

# Pediatric Behavioral Therapies Benefit Billing Manual

---

<b>Pediatric Behavioral Therapies Benefit Billing Manual</b> .....	<b>i</b>
<b>Pediatric Behavioral Therapies Benefit Billing Manual</b> .....	<b>1</b>
<b>Behavioral Therapies Benefit Overview</b> .....	<b>1</b>
<b>Billing Information</b> .....	<b>2</b>
<i>National Provider Identifier (NPI)</i> .....	2
<b>Eligible Providers</b> .....	<b>2</b>
<i>Prescribing/Ordering Providers</i> .....	2
<i>Rendering and Billing Provider Numbers</i> .....	2
<b>Prior Authorization Requests (PARs)</b> .....	<b>2</b>
<i>PAR Requirements</i> .....	3
<i>Peer-to-Peer and Reconsideration Process</i> .....	4
<b>Claim Submission</b> .....	<b>4</b>
<i>Paper Claims</i> .....	4
<i>Electronic Claims</i> .....	5
<b>Procedure/HCPCS Codes Overview</b> .....	<b>5</b>
<i>Pediatric Behavioral Therapy Benefit Procedure Code Table</i> .....	5
<b>Paper Claim Reference Table</b> .....	<b>7</b>
<i>Pediatric Behavioral Therapy Claim Example</i> .....	17
<b>Late Bill Override Date</b> .....	<b>18</b>

# 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 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
- 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](http://www.colorado.gov/pacific/hcpf/early-and-periodic-screening-diagnostic-and-treatment-epsdt).

### Behavior 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/](http://www.coloradopar.com/) for more information.

Assessments for services are available for all Health First Colorado (Colorado's Medicaid Program) 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](http://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](http://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](http://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](http://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. Class A and Class B Home Care Agencies must have a NPI in order to bill for services rendered.

## **Eligible Providers**

### **Prescribing/Ordering Providers**

- Must qualify as provider type 25 – non-physician clinic or as a Psychologist PhD or Psychologist MA

### **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.

Agencies billing for Behavioral Therapy services through the Web Portal must enter their billing number in the Rendering Provider ID field (as Provider Type 24) 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](http://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. The approved PAR identification number must be submitted with the claim to receive payment.

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. 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**

Behavioral Therapy claims are submitted on the CMS 1500 claim form. 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 30, Denver, CO 80201-0090.

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 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.”

For more detailed CMS 1500 billing instructions, refer to the CMS 1500 General Billing Information manual in the Provider Services [Billing Manuals](#) section.

## Electronic Claims

Instructions for completing and submitting electronic claims are available through the 837 Professional (837P) Web Portal User guide via the Web Portal and also on the [Department's Colorado Medical Assistance Program Web Portal](#) page.

Electronically mandated claims submitted on paper are processed, denied, and marked with the message "Electronic Filing Required."

The Colorado Medical Assistance Program collects claim information interactively through the Colorado Medical Assistance Program Secure Web Portal ([Web Portal](#)) or via batch submission through a host system. Refer to the [CMS 1500 General Billing Information Manual](#) (for additional electronic billing information).

The Special Program Indicator (SPI) must be completed on claims submitted electronically. Claims submitted electronically and on paper are identified by using the specific national modifiers along with the procedure code. The appropriate procedure codes and modifiers for each HCBS waiver are noted throughout this manual. When the services are approved, the claim may be submitted to the Department's fiscal agent. For more detailed billing instructions, refer to the CMS 1500 General Billing Information in the Provider Services [Billing Manuals](#) section.

## 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 Colorado Medical Assistance Program members. The procedure codes represent services that may be provided by enrolled certified Colorado Medical Assistance Program 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:

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

<b>CMS Field #</b>	<b>Field Label</b>	<b>Field is?</b>	<b>Instructions</b>
<b>1</b>	<b>Insurance Type</b>	Required	Place an "X" in the box marked as Medicaid.
<b>1a</b>	<b>Insured's ID Number</b>	Required	Enter the member's Colorado Medical Assistance Program seven-digit Medicaid ID number as it appears on the Medicaid Identification card. Example: A123456.
<b>2</b>	<b>Patient's Name</b>	Required	Enter the member's last name, first name, and middle initial.
<b>3</b>	<b>Patient's Date of Birth / Sex</b>	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.
<b>4</b>	<b>Insured's Name</b>	Not Required	
<b>5</b>	<b>Patient's Address</b>	Not Required	
<b>6</b>	<b>Patient's Relationship to Insured</b>	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.
<b>7</b>	<b>Insured's Address</b>	Not Required	
<b>8</b>	<b>Reserved for NUCC Use</b>		

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

CMS Field #	Field Label	Field is?	Instructions
11c	<b>Insurance Plan Name or Program Name</b>	Not Required	
11d	<b>Is there another Health Benefit Plan?</b>	Conditional	When appropriate, place an "X" in the correct box. If marked "YES," complete 9, 9a, and 9d.
12	<b>Patient's or Authorized Person's signature</b>	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	<b>Insured's or Authorized Person's Signature</b>	Not Required	
14	<b>Date of Current Illness Injury or Pregnancy</b>	Not Required	
15	<b>Other Date</b>	Not Required	
16	<b>Date Patient Unable to Work in Current Occupation</b>	Not Required	
17	<b>Name of Referring Physician</b>	Not Required	
18	<b>Hospitalization Dates Related to Current Service</b>	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

CMS Field #	Field Label	Field is?	Instructions
			July 1, 2016. If the member is still hospitalized, the discharge date may be omitted. This information is not edited.
19	<b>Additional Claim Information</b>	Conditional	<b>LBOD</b> Use to document the Late Bill Override Date for timely filing.
20	<b>Outside Lab? \$ Charges</b>	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	<b>Diagnosis or Nature of Illness or Injury</b>	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	<b>Medicaid Resubmission Code</b>	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	<b>Prior Authorization</b>	Required	

CMS Field #	Field Label	Field is?	Instructions																		
24	Claim Line Detail	Information	<p>The paper claim form allows entry of up to six detailed billing lines. Fields 24A through 24J apply to each billed line.</p> <p><b>Do not enter more than six lines of information</b> on the paper claim. If more than six lines of information are entered, the additional lines will not be entered for processing.</p> <p>Each claim form must be fully completed (totaled).</p> <p><b>Do not file continuation claims</b> (e.g., Page 1 of 2).</p>																		
24A	Dates of Service	Required	<p>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</p> <p style="text-align: center;">From                      To</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px;">01</td> <td style="width: 20px;">01</td> <td style="width: 20px;">16</td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> </tr> </table> <p style="text-align: center;">Or</p> <p style="text-align: center;">From                      To</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px;">01</td> <td style="width: 20px;">01</td> <td style="width: 20px;">16</td> <td style="width: 20px;">01</td> <td style="width: 20px;">01</td> <td style="width: 20px;">16</td> </tr> </table> <p style="text-align: center;">Span dates of service</p> <p style="text-align: center;">From                      To</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px;">01</td> <td style="width: 20px;">01</td> <td style="width: 20px;">16</td> <td style="width: 20px;">01</td> <td style="width: 20px;">31</td> <td style="width: 20px;">16</td> </tr> </table> <p><b>EPSDT</b></p> <p>All dates of service must by the same date as screening.</p>	01	01	16				01	01	16	01	01	16	01	01	16	01	31	16
01	01	16																			
01	01	16	01	01	16																
01	01	16	01	31	16																
24B	Place of Service	Required	<p>Enter the Place of Service (POS) code that describes the location where services were rendered. The Colorado Medical Assistance Program accepts the CMS place of service codes.</p> <p>12    Home</p>																		

<b>CMS Field #</b>	<b>Field Label</b>	<b>Field is?</b>	<b>Instructions</b>
<b>24C</b>	<b>EMG</b>	Conditional	<p>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.</p> <p>If a "Y" for YES is entered, the service on this detail line is exempt from co-payment requirements.</p>
<b>24D</b>	<b>Procedures, Services, or Supplies</b>	Required	<p>Enter the HCPCS procedure code that specifically describes the service for which payment is requested.</p> <p>All procedures must be identified with codes in the current edition of Physicians Current Procedural Terminology (CPT). CPT is updated annually.</p> <p>HCPCS Level II Codes</p> <p>The current Medicare coding publication (for Medicare crossover claims only). Only approved codes from the current CPT or HCPCS publications will be accepted.</p>
<b>24E</b>	<b>Diagnosis Pointer</b>	Required	<p>Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis.</p> <p>At least one diagnosis code reference letter must be entered.</p> <p>When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow.</p> <p>This field allows for the entry of 4 characters in the unshaded area.</p>
<b>24F</b>	<b>\$ Charges</b>	Required	<p>Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar</p>

CMS Field #	Field Label	Field is?	Instructions
			<p>amounts. Enter 00 in the cents area if the amount is a whole number.</p> <p>Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one procedure from the same group is billed, special multiple pricing rules apply.</p> <p>The base procedure is the procedure with the highest allowable amount. The base code is used to determine the allowable amounts for additional CPT surgical procedures when more than one procedure from the same grouping is performed.</p> <p>Submitted charges cannot be more than charges made to non-Colorado Medical Assistance Program covered individuals for the same service.</p> <p>Do not deduct Colorado Medical Assistance Program co-payment or commercial insurance payments from the usual and customary charges.</p>
24G	Days or Units	Required	<p>Enter the number of services provided for each procedure code.</p> <p>Enter whole numbers only - do not enter fractions or decimals.</p>
24H	EPSDT/Family Plan	Conditional	<p><b>EPSDT</b> (shaded area)</p> <p>For Early &amp; Periodic Screening, Diagnosis, and Treatment related services, enter the response in the shaded portion of the field as follows:</p> <p>AV Available- Not Used</p> <p>S2 Under Treatment</p> <p>ST New Service Requested</p> <p>NU Not Used</p> <p><b>Family Planning</b> (unshaded area)</p> <p>Not Required</p>

CMS Field #	Field Label	Field is?	Instructions
24I	ID Qualifier	Not Required	
24J	Rendering Provider ID #	Required	<p>In the unshaded portion of the field, enter the eight-digit Health First Colorado provider number assigned to the <u>individual</u> who actually performed or rendered the billed service. This number cannot be assigned to a group or clinic. Class B agencies providing services should use their billing provider ID in this line.</p> <p>NOTE: When billing a paper claim form, do not use the individual’s NPI.</p>
25	Federal Tax ID Number	Not Required	
26	Patient’s Account Number	Optional	<p>Enter information that identifies the patient or claim in the provider’s billing system.</p> <p>Submitted information appears on the Provider Claim Report (PCR).</p>
27	Accept Assignment?	Required	<p>The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer’s program.</p>
28	Total Charge	Required	<p>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.</p>
29	Amount Paid	Conditional	<p>Enter the total amount paid by Medicare or any other commercial health insurance that has made payment on the billed services.</p> <p>Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.</p>

CMS Field #	Field Label	Field is?	Instructions
30	Rsvd for NUCC Use		
31	Signature of Physician or Supplier Including Degrees or Credentials	Required	<p>Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent.</p> <p>A holographic signature stamp may be used <u>if</u> authorization for the stamp is on file with the fiscal agent.</p> <p>An authorized agent or representative may sign the claim for the enrolled provider <u>if</u> the name and signature of the agent is on file with the fiscal agent.</p> <p>Each claim must have the date the enrolled provider or registered authorized agent signed the claim form. Enter the date the claim was signed using two digits for the month, two digits for the date and two digits for the year. Example: 070116 for July 1, 2016.</p> <p><b>Unacceptable signature alternatives:</b></p> <p>Claim preparation personnel may not sign the enrolled provider’s name.</p> <p>Initials are not acceptable as a signature.</p> <p>Typed or computer printed names are not acceptable as a signature.</p> <p>“Signature on file” notation is not acceptable in place of an authorized signature.</p>
32	<b>32- Service Facility Location Information</b> <b>32a- NPI Number</b> <b>32b- Other ID #</b>	Not Required	

CMS Field #	Field Label	Field is?	Instructions
33	<b>33- Billing Provider Info &amp; Ph. #</b> <b>33a- NPI Number</b> <b>33b- Other ID #</b>	Required	Enter the name of the individual or organization that will receive payment for the billed services in the following format: 1 <sup>st</sup> Line Name 2 <sup>nd</sup> Line Address 3 <sup>rd</sup> Line City, State and ZIP Code 33a- NPI Number Enter the NPI of the billing provider 33b- Other ID # Enter the eight-digit Colorado Medical Assistance Program provider number of the individual or organization.

# Pediatric Behavioral Therapy Claim Example



## HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> PICA <span style="float: right;"><input type="checkbox"/> PICA</span>																																																																																																																									
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (ID#/DoD#) (Member ID#) (ID#) (ID#)</small>					1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>D444444</b>																																																																																																																				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Client, Ima A</b>					3. PATIENT'S BIRTH DATE MM DD YY <b>10 16 45</b>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)		SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F																																																																																																																
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)					6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)																																																																																																																		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10g. RESERVED FOR LOCAL USE		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M F b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 5, 9a and 9d.</i>																																																																																																																		
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 <u>Signature on File</u> DATE <u>1/1/15</u>										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 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)																																																																																																															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. <u>0</u> A. <u>F84.0</u> B. _____ C. _____ D. _____ E. <u>F90.9</u> F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO					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. #9901 (only 9901) I. ID QUAL J. RENDERING PROVIDER ID.#										<table border="1"> <tr> <td>1</td> <td>01</td> <td>01</td> <td>15</td> <td>01</td> <td>01</td> <td>15</td> <td>12</td> <td>T1019</td> <td></td> <td></td> <td></td> <td>142</td> <td>50</td> <td>30</td> <td>NPI</td> <td>311Z00000X</td> </tr> <tr> <td>2</td> <td></td> <td>NPI</td> <td></td> </tr> <tr> <td>3</td> <td></td> <td>NPI</td> <td></td> </tr> <tr> <td>4</td> <td></td> <td>NPI</td> <td></td> </tr> <tr> <td>5</td> <td></td> <td>NPI</td> <td></td> </tr> <tr> <td>6</td> <td></td> <td>NPI</td> <td></td> </tr> </table>										1	01	01	15	01	01	15	12	T1019				142	50	30	NPI	311Z00000X	2															NPI		3															NPI		4															NPI		5															NPI		6															NPI	
1	01	01	15	01	01	15	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. <u>Optional</u>					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ <u>142</u> <u>50</u>		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 <u>Signature</u> DATE <u>1/1/15</u>					32. SERVICE FACILITY LOCATION INFORMATION					33. BILLING PROVIDER INFO & PH# ( ) Personal Care Provider 100 Any Street Any City																																																																																																															

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

PLEASE PRINT OR TYPE

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

## Late Bill Override Date

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

### Valid Delay Reason Codes

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



The Late Bill Override Date (LBOD) allows providers to document compliance with timely filing requirements when the initial timely filing period has expired. Colorado Medical Assistance Program providers have 120 days from the date of service to submit their claim. For information on the 60-day resubmission rule for denied/rejected claims, 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.

<b>Billing Instruction Detail</b>	<b>Instructions</b>
<b>LBOD Completion Requirements</b>	<ul style="list-style-type: none"> <li>• Electronic claim formats provide specific fields for documenting the LBOD.</li> <li>• Supporting documentation must be kept on file for 6 years.</li> <li>• For paper claims, follow the instructions appropriate for the claim form you are using.                             <ul style="list-style-type: none"> <li>➤ <i>UB-04</i>: Occurrence code 53 and the date are required in FL 31-34.</li> <li>➤ <i>CMS 1500</i>: Indicate "LBOD" and the date in box 19 – Additional Information.</li> <li>➤ <i>2006 ADA Denta</i>: Indicate "LBOD" and the date in box 35 - Remarks</li> </ul> </li> </ul>

<b>Billing Instruction Detail</b>	<b>Instructions</b>
<b>Adjusting Paid Claims</b>	<p>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.</p> <p><b>Adjust the claim within 60 days</b> of the claim payment. Retain all documents that prove compliance with timely filing requirements.</p> <p><i>Note: There is no time limit for providers to adjust paid claims that would result in repayment to the Colorado Medical Assistance Program.</i></p> <p><b>LBOD</b> = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the payment.</p>
<b>Denied Paper Claims</b>	<p>If the initial timely filing period has expired and a previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was denied.</p> <p><b>Correct the claim errors and refile within 60 days</b> of the claim denial or rejection. Retain all documents that prove compliance with timely filing requirements.</p> <p><b>LBOD</b> = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the denial.</p>
<b>Returned Paper Claims</b>	<p>A previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was returned for additional information.</p> <p><b>Correct the claim errors and re-file within 60 days</b> of the date stamped on the returned claim. Retain a copy of the returned claim that shows the receipt or return date stamped by the fiscal agent.</p> <p><b>LBOD</b> = the stamped fiscal agent date on the returned claim.</p>

Billing Instruction Detail	Instructions
<p><b>Rejected Electronic Claims</b></p>	<p>An electronic claim that was previously entered within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was rejected and information needed to submit the claim was not available to refile at the time of the rejection.</p> <p><b>Correct claim errors and refile within 60 days</b> of the rejection. Maintain a printed copy of the rejection notice that identifies the claim and date of rejection.</p> <p><b>LBOD</b> = the date shown on the claim rejection report.</p>
<p><b>Denied/Rejected Due to Member Eligibility</b></p>	<p>An electronic eligibility verification response processed during the original Colorado Medical Assistance Program timely filing period states that the individual was not eligible but you were subsequently able to verify eligibility. Read also instructions for retroactive eligibility.</p> <p><b>File the claim within 60 days</b> 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.</p> <p><b>LBOD</b> = the date shown on the eligibility rejection report.</p>
<p><b>Retroactive Member Eligibility</b></p>	<p>The claim is for services provided to an individual whose Colorado Medical Assistance Program eligibility was backdated or made retroactive.</p> <p>File the claim within 120 days of the date that the individual’s eligibility information appeared on state eligibility files. Obtain and maintain a letter or form from the county departments of social services that:</p> <ul style="list-style-type: none"> <li>• Identifies the patient by name</li> <li>• States that eligibility was backdated or retroactive</li> <li>• Identifies the date that eligibility was added to the state eligibility system.</li> </ul> <p><b>LBOD</b> = the date shown on the county letter that eligibility was added to or first appeared on the state eligibility system.</p>

Billing Instruction Detail	Instructions
<p><b>Delayed Notification of Eligibility</b></p>	<p>The provider was unable to determine that the patient had Colorado Medical Assistance Program coverage until after the timely filing period expired.</p> <p><b>File the claim within 60 days</b> 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 Appendix H of the Appendices in the Provider Services <a href="#">Billing Manuals</a> section) that identifies the member, indicates the effort made to identify eligibility, and shows the date of eligibility notification.</p> <ul style="list-style-type: none"> <li>• Claims must be filed within 365 days of the date of service. No exceptions are allowed.</li> <li>• This extension is available only if the provider had no way of knowing that the individual had Colorado Medical Assistance Program coverage.</li> <li>• Providers who render services in a hospital or nursing facility are expected to get benefit coverage information from the institution.</li> <li>• The extension does not give additional time to obtain Colorado Medical Assistance Program billing information.</li> <li>• If the provider has previously submitted claims for the member, it is improper to claim that eligibility notification was delayed.</li> </ul> <p><b>LBOD</b> = the date the provider was advised the individual had Colorado Medical Assistance Program benefits.</p>
<p><b>Electronic Medicare Crossover Claims</b></p>	<p>An electronic claim is being submitted for Medicare crossover benefits within 120 days of the date of Medicare processing/payment. (Note: On the paper claim form (only), the Medicare SPR/ERA date field documents crossover timely filing and completion of the LBOD is not required.)</p> <p><b>File the claim within 120 days</b> of the Medicare processing/payment date shown on the SPR/ERA. Maintain the original SPR/ERA on file.</p> <p><b>LBOD</b> = the Medicare processing date shown on the SPR/ERA.</p>

<b>Billing Instruction Detail</b>	<b>Instructions</b>
<b>Medicare Denied Services</b>	<p>The claim is for Medicare denied services (Medicare non-benefit services, benefits exhausted services, or the member does not have Medicare coverage) being submitted within 60 days of the date of Medicare processing/denial.</p> <p><i>Note: This becomes a regular Colorado Medical Assistance Program claim, not a Medicare crossover claim.</i></p> <p><b>File the claim within 60 days</b> of the Medicare processing date shown on the SPR/ERA. Attach a copy of the SPR/ERA if submitting a paper claim and maintain the original SPR/ERA on file.</p> <p><b>LBOD</b> = the Medicare processing date shown on the SPR/ERA.</p>
<b>Commercial Insurance Processing</b>	<p>The claim has been paid or denied by commercial insurance.</p> <p><b>File the claim within 60 days</b> of the insurance payment or denial. Retain the commercial insurance payment or denial notice that identifies the patient, rendered services, and shows the payment or denial date.</p> <p>Claims must be filed within 365 days of the date of service. No exceptions are allowed. If the claim is nearing the 365-day limit and the commercial insurance company has not completed processing, file the claim, receive a denial or rejection, and continue filing in compliance with the 60-day rule until insurance processing information is available.</p> <p><b>LBOD</b> = the date commercial insurance paid or denied.</p>
<b>Correspondence LBOD Authorization</b>	<p>The claim is being submitted in accordance with instructions (authorization) from the Colorado Medical Assistance Program for a 60 day filing extension for a specific member, claim, services, or circumstances.</p> <p><b>File the claim within 60 days</b> of the date on the authorization letter. Retain the authorization letter.</p> <p><b>LBOD</b> = the date on the authorization letter.</p>

<b>Billing Instruction Detail</b>	<b>Instructions</b>
<b>Member Changes Providers during Obstetrical Care</b>	<p>The claim is for obstetrical care where the patient transferred to another provider for continuation of OB care. The prenatal visits must be billed using individual visit codes but the service dates are outside the initial timely filing period.</p> <p><b>File the claim within 60 days</b> of the last OB visit. Maintain information in the medical record showing the date of the last prenatal visit and a notation that the patient transferred to another provider for continuation of OB care.</p> <p><b>LBOD</b> = the last date of OB care by the billing provider.</p>

**Pediatric Behavioral Therapy Specialty Manual Revisions Log**

<i>Revision Date</i>	<i>Additions/Changes</i>	<i>Pages</i>	<i>Made by</i>
8/29/16	Creation of billing manual	All	gr
8/29/16	Added new code to code table	5	gr