Outpatient Physical and Occupational Therapy Fee-For-Service

Physical and Occupational Therapy Outpatient – Fee-For-Service 2
Provider Qualifications 2
Billing Information 3
National Provider Identifier (NPI) 3
Paper Claims 3
Electronic Claims 3
Interactive Claim Submission and Processing 3
Batch Electronic Claim Submission 4
Testing and Vendor Certification 5
Procedure/HCPCS Code Overview 5
National Correct Coding Initiative (NCCI) 6
Physical Therapy (PT) and Occupational Therapy (OT) Codes 6
Definition of Habilitative Therapy 6
Benefit Limits for Habilitative and Rehabilitative Physical and Occupational Therapy 6
Service Limitations and Prior Authorization Requests (PARs) 7
Daily Unit Limits 7
Prior Authorization Requests (PARs) 7
Additional Limitations: 8
PAR Requirements: 8
PAR Revisions 9
Paper PAR Instructional Reference 10
Physical Therapy PAR Form Example 14
Occupational Therapy PAR Form Example 15
CMS 1500 Paper Claim Reference Table 16
UB-04 Paper Claim Reference Table 16
Institutional Provider Certification 45
CMS 1500 OT/PT Claim Example 46
UB-04 Outpatient PT Claim Example 47
Late Bill Override Date 48

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 (§12-41-113(1) C.R.S.).

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.

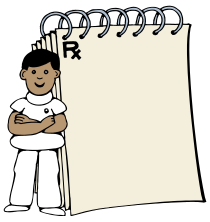
Occupational therapy assistants (OTA) must practice under the general supervision of a Colorado registered occupational therapist.

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

As of July 1, 2002, 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 specific information when providing physical and occupational therapy.

All PT/OT services must be prescribed by an M.D. or D.O., nurse practitioner or physician's assistant. Early Intervention PT/PT are covered services and require an approved IFSP (individual family service plan). Educational, personal need, and comfort therapies are not covered benefits of fee-for-service for any member regardless of age. Medically necessary as defined under 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.

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 5 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.

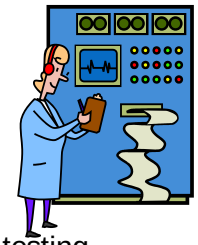
The X12N 837 Professional (837P), Institutional (837I), or Dental (837D) transaction data will be submitted to the EDI Gateway, which validates submission of American National Standards Institute (ANSI) X12N format(s).

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

The Healthcare Common Procedural Coding System (HCPCS) is divided into two 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.

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

Physical Therapy (PT) and Occupational Therapy (OT) Codes

Habilitative therapy is now a covered benefit for Medicaid expansion members ages 19 through 64 receiving benefits through the Alternative Benefits Plan (ABP). Eligible members may receive outpatient PT, OTbenefits for the purposes of habilitation **in addition** to rehabilitation.

Definition of Habilitative Therapy

The Colorado Division of Insurance has 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 (EHB) benchmark plan. Parity in this context means of like type and substantially equivalent in scope, amount, and duration.

Benefit Limits for Habilitative and Rehabilitative Physical and Occupational Therapy

Members may receive up to 24 units of Rehabilitative PT and up to 24 units of Rehabilitative OT per 12 month period before a Prior Authorization Request (PAR) is required, **and** up to 24 units of Habilitative PT and up to 24 units of Habilitative OT per 12 month period with a PAR submitted in advance of the services. Units of service exceeding the initial 24 units for each therapy type will not be reimbursed without an approved PAR. Please refer to the below table.

Benefit	Rehabilitative	Habilitative
Physical Therapy	24 units of PT and 24 units of OT per 12 months.	24 units of PT and 24 units of OT per 12 months.
Occupational Therapy	5 units of either PT *or* OT per date of service.	5 units of either PT *or* OT per date of service.
PAR Requirement	Required for PT and OT.	Required for PT, OT, and ST.

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.

A member is eligible for another 24 units of service without a PAR when the member has not received any PT or OT services within a 366 consecutive day period. The 24 units accumulate from paid units for a specific member, regardless of provider, for each treatment modality. A unit equals 1) a timed increment or 2) one treatment session as described in the specific CPT procedure codes.

PT and OT must be deemed medically necessary, and the member's physician, nurse practitioner or physician assistant must provide a written prescription for service to be reimbursed.

In addition to procedure codes, PT and OT providers are able to bill for the following orthotics:

L3730, L3763, L3764, L3808, L3900, L3906, L3908, L3911, L3912, L3919, L3929, L3933, L3982

For further billing information on the above 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. DME products **cannot** be requested on the same PAR as therapy services.

Service Limitations and Prior Authorization Requests (PARs)

Daily Unit Limits

A daily limit of five units of therapy services is allowed for PT/OT, whether it is Rehabilitative or Habilitative. All PT/OT 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.
- All OT claims must have the modifier 'GO' attached to each procedure code.
- All Early Intervention PT/OT claims must have a modifier "TL" attached in addition to "GP" or "GO" to each procedure code.

Members cannot receive both Rehabilitative and Habilitative therapy on the same date of service (DOS). Some specific daily limits per procedure code do apply, please refer to the below table. This table may not be inclusive of all therapy procedure codes available for use.

Procedure Code	Daily Limit	Procedure Code	Daily Limit
97012	1	97150	1
97014	1	97530	3
97016	1	97532	3
97024	1	97533	4
97026	1	97535	4
97028	1	97537	4
97039	1	97542	4
97110	4	97760	4
97113	2	97761	4
97116	3	97762	4
97139	3	97799	1
97140	2	97607	
97608			

Prior Authorization Requests (PARs)

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

- The member has exceeded 24 units of service provided by a PT, or

- The member has exceeded 24 units of service provided by an OT.
- When Habilitative PT/OT is being sought a PAR must always be submitted.

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. Duplicated services will not be reimbursed. 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.

- When submitting Rehabilitative Therapy PARs, and subsequent claims, CPT codes for PT service providers, must use the GP modifier (e.g. 97001+GP).
- When submitting Habilitative Therapy PARs, and subsequent claims, CPT codes for PT service providers, must use the GP modifier and HB modifier (e.g. 97001+GP+HB).
- When submitting Rehabilitative Therapy PARs, and subsequent claims, CPT codes for OT service providers, must use the GO modifier (e.g. 97003+GO).
- When submitting Habilitative PARs, and subsequent claims, CPT codes for OT service providers, must use the GO modifier and HB modifier (e.g. 97003+GO+HB).

PAR/Claim Modifier	Rehabilitative	Habilitative
Physical Therapy	GP	GP + HB
Occupational Therapy	GO	GO + HB
Early Intervention PT	GP + TL	-
Early Intervention OT	GO + TL	-

Additional Limitations:

- A member 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 DOS.
- A member may not receive both Rehabilitative and Habilitative therapies of the same type (e.g. Rehabilitative PT and Habilitative PT) on the same DOS.
- The same modifiers used for the PAR must be used when submitting claims.
- A member may have <u>one</u> active PAR for each type of therapy (Rehabilitative PT, Rehabilitative OT, Habilitative PT, Habilitative OT) with independent time spans. Early Intervention PARs are excluded from this requirement.

PAR Requirements:

- Legibly written and signed ordering practitioner prescription, to include diagnosis (preferably with ICD-9 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.

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 payment.

Approval of a PAR does not guarantee Colorado Medical Assistance Program payment 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 payment 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: 1-888-454-7686

PAR Fax Line: 1-866-492-3176

The Colorado Medical Assistance Program PAR forms are available in the Provider Services Forms section or by contacting the ColoradoPAR Program at 1-888-454-7686 (toll free).

Providers can fax documents to the ColoradoPAR Program at 1-866-492-3176. Documents that may be compromised by faxing can be mailed to:

APS Healthcare

55 N. Robinson Ave., Suite 600

Oklahoma City, OK 73102

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.

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 ☐ Y ☐ 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 ☐ Y ☐ 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. Authorized services must be provided within these dates.
9. Does Member Reside in a Nursing Facility?	Check box ☐ Y ☐ N	Required Check the appropriate box.
10. Group Home Name if Patient Resides in a Group Home	Text	Not applicable.

Field Label	Completion Format	Instructions
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. 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.

Field Label	Completion Format	Instructions
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 Enter the name and telephone number of the provider who will be billing for the service.
26. Requesting Physician Signature	Text	Required 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. A rubber stamp facsimile signature is not acceptable on the PAR.
27. Date Signed	6 Digits	Required Enter the date the PAR form is signed by the requesting provider.
Telephone Number	Text	Required Enter the telephone number of the requesting provider.

Field Label	Completion Format	Instructions
28. Requesting Physician Provider Number	8 Digits	Required Enter the eight-digit Colorado Medical Assistance Program provider number of the requesting provider.
29. Billing Provider Number	8 Digits	Required Enter the eight-digit Colorado Medical Assistance Program provider number of the billing provider. All rendering and billing providers must be Colorado Medical Assistance program providers.
30. Comments	Text	Leave Blank This field is completed by the authorizing agency. 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

INVOICE/PAT. ACCOUNT NUMBER

DOES CLIENT HAVE PRIMARY INSURANCE? ☐ YES ☐ NO

MEDICAID PRIOR AUTHORIZATION REQUEST (PAR)

To avoid delay, please answer all questions completely.

1. CLIENT NAME (Last, First, Middle Initial)	2. CLIENT IDENTIFICATION NUMBER	3. SEX	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	***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 REFFERRING 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

FORM NO. 10013
(REV. 0811)
COL — 106

Occupational Therapy PAR Form Example

* ***Required Field***

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND FINANCING

INVOICE/PAT. ACCOUNT NUMBER

DOES CLIENT HAVE PRIMARY INSURANCE? ☐ YES ☐ NO

MEDICAID PRIOR AUTHORIZATION REQUEST (PAR)

To avoid delay, please answer all questions completely.

1. CLIENT NAME (Last, First, Middle Initial)	2. CLIENT IDENTIFICATION NUMBER	3. SEX	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	***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

TELEPHONE NUMBER

23. PCP PROVIDER NUMBER

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

Enter the PCP's address

24. NAME AND ADDRESS OF PHYSICIAN REFFERRING 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

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.

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.
7	**Insured's Address**	Not Required	

CMS Field #	Field Label	Field is?	Instructions
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.
11a	**Insured's Date of Birth, Sex**	Conditional	Complete if the member is covered by a **Medicare** health insurance policy. Enter the insured's birth date using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. Place an "X" in the appropriate box to indicate the sex of the insured.

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

CMS Field #	Field Label	Field is?	Instructions
			the date and two digits for the year. Example: 070114 for July 1, 2014. If the member is still hospitalized, the discharge date may be omitted. This information is not edited.
19	**Additional Claim Information**	Conditional	**LBOD** Use to document the Late Bill Override Date for timely filing.
20	**Outside Lab?** **$ Charges**	Conditional	Complete if all laboratory work was referred to and performed by an outside laboratory. If this box is checked, no payment will be made to the physician for lab services. Do not complete this field if any laboratory work was performed in the office. Practitioners may not request payment for services performed by an independent or hospital laboratory.
21	**Diagnosis or Nature of Illness or Injury**	Required	Enter at least one but no more than twelve diagnosis codes based on the member's diagnosis/condition. Enter applicable ICD indicator to identify which version of ICD codes is being reported. 9 ICD-9-CM 0 ICD-10-CM
22	**Medicaid Resubmission Code**	Conditional	List the original reference number for resubmitted claims. When resubmitting a claim, enter the appropriate bill frequency code in the left-hand side of the field. 7 Replacement of prior claim 8 Void/Cancel of prior claim 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

CMS Field #	Field Label	Field is?	Instructions
			unless advised to do so by the authorizing agent or the fiscal agent.
24	**Claim Line Detail**	Information	The paper claim form allows entry of up to six detailed billing lines. Fields 24A through 24J apply to each billed line. **Do not enter more than six lines of information** on the paper claim. If more than six lines of information are entered, the additional lines will not be entered for processing. Each claim form must be fully completed (totaled). **Do not file continuation claims** (e.g., Page 1 of 2).
24A	Dates of Service	Required	The field accommodates the entry of two dates: a "From" date of services and a "To" date of service. Enter the date of service using two digits for the month, two digits for the date and two digits for the year. Example: 010114 for January 1, 2014 From To 01 01 14 | | | Or From To 01 01 14 01 01 14 Span dates of service From To 01 01 14 01 31 14 <u>Single Date of Service</u>: 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. <u>Span billing</u>: 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
			N4 National Drug Codes VP Vendor Product Number OZ Product Number CTR Contract Rate JP Universal/National Tooth Designation JO Dentistry Designation System for Tooth & Areas of Oral Cavity
24B	Place of Service	Required	Enter the Place of Service (POS) code that describes the location where services were rendered. The Colorado Medical Assistance Program accepts the CMS place of service codes. 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 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

CMS Field #	Field Label	Field is?	Instructions
			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). 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. GO **Occupational Therapy** GP **Physical Therapy** HB **Habilitative Therapy (must be in addition to GO/GP)** TL **Early Intervention service (must be in addition to GO/GP)**
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

CMS Field #	Field Label	Field is?	Instructions
			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-Colorado Medical Assistance Program covered individuals for the same service. Do not deduct Colorado Medical Assistance Program co-payment or commercial insurance payments from the usual and customary charges.
24G	**Days or Units**	Required	Enter the number of services provided for each procedure code. Enter whole numbers only- do not enter fractions or decimals.
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)

CMS Field #	Field Label	Field is?	Instructions
			If the service is Family Planning, enter "Y" for YES or "N" for NO in the bottom, unshaded area of the field**.**
24I	**ID Qualifier**	Not Required	
24J	**Rendering Provider ID #**	Required	In the shaded portion of the field, enter the eight-digit Colorado Medical Assistance Program provider number assigned to the individual who actually performed or rendered the billed service. This number cannot be assigned to a group or clinic. NOTE: When billing a paper claim form, do not use the individual's NPI.
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**	Required	Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent.

CMS Field #	Field Label	Field is?	Instructions
	Degrees or Credentials		A holographic signature stamp may be used if authorization for the stamp is on file with the fiscal agent. An authorized agent or representative may sign the claim for the enrolled provider if the name and signature of the agent is on file with the fiscal agent. Each claim must have the date the enrolled provider or registered authorized agent signed the claim form. Enter the date the claim was signed using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. **Unacceptable signature alternatives:** Claim preparation personnel may not sign the enrolled provider's name. Initials are not acceptable as a signature. Typed or computer printed names are not acceptable as a signature. "Signature on file" notation is not acceptable in place of an authorized signature.
32	**32- Service Facility Location Information** **32a- NPI Number** **32b- Other ID #**	Conditional	Complete for services provided in a hospital or nursing facility in the following format: 1st Line Name 2nd Line Address 3rd Line City, State and ZIP Code 32a- NPI Number Enter the NPI of the service facility (if known). 32b- Other ID # Enter the eight-digit Colorado Medical Assistance Program provider number of the service facility (if known). The information in field 32, 32a and 32b is not edited.
33	**33- Billing Provider Info & Ph #** **33a- NPI Number** **33b- Other ID #**	Required	Enter the name of the individual or organization that will receive payment for the billed services in the following format: 1st Line Name 2nd Line Address 3rd Line City, State and ZIP Code 33a- NPI Number

CMS Field #	Field Label	Field is?	Instructions
			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 Zip Code Abbreviate the state using standard post office abbreviations. Enter the telephone number.

Form Locator and Label	Completion Format	Instructions
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 Provider Claim Report.
3b. Medical Record Number	17 digits	Optional Enter the number assigned to the patient to assist in retrieval of medical records.
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)

Form Locator and Label	Completion Format	Instructions
		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)
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): <u>Digit 2</u> <u>Bill Classification (Except clinics & special facilities):</u> 8 Swing Beds 9 Other
		<u>Digit 2</u> <u>Bill Classification (Clinics Only):</u> 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 <u>Digit 2</u> <u>Bill Classification (Special Facilities Only):</u> 1 Hospice (Non-Hospital Based) 2 Hospice (Hospital Based) 3 Ambulatory Surgery Center 4 Freestanding Birthing Center 5 Critical Access Hospital 6 Residential Facility <u>Digit 3</u> <u>Frequency:</u> 0 Non-Payment/Zero Claim

Form Locator and Label	Completion Format	Instructions
		1 Admit through discharge claim 2 Interim - First claim 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. *For Example:* January 1, 2011 = 0101011 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

Form Locator and Label	Completion Format	Instructions
		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 (MMDDCCYY)	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: 01012010 for January 1, 2010.
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**

Form Locator and Label	Completion Format	Instructions
		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.
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)

Form Locator and Label	Completion Format	Instructions
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.)
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/Transferd to Other HC Insitution 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.
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 01 Military service related 02 Employment related 04 HMO enrollee 05 Lien has been filed

Form Locator and Label	Completion Format	Instructions
		06 ESRD patient - First 18 months entitlement 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 Inpatinet 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

Form Locator and Label	Completion Format	Instructions
		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
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 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 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 <u>must</u> 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) 68 EPO-Drug 80 Covered Days 81 Non-Covered Days

Form Locator and Label	Completion Format	Instructions
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 for the same date of service. Refer to instructions under FL 44 (HCPCS/Rates). Psychiatric step down Use the following revenue codes: 0114 Psychiatric Step Down 1 0124 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. **When reporting an NDC** ▪ 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): ✓ F2 – International Unit ✓ GR – Gram ✓ ML – Milliliter ✓ UN – Units ▪ Enter the NDC unit of measure quantity
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. 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.

Form Locator and Label	Completion Format	Instructions
		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.
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 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.
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 The Colorado Medical Assistance Program. <u>Source Payment Codes</u> 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 Line A Primary Payer Line B Secondary Payer Line C Tertiary Payer
51. Health Plan ID	8 digits	Required Enter the provider's Health Plan ID for each payer name. Enter the eight digit Colorado Medical Assistance

Form Locator and Label	Completion Format	Instructions
		Program 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 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.
56. National Provider Identifier (NPI)	10 digits	Optional 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 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.

Form Locator and Label	Completion Format	Instructions
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.
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.

Form Locator and Label	Completion Format	Instructions
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.
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 - (Colorado Medical Assistance Provider #) – Required**	NPI - 10 digits QUAL – Text Medicaid ID - 8 digits	Colorado Medical Assistance Program ID Required 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 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 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.

Form Locator and Label	Completion Format	Instructions
Attending- Last/First Name	Text	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.
78-79. Other ID **NPI – Conditional** **QUAL - Conditional** **ID - (Colorado Medical Assistance Provider #) – Conditional**	NPI - 10 digits QUAL – Text Medicaid ID - 8 digits	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 member'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.
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

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

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 MM 10 DD 16 YY 45 SEX M [ ] F [X]

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

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

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

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [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 1/1/15

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

SIGNED

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

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. 17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

A. 3439 B. 8233 C. 7845 D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

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

1 City Hospital
100 Saginaw St.
Anytown, CO 80000
333-333-3333

2

3a PAT. CNTL. #
b. MED. REC. #
4 TYPE OF BILL: 131
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM: 02/06/14 THROUGH: 02/06/14
7

8 PATIENT NAME a
b Client, Ima
9 PATIENT ADDRESS a 123 Main Street
b Anytown c CO d 80000 e

10 BIRTHDATE: 01/04/2006
11 SEX: F
12 ADMISSION DATE
13 HR
14 TYPE: 3
15 SRC: 3
16 DHR
17 STAT
18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES
29 ACDT STATE
30

31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37

38

39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT

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					57 OTHER PRV ID

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 A B C D E F G H I J K L M N O P Q 68

69 ADMIT DX
70 PATIENT REASON DX a b c
71 PPS CODE
72 ECI a b c 73

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE 75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

80 REMARKS
81 CC a b c d

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.

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

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

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

Billing Instruction Detail	Instructions
	insurance company has not completed processing, file the claim, receive a denial or rejection, and continue filing in compliance with the 60-day rule until insurance processing information is available. **LBOD** = the date commercial insurance paid or denied.
Correspondence LBOD Authorization	The claim is being submitted in accordance with instructions (authorization) from the Colorado Medical Assistance Program for a 60 day filing extension for a specific member, claim, services, or circumstances. **File the claim within 60 days** of the date on the authorization letter. Retain the authorization letter. **LBOD** = the date on the authorization letter.
Member Changes Providers during Obstetrical Care	The claim is for obstetrical care where the patient transferred to another provider for continuation of OB care. The prenatal visits must be billed using individual visit codes but the service dates are outside the initial timely filing period. **File the claim within 60 days** of the last OB visit. Maintain information in the medical record showing the date of the last prenatal visit and a notation that the patient transferred to another provider for continuation of OB care. **LBOD** = the last date of OB care by the billing provider.

PT and OT Therapy Revisions Log

Revision Date	Additions/Changes	Pages	Made by
04/22/2009	*Drafted Manual*	*All*	*jg*
09/14/2009	*Updates and formatting*	*Throughout*	*jg*
10/19/2009	*LBOD*	*44*	*jg*
01/12/2010	*Updated Web site links*	*Throughout*	*jg*
02/10/2010	*Changed EOMB to SPR*	*23 & 46*	*jg*
03/04/2010	*Added link to Program Rules*	*2*	*jg*
07/14/2010	*Updated date examples for field 19A* *Updated Colorado 1500 claim example UB-04 claim example*	*19* *49 & 50*	*jg*
07/15/2010	*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*	*23* *46*	*jg*
08/30/2011	*Deleted CFMC information and added ColoradoPAR fax number and address*	*8*	*crc*
09/13/2011	*Updated Par Reference Table to reflect changes to PAR form*		*vr*
09/15/2011	*Updated PAR Form Examples*		*jg*
12/06/2011	*Replaced 997 and 999* *Replaced wpc-edi.com/hipaa with wpc-edi.com/Replaced Implementation Guide with Technical Report 3 (TR3)*	*5* *3* *3*	*ss*
05/18/2012	*Redrafted Manual* *Removed all Speech Therapy references* *Added in contact information, etc for ColoradoPAR*	*Throughout*	*akb*
10/01/2012	*Updated Global information such as Electronic Claim Submission and LBOD*	*3* *54*	*vr*
10/01/2012	*Reformatted* *Updated TOC*	*All* *i*	*jg*
10/03/2012	*Reformatted* *Updated TOC*	*All* *i*	*jg*
02/7/2014	*Significant changes throughout. Added Habilitation Therapy content.*	*All*	*as*

Revision Date	Additions/Changes	Pages	Made by
02/27/2014	*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*	 *34-35* *36* *37* *37* *39* *40* *40* *40* *42-43*	*cc*
02/07/2014	*Updated TOC* *Formatted* *Updated PAR Examples* *Updated Claim Examples*	*i* *Throughout* *12 & 13* *46 & 47*	*jg*
5/21/2014	*Added modifier language to service limitations and PARs*	*6 & 7*	*As*
8/22/14	*Replaced all CO 1500 references with CMS 1500*	*Throughout*	*ZS*
8/22/14	*Updated Professional Claim Billing Instructions section with CMS 1500 information.*		*ZS*
8/22/14	*Replaced all CO 1500 references with CMS 1500*	*Throughout*	*ZS*
8/25/14	*Updated all weblinks for the Department's new website*	*Throughout*	*MM*
8/29/14	*Add Early Intervention PT/OT information per policy*	*1, 7 - 9*	*MM*
12/08/14	*Removed Appendix H information, added Timely Filing document information*	*51*	*mc*
12/29/14	*Added 2015 HCPCS: 97607 and 97608*	*7*	*mc*
12/29/14	*Changed "client" to "member"*	*throughout*	*mc*
12/29/14	*Updated TOC*	*1*	*bl*
04/28/2015	*Changed the word unshaded to shaded*	*24J*	*bl*

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