial.
9a. Patient Address – Street	Characters Letters & numbers	Required Enter the member's street/post office box as determined at the time of admission.
9b. Patient Address – City	Text	Required Enter the member's city as determined at the time of admission.
9c. Patient Address – State	Text	Required Enter the member's state as determined at the time of admission.
9d. Patient Address – Zip	Digits	Required Enter the member's zip code as determined at the time of admission.
9e. Patient Address – Country Code	Digits	Optional
10. Birthdate	8 digits (MMDDCC YY)	Required Enter the member's birthdate using two digits for the month, two digits for the date, and four digits for the year (MMDDCCYY format). Example:
11. Patient Sex	1 letter	Required Enter an M (male) or F (female) to indicate the member's sex.

12. Admission Date	6 digits	Conditional Required for observation holding beds only
13. Admission Hour	6 digits	Conditional Required for observation holding beds only

14. Admission Type	1 digit	Required Enter the following to identify the admission priority: 1 – Emergency Member 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. **2 - Urgent** The member requires immediate attention for the care and treatment of a physical or mental disorder. **3 - Elective** **The member's condition permits adequate time to schedule the availability of accommodations.** **4 - Newborn** Required for inpatient and outpatient hospital. **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 and involving trauma activation. **Clinics** Required only for emergency visit.

Form Locator and Label	Completion Format	Instructions
15. Source of Admission	1 digit	Required 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). 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 **Newborns** 1 Normal Delivery 2 Premature Delivery 3 Sick Baby 4 Extramural Birth (Birth in a non-sterile environment)
16. Discharge Hour	2 digits	Not Required Enter the hour the member was discharged from inpatient hospital care. Use the same coding used in FL 13 (Admission Hr.)

Form Locator and Label	Completion Format	Instructions
17. Patient Discharge Status	2 digits	Conditional Enter patient status as of discharge date. 01 Discharged to Home or Self Care (Dialysis is limited to code 01) 02 Discharged/transferred to another short-term hospital
17. Patient Discharge Status (continued)	2 digits	70 Discharged/Transferred to Other HC Institution 71 Discharged/transferred/referred to another institution for outpatient services 72 Discharged/transferred/referred to this institution for outpatient services Use code 02 for a PPS hospital transferring a patient to another PPS hospital. Code 05, Discharged to Another Type Institution, is the most appropriate code to use for a PPS hospital transferring a patient to an exempt hospital. **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. Interim bills may be submitted for Prospective Payment System (PPS)-DRG claims but must meet specific billing requirements For exempt hospitals use the appropriate code from the codes listed. Note: Refer to the "Interim" billing instruction in this section of the manual.

Form Locator and Label	Completion Format	Instructions
18-28. Condition Codes	2 Digits	Conditional Complete with as many codes necessary to identify conditions related to this bill that may affect payer processing. Condition Codes 1 Military service related 2 Employment related 4 HMO enrollee 5 Lien has been filed 6 ESRD patient - First 18 months entitlement 7 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

Form Locator and Label	Completion Format	Instructions
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 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

Form Locator and Label	Completion Format	Instructions
		C6 Admission preauthorization C7 Extended authorization
29. Accident State		Optional

Form Locator and Label	Completion Format	Instructions
31-34. Occurrence Code/Date	2 digits and 6 digits	Conditional 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. **Occurrence Codes:** 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 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
		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 *Other Payer occurrence codes 24 and 25 must be used when applicable. The claim must be submitted with the third-party information

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	Conditional 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. Never enter negative amounts. If a value code is entered, a dollar amount or numeric value related to the code **must** always be entered. 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 member'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 member: 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 revenue code must appear only once per date of service. If more than one of the same service is provided on the same day, combine the units 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: 114 Psychiatric Step Down 1 124 Psychiatric Step Down 2

Form Locator and Label	Completion Format	Instructions
43. Revenue Code Description	Text	Required Enter the revenue code description or abbreviated description.
44. HCPCS / Rates / HIPPS Rate Codes	5 digits	Conditional Enter only the HCPCS code for each detail line. Use approved modifiers listed in this section for hospital-based transportation services. 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: ▪ 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 HCPCS codes cannot be repeated for the same date of service. Combine the units in FL 46 (Service Units) to report multiple services.

Form Locator and Label	Completion Format	Instructions
		The following revenue codes always require a HCPCS code. Please reference the Bulletins web page for a list of physician-administered drugs that also require an NDC code. 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. 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	Required For span bills only Enter the date of service using MMDDYY format for each detail line completed. Each date of service must fall within the date span entered in the "Statement Covers Period" (FL 6). Not required for single date of service claims.

Form Locator and Label	Completion Format	Instructions
46. Service Units	3 digits	Required 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) The grand total line (Line 23) does not require a unit value. For span bills, the units of service reflect only those visits, miles or treatments provided on dates of service in FL 45.

Form Locator and Label	Completion Format	Instructions
47. Total Charges	9 digits	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.
48. Non-Covered Charges	9 digits	Conditional Enter incurred charges that are not payable by Health First Colorado. 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.
50. Payer Name	1 letter and text	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 Health First Colorado. Source Payment Codes B Workmen's Compensation C Medicare D Health First Colorado E Other Federal Program F Insurance Company G Blue Cross, including Federal Employee Program H Other - Inpatient (Part B Only) I Other Line A Primary Payer Line B Secondary Payer Line C

Form Locator and Label	Completion Format	Instructions
51. Health Plan ID	Up to 10 digits	Required Enter the provider's Health Plan ID for each payer name. Enter the Health First Colorado provider number assigned to the **billing provider**. Payment is made to the enrolled provider or agency that is assigned this number.
52. Release of Information		Not required Submitted information is not entered into the claim processing system.
53. Assignment of Benefits		Not required Submitted information is not entered into the claim processing system.
54. Prior Payments	Up to 9 digits	Conditional Complete when there are Medicare or third-party payments. Enter third party and/or Medicare payments.
55. Estimated Amount Due	Up to 9 digits	Conditional Complete when there are Medicare or third-party payments. Enter the net amount due from Health First Colorado 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.
56. National Provider Identifier (NPI)	10 digits	Required Enter the billing provider's 10-digit National Provider Identifier (NPI).
57. Other Provider ID		Not required Submitted information is not entered into the claim processing system.
58. Insured's Name	Up to 30 characters	Required Enter the member's name on the Health First Colorado line.

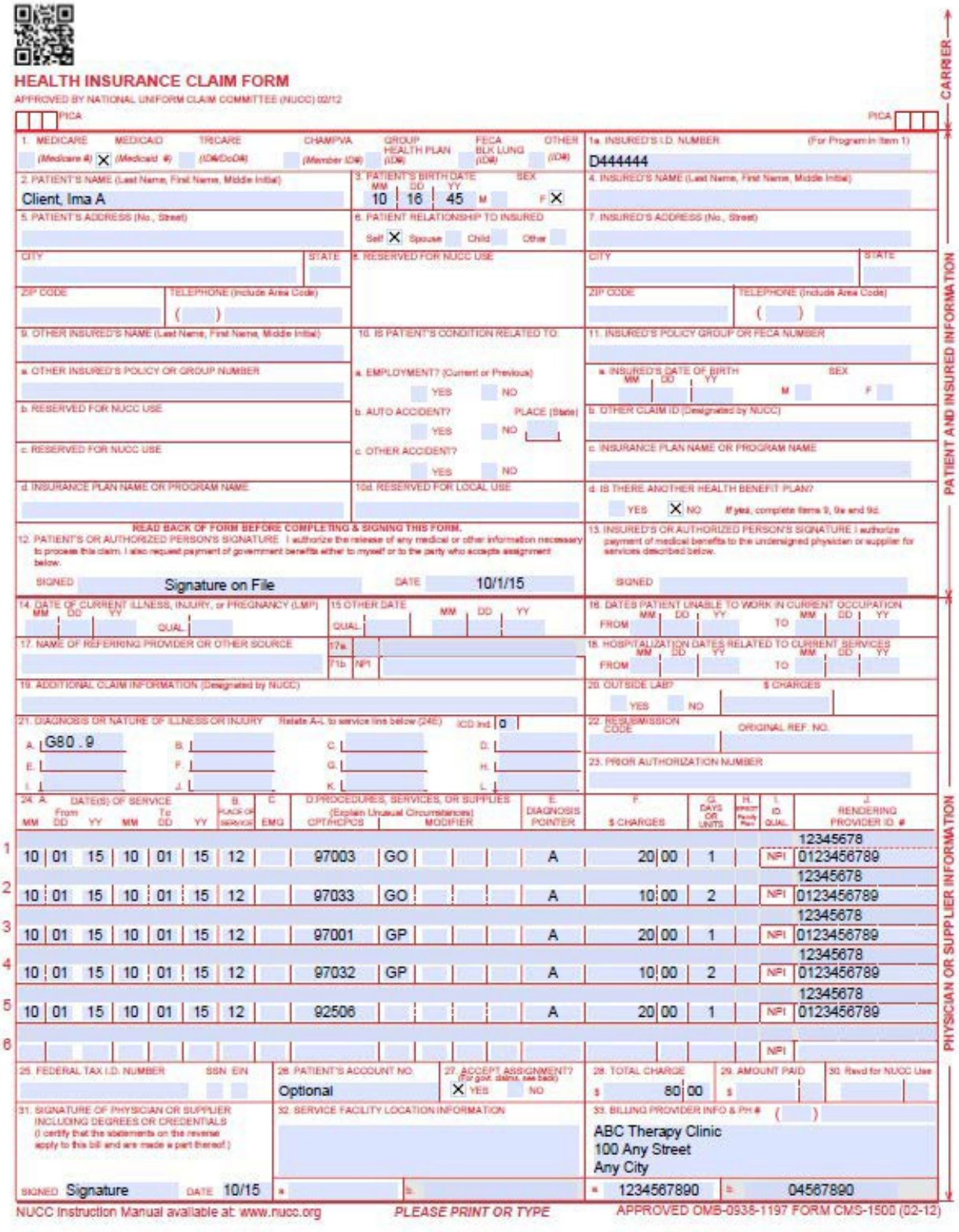
Form Locator and Label	Completion	Instructions
		Other Insurance/Medicare Complete additional lines when there is third party coverage. Enter the policyholder's last name, first name, and middle initial.
60. Insured's Unique ID	Up to 20 characters	Required Enter the insured's unique identification number 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	Conditional Complete when there are additional significant procedure codes. 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.
76.Attending **NPI – Conditional** **QUAL - Conditional** **ID - (Health First Colorado #) – Required** **Attending-Last/First Name**	NPI - 10 digits QUAL – Text Text	Health First Colorado ID Required NPI - Enter the 10-digit NPI number assigned to the physician having primary responsibility for the patient's medical care and treatment. This number is obtained from the physician and **cannot** be a clinic or group number. (If the attending physician is not enrolled in Health First Colorado or if the member leaves the ER before being seen by a physician, the hospital may enter their individual numbers.) Hospitals may enter the member's regular physician's 10-digit NPI in the Attending Physician ID form locator if the locum tenens physician is not enrolled in Health First Colorado. QUAL – Enter "1D" for Medicaid Enter the attending physician's last and first name. This form locator must be completed for all services.
77. Operating-NPI/QUAL/ID		Not required Submitted information is not entered into the claim processing system.

Form Locator and Label	Completion Format	Instructions
78-79. Other ID **NPI – Conditional** **QUAL - Conditional** **ID - (Health First Colorado #) – Conditional**	NPI - 10 digits QUAL – Text	Conditional – Complete when attending physician is not the PCP or to identify additional physicians. NPI - Enter up to two 10-digit NPI 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 NPI number as the referring physician. The name of the Health First Colorado member's PCP appears on the eligibility verification. Review either for eligibility and PCP. Health First Colorado 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.
80. Remarks	Text	Optional Enter specific additional information necessary to process the claim or fulfill reporting requirements.
81. Code-Code QUAL/CODE /VALUE (a-d)		Optional Submitted information is not entered into the claim processing system

CMS 1500 OT/PT Claim Example



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

3. PATIENT'S BIRTH DATE: 10 | 16 | 45 SEX: M | F X

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

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

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

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

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES | NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: Signature on File DATE: 10/1/15

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

SIGNED

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

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES | NO $ CHARGES

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

A. G80.9 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 01 15	10 01 15	12		97003	GO		A	20 00	1		NPI	12345678 / 0123456789
2	10 01 15	10 01 15	12		97033	GO		A	10 00	2		NPI	12345678 / 0123456789
3	10 01 15	10 01 15	12		97001	GP		A	20 00	1		NPI	12345678 / 0123456789
4	10 01 15	10 01 15	12		97032	GP		A	10 00	2		NPI	12345678 / 0123456789
5	10 01 15	10 01 15	12		92506			A	20 00	1		NPI	12345678 / 0123456789
6												NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. Optional

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

28. TOTAL CHARGE $ 80 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED Signature DATE 10/15

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

ABC Therapy Clinic
100 Any Street
Any City

a. 1234567890 b. 04567890

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

UB-04 Outpatient PT Claim Example

Field	Value
1	City Hospital 100 Saginaw St. Anytown, CO 80000 333-333-3333
4 Type of Bill	131
6 Statement Covers Period From	02/06/14
6 Statement Covers Period Through	02/06/14
8 Patient Name b	Client, Ima
9 Patient Address a	123 Main Street
9 b	Anytown
9 c	CO
9 d	80000
10 Birthdate	01/04/2006
11 Sex	F
14 Type	3
15 SRC	3

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
440	Speech therapy	92502	02/06/14	1	21 64		
440	Speech Therapy	92507	02/06/14	1	21 64		
	PAGE 1 OF 1	CREATION DATE		TOTALS	43 28		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
A D - Medicaid	12345678					

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A Client, Ima		Y123456		

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX: 434.91

69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE DATE | 76 ATTENDING NPI QUAL LAST FIRST | 77 OPERATING NPI QUAL LAST FIRST

80 REMARKS | 81CC | 78 OTHER NPI QUAL LAST FIRST | 79 OTHER NPI QUAL LAST FIRST

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Timely Filing

For more information on timely filing policy, including the resubmission rules for denied claims, please see the General Provider Information manual.

PT and OT Therapy Revisions Log

Revision Date	Additions/Changes	Pages	Made by
12/01/2016	*Manual revised for interChange implementation. For manual revisions prior to 12/01/2016, please refer to Archive.*	*All*	*HPE (now DXC)*
1/5/2017	*Updates based on Colorado iC Stage II Provider Billing Manual_Bundle 2 Comment Logv0_2.xlsx*	*Multiple*	*HPE (now DXC)*
1/13/2017	*Updates based on Colorado iC Stage II Provider Billing Manual_Bundle 2 Comment Logv0_3.xlsx*	*4-6, 10, 15-18*	*HPE (now DXC)*
1/13/2017	*Updates based on Colorado iC Stage II Provider Billing Manual_Bundle 2 Comment Logv0_4.xlsx*	*Multiple*	*HPE (now DXC)*
2/3/2017	*Updates based on 1/30/2017 Department approval email.*	*Accepted tracked changes throughout*	*HPE (now DXC)*
3/6/2017	*Changed information about checking a member's ID in the eligibility portal.*	*Page 7*	*AW*
5/26/2017	*Updates based on Fiscal Agent name change from HPE to DXC*	*4*	*DXC*
8/22/2017	*Organizational updates throughout. Clarified policy on IFSPs and CCBs.*	*Multiple*	*AW*
11/3/2017	*Incorporated policy from discontinued benefit coverage standard. Updated benefit limitation policy.*	*Multiple2-13, 15-22, 24-26, 30-32*	*AW*

1/15/2018	*Updated modifier and procedure code tables, included provider qualifications including other medical professionals, included eligible place of service code table, optimized content throughout.*	*Multiple*	*AW*
2/28/2018	*Removed NDC supplemental qualifier - not relevant for PT/OT providers*	*32, 54*	*DXC*
6/15/2018	*Updated timely filing information and removed references to LBOD; removed general billing information already available in the General Provider Information manual; added clarification concerning therapy assistants; reformatted and updated the covered procedure code table; added clarification concerning Early Intervention PT/OT Prior Authorizations.*	*3, 15, 17, 25-27, 29, 49, 66*	*DXC*
6/27/2018	*Updated ToC, timely filing*	*1, 62*	*HCPF*
6/28/2018	*Removed duplicated references, continuation references, institutional certification form*	*Throughout*	*HCPF*

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.