

Private Duty Nursing

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Private Duty Nursing

Providers must be enrolled as a Colorado Medical Assistance Program provider in order to:

- Treat a Colorado Medical Assistance Program member
- Submit claims for payment to the Colorado Medical Assistance Program



The Private Duty Nursing (PDN) program provides skilled nursing services on an intermittent basis to Colorado Medical Assistance Program members in their place of residence. A plan of care as ordered by the attending physician is developed by the Home Health agency. The plan of care is reviewed periodically by the physician. All plan of care services are subject to post-payment review for medical necessity and regulation compliance.

Providers should refer to the [Code of Colorado Regulations](#), Program Rules (10 C.C.R. 2505-10), for specific information when providing Private Duty Nursing (PDN).

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 prior authorized by the Department. Requests for paper claim submission 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 prior 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. In addition, the UB-04 Certification document must be completed and attached to all claims submitted on the paper UB-04. Electronically mandated claims submitted on paper are processed, denied, and marked with the message "Electronic Filing Required".

Electronic Claims

Instructions for completing and submitting electronic claims are available through the following:

- X12N Technical Report 3 (TR3) for the 837P, 837I, or 837D (wpc-edi.com)
- Companion Guides for the 837P, 837I, or 837D in the Provider Services [Specifications](#) section of the Department's website.
- Web Portal User Guide (via within the 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 General Provider Information manual for additional electronic billing information.



General Prior Authorization Requirements

All PDN Prior Authorization Requests (PARs) must be submitted via CareWebQI ([CWQI](#)). The additional forms necessary for PDN PAR submission are available in the Provider Services [Forms](#) section or from the authorizing agency. PAR forms must be completed and sent to the authorizing agency before services can be billed. Instructions for completing the PAR form are included in this manual. Authorizing agency information is listed in Appendices C and D of the Appendices in the Provider Services [Billing Manuals](#) section.

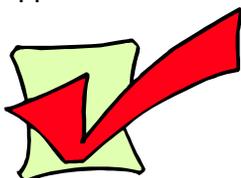
The Colorado Medical Assistance Program requires the completion of a PAR form for:

- All Private Duty Nursing services prior to starting services

Orders must specify how often treatment or visits will be and the length of visit.

- Time submitted that is outside of or different from the orders will be deducted and the units adjusted accordingly.
- Do not submit claims before a copy of the PAR is received or made available unless submission is necessary to meet timely filing requirements. Refer to the [Department Program Rules - Code of Colorado Regulations](#) located in Boards & Committees in the Medical Services Board section of the Department’s website for required attachments.

Approval of a PAR does **not** guarantee Colorado Medical Assistance Program payment and does not serve as a timely filing waiver. Authorization only assures that the approved service is a medical necessity and is considered a benefit of the Colorado Medical Assistance Program. All claims, including those for prior authorized services, must meet eligibility and claim submission requirements (e.g. timely filing, Primary Care Physician information completed appropriately, third party resources payments pursued, required attachments included, etc.).



After a PAR has been reviewed, the status of the PAR is sent to the fiscal agent and a PAR letter is sent to the provider. For approved services, allow sufficient time for the authorizing agency to enter the PAR data into the Medicaid Management Information System (MMIS) before submitting a claim for the authorized service. Submitted claim data is checked against the PAR file, therefore, **do not** submit a copy of the PAR with the claim. The authorizing agency identifies the appropriate PAR data using member identification information and the PAR number noted on the claim.

Note: When a PAR is revised, the number on the original PAR must be used on the claim. (Do not use the PAR number assigned to the revision when completing a claim. Use the original PAR number.)

General Prior Authorization Request Instructions

Submit all appropriate documentation to support your PDN request including detailed demographics, diagnosis, physician’s orders, treatment plans, nursing summaries, nurse aide assignment sheets, medications, etc. via CWQI.

Revision must also be submitted via CWQI and must be completed in a timely manner prior to the expiration of the PAR. Revenue Coding

The following table identifies the only valid revenue codes for billing Private Duty Nursing to the Colorado Medical Assistance Program. Valid revenue codes are not always a Colorado Medical Assistance Program benefit. When valid non-benefit revenue codes are used, the claim must be completed according to the billing instructions for non-covered charges.

Private duty nursing providers billing on the UB-04 claim form for services provided to authorized members must use the appropriate condition code in form locators 18 through 28 (Condition Codes) and use the revenue codes listed below. Claims submitted with revenue codes that are not listed below are denied.

Private Duty Nursing Revenue Codes

Service Type	Revenue Code	Procedure Code	Modifier	Unit Value
PDN-RN	552	T1000	TD	Hour
PDN-LPN	559	T1000	TE	Hour
PDN-RN (group-per member)	580	T1000	HQ, TD	Hour
PDN-LPN (group-per member)	581	T1000	HQ, TE	Hour
"Blended" group rate / member*	582	T1000	HQ, TD, TE	Hour

Paper Claim Reference Table

The information in the following table provides instructions for completing form locators as they appear on the paper UB-04 claim form. Instructions for completing the UB-04 claim form are based on the current *National Uniform Billing Committee (NUBC) UB-04 Reference Manual*. Unless otherwise noted, all data form locators on the UB-04 have the same attributes (specifications) for the Colorado Medical Assistance Program as those indicated in the *NUBCUB-04 Reference Manual*.

All code values listed in the *NUBC UB-04 Reference Manual* for each form locator **may not** be used for submitting paper claims to the Colorado Medical Assistance Program. The appropriate code values listed in this manual must be used when billing the Colorado Medical Assistance Program.

The UB-04 Certification document (located after the Late Bill Override Date instructions and in the Provider Services [Forms](#) section) must be completed and attached to all claims submitted on the paper UB-04. Completed UB-04 paper Colorado Medical Assistance Program claims, including hardcopy Medicare claims, should be mailed to the correct fiscal agent address located in Appendix A in the Appendices of the Provider Services [Billing Manuals](#) section.

Do not submit "continuation" claims. Each claim form has a set number of billing lines available for completion. Do not crowd more lines on the form. Billing lines in excess of the designated number are not processed or acknowledged. Claims with more than one page, may be submitted through the Web Portal.

The Paper Claim Reference Table below lists the required, optional and/or conditional form locators for submitting the paper UB-04 claim form to the Colorado Medical Assistance Program for PDN claims.



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



Form Locator and Label	Completion Format	Instructions
<p>4. Type of Bill</p>	<p>3 digits</p>	<p>Required</p> <p>Private Duty Nursing</p> <p>Use 33X for Private Duty Nursing services</p> <p>Use 321-324 or 341-344 for Medicare crossover claims.</p> <p>Enter the three-digit number indicating the specific type of bill. The three-digit code requires one digit each in the following sequences (Type of facility, Bill classification, and Frequency):</p> <p><u>Digit 1</u> <u>Type of Facility</u></p> <p>1 Hospital</p> <p>2 Skilled Nursing Facility</p> <p>3 Home Health</p> <p>4 Religious Non-Medical Health Care Institution Hospital Inpatient</p> <p>5 Religious Non-Medical Health Care Institution Post-Hospital Extended Care Services</p> <p>6 Intermediate Care</p> <p>7 Clinic (Rural Health/FQHC/Dialysis Center)</p> <p>8 Special Facility (Hospice, RTCs)</p> <p><u>Digit 2</u> <u>Bill Classification (Except clinics & special facilities):</u></p> <p>1 Inpatient (Including Medicare Part A)</p> <p>2 Inpatient (Medicare Part B only)</p> <p>3 Outpatient</p> <p>4 Other (for hospital referenced diagnostic services or home health not under a plan of treatment)</p> <p>5 Intermediate Care Level I</p> <p>6 Intermediate Care Level II</p> <p>7 Sub-Acute Inpatient (revenue code 19X required with this bill type)</p> <p>8 Swing Beds</p> <p>9 Other</p> <p><u>Digit 2</u> <u>Bill Classification (Clinics Only):</u></p> <p>1 Rural Health/FQHC</p> <p>2 Hospital Based or Independent Renal Dialysis Center</p> <p>3 Freestanding</p>

Form Locator and Label	Completion Format	Instructions
4. Type of Bill (continued)	3 digits	<u>Digit 3</u> <u>Frequency:</u> 0 Non-Payment/Zero Claim 1 Admit through discharge claim 2 Interim - First claim 3 Interim - Continuous claim 4 Interim - Last claim 7 Replacement of prior claim 8 Void of prior claim
5. Federal Tax Number	None	Submitted information is not entered into the claim processing system.
6. Statement Covers Period – From/Through	From: 6 digits MMDDYY Through: 6 digits MMDDYY	Required Private Duty Nursing "From" date is the actual start date of services. "From" date cannot be prior to the start date reported on the initial prior authorization, if applicable, or is the first date of an interim bill. "Through" date is the actual discharge date, or final date of an interim bill. "From" and "Through" dates cannot exceed a calendar month (e.g., bill 01/15/10 thru 01/31/10 and 02/01/10 thru 02/15/10, not 01/15/10 thru 02/15/10). Dates must match the prior authorization if applicable. If patient is admitted and discharged the same date, that date must appear in both fields. Detail dates of service must be within the "Statement Covers Period" dates.
8a. Patient Identifier		Submitted information is not entered into the claim processing system.
8b. Patient Name	Up to 25 characters: Letters & spaces	Required Enter the member's last name, first name and middle initial.
9a. Patient Address – Street	Characters Letters & numbers	Required Enter the member's street/post office box as determined at the time of admission.
9b. Patient Address – City	Text	Required Enter the member's city as determined at the time of admission.

Form Locator and Label	Completion Format	Instructions
9c. Patient Address – State	Text	Required Enter the member’s state as determined at the time of admission.
9d. Patient Address – Zip	Digits	Required Enter the member’s zip code as determined at the time of admission.
9e. Patient Address – Country Code	Text	Optional
10. Birthdate	8 digits (MMDDCCYY)	Required Enter the member’s birthdate using two digits for the month, two digits for the date, and four digits for the year (MMDDCCYY format). Example: 01012009 for January 1, 2009.
11. Patient Sex	1 letter	Required Enter an M (male) or F (female) to indicate the member’s sex.
12. Admission Date	6 digits	Required Private Duty Nursing Enter the date care originally started from any funding source (e.g., Medicare, Colorado Medical Assistance Program, Third Party Resource, etc.).
13. Admission Hour		Not Required
14. Admission Type		Not Required
15. Source of Admission		Not Required
16. Discharge Hour		Not Required
17. Patient Discharge Status	2 digits	Required Private Duty Nursing Enter member status as ongoing patient (code 30) or as of discharge date. Agencies are limited to the following codes: 01 Discharged to Home 03 Discharged/Transferred to SNF 04 Discharged/Transferred to ICF

Form Locator and Label	Completion Format	Instructions
		05 Discharged/Transferred to Another Type of Institution 06 Discharged/Transferred to organized Home Health Care Program (HCBS) 07 Left Against Medical Advice 20 Expired (Deceased - Not for Hospice use) 30 Still patient (ongoing) 40 Expired at home
17. Patient Discharge Status	2 digits	41 Expired in hospital, SNF, ICF, or free-standing hospice 42 Expired - place unknown 50 Hospice - Home 51 Hospice - Medical Facility
18-28. Condition Codes	2 Digits	Conditional Use condition code A1 to bill PDN hours greater than 16 for children
29. Accident State		Optional
31-34. Occurrence Code/Date	2 digits and 6 digits	Required Use occurrence code 27 and enter the Plan of Care start date. Enter the date using MMDDYY format.
35-36. Occurrence Span Code From/ Through	None	Leave Blank
38. Responsible Party Name/ Address	None	Leave blank
39-41. Value Code and Amount	2 characters and 9 digits	Conditional Enter appropriate codes and related dollar amounts to identify monetary data or number of days using whole numbers, necessary for the processing of this claim. Never enter negative amounts. Fields and codes must be in ascending order. If a value code is entered, a dollar amount or numeric value related to the code <u>must</u> always be entered. 01 Most common semiprivate rate (Accommodation Rate) 06 Medicare blood deductible

Form Locator and Label	Completion Format	Instructions
		14 No fault including auto/other 15 Worker's Compensation 31 Patient Liability Amount 32 Multiple Patient Ambulance Transport 37 Pints of Blood Furnished 38 Blood Deductible Pints 40 New Coverage Not Implemented by HMO
39-41. Value Code and Amount (continued)	2 characters and 9 digits	Conditional 45 Accident Hour Enter the hour when the accident occurred that necessitated medical treatment. Use the same coding used in FL 18 (Admission Hour). 49 Hematocrit Reading - EPO Related 49 Hematocrit Reading - EPO Related 58 Arterial Blood Gas (PO2/PA2) 68 EPO-Drug 80 Covered Days 81 Non-Covered Days Enter the amount paid by indicated payer: A3 Estimated Responsibility Payer A B3 Estimated Responsibility Payer B C3 Estimated Responsibility Payer C For Rancho Coma Score bill with appropriate diagnosis for head injury.
42. Revenue Code	3 digits	Required Enter the revenue code that identifies the specific accommodation or ancillary service provided. List revenue codes in ascending order. A <u>revenue code</u> must appear only <u>once</u> per date of <u>service</u> . If more than one of the same service is provided on the same day, combine the <u>units</u> and charges on one line accordingly. Enter the appropriate Revenue code. <i>Private Duty Nursing services cannot be provided to Nursing Facility residents.</i>
43. Revenue Code Description	Text	Required Enter the revenue code description or abbreviated description.

Form Locator and Label	Completion Format	Instructions
44. HCPCS/Rates/HIPPS Rate Codes	5 digits	Required for the following: <ul style="list-style-type: none"> ▪ Private Duty Nursing RN visit: Use only HCPCS code T1000 with modifier TD for revenue code 552. ▪ Private Duty Nursing LPN visit: Use only HCPCS code T1000 with modifier TE for revenue code 559. ▪ Private Duty Nursing private duty nursing RN group visit: Use only HCPCS code T1000 with modifiers HQ and TD for revenue code 580. ▪ Private Duty Nursing private duty nursing LPN group visit: Use only HCPCS code T1000 with modifiers HQ and TE for revenue code 581. When billing HCPCS codes, the appropriate revenue code must also be billed.
45. Service Date	6 digits	Required Enter the date of service using MMDDYY format for each detail line completed.
46. Service Units	3 digits	Required Enter a unit value on each line completed. Use whole numbers only. Do not enter fractions or decimals and do not show a decimal point followed by a 0 to designate whole numbers (e.g., Do not enter 1.0 to signify one unit)
47. Total Charges	9 digits	Required Enter the total charge for each line item. Calculate the total charge as the number of units multiplied by the unit charge. Do not subtract Medicare or third party payments from line charge entries. Do not enter negative amounts. A grand total in line 23 is required for all charges.
48. Non-Covered Charges	Up to 9 digits	Conditional Enter incurred charges that are not payable by the Colorado Medical Assistance Program. Non-covered charges must be entered in both FL 47 (Total Charges) and FL 48 (Non-Covered Charges.) Each column requires a grand total.
50. Payer Name	1 letter and text	Required Enter the payment source code followed by name of each payer organization from which the provider might expect payment.

Form Locator and Label	Completion Format	Instructions
		At least one line must indicate The Colorado Medical Assistance Program. Source Payment Codes B Workmen's Compensation C Medicare D Colorado Medical Assistance Program E Other Federal Program F Insurance Company G Blue Cross, including Federal Employee Program H Other - Inpatient (Part B Only) I Other Line A Primary Payer Line B Secondary Payer Line C Tertiary Payer
51. Health Plan ID	8 digits	Required Enter the provider's Health Plan ID for each payer name. Enter the eight digit Colorado Medical Assistance Program provider number assigned to the billing provider . Payment is made to the enrolled provider or agency that is assigned this number.
52. Release of Information	N/A	Submitted information is not entered into the claim processing system.
53. Assignment of Benefits	N/A	Submitted information is not entered into the claim processing system.
54. Prior Payments	Up to 9 digits	Conditional Complete when there are Medicare or third party payments. Enter third party and/or Medicare payments.
55. Estimated Amount Due	Up to 9 digits	Conditional Complete when there are Medicare or third party payments. Enter the net amount due from The Colorado Medical Assistance Program after provider has received other third party, Medicare or patient liability amounts.

Form Locator and Label	Completion Format	Instructions
55. Estimated Amount Due (continued)	Up to 9 digits	Medicare Crossovers Enter the sum of the Medicare coinsurance plus Medicare deductible less third party payments and patient liability amounts.
56. National Provider Identifier (NPI)	10 digits	Optional Enter the billing provider’s 10-digit National Provider Identifier (NPI).
57. Other Provider ID		Optional Submitted information is not entered into the claim processing system.
58. Insured’s Name	Up to 30 characters	Required Enter the member’s name on the Colorado Medical Assistance Program line. Other Insurance/Medicare Complete additional lines when there is third party coverage. Enter the policyholder's last name, first name, and middle initial.
60. Insured’s Unique ID	Up to 20 characters	Required Enter the insured's unique identification number assigned by the payer organization. Include letter prefixes or suffixes.
61. Insurance Group Name	14 letters	Conditional Complete when there is third party coverage. Enter the name of the group or plan providing the insurance to the insured.
62. Insurance Group Number	17 digits	Conditional Complete when there is third party coverage. Enter the identification number, control number, or code assigned by the carrier or fund administrator identifying the group under which the individual is covered.
63. Treatment Authorization Code	Up to 18 characters	Conditional Complete when the service requires a PAR. Enter the PAR/authorization number in this field, if a PAR is required and has been approved for services.
64. Document Control Number		Optional Submitted information is not entered into the claim processing system.

Form Locator and Label	Completion Format	Instructions
65. Employer Name	Text	Conditional Complete when there is third party coverage. Enter the name of the employer that provides health care coverage for the individual identified in FL 58 (Insured Name).
66. Diagnosis Version Qualifier		Optional Submitted information is not entered into the claim processing system.
67. Principal Diagnosis Code	Up to 6 digits	Required Enter the exact diagnosis code describing the principal diagnosis that exists at the time of admission or develops subsequently and affects the length of stay. Do not add extra zeros to the diagnosis code.
67A- 67Q. Other Diagnosis	6 digits	Optional Enter the exact diagnosis code corresponding to additional conditions that co-exist at the time of admission or develop subsequently and which effect the treatment received or the length of stay. Do not add extra zeros to the diagnosis code.
69. Admitting Diagnosis Code	6 digits	Not Required Enter the diagnosis code as stated by the physician at the time of admission.
70. Patient Reason Diagnosis		Submitted information is not entered into the claim processing system.
71. PPS Code		Submitted information is not entered into the claim processing system.
72. External Cause of Injury Code (E-code)	6 digits	Optional Enter the diagnosis code for the external cause of an injury, poisoning, or adverse effect. This code must begin with an "E".
74. Principal Procedure Code/ Date	N/A	Not Required
74A. Other Procedure Code/Date	N/A	Not Required

Form Locator and Label	Completion Format	Instructions
<p>76. Attending NPI – Conditional QUAL - Conditional ID - (Colorado Medical Assistance Provider #) – Required</p>	<p>10 digits 8 digits 8 digits</p>	<p>NPI - Enter the 10-digit NPI assigned to the physician having primary responsibility for the patient's medical care and treatment. QUAL – Enter "1D" for Medicaid followed by the provider's eight-digit Colorado Medical Assistance Program provider ID. Medicaid ID - Enter the eight-digit Colorado Medical Assistance Program provider number assigned to the physician having primary responsibility for the patient's medical care and treatment. Numbers are obtained from the physician, and <u>cannot</u> be a clinic or group number. (If the attending physician is not enrolled in the Colorado Medical Assistance Program or if the member leaves the ER before being seen by a physician, the hospital may enter their individual numbers.) Enter the attending physician's last and first name. This form locator must be completed for all services.</p>
<p>77. Operating- NPI/QUAL/ID</p>		<p>Optional Submitted information is not entered into the claim processing system.</p>
<p>78-79. Other ID NPI – Conditional QUAL - Conditional ID - (Colorado Medical Assistance Provider #) – Conditional</p>	<p>NPI - 10 digits QUAL – Text Medicaid ID - 8 digits</p>	<p>Conditional Complete when attending physician is not the PCP or to identify additional physicians. Enter up to two 10-digit NPI and eight digit physician Colorado Medical Assistance Program provider numbers, when applicable. This form locator identifies physicians other than the attending physician. If the attending physician is not the primary care physician (PCP) or if a clinic is a PCP agent, enter the PCP eight digit Colorado Medical Assistance Program provider number in FL 78. The name of the Colorado Medical Assistance Program member's PCP appears on the eligibility verification. The Colorado Medical Assistance Program does not require that the primary care physician number appear more than once on each claim submitted. The "other" physician's last and first names are optional.</p>
<p>80. Remarks</p>	<p>Text</p>	<p>Enter specific additional information necessary to process the claim or fulfill reporting requirements.</p>

Form Locator and Label	Completion Format	Instructions
81. Code-Code-QUAL/CODE/VALUE (a-d)		Submitted information is not entered into the claim processing system.

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 a 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>

Billing Instruction Detail	Instructions
	<p>LBOD = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the payment.</p>
<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 member by name

Billing Instruction Detail	Instructions
	<ul style="list-style-type: none"> • 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>
<p>Delayed Notification of Eligibility</p>	<p>The provider was unable to determine that the member 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>

Billing Instruction Detail	Instructions
	<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 member, 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>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 member 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 member transferred to another provider for continuation of OB care.</p> <p>LBOD = the last date of OB care by the billing provider.</p>



Colorado Medical Assistance Program

Institutional Provider Certification

This is to certify that the foregoing information is true, accurate and complete.

This is to certify that I understand that payment of this claim will be from Federal and State funds and that any falsification, or concealment of material fact, may be prosecuted under Federal and State Laws.

Signature: _____ *Date:* _____

This document is an addendum to the UB-04 claim form and is required per 42 C.F.R. 445.18 (a)(1-2) to be attached to paper claims submitted on the UB-04.

Private Duty Nursing Claim Example

1 Home Health Agency 100 Saginaw Street Anytown, CO 80201 303-333-3333		2		3a PAT CNTL.# b. MED. REC.#		4 TYPE OF BILL 331	
8 PATIENT NAME a Client, Ima D.		9 PATIENT ADDRESS a 123 Main Street		c CO		d 88888	
10 BIRTHDATE 02/13/1948		11 SEX F		12 DATE 01/05/05		13 ADMISSION 13 HR 14 TYPE 15 SRC 16 DHR 1 30	
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PDN Revisions Log

Revision Date	Additions/Changes	Pages	Made by
02/13/2008	<i>Electronic Claims – Updated first two paragraphs with bullets</i>	1	<i>pr-z</i>
04/24/2008	<i>PARs – Added additional Information about submission within 10-days</i>	4	<i>jg</i>
04/24/2008	<i>Updated new name for DDM and corrected address for CFMC</i>	7	<i>jg</i>
11/05/2008	<i>Updated web addresses</i>	<i>Throughout</i>	<i>jg</i>
03/29/2009	<i>General Updates</i>	<i>Throughout</i>	<i>jg</i>
01/18/2010	<i>Updated Web site links</i>	<i>Throughout</i>	<i>jg</i>
02/17/2010	<i>Changed EOMB to SPR</i>	25	<i>jg</i>
03/04/2010	<i>Added link to Program Rules</i>	1	<i>jg</i>
08/31/2011	<i>Changed wording from authorizing agent to authorizing agency. Deleted CFMC, added ColoradoPAR address and fax number</i>	4,7 7	<i>crc</i>
09/21/2011	<i>Added TOC Accepted changes Created new claim examples</i>	1 <i>Throughout</i> 29-31	<i>Jg</i>
12/06/2011	<i>Replaced 997 with 999 Replaced wpc-edi.com/hipaa with wpc-edi.com/ Replaced Implementation Guide with Technical Report 3 (TR3)</i>	4 3 3	<i>ss</i>
07/20/2012	<i>Removed PAR Instructional Reference Removed old PAR form Added new PAR form and Completion Instructions Updated TOC</i>	5-8 9 6 & 7 1	<i>jg</i>
08/27/2012	<i>Updated flowchart</i>	7	<i>jg</i>
10/28/2013	<i>Removed Home Health Information</i>	<i>Throughout</i>	<i>gb</i>
01/06/2014	<i>Updated Billing Information Formatted and updated Paper Claim Reference Table Formatting</i>	1 & 2 5-15 <i>Throughout</i>	<i>Jg</i>
8/29/14	<i>Replaced all references of client to member</i>	<i>Throughout</i>	<i>ZS</i>
8/29/14	<i>Replaced 1 instance of CO 1500 to CMS 1500</i>		<i>ZS</i>
9/3/14	<i>Updated all web links to the Department’s new website</i>	<i>Throughout</i>	<i>MM</i>
12/08/14	<i>Removed Appendix H information, added Timely Filing document information</i>	17	<i>mc</i>

<i>2/5/15</i>	<i>Replaced Revenue Code 582 with 581 in Label 44 Instructions</i>	<i>10</i>	<i>Ak</i>
<i>3/6/15</i>	<i>Corrected formatting, changed font to Tahoma, revised patient/client to members in appropriate places. Swapped out seal.</i>	<i>Throughout, 21</i>	<i>JH</i>
<i>03/06/2015</i>	<i>TOC Updates</i>	<i>1</i>	<i>bl</i>

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.*

Note: Medicare crossover claims are valid only with Medicare claims for visits rather than episodes. LUPA payments not episode case mix payment.