

# CMS 1500 Specialty Manuals

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# Colorado Medical Assistance Managed Care Programs

Some Colorado Medical Assistance Program members obtain Medicaid through enrollment in a Colorado Medical Assistance Managed Care Organization (MCO). The Colorado Medical Assistance Program offers several Managed Care options described in this section.

- Managed Care Organizations (MCOs)
  - Denver Health & Hospital Authority
  - Colorado Access
  - Rocky Mountain Hospital & Med
- Program of All-Inclusive Care for the Elderly (PACE)
- Mental Health Capitation Program (MHCP)



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## Identifying Colorado Medical Assistance Program Managed Care Enrollment

Colorado Medical Assistance Managed Care enrollment may be identified through verifying eligibility.

- An inquiry response through the Colorado Medical Assistance Program Secure Web Portal (Web Portal) will first display member information under “Member Details”, followed by the member’s eligibility status under “Member Eligibility Details.” Please note that a member may show as Medicaid “eligible” on the Web Portal response, but not be eligible for Medicaid medical assistance payments. It is important to review the entire response. If the Web Portal displays “Third Party Liability” and Medicare is listed, the message “Member has Medicare covered services only, no drug benefits” means that the member is eligible only for premium assistance. All provider billings to Medicaid will be denied for lack of coverage. Only Medicare will pay for services (in essence, Medicaid purchases Medicare services for the member, but does not provide any direct Medicaid medical benefits at all.
- Co-payment information is displayed next under “Co-payment”.
- If the member is enrolled in Managed Care, that information is displayed under the title “Prepaid Health Plan.” Almost all Medicaid members are enrolled in the mandatory Mental Health Capitation Program. The member’s behavioral health organization is usually displayed first with the message “MHPROV Services” in large bold letters to identify the Managed Care plan as a mental health plan.

Managed Care enrollment information (if any) is often displayed last under the “Prepaid Health Plan” title. A bolded message reminds providers to get authorization from the plan before providing “non-exempt services.” (See section below for a list of Services that can be provided without managed care approval).

Providers must always verify eligibility information, including managed care participation, *before* providing services. Failure to verify eligibility information increases the risk of not receiving payment for rendered services. Fee-for-service claims for members who are enrolled in Colorado Medical Assistance MCO will be denied.

**Providers must comply with the requirements of Managed Care Organizations.**

- For MCOs, service providers must be enrolled in the MCO network or have authorization to provide non-exempt services (see information below under Managed Care Organizations). The name and telephone number of the MCO is identified on the eligibility verification response.

**Enrollment Services**

Members who wish to enroll in managed care can receive counseling and enrollment assistance from Health Colorado. Members can call 303-839-2120 in the Denver Metro area, or 1-888-367-6557 outside the metro area, or visit the Health Colorado website at [www.healthcolorado.net](http://www.healthcolorado.net).

**Managed care support services for providers**

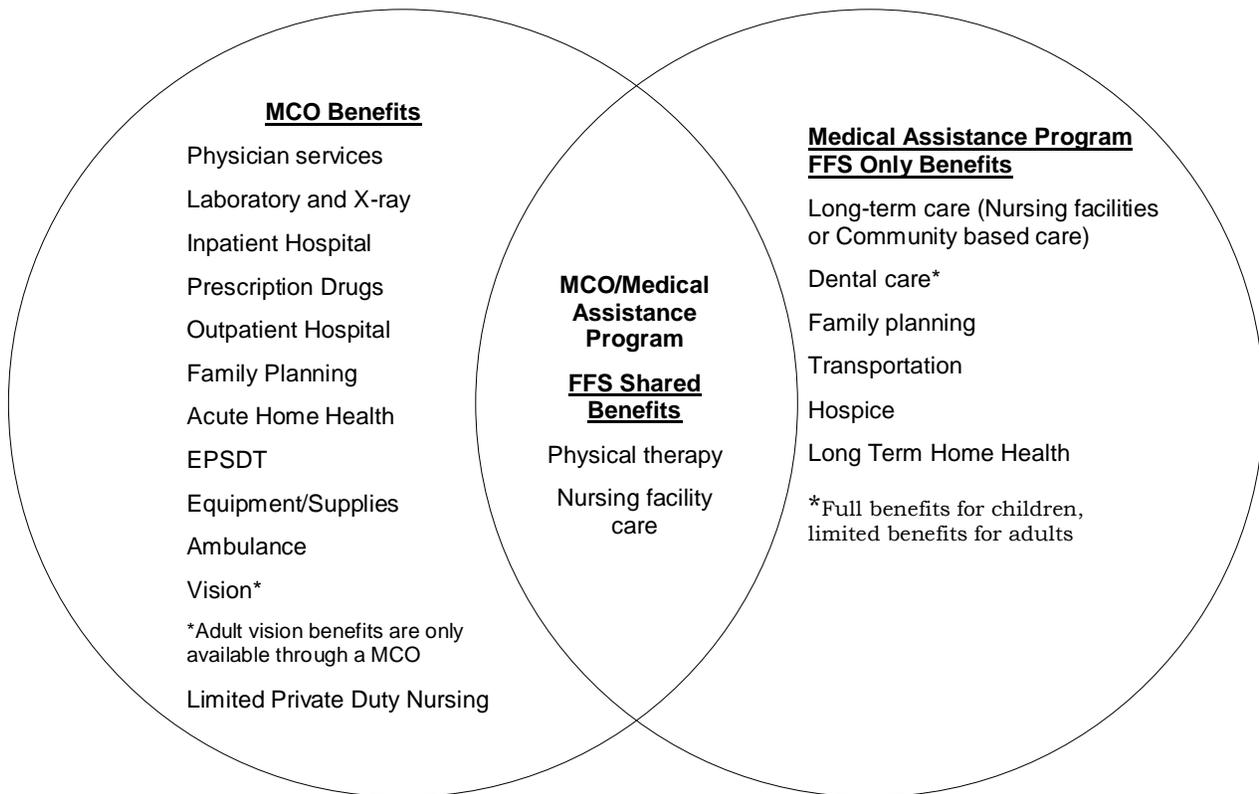
Questions about the policies and billing procedures for a specific MCO should be directed to that MCO.

## Managed Care Organizations (MCOs)

The Colorado Medical Assistance Program contracts with MCOs to provide benefits to Medical Assistance Program members enrolled in the MCO. MCO-enrolled members must obtain available services from the MCO.



## Benefit availability



MCO enrolled members are entitled to the same Colorado Medical Assistance Program benefits as members who are not enrolled in managed care.



- MCOs provide most of the Colorado Medical Assistance Program benefits available to enrolled members.
- Some benefits are not available from the MCO and these benefits are provided through FFS reimbursement.
- If the MCO offers a limited benefit, MCO enrolled members must obtain available services from the MCO. When the MCO benefit is exhausted, additional medically necessary services are provided through FFS reimbursement.

## Fee-for-Service Benefits for MCO-Enrolled Members

The Colorado Medical Assistance Program pays FFS claims for MCO-enrolled members under the following circumstances:

- When a Colorado Medical Assistance Program benefit is not provided by the MCO,
- When the member has exhausted MCO benefits and requires additional Colorado Medical Assistance Program benefit services.

**When the service is one of the following exempt-from-authorization services:**

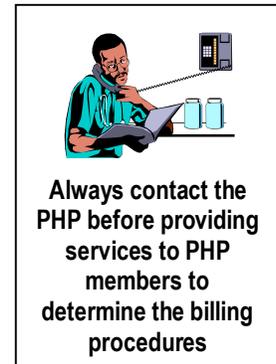
- |                                |                            |
|--------------------------------|----------------------------|
| ▪ Emergency Services           | ▪ EPSDT dental services    |
| ▪ Emergency Transportation     | ▪ Obstetrical services     |
| ▪ Non-emergency transportation | ▪ Family Planning Services |

FFS claims for services provided to MCO enrolled members must have the following attachments:

- A benefits exhausted statement (explanation of benefits) for MCO exhausted benefits.
- A statement from the MCO indicating the service is not a provided MCO benefit. If the MCO routinely does not provide a specific service (e.g., nursing facility, physical therapy, etc.), the non-benefit statement is optional. Benefit coverage may vary from one MCO to another.

## MCO Benefits by Non-MCO Providers

The Colorado Medical Assistance Program will not pay claims for services provided to a MCO enrolled member that are available through the MCO. Providers should always contact the member’s MCO before providing services to determine the extent of benefits available through the MCO. Direct questions about MCO covered benefits and billing instructions to the MCO listed on the eligibility verification response.



### Emergency Care

Emergency care and out-of-area URGENT care provided by a non-MCO provider is the responsibility of the MCO. The non-MCO provider must comply with all MCO notification requirements.

- The non-MCO provider must contact the MCO within 48 hours of providing services.
- The non-MCO provider must contact the MCO for authorization before providing non-emergency services.
- The MCO may not pay for services determined to be non-emergent.

### Inquiries



Inquiries about MCO payments or denials should be directed to the MCO.

Inquiries about claims submitted to the fiscal agent, Xerox State Healthcare at 1-800-237-0757, for exhausted MCO benefits or non-covered MCO services should be directed to the fiscal agent.

## Program of All-Inclusive Care for the Elderly (PACE)

### What is PACE?

The Program of All-Inclusive Care for the Elderly (PACE) is a Medicare/Medicaid managed care system that provides health care and support services to persons 55 years of age and older. The goal of PACE is to assist frail individuals to live in their communities as independently as possible by providing services depending on their needs. PACE-enrolled members obtain **all** medical care services—acute as well as nursing facility care through the PACE provider. There are several PACE providers with service areas in the Denver Metropolitan area, and Delta, Montrose and El Paso Counties.

### Who is Eligible?

- Persons age 55 or older.
- Persons must meet nursing facility level of care. This is determined by a State Medicaid agency.
- Persons must live in the area of the PACE organization.



- Persons must be able to live in a community setting without jeopardizing his or her health or safety.

**PACE Benefits**

All PACE providers provide adult day health care, home care, in-home support services, acute hospital care, and nursing facility care. A multidisciplinary team coordinates and plans all services based on each participant’s individual medical and supportive care needs. The PACE PCP authorizes all health care services and supplies provided to PACE members.

Services provided by hospitals, nursing facilities, medical specialists, and other selected health providers are delivered by contract between the service provider and the PACE site/provider.

The fiscal agent denies claims submitted for services to PACE members.

**Community Behavioral Health Services Program  
(Mental Health Program)**

The Colorado Medical Assistance Program mental health and substance use disorder benefits are provided through the Community Behavioral Health Services Program (Behavioral Health Program). State contracted Behavioral Health Organizations (BHOs), are responsible for Colorado Medical Assistance Program behavioral health services provided to enrolled members who reside in the BHOs geographical area. Mental health providers must apply to become a network provider with the BHO in their area. If the network is not accepting new providers, providers are limited to providing services to Medicaid members with diagnoses that are not covered under the BHO contract. The BHOs contact information is located in the [Behavioral Health Organizations](#) section of the Department’s website at [colorado.gov/hcpf](http://colorado.gov/hcpf).

**Enrollment and Participation**

Almost all Colorado Medical Assistance Program members are enrolled in the Mental Health Program. Colorado Medical Assistance Program members in the following aid categories are automatically enrolled in the Mental Health Program.

- Old Age Pension, Part A and Part B
- Aid to the Needy Disabled
- Aid to the Blind
- Temporary Aid to Needy Families
- Baby Care Kids Care
- Foster Care

**Behavioral Health Program Benefits**

The BHOs are responsible for the cost of

- Mental health benefits
- Substance Use Disorder (SUD) benefits

The two benefits of mental health and substance use disorder combined are referred to as *behavioral health* benefits as they encompass the varying diagnoses, conditions, and treatments that are found in traditional mental health and substance use disorder benefits. An exhaustive list of covered benefits is provided by the BHO.

Behavioral health providers should always determine Behavioral Health Program eligibility before providing services by checking the member’s eligibility in the provider web portal.

**Note:** The Colorado Medical Assistance Program does not pay FFS claims for benefits covered by the Behavioral Health Program. The BHO's do not pay for unauthorized services.

All behavioral health services benefits for Behavioral Health Program members must be obtained through the BHO (with the exception of Medicare-covered behavioral health services provided to Medicare/Colorado Medical Assistance-eligible members and emergency care as listed below).

Refer to Appendix T in the Department's Provider Services [Billing Manuals](#) section to determine if a specific procedure or diagnosis must be provided through the BHO.

## Emergency Care

- Non-network providers who render emergency mental health services must bill the BHO.
- Non-network providers who render emergency substance use disorder services must bill FFS to the Department's fiscal agent.
- The non-network practitioner and the BHO negotiate payment rates and billing procedures.
- BHOs may deny payment for non-emergency services and follow up care provided without prior authorization from the BHO.

## Member Enrollment

With the exception of some select populations/individuals, essentially all Colorado Medical Assistance Program members are automatically enrolled in the Community Behavioral Health Program. Exceptions can found in the [Code of Colorado Regulations](#) (10 CCR 2505-10 8.212).

## Full Benefit Medicare-Medicaid Enrollees

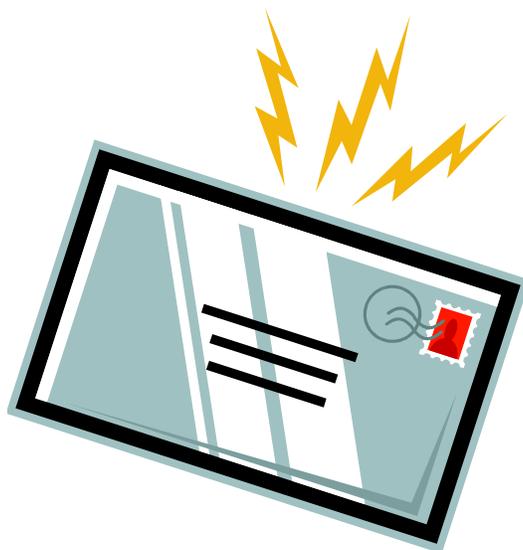
- Full Benefit Medicare-Medicaid Enrollees may obtain Medicare-covered services from either BHO or non-BHO providers. The fiscal agent accepts and processes submitted Medicare crossover claims.
- If the behavioral health service is covered by the Colorado Medical Assistance Program only, the Full Benefit Medicare-Medicaid Enrollee must obtain the service from the BHO.



## Behavioral Health Program Non-included Services

- Behavioral health-related prescription drugs. Claims for prescription drugs are submitted to the Department's fiscal agent under the FFS Reimbursement Program or to the MCO for MCO-enrolled members.
- Nursing facility residential care. Nursing facility claims are submitted to the Department's fiscal agent for FFS reimbursement.
- Services in a Residential Treatment Center (RTC). RTC claims are submitted to the Department's fiscal agent for FFS reimbursement.
- Claims submitted to the Department's fiscal agent, Xerox State Healthcare, should be addressed to:

Fiscal Agent for the Colorado Medical Assistance Program  
Claims and PARs Submission  
P.O. Box 30  
Denver, CO 80201



# School Health Services



The Colorado School Health Services Program is a state program that allows school districts and Boards of Cooperative Education Services (BOCES) to access federal Medicaid funds for delivering Medicaid allowable school health services to Medicaid eligible children. Reimbursement received by a district through the School Health Services Program shall be used by the district to provide additional and expanded health services.

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## School Health Services Program Manual

For an in depth look at the policy requirements of Medicaid School Health Services Program please refer to the [School Health Services Program Manual](#) that is located on the [Department's Web Site](#). The manual includes information on covered services, provider enrollment, random moment time study, reimbursement and administrative claiming.

### Prior authorization requirements

There are no prior authorization requirements for School Health Services.



### Procedure Codes



The School Health Services Program uses procedure codes that are approved by the Centers for Medicare & Medicaid Services (CMS). The codes are used for submitting claims for services provided to Colorado Medical Assistance Program members and 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 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.

Valid codes and descriptions for the School Health Services Program are listed below.

PROCEDURE CODE	PROCEDURE CODE DESCRIPTIONS	MODIFIER	
		1	2
<b>Behavioral Health Services</b>			
96150	Mental Health/Behavioral Assessment – LPC/MFT		
96150	Mental Health/Behavioral Assessment – PSY	AH	
96150	Mental Health/Behavioral Assessment – SW	AJ	
96151	Mental Health/Behavior Re-Assessment – LPC/MFT		
96151	Mental Health/Behavior Re-Assessment – PSY	AH	
96151	Mental Health/Behavior Re-Assessment – SW	AJ	
H0004	Behavioral Health Counseling/Therapy – LPC/MFT		
H0004	Behavioral Health Counseling/Therapy – PSY	AH	
H0004	Behavioral Health Counseling/Therapy – SW	AJ	
H0004	Behavioral Health Counseling/Therapy, Group – LPC/MFT	HQ	
H0004	Behavioral Health Counseling/Therapy, Group – PSY	AH	HQ
H0004	Behavioral Health Counseling/Therapy, Group – SW	AJ	HQ
<b>Motor Therapy Services</b>			
97001	Physical Therapy Evaluation (1 unit per evaluation)		
97002	Physical Therapy Re-Evaluation (1 unit per evaluation)		
97110	Physical Therapy – PT	GP	
97110	Physical Therapy – PTA	H M	
97150	Physical Therapy, Group – PT	GP	
97150	Physical Therapy, Group – PTA	H M	
97003	Occupational Therapy Evaluation (1 unit per evaluation)		
97004	Occupational Therapy Re-Evaluation (1 unit per evaluation)		
97530	Occupational Therapy – OT	G O	
97530	Occupational Therapy –COTA	H M	

PROCEDURE CODE	PROCEDURE CODE DESCRIPTIONS	MODIFIER	
		1	2
97139	Occupational Therapy, Group – OT	G O	
97139	Occupational Therapy, Group – COTA	H M	
T1023	Orientation & Mobility Evaluation		
T1023	Orientation & Mobility Re-Evaluation	52	
97116	Gait Training (O&M only)		
97116	Gait Training, Group (O&M only)	HQ	
97533	Sensory Integration (O&M only)		
97533	Sensory Integration, Group (O&M only)	HQ	
<b>Nursing Services</b>			
T1001	Nursing Assessment/Evaluation (RN only)		
T1002	RN Services, Up To 15 Min		
T1002	RN Services, Group, Up To 15 Min	HQ	
T1003	LPN Services, Up To 15 Min (delegated RN service)		
T1003	LPN Services, Group, Up To 15 Min (delegated RN service)	HQ	
T1004	Qualified Nursing Aide, Up To 15 Min (delegated RN service)		
T1004	Qualified Nursing Aide, Group, Up To 15 Min (delegated RN service)	HQ	
<b>Personal Care Services</b>			
T1019	Personal Care Services, Individual (per 15 minutes)		
S5125	Personal Care Services, Group (per 15 min) – Safety/Behavior Monitoring Only		
<b>Physician Services</b>			
99201	New Patient Evaluation and Management (10 minutes)		
99202	New Patient Evaluation and Management (20 minutes - expanded)		
99203	New Patient Evaluation and Management (30 minutes - detailed)		

PROCEDURE CODE	PROCEDURE CODE DESCRIPTIONS	MODIFIER	
		1	2
99204	New Patient Evaluation and Management (45 minutes - comprehensive)		
99205	New Patient Evaluation and Management (60 minutes – high complexity)		
99212	Established Patient Eval/Management (10 minutes – straightforward)		
99213	Established Patient Eval/Management (15 minutes – low complexity)		
99214	Established Patient Eval/Management (25 minutes – moderate complexity)		
99215	Established Patient Eval/Management (40 minutes – high complexity)		
<b>Speech and Audiology Services</b>			
92506	Speech Evaluation – SLP	GN	
92507	Speech Language Therapy, Individual		
92508	Speech Language Therapy, Group		
V5008	Audiology Screening/Evaluation (Audiologist only)		
V5299	Audiology Services		
V5299	Audiology Services, Group	HQ	
<b>Targeted Case Management Services</b>			
T1017	Targeted Case Management		
<b>Transportation Services</b>			
T2001	Non-Emergency Transportation - Patient Attendant/Escort/Aide (per 15 minutes)		
T2001	Non-Emergency Transportation, Group - Patient Attendant/Escort/Aide (per 15 minutes)	HQ	
T2003	Non-Emergency Transportation – Trip Encounter (per one-way trip)		

## Acronyms

SLP - Speech Language Pathologist

RN - Registered Nurse

LPC - Licensed Practical Counselor

MFT - Marriage & Family Therapist

PSY - Psychologist

SW - Social Worker

OT - Occupational Therapist

LPN - Licensed Practical Nurse

PT - Physical Therapist

PTA - Physical Therapy Assistant

OT - Occupational Therapist

COTA - Certified Occupational Therapy Assistant

## Paper Claim Reference Table

The paper claim reference table lists required and conditional fields for the CMS 1500 paper claim form for School Health Services. For complete CMS 1500 paper claim instructions, see the Paper Claim Instructional Reference in the [Medicaid Provider Information](#) manual.

Instructions for completing and submitting electronic claims are available through the X12N Technical Report 3 (TR3) for the 837P ([wpc-edi.com](http://wpc-edi.com)), 837P Companion Guide (in the Provider Services [Specifications](#) section of the Department’s Web site), and in the Web Portal User Guide (via within the portal).

School Health Services’ claims shall be billed as a single date of service, using the specific date a service is provided. Use number of units to identify repeated services by the same provider, on the same date.

CMS Field #	Special Instructions
<b>1. Insurance Type</b>	Required
<b>1a. Insured’s ID Number</b>	Required
<b>2. Patient’s Name</b>	Required
<b>3. Patient’s Date of Birth / Sex</b>	Required
<b>4. Insured’s Name</b>	Conditional Complete if the member is eligible for Medicare benefits.
<b>5. Patient’s Address</b>	Not Required
<b>6. Client Relationship to Insured</b>	Conditional Complete if the member is covered by a commercial health care insurance policy.
<b>7. Insured’s Address</b>	Not Required
<b>8. Reserved for NUCC Use</b>	Not Required
<b>9. Other Insured’s Name</b>	Conditional Complete if the member is covered by a commercial health care insurance policy.
<b>9a. Other Insured’s Policy or Group Number</b>	Conditional Complete if the member is covered by a commercial health care insurance policy.

CMS Field #	Special Instructions
9b. Reserved for NUCC Use	
9c. Reserved for NUCC Use	
9d. Insurance Plan or Program Name	Conditional Complete if the member is covered by a commercial health care insurance policy.
10a-c. Complete if the member is covered by a commercial health care insurance policy.	Conditional
10d. Reserved for Local Use	
11. Insured's Policy, Group or FECA Number	Conditional
11a. Insured's Date of Birth, Sex	Conditional
11b. Other Claim ID	Not Required
11c. Insurance Plan Name or Program Name	Not Required
11d. Is there another Health Benefit Plan?	Conditional Complete if the member is covered by a commercial health care insurance policy.
12. Patient's or Authorized Person's signature	Required
13. Insured's or Authorized Person's Signature	Not Required
14. Date of Current Illness Injury or Pregnancy	Conditional
15. Other Date	Not Required
16. Date Patient Unable to Work in Current Occupation	Not Required

CMS Field #	Special Instructions
17. Name of Referring Physician	Not Required
18. Hospitalization Dates Related to Current Service	Conditional
19. Additional Claim Information	Conditional
20. Outside Lab? \$ Charges	Conditional
21. Diagnosis or Nature of Illness or Injury	Required
22. Medicaid Resubmission Code	Conditional
23. Prior Authorization	Conditional
24A. Dates of Service	Required
24B. Place of Service	Required
24C. EMG	Conditional
24D. Procedures, Services, or Supplies	Required
24D. Modifier	Conditional
24E. Diagnosis Pointer	Required
24F. \$ Charges	Required
24G. Days or Units	Required
24H. EPSDT/Family Plan	Conditional

CMS Field #	Special Instructions
24I. ID Qualifier	Not Required
24J. Rendering Provider ID #	Required
25. Federal Tax ID Number	Not Required
26. Patient's Account Number	Optional
27. Accept Assignment?	Required
28. Total Charge	Required
29. Amount Paid	Conditional
30. Rsvd for NUCC Use	
31. Signature of Physician or Supplier Including Degrees or Credentials	Required
32. 32- Service Facility Location Information 32a- NPI Number 32b- Other ID #	Conditional
33. 33- Billing Provider Info & Ph # 33a- NPI Number 33b- Other ID #	Required



### CMS 1500 Specialty Manuals Revisions Log

Revision Date	Section/Action	Pages	Made by
03/09/2007	<i>EPSDT – Replaced Immunization Schedules</i>	28-31	<i>jk</i>
03/09/2007	<i>Medical/Surgical – Corrected crossover claim</i>	62	<i>jk</i>
03/09/2007	<i>Obstetrical Care – Updated PE information</i>	71	<i>jk</i>
03/09/2007	<i>Outpatient Substance Abuse Treatment – Added no PCP referral required</i>	99	<i>jk</i>
03/09/2007	<i>Outpatient Substance Abuse Treatment – Updated claim example</i>	106	<i>jk</i>
03/29/2007	<i>Outpatient Substance Abuse Treatment – Corrected typo on page 100</i>	100	<i>jk</i>
03/30/2007	<i>Updated Appendices references</i>	<i>Throughout</i>	<i>jk</i>
09/10/2007	<i>Outpatient Substance Abuse Treatment – Added procedure codes on page 104</i>	104	<i>jk</i>
09/21/2007	<i>Added Telemedicine section</i>	133-141	<i>jk</i>
11/29/2007	<i>Corrected Telemedicine Originator claim example</i>	140	<i>jk</i>
11/30/2007	<i>Obstetrical Care – Changed MID to MIC</i>	67	<i>jk</i>
03/18/2008	<i>EPSDT – Revised Immunization Schedule statement</i>	23	<i>jk</i>
04/15/2008	<i>PT/OT/S&amp;LT – Updated introduction and Benefits and Limitations</i>	79-80	<i>jk</i>
05/22/2008	<i>PACE – Updated information</i>	65	<i>jk</i>
02/04/2010	<i>Updated TOC and Web site links</i>	1-4, <i>Throughout</i>	<i>jk</i>
02/26/2010	<i>Verified TOC and Relabeled Telemedicine claim examples</i>	1-4 136 & 137	<i>jk</i>
03/29/2010	<i>Change field number for Member Sex from 4 to 5</i>	101	<i>jk</i>
07/01/2011	<i>Removed the completed specialty manuals (Audiology, ASCs, EPSDT, Independent Lab, Medical/Surgical Services, OP Substance Abuse Treatment, Supplies &amp; DME, Telemedicine and Vision and Eyewear) Spelled out Colorado 1500 Updated PE reference Updated narrative for codes 59400 &amp; 59510 Updated narrative for codes 59410 &amp; 59409 Added X for 4th &amp; 5th digit in diagnosis examples Deleted code example in second sentence under anesthesia Deleted and added new code 99460-99463 range in first paragraph under Examination and evaluation of healthy newborn</i>	<i>Throughout</i>  TOC 10 11 12 13 14 16	<i>dc</i>

<b>Revision Date</b>	<b>Section/Action</b>	<b>Pages</b>	<b>Made by</b>
07/01/2011	Deleted instructions and added no longer a benefit criteria under Routine or ritual circumcision, added code 54161 Deleted and added new code 99465 under Newborn resuscitation or care of the high risk newborn at delivery Spelled out Colorado in 1500 Paper Claim Reference Table Deleted last sentence in under Paper Claim Reference Table and spelled out Colorado 1500 for TRCCF required fields Spelled out Colorado 1500 Spelled out Colorado 1500 on Transportation Claim example Changed the UB92 to UB-04 on the Paper UB-04 Transportation Instructional Reference Renamed the Form Locator and Label names for numbers: 1, 6, 8b, 9a, 10, 11, 18-28, 42, 45, 46, 50, 60, 67, 76 Deleted 82, 85, and 86 as form locators Added the Institutional Provider Certification	17 17 42 42 56 59 62 62 63 65	dc
01/31/2012	Changed authorizing agent to authorizing agency	50, 51, 53, 54, 57	jg
09/18/2012	Added link to Colorado Access Changed link from Billing Information to Colorado 1500 General Billing Information in Paper Claim Reference Table descriptions Updated RCCF claim form Added UB-04 Transportation Claim example	1 18, 27, 32 & 49 35 57	jg
09/26/2012	Updated Transportation claim examples	52-54	cc
09/28/2012	Added new Colorado 1500 Transportation claim examples Checked formatting Updated TOC	50-52 All i & ii	jg
12/05/2012	Replaced Dually Eligible with Medicare-Medicaid enrollee	9	jg
03/03/2013	Removed RCCF Program information into the RCCF Billing Manual	31-36	cc
07/26/2013	Updated BHO information per Provider Enrollment documents	8-11	cc
09/27/2013	Added links to the MED-178 instructions and form	15	cc
10/14/2013	Removed Department's Customer Service 303-866-3513 number	4	jg
01/25/2014	Removed Obstetrical Care – Moved to the Obstetrical Care Billing Manual	10-22	jg
01/27/2014	Removed Transportation – Moved to Transportation Manual	18-38	jg
05/14/2014	Updated billing manual for removal of the Primary Care Physician Program	Throughout	Mm
07/07/2014	Updated various wording and content via benefit SME	Throughout	Mm

<b>Revision Date</b>	<b>Section/Action</b>	<b>Pages</b>	<b>Made by</b>
<i>07/07/2014</i>	<i>Updated references of 'Client' to 'Member'</i>	<i>Throughout</i>	<i>Mm</i>
<i>8/29/14</i>	<i>Updated claims reference table</i>		<i>ZS</i>
<i>8/29/14</i>	<i>Updated references of CO 1500 to CMS 1500</i>	<i>Throughout</i>	<i>ZS</i>
<i>9/3/14</i>	<i>Updated all web links for the Department's new website</i>	<i>Throughout</i>	<i>MM</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.*