

Prenatal Plus Program

Outpatient – Fee-For-Service

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Prenatal Plus Program

The Prenatal Plus Program (PNP) is administered by the Colorado Department of Health Care Policy and Financing (the Department). This manual details information regarding the program's programmatic components and billing requirements. The Department periodically modifies the Prenatal Plus Program benefits and services therefore, the information in this manual is subject to change, and the manual is updated as new policies are implemented.

For general information about Colorado's Medical Assistance Program, please refer to the Medicaid Provider Information found on [Billing Manuals](#) web page of the Department's website. The manual provides information about billing the Colorado Medical Assistance Program, reimbursement policies, provider participation, eligibility requirements and other useful information.

Program Overview

The Prenatal Plus Program is a case management program for pregnant women who receive Medicaid benefits and who are at risk of negative maternal and infant health outcomes. The program gives women access to a care coordinator, a registered dietician, and a mental health professional who work together to help the woman reduce her risk of having a low birth weight baby. Prenatal Plus Program services are in addition to a woman's regular prenatal care services.



- To be eligible for the program, a woman must meet the following criteria:
- Be eligible for Medicaid;
- Be pregnant;
- Be at risk of negative maternal or infant health outcomes due to lifestyle, behavioral, and non-medical parts of the woman's life that could affect her pregnancy (see Eligibility Screening Form).

For more information about the Prenatal Plus Program, please visit the [Prenatal Plus Program's](#) web page.

Reimbursable Services

Reimbursable services include nutrition and psychosocial counseling and support; general education and health promotion; and targeted case management services. With the exception of targeted case management, all services can be offered to members in an individual or group setting.

- Nutrition counseling and support provided by the registered dietitian may include nutrition screening, education, and counseling. Counseling includes such activities as nutrition care-planning, goal-setting, monitoring, follow-up, and revision of the care plan.
- Psychosocial counseling and support provided by the mental health professional may include psychosocial health screening, assessment, and counseling. Counseling and support includes such activities as care-planning, goal-planning, monitoring, follow-up, and revision of the care plan.
- General member education, health promotion, and targeted case management are services offered by the care coordinator. Topics may include basic understanding of the prenatal period, concerns related to childbirth and breastfeeding, and the post partum period and healthy infancy. Targeted case management helps member gain access to needed medical, education, social, and other services.

Rules and Regulations

The Prenatal Plus Program is administered by the Department. Rules governing the program are outlined in the Code of Colorado Regulations, 10 C.C.R. 2505 – 10 §8.748. Providers are required to

comply with all of the rules and guidance provided by the Department and are encouraged to contact the Department's policy specialist with any questions.

Required Documentation

Prenatal Plus Program sites utilize three specific forms to implement the program. All of these documents can be found on the [Prenatal Plus Program's](#) section of the Department's website at colorado.gov/hcpf. They include:

- Prenatal Plus Eligibility Screening Form
- Initial Assessment Form
- Prenatal Weight Gain Chart

While these forms are required, the method and detail of documentation of member's service plans is up to the discretion of the local Prenatal Plus Program staff. Every claim for reimbursement must be supported by clear evidence in the member's record/chart.

Provider Enrollment and Participation

Providers must be enrolled as a Colorado Medical Assistance Program provider in order to treat a Colorado Medical Assistance Program member and to submit claims for payment to the Colorado Medical Assistance Program.

If interested in becoming a Colorado Medical Assistance Program provider, please refer to the [Provider Services Enrollment](#) section of the Department's website. Enrollment documents may be downloaded and mailed to the Department's fiscal agent at:

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

- Once enrolled in the Colorado Medical Assistance Program, providers who want to provide Prenatal Plus Program services must submit a Prenatal Plus Program Provider Participation Form as an addendum to the Colorado Medical Assistance Program Provider Participation Agreement. This form is found in the Forms section of the Department's website → For Our Providers → Provider Services → [Forms](#)

Prenatal Plus Program providers must be enrolled in the Colorado Medical Assistance Program as one of the following Provider Types:

- Clinic
- Federally Qualified Health Center
- Rural Health Center
- Non-Physician Practitioner Group
- Physician
- Nurse Practitioner
- Certified Nurse-Midwife
- Physician's Assistant

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.

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
- 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. Please refer to the [Medicaid Provider Information manual](#) for additional electronic billing information.

Procedure/Healthcare Common Procedural Coding System (HCPCS) 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 Current Procedural Terminology (CPT), 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.

Prenatal Plus Program Procedure Codes and Modifiers

The Prenatal Plus Program’s services are billed using one procedure code and a combination of modifiers. The code and modifiers are explained in the tables below.

Procedure Code	Description
H1005	Prenatal care, at-risk enhanced service package

Modifier(s)	Description
52	Reduced services
TF	Intermediate level of care
TG	Complex/high tech level of care
TH	Obstetrical treatment/services, prenatal or post partum

Prenatal Plus Billing Packages

The billing options for the Prenatal Plus Program are described in the table below.

Package Type	Procedure Code	Required Modifier(s)	Condition(s) Under Which Code Can Be Billed
Partial	H1005	TH and 52	Member enrolls at 28 or more weeks gestation and receives 1-4 contacts, at least one of which must be a face-to-face contact; OR Member enrolls in the first or second trimester (prior to 28 weeks) and receives 1-4 contacts, at least one of which must be a face-to-face contact, but withdraws from the program before delivery OR does not meet the criteria for the other package categories.
Partial Plus	H1005	TH and TF	Member enrolls at 28 or more weeks gestation and receives 5-9 contacts; OR Member enrolls in the first or second trimester (prior to 28 weeks) and receives 5-9 contacts, but withdraws from the program before delivery OR does not meet the criteria for the Full package categories. With appropriate documentation, one telephone call can be counted as a contact. Calls to reschedule an appointment or to make an appointment with a member cannot be considered a contact.

Package Type	Procedure Code	Required Modifier(s)	Condition(s) Under Which Code Can Be Billed
Full	H1005	TH	Member enrolls at 27 or fewer weeks gestation; A minimum of one case conference is held; AND Member receives a total of ten (10) contacts over the course of the pregnancy and through the end of the second month following the month in which the member delivered. With appropriate documentation, one telephone call can be counted as a contact. Calls to reschedule an appointment or to make an appointment with a member cannot be considered a contact.
Full Plus	H1005	TH and TG	Member enrolls at 27 or fewer weeks gestation; A minimum of one case conference is held; AND Member receives a minimum of eleven (11) contacts over the course of the pregnancy and through the end of the second month following the month in which the member delivered. With appropriate documentation, one telephone call can be counted as a contact. Calls to reschedule an appointment or to make an appointment with a member cannot be considered a contact.

Claims Submission and Timely Filing

Prenatal Plus Program claims must be submitted directly to the Colorado Medical Assistance Program for processing within 120 days after the last date of service. The last date of service is either the delivery date or the last date of contact for those who withdraw from the program. Providers should bill completed packages as soon as possible after the delivery date, even if the member may be seen for additional visits. Please see the Late Bill Override Date (LBOD) section of this manual for more information.

Other Insurance Coverage

Occasionally, Prenatal Plus Program members have primary insurance coverage in addition to being eligible for Medicaid coverage. In these cases, claims for services must first be submitted to the primary insurance company. If the primary insurance company denies the claim, the claim can be submitted to the Colorado Medical Assistance Program for processing, along with a copy/date of the denial.

If the member is covered by one of the Colorado Medical Assistance Program’s managed care organizations, a denial is not necessary before billing for Prenatal Plus services covered by Medicaid.

Please refer to the Medicaid Provider Information found on [Billing Manuals](#) web page of the Department’s website for more information on the payer of last resort.

Billing more than once in a nine-month period

The Colorado Medicaid Management Information System (MMIS) allows for one billing per member in a nine-month period using Prenatal Plus billing codes. However, the following exceptions may be made:

- A member is seen for an initial pregnancy, subsequently has either a miscarriage or an abortion, and becomes pregnant again within a nine-month period. In this case, the provider may bill for the second pregnancy within the nine-month period.
- A member receives a Partial or Partial Plus package from one provider, then moves from the area and re-enrolls with a new provider. In this case, the first provider may bill a Partial or Partial Plus package, and the second provider may bill either a Partial, Partial Plus, Full or Full Plus package depending on the level of services provided (i.e., if all requirements for a Full package have been met, the provider can bill a Full package).

If a member leaves the program, and then re-enrolls with the same provider during the same pregnancy, the provider must request that the claim for the previously billed service package be voided out of the MMIS. Billing for the new service package can be done once criteria for the new package are met. An agency cannot bill the Colorado Medical Assistance Program for two separate packages for the same member during the same pregnancy.

Deactivate Participation in the Prenatal Plus Program

Prenatal Plus Program sites can end participation in the program at any time. Instructions can be found on the [Prenatal Plus Program's](#) web page.

Other Covered Maternity Services Not Part of the Prenatal Plus Program

The following services are available to pregnant women but must be billed in addition to Prenatal Plus Program claims:

- Clinical prenatal and postpartum care, labor, and delivery
- Depression screening for members age 20 and under
- Non-emergent medical transportation (transportation to and from Medicaid services)
- Prenatal vitamins
- Substance use disorder counseling
- Tobacco cessation counseling and medications

Contact Information

Please contact the Department's fiscal agent, Xerox State Healthcare, at 1-800-237- 0757 with billing inquiries.

The Department's Prenatal Plus Program policy specialist at 303-866-2844 can be contacted for all other inquiries.



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.

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	
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.

CMS Field #	Field Label	Field is?	Instructions
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.
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	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	Not Required	
19	Additional Claim Information	Conditional	LBOD Use to document the Late Bill Override Date for timely filing.
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

CMS Field #	Field Label	Field is?	Instructions
			<p>to the physician for lab services. Do not complete this field if <u>any</u> laboratory work was performed in the office.</p> <p>Practitioners may not request payment for services performed by an independent or hospital laboratory.</p>
21	Diagnosis or Nature of Illness or Injury	Required	<p>Enter at least one but no more than twelve diagnosis codes based on the member's diagnosis/condition.</p> <p>Enter applicable ICD indicator to identify which version of ICD codes is being reported.</p> <p>9 ICD-9-CM 0 ICD-10-CM</p>
22	Medicaid Resubmission Code	Conditional	<p>List the original reference number for resubmitted claims.</p> <p>When resubmitting a claim, enter the appropriate bill frequency code in the left-hand side of the field.</p> <p>7 Replacement of prior claim 8 Void/Cancel of prior claim</p> <p>This field is not intended for use for original claim submissions.</p>
23	Prior Authorization	Conditional	<p>CLIA</p> <p>When applicable, enter the word "CLIA" followed by the number.</p> <p>Prior Authorization</p> <p>Not Required</p>
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>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.</p> <p>Each claim form must be fully completed (totaled).</p> <p>Do not file continuation claims (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</p>

CMS Field #	Field Label	Field is?	Instructions																		
			<p>using two digits for the month, two digits for the date and two digits for the year. Example: 010114 for January 1, 2014</p> <p>For Prenatal Plus, the Date of Service is the date of final 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;">14</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;">14</td> <td style="width: 20px;">01</td> <td style="width: 20px;">01</td> <td style="width: 20px;">14</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;">14</td> <td style="width: 20px;">01</td> <td style="width: 20px;">31</td> <td style="width: 20px;">14</td> </tr> </table> <p>Practitioner claims must be consecutive days.</p> <p><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.</p> <p><u>Span billing:</u> permissible if the same service (same procedure code) is provided on consecutive dates.</p> <p>Supplemental Qualifier</p> <p>To enter supplemental information, begin at 24A by entering the qualifier and then the information.</p> <ul style="list-style-type: none"> ZZ Narrative description of unspecified code N4 National Drug Codes VP Vendor Product Number OZ Product Number CTR Contract Rate JP Universal/National Tooth Designation JO Dentistry Designation System for Tooth & Areas of Oral Cavity 	01	01	14				01	01	14	01	01	14	01	01	14	01	31	14
01	01	14																			
01	01	14	01	01	14																
01	01	14	01	31	14																
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>																		

CMS Field #	Field Label	Field is?	Instructions
			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 65 End Stage Renal Dialysis Trtmt Facility 71 State-Local Public Health Clinic 99 Other Unlisted
24C	EMG	Not Required	
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.

CMS Field #	Field Label	Field is?	Instructions
			<p>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. Prenatal Plus Program H1005 for prenatal care, at-risk enhanced service package</p>
24D	Modifier	Conditional	<p>Enter the appropriate procedure-related modifier that applies to the billed service. Up to four modifiers may be entered when using the paper claim form.</p> <p>52 Reduced services TF Intermediate level of care TG Complex/high tech level of care TH Obstetrical treatment/services, prenatal or post partum</p>
24E	Diagnosis Pointer	Required	<p>Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis.</p> <p>At least one diagnosis code reference letter must be entered.</p> <p>When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow.</p> <p>This field allows for the entry of 4 characters in the unshaded area.</p>
24F	\$ Charges	Required	<p>Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.</p> <p>Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one procedure from the same group is billed, special multiple pricing rules apply.</p> <p>The base procedure is the procedure with the highest allowable amount. The base code is used to determine the allowable amounts for additional CPT surgical procedures when more than one procedure from the same grouping is performed.</p>

CMS Field #	Field Label	Field is?	Instructions
			<p>Submitted charges cannot be more than charges made to non-Colorado Medical Assistance Program covered individuals for the same service.</p> <p>Do not deduct Colorado Medical Assistance Program co-payment or commercial insurance payments from the usual and customary charges.</p>
24G	Days or Units	Required	<p>Enter the number of services provided for each procedure code.</p> <p>Enter whole numbers only- do not enter fractions or decimals.</p>
24H	EPSDT/Family Plan	Conditional	<p>EPSDT (shaded area)</p> <p>For Early & Periodic Screening, Diagnosis, and Treatment related services, enter the response in the shaded portion of the field as follows:</p> <p>AV Available- Not Used S2 Under Treatment ST New Service Requested NU Not Used</p> <p>Family Planning (unshaded area)</p> <p>If the service is Family Planning, enter “Y” for YES or “N” for NO in the bottom, unshaded area of the field.</p>
24I	ID Qualifier	Not Required	
24J	Rendering Provider ID #	Required	<p>In the shaded portion of the field, enter the eight-digit Colorado Medical Assistance Program provider number assigned to the <u>individual</u> who actually performed or rendered the billed service. This number cannot be assigned to a group or clinic.</p> <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>

CMS Field #	Field Label	Field is?	Instructions
			Submitted information appears on the Provider Claim Report (PCR).
27	Accept Assignment?	Required	The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.
28	Total Charge	Required	Enter the sum of all charges listed in field 24F. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
29	Amount Paid	Conditional	Enter the total amount paid by Medicare or any other commercial health insurance that has made payment on the billed services. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
30	Rsvd for NUCC Use		
31	Signature of Physician or Supplier Including Degrees or Credentials	Required	<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 if 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 if 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: 070114 for July 1, 2014.</p> <p>Unacceptable signature alternatives:</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>

CMS Field #	Field Label	Field is?	Instructions
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: 1 st Line Name 2 nd Line Address 3 rd 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: 1 st Line Name 2 nd Line Address 3 rd Line City, State and ZIP Code 33a- NPI Number Enter the NPI of the billing provider 33b- Other ID # Enter the eight-digit Colorado Medical Assistance Program provider number of the individual or organization.



CMS 1500 Prenatal Plus Claim Example



HEALTH INSURANCE CLAIM FORM

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

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
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#)</small>										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 M <input checked="" type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)					6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <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)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) <input type="text"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>					11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED Signature on File DATE 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 MM DD YY QUAL									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. 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 <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES					22. RESUBMISSION CODE ORIGINAL REF. NO.									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind 9 A. V23 B. C. D. E. F. G. H. I. J. K. L.					23. PRIOR AUTHORIZATION NUMBER					24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLAC OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. I. ID. QUAL. J. RENDERING PROVIDER ID #									
1					01 01 15 01 01 15 71 H1005 TH TG A 798 15 1 NPI 12345678 0123456789														
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) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									
28. TOTAL CHARGE \$ 798 15					29. AMOUNT PAID \$					30. Revd for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Signature DATE 1/1/15					32. SERVICE FACILITY LOCATION INFORMATION					33. BILLING PROVIDER INFO & PH # ABC Prenatal Clinic 100 Any Street Any City a. 1234567890 b. 04567890									

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

Late Bill Override Date

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

Valid Delay Reason Codes

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



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

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

Billing Instruction Detail	Instructions
LBOD Completion Requirements	<ul style="list-style-type: none"> • Electronic claim formats provide specific fields for documenting the LBOD. • Supporting documentation must be kept on file for 6 years. • For paper claims, follow the instructions appropriate for the claim form you are using. <ul style="list-style-type: none"> ➤ <i>UB-04</i>: Occurrence code 53 and the date are required in FL 31-34. ➤ <i>CMS 1500</i>: Indicate “LBOD” and the date in box 19 – Additional Claim Information. ➤ <i>2006 ADA Dental</i>: Indicate “LBOD” and the date in box 35 - Remarks
Adjusting Paid Claims	<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>Adjust the claim within 60 days of the claim payment. Retain all documents that prove compliance with timely filing requirements.</p> <p><i>Note: There is no time limit for providers to adjust paid claims that would result in repayment to the Colorado Medical Assistance Program.</i></p> <p>LBOD = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the payment.</p>

Billing Instruction Detail	Instructions
<p>Denied Paper Claims</p>	<p>If the initial timely filing period has expired and a previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was denied.</p> <p>Correct the claim errors and refile within 60 days of the claim denial or rejection. Retain all documents that prove compliance with timely filing requirements.</p> <p>LBOD = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the denial.</p>
<p>Returned Paper Claims</p>	<p>A previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was returned for additional information.</p> <p>Correct the claim errors and re-file within 60 days of the date stamped on the returned claim. Retain a copy of the returned claim that shows the receipt or return date stamped by the fiscal agent.</p> <p>LBOD = the stamped fiscal agent date on the returned claim.</p>
<p>Rejected Electronic Claims</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>Correct claim errors and refile within 60 days of the rejection. Maintain a printed copy of the rejection notice that identifies the claim and date of rejection.</p> <p>LBOD = the date shown on the claim rejection report.</p>
<p>Denied/Rejected Due to Member Eligibility</p>	<p>An electronic eligibility verification response processed during the original Colorado Medical Assistance Program timely filing period states that the individual was not eligible but you were subsequently able to verify eligibility. Read also instructions for retroactive eligibility.</p> <p>File the claim within 60 days of the date of the rejected eligibility verification response. Retain a printed copy of the rejection notice that identifies the member and date of eligibility rejection.</p> <p>LBOD = the date shown on the eligibility rejection report.</p>
<p>Retroactive Member Eligibility</p>	<p>The claim is for services provided to an individual whose Colorado Medical Assistance Program eligibility was backdated or made retroactive.</p> <p>File the claim within 120 days of the date that the individual's eligibility information appeared on state eligibility files. Obtain and maintain a letter or form from the county departments of social services that:</p> <ul style="list-style-type: none"> • Identifies the patient by name • States that eligibility was backdated or retroactive • Identifies the date that eligibility was added to the state eligibility system. <p>LBOD = the date shown on the county letter that eligibility was added to or first appeared on the state eligibility system.</p>

Billing Instruction Detail	Instructions
<p>Delayed Notification of Eligibility</p>	<p>The provider was unable to determine that the patient had Colorado Medical Assistance Program coverage until after the timely filing period expired.</p> <p>File the claim within 60 days of the date of notification that the individual had Colorado Medical Assistance Program coverage. Retain correspondence, phone logs, or a signed Delayed Eligibility Certification form (see Certification & Request for Timely Filing Extension in the Provider Services Forms section) that identifies the member, indicates the effort made to identify eligibility, and shows the date of eligibility notification.</p> <ul style="list-style-type: none"> • Claims must be filed within 365 days of the date of service. No exceptions are allowed. • This extension is available only if the provider had no way of knowing that the individual had Colorado Medical Assistance Program coverage. • Providers who render services in a hospital or nursing facility are expected to get benefit coverage information from the institution. • The extension does not give additional time to obtain Colorado Medical Assistance Program billing information. • If the provider has previously submitted claims for the member, it is improper to claim that eligibility notification was delayed. <p>LBOD = the date the provider was advised the individual had Colorado Medical Assistance Program benefits.</p>
<p>Electronic Medicare Crossover Claims</p>	<p>An electronic claim is being submitted for Medicare crossover benefits within 120 days of the date of Medicare processing/ payment. (Note: On the paper claim form (only), the Medicare SPR/ERA date field documents crossover timely filing and completion of the LBOD is not required.)</p> <p>File the claim within 120 days of the Medicare processing/ payment date shown on the SPR/ERA. Maintain the original SPR/ERA on file.</p> <p>LBOD = the Medicare processing date shown on the SPR/ERA.</p>
<p>Medicare Denied Services</p>	<p>The claim is for Medicare denied services (Medicare non-benefit services, benefits exhausted services, or the member does not have Medicare coverage) being submitted within 60 days of the date of Medicare processing/denial.</p> <p><i>Note: This becomes a regular Colorado Medical Assistance Program claim, not a Medicare crossover claim.</i></p> <p>File the claim within 60 days of the Medicare processing date shown on the SPR/ERA. Attach a copy of the SPR/ERA if submitting a paper claim and maintain the original SPR/ERA on file.</p> <p>LBOD = the Medicare processing date shown on the SPR/ERA.</p>
<p>Commercial Insurance Processing</p>	<p>The claim has been paid or denied by commercial insurance.</p> <p>File the claim within 60 days of the insurance payment or denial. Retain the commercial insurance payment or denial notice that identifies the patient, rendered services, and shows the payment or denial date.</p> <p>Claims must be filed within 365 days of the date of service. No exceptions are allowed. If the claim is nearing the 365-day limit and the commercial</p>

Billing Instruction Detail	Instructions
	<p>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>LBOD = the date commercial insurance paid or denied.</p>
<p>Correspondence LBOD Authorization</p>	<p>The claim is being submitted in accordance with instructions (authorization) from the Colorado Medical Assistance Program for a 60 day filing extension for a specific member, claim, services, or circumstances.</p> <p>File the claim within 60 days of the date on the authorization letter. Retain the authorization letter.</p> <p>LBOD = the date on the authorization letter.</p>
<p>Member Changes Providers during Obstetrical Care</p>	<p>The claim is for obstetrical care where the patient transferred to another provider for continuation of OB care. The prenatal visits must be billed using individual visit codes but the service dates are outside the initial timely filing period.</p> <p>File the claim within 60 days of the last OB visit. Maintain information in the medical record showing the date of the last prenatal visit and a notation that the patient transferred to another provider for continuation of OB care.</p> <p>LBOD = the last date of OB care by the billing provider.</p>



Prenatal Plus Revisions Log

Revision Date	Additions/Changes	Pages	Made by
12/03/2012	Manual Created	All	km,vcr, jg
04/26/2013	Formatted and updated TOC	All	jg
05/22/2014	Updated manual for removal of the Primary Care Physician Program	Throughout	Mm
8/15/14	Replaced all CO 1500 references with CMS 1500	Throughout	ZS
8/15/14	Updated Professional Claim Billing Instructions section with CMS 1500 information.		ZS
8/15/14	Replaced all client references with member	Throughout	ZS
8/21/14	Updated all weblinks for the Department's new website	Throughout	MM
12/08/14	Removed Appendix H information, added Timely Filing document information	20	mc
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.