Pediatric Behavioral Therapies Benefit Billing Manual

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Pediatric Behavioral Therapies Benefit Billing Manual

The purpose of this billing manual is to provide policy and billing guidance to providers to obtain reimbursement for behavioral therapy services. This manual is updated periodically to reflect changes in policy and regulations. It applies only to the Health First Colorado (Colorado's Medicaid Program) Pediatric Behavioral Therapies benefit and does not address services available through other Health First Colorado benefits or any services available through Home and Community-Based Services (HCBS) waiver programs.

Behavioral Therapies Benefit Overview

Behavioral therapy services are a treatment that helps change maladaptive behaviors. These services must be found to be medically necessary in order to be covered.

The Pediatric behavioral therapies benefit is available to Health First Colorado members who:

- Are 20 years old and younger
- Are required to meet the EPSDT medically necessary criteria for behavioral therapy services.

For more information on medical necessity, please visit www.colorado.gov/pacific/hcpf/early-and-periodic-screening-diagnostic-and-treatment-epsdt.

Behavioral Therapies and the BHO Behavioral services are also available to children who have mental health related diagnosis and services must be requested from the Behavioral health organization (BHO) by BHO contracted providers for those covered diagnosis.

All behavioral therapy services must be pre-approved in a Prior Authorization Request (PAR) process. Please visit www.coloradopar.com/ for more information.

Assessments for services are available for all Health First Colorado eligible children and services should be requested and denied by the BHO prior to submitting a PAR to ColoradoPAR for services. The only exception is for those children who have a single diagnosis of Autism (299.00/F84.0) and are not covered by BHO contract requirements at this time. For more information about BHOs please visit www.colorado.gov/pacific/hcpf/behavioral-health-organizations.

If a member requires support of a medically skilled caregiver to complete a task, such as bathing or hygiene, the associated task shall be considered skilled in nature and covered under other Health First Colorado state plan benefits. Visit www.colorado.gov/pacific/hcpf/home-health-program-0 for more information.

If a member requires assistance with personal care tasks, those services are covered under other Health First Colorado state plan benefits. Visit www.colorado.gov/pacific/sites/default/files/Bulletin_PC_1500372.pdf for more information.

Additional information about this benefit, including eligibility rules for providers, criteria, details about what needs to be included in a prior authorization request, can be found in the Behavioral

Therapies Benefit Fact Sheet or Frequently Asked Questions page found at: www.colorado.gov/pacific/sites/default/files/Behavioral%20Therapy%20FAQs.pdf.

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 that transmit any health information electronically in connection with a transaction for which the Secretary of Health and Human Services has adopted a standard) use NPIs in standard transactions

Eligible Providers

Prescribing/Ordering Providers

The billing provider must be a Non-Physician practitioner group (type 25). The rendering provider must be either a non-physician practitioner (type 24) with a BCBA certificate, or a Psychologist with a Masters or Doctorate (types 37 and 38).

Rendering and Billing Provider Numbers

Behavioral Therapy services must be billed using the 837 Professional (837P) transaction or CMS 1500 form, which requires using rendering provider identification numbers.

The billing provider must be a Non-Physician practitioner group (type 25). The rendering provider must be either a non-physician practitioner (type 24) with a BCBA certificate, or a Psychologist with a Masters or Doctorate (types 37 and 38) on the Detail Line Items tab or in line 24J of the CMS 1500 Professional claim form.

Each agency's specific billing number will be used to reimburse the claim.

Prior Authorization Requests (PARs)

The ColoradoPAR Program is Health First Colorado's Utilization Management (UM) Program. A third-party vendor reviews Prior Authorization Requests (PARs) to ensure services requested meet medical necessity guidelines and are within Health First Colorado's policies.

The ColoradoPAR Program's third-party vendor processes electronic PARs through an online PAR portal. The online PAR portal is a web-based HIPAA-compliant PAR system that offers providers 24/7 access to the information and functions providers need. Clinical documentation will be accepted in the following formats: doc, docx, xls, xlsx, ppt, pdf, jpg, gif, bmp, tiff, tif, and jpeg.

See ColoradoPAR.com for information and instructions on how to submit PARs electronically through the online PAR portal. For additional assistance or support, contact the ColoradoPAR provider helpline at 888-801-9355. PAR status may be verified in the online PAR portal or by contacting the ColoradoPAR provider helpline.

Claims for prior authorized services must be submitted within 120 days of the date of service. Services rendered prior to the authorized date will be denied reimbursement.

Approval of the PAR does not guarantee payment by Health First Colorado (Colorado's Medicaid Program). The member and the provider shall meet all applicable eligibility requirements at the time services are rendered and services shall be delivered in accordance with all applicable service limitations. It is the providers responsibility to check for member eligibility prior to submitting a PAR and before services are rendered. The PAR does not guarantee payment. Health First Colorado is the payer of last resort and the presence of an approved or partially approved PAR does not release the agency from the requirement to bill Medicare or other third party insurance prior to billing Health First Colorado.

PAR Requirements

Any provider submitting a PAR must be enrolled in the Health First Colorado Program. Providers must also verify eligibility at the time service is rendered and include the necessary information with the PAR.

- All Behavioral therapy services require prior authorization by Health First Colorado's third-party vendor using the approved prior authorization request online portal.
- It is the agency's responsibility to provide sufficient documentation to support the medical necessity for the requested services.
- Behavioral therapy services PARs may be submitted for up to 6 months of anticipated services.
- PARs must be submitted to Health First Colorado's third-party vendor in accordance with 10 CCR 2505-10 § 8.058.
- A PAR will be pended by Health First Colorado's third-party vendor if all of the required information is not provided in the PAR, or additional information is required by the third-party vendor to complete the review. If the third-party vendor does not receive the required documentation within four (4) business days, the PAR will be denied for lack of information.
- When a PAR includes a request for reimbursement for two (2) staff members at the same time (excluding supervisory visits) to perform two-person tasks, documentation supporting the need for two (2) people and the reason must be included.
- All other information determined necessary by Health First Colorado's third-party vendor to make a decision on the medical necessity and appropriateness of the proposed treatment plan must be included.
- The agency is required to submit a PAR revision, which must include revisions to all documentation, including the Plan of Care, if/when the member experiences a change in condition necessitating a change in the amount, duration, or frequency of a member's services.
- The PAR will be reviewed by medical experts in children's health who work for the Health First Colorado program's third-party vendor. Nurses and doctors will decide if the request for Behavioral Therapy meets the rules for medical necessity and for the Behavioral Therapy Benefit.

- An approved PAR is valid for up to 6 months. After 6 months, a Behavioral Therapy provider must submit a new PAR for another 6 months of services.

Peer-to-Peer and Reconsideration Process

Prior to denying or partially denying a PAR, the MD, DO, or APN who requested the PAR will be contacted to discuss the PAR over the phone in a process called a Peer-To-Peer review. If the Peer-To-Peer review still results in a denied or partially denied PAR, the Behavioral Therapy provider can work with the MD, DO, or APN on these two (2) options:

- PAR Reconsideration: A PAR Reconsideration is similar to a second opinion and must be requested by the Behavioral Therapy provider. A MD, DO, or APN who is different from the one who made the initial PAR denial will re-review the PAR along with the new information and make a final PAR decision. Additional documents not submitted with the original request may be submitted during the Reconsideration process.
- PAR Resubmission: Submit a new PAR that includes additional medical information needed for the PAR review.

The provider will be notified of the final PAR determination via the online PAR portal. The provider and member will receive the final PAR determination letter from the Department's fiscal agent. If the PAR is denied, the provider will also receive a detailed explanation of why the PAR was denied. A member who receives a denial notification letter has the option to submit a written request for an appeal to the Office of Administrative Courts.

Claim Submission

Paper Claims

Electronic claims format shall be required unless hard copy claims submittals are specifically prior authorized by the Department. Requests may be sent to DXC Technology (DXC), P.O. Box 30, Denver, CO 80201-0030. The following claims can be submitted on paper and processed for payment:

- Claims from providers who consistently submit five (5) claims or fewer per month (requires prior approval)
- Claims that, by policy, require attachments
    - Note: claims with attachments may now be submitted electronically.
- Reconsideration claims

Paper claims require an NPI for those provider types that can obtain one. Providers that cannot obtain an NPI are required to use an assigned Health First Colorado provider number on their claims. 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 EDI support section of the Department's website (edi-support)
- Online Portal User Guide (via within the Online Portal)

The Health First Colorado collects electronic claim information interactively through the Health First Colorado Secure Online Portal (Online Portal) or via batch submission through a host system. Please refer to the Colorado General Provider Information Manual for additional electronic information.

Procedure/HCPCS Codes Overview

The Department develops procedure codes that are approved by the Centers for Medicare & Medicaid Services (CMS). The codes are used to submit claims for services provided to Health First Colorado members. The procedure codes represent services that may be provided by enrolled certified Health First Colorado providers.

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.

These include ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DME/Supplies) when used outside a physician's office. Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter followed by four (4) numeric digits. CPT codes are identified using five (5) numeric digits.

Pediatric Behavioral Therapy Benefit Procedure Code Table

Providers may bill the following procedure codes for Pediatric Behavioral Therapy services:

Pediatric Behavioral Therapy Benefit Procedure Code Table

HCPCS Procedure Code Description	Procedure Code	Units
Comprehensive Community Support Services Department Description: Adaptive behavior treatment, administered by technician	H2015	1 unit = 15 minutes
Community Psychiatric Supportive Treatment, face to face Department Description: Adaptive behavior treatment, administered by BCBA	H0036	1 unit = 15 minutes
Mental Health Assessment by non MD Department Description: Behavior identification assessment, face-to-face with member and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, member observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/ caregiver(s), and preparation of report.	H0031	Per assessment code – can be used one (1) x per year
Behavior identification re-assessment, limited to two (2) units per six (6) months	H0031/TS	Can be used once every six (6) months

Paper Claim Reference Table

The following paper form reference table gives required and/or conditional fields for the paper CMS 1500 claim form for Pediatric Behavioral Therapies claims:

CMS Field #	Field Label	Field is?	Instructions
1	Insurance Type	Required	Place an "X" in the box marked as Medicaid.
1a	Insured's ID Number	Required	Enter the member's Health First Colorado seven-digit Medicaid ID number as it appears on the Medicaid Identification card. Example: A123456.
2	Patient's Name	Required	Enter the member's last name, first name, and middle initial.
3	Patient's Date of Birth / Sex	Required	Enter the member's birth date using two digits for the month, two digits for the date, and two digits for the year. Example: 070115 for July 1, 2015. Place an "X" in the appropriate box to indicate the sex of the member.
4	Insured's Name	Not Required	
5	Patient's Address	Not Required	
6	Patient's Relationship to Insured	Conditional	Complete if the member is covered by a commercial health insurance policy. Place an "X" in the box that identifies the member's relationship to the policyholder.
7	Insured's Address	Not Required	
8	Reserved for NUCC Use		

CMS Field #	Field Label	Field is?	Instructions
9	Other Insured's Name	Conditional	If field 11d is marked "YES," enter the insured's last name, first name and middle initial.
9a	Other Insured's Policy or Group Number	Conditional	If field 11d is marked "YES," enter the policy or group number.
9b	Reserved for NUCC Use		
9c	Reserved for NUCC Use		
9d	Insurance Plan or Program Name	Conditional	If field 11d is marked "YES," enter the insurance plan or program name.
10a-c	Is Patient's Condition Related to?	Not Required	
10d	Reserved for Local Use		
11	Insured's Policy, Group or FECA Number	Not Required	
11a	Insured's Date of Birth, Sex	Not Required	
11b	Other Claim ID	Not Required	
11c	Insurance Plan Name or Program Name	Not Required	

CMS Field #	Field Label	Field is?	Instructions
11d	Is there another Health Benefit Plan?	Conditional	When appropriate, place an "X" in the correct box. If marked "YES," complete 9, 9a, and 9d.
12	Patient's or Authorized Person's signature	Required	Enter "Signature on File," "SOF," or legal signature. If there is no signature on file, leave blank or enter "No Signature on File." Enter the date the claim form was signed.
13	Insured's or Authorized Person's Signature	Not Required	
14	Date of Current Illness Injury or Pregnancy	Not Required	
15	Other Date	Not Required	
16	Date Patient Unable to Work in Current Occupation	Not Required	
17	Name of Referring Physician	Conditional	
18	Hospitalization Dates Related to Current Service	Conditional	Complete for services provided in an inpatient hospital setting. Enter the date of hospital admission and the date of discharge using two digits for the month, two digits for the date and two digits for the year. Example: 070116 for July 1, 2016. If the member is still hospitalized, the discharge date may be omitted. This information is not edited.
19	Additional Claim Information	Conditional	

CMS Field #	Field Label	Field is?	Instructions
20	Outside Lab? $ Charges	Conditional	Complete if <u>all</u> laboratory work was referred to and performed by an outside laboratory. If this box is checked, no payment will be made to the physician for lab services. Do not complete this field if <u>any</u> laboratory work was performed in the office. Practitioners may not request payment for services performed by an independent or hospital laboratory.
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. 0 ICD-10-CM
22	Medicaid Resubmission Code	Conditional	List the original reference number for adjusted claims. When resubmitting a claim as a replacement or a void, enter the appropriate bill frequency code in the left-hand side of the field. 7 Replacement of prior claim 8 Void/Cancel of prior claim This field is not intended for use for original claim submissions.
23	Prior Authorization	Required	
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

CMS Field #	Field Label	Field is?	Instructions
			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: 010116 for January 1, 2016 From To **01 01 16** | | | | | | Or From To **01 01 16 01 01 16** Span dates of service From To **01 01 16 01 31 16** **EPSDT** All dates of service must by the same date as screening.
24B	Place of Service	Required	Enter the Place of Service (POS) code that describes the location where services were rendered. The Health First Colorado accepts the CMS place of service codes. 11 Office 12 Home

CMS Field #	Field Label	Field is?	Instructions
24C	EMG	Conditional	Enter a "Y" for YES or leave blank for NO in the bottom, unshaded area of the field to indicate the service is rendered for a life-threatening condition or one that requires immediate medical intervention. If a "Y" for YES is entered, the service on this detail line is exempt from co-payment requirements.
24D	Procedures, Services, or Supplies	Required	Enter the HCPCS procedure code that specifically describes the service for which payment is requested. All procedures must be identified with codes in the current edition of Physicians Current Procedural Terminology (CPT). CPT is updated annually. HCPCS Level II Codes The current Medicare coding publication (for Medicare crossover claims only). Only approved codes from the current CPT or HCPCS publications will be accepted.
24E	Diagnosis Pointer	Required	Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis. At least one diagnosis code reference letter must be entered. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. This field allows for the entry of 4 characters in the unshaded area.
24F	$ Charges	Required	Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is

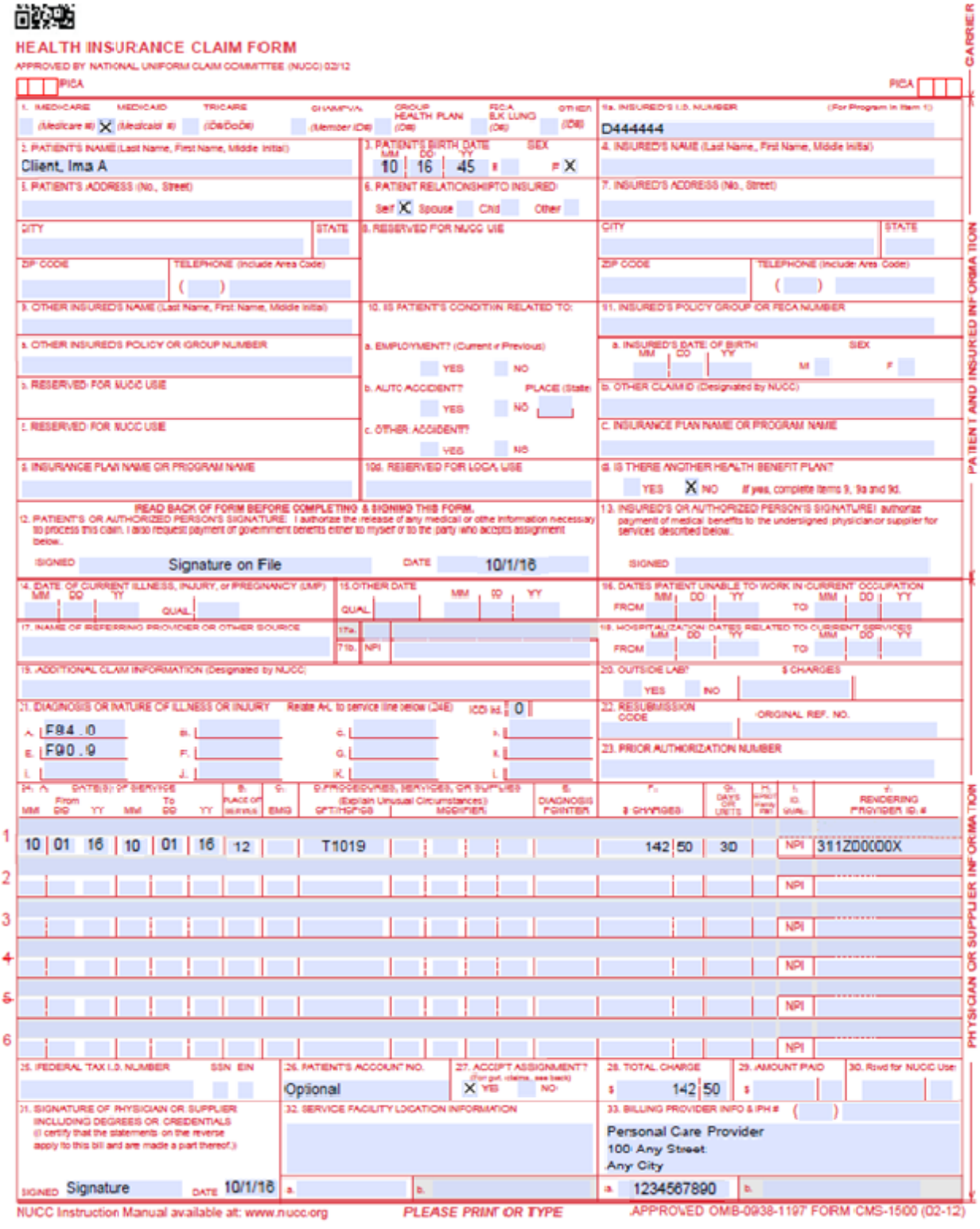
CMS Field #	Field Label	Field is?	Instructions
			a whole number. Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one procedure from the same group is billed, special multiple pricing rules apply. The base procedure is the procedure with the highest allowable amount. The base code is used to determine the allowable amounts for additional CPT surgical procedures when more than one procedure from the same grouping is performed. Submitted charges cannot be more than charges made to non-Health First Colorado covered individuals for the same service. Do not deduct Health First Colorado co-payment or commercial insurance payments from the usual and customary charges.
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) Not Required

CMS Field #	Field Label	Field is?	Instructions
24I	ID Qualifier	Not Required	
24J	Rendering Provider ID #	Required	In the shaded portion of the field, enter the NPI of the Health First Colorado provider number assigned to the individual who actually performed or rendered the billed service. This number cannot be assigned to a group or clinic.
25	Federal Tax ID Number	Not Required	
26	Patient's Account Number	Optional	Enter information that identifies the member or claim in the provider's billing system. Submitted information appears on the Remittance Advice (RA).
27	Accept Assignment?	Required	The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.
28	Total Charge	Required	Enter the sum of all charges listed in field 24F. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
29	Amount Paid	Conditional	Enter the total amount paid by Medicare or any other commercial health insurance that has made payment on the billed services. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
30	Rsvd for NUCC Use		
31	Signature of Physician or Supplier Including Degrees or	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
	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: 070116 for July 1, 2016. **Unacceptable signature alternatives:** Claim preparation personnel may not sign the enrolled provider's name. Initials are not acceptable as a signature. Typed or computer printed names are not acceptable as a signature. "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 #	Not Required	Complete for services provided in a hospital or nursing facility in the following format: 1st Line Facility Name 2nd Line Address 3rd Line City, State and ZIP Code 32a- NPI Number Enter the NPI of the service facility (if known).
33	33- Billing Provider Info & Ph. # 33a- NPI Number	Required	Enter the name of the individual or organization that will receive payment for the billed services in the following format: 1st Line Name

CMS Field #	Field Label	Field is?	Instructions
	33b- Other ID #		2nd Line Address 3rd Line City, State and ZIP Code 33a- NPI Number Enter the NPI of the billing provider

Pediatric Behavioral Therapy 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 DD YY: 10 16 45 SEX: 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

ZIP CODE | TELEPHONE (Include Area Code)

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED: Signature on File DATE: 10/1/16

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

SIGNED

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

15. OTHER DATE MM DD YY | QUAL

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO | $ CHARGES

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

A. F84.0 B. C. D.

E. F90.9 F. G. H.

I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 01 16	10 01 16	12		T1019			142 50	30		NPI 311Z00000X
2											NPI
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: Optional

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

28. TOTAL CHARGE: $ 142 50

29. AMOUNT PAID: $

30. Rsvd for NUCC Use

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

SIGNED Signature DATE 10/1/16

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH #

Personal Care Provider
100 Any Street
Any City

a. 1234567890 b.

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

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION — CARRIER

Timely Filing

The Health First Colorado allows providers to document compliance with timely filing requirements when the initial timely filing period has expired. Health First Colorado 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, 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.

Pediatric Behavioral Therapy Specialty Manual Revisions Log

Revision Date	Additions/Changes	#Pages	Made by
12/01/2016	*Manual revised for interChange implementation. For manual revisions prior to 12/01/2016, please refer to Archive.*	*All*	*HPE (now DXC)*
12/27/2016	*Updates based on Colorado iC Stage II Provider Billing Manual Comment Log v0_2.xlsx*	*Multiple*	*HPE (now DXC)*
1/10/2017	*Updates based on Colorado iC Stage Provider Billing Manual Comment Log v0_3.xlsx*	*Multiple*	*HPE (now DXC)*
1/19/2017	*Updates based on Colorado iC Stage Provider Billing Manual Comment Log v0_4.xlsx*	*Multiple*	*HPE (now DXC)*
1/26/2017	*Updates based on Department 1/20/2017 approval email*	*Accepted tracked changes throughout*	*HPE (now DXC)*
5/22/2017	*Updates based on Fiscal Agent name change from HPE to DXC*	*5*	*DXC*

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 occurred.