Speech Therapy Outpatient – Fee-For-Service Billing and Policy Manual

Provider Qualifications

Eligible Providers

Eligible providers may be individual practitioners or may be employed by home care agencies, children's developmental service agencies, health departments, Federally Qualified Health Centers (FQHC), clinics, or hospital outpatient facilities. The provider agency or the individual provider must verify that rendering providers meet the following qualifications:

Speech-language Pathologists (SLPs) must have a current certification by the Colorado Department of Regulatory Agencies (DORA) pursuant to the Speech-language Pathology Practice Act.

Speech-language Pathology Assistants are support personnel who, following academic and/or on-the-job training, perform tasks prescribed, directed, and supervised by DORA-certified speech-language pathologists. Speech-language pathologists must follow the ASHA guidelines on the training, use, and supervision of assistants. **Speech-language pathology assistants** must practice under the general supervision of a Colorado registered speech-language pathologist.

- Speech-language pathology assistants cannot enroll with Health First Colorado and therefore cannot place any identifying number on a claim form. Therefore, the supervising therapist's NPI must be used as the *rendering provider* on the claim form for services rendered by the assistant.

Clinical Fellows, practicing under the general supervision of a DORA-certified speech-language pathologist may provide speech therapy services.

- Clinical Fellows cannot enroll with Health First Colorado and therefore cannot place any identifying number on a claim form. Therefore, the supervising therapist's NPI must be used as the rendering provider on the claim form for services rendered by the Clinical Fellow.

Provider Participation

Providers must be enrolled as a Health First Colorado provider in order to:

- Treat a Health First Colorado member
- Submit claims for payment to the Health First Colorado

All speech therapists must submit a completed provider enrollment to become a Health First Colorado provider. Providers will find enrollment information in the Provider Services Enrollment section of the Department's website (colorado.gov/hcpf).

General Policies

1. The term "Outpatient" means any therapy which is not performed in an Inpatient Hospital or School setting, or by a Home Health Agency.
2. Speech-language pathologists not employed by an agency, clinic, hospital, school district, or physician may bill the Health First Colorado directly. Providers should refer to the Code of Colorado Regulations, Qualified Non-Physician Practitioners Eligible to Provide Physician's

Services (10 CCR 2505-10, Section 8.2003.C), for specific information when providing speech therapy.

3. All Outpatient Speech Therapy services must have a written order/prescription/referral by any of the following:
    - Physician (M.D. or D.O.)
    - Physician Assistant
    - Nurse Practitioner
    - An approved Individualized Family Service Plan (IFSP) for Early Intervention Speech Therapy
4. Speech Therapy services must be medically necessary to qualify for Health First Colorado (Colorado's Medicaid Program) reimbursement. Medical necessity, as defined under program rule 8.200.1, physician services, means:

    A covered service that will, or is reasonably expected to prevent, diagnose, cure, correct, reduce or ameliorate the pain and suffering, or the physical, mental, cognitive or developmental effects of an illness, injury or disability; and for which there is no other equally effective or substantially less costly course of treatment suitable for the member's needs.
5. Speech therapy services must always be rendered in conjunction with a written evaluation and Plan of Care. This Plan of Care must outline:
    - Specific treatment goals
    - Proposed interventions/treatment to be provided during the episode of care
    - Proposed duration and frequency of each service to be provided
    - Estimated duration of episode of care

    The therapist's Plan of Care must be reviewed, revised if necessary, and signed, as medically necessary by the member's physician, or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law at least once every 90 days. The care plan should not cover more than a 90-day period or the time frame documented in the Individual Family Service Plan (IFSP). (Senate bill 07-004 states the IFSP "shall qualify as meeting the standard for medically necessary services." Therefore no physician is required to sign a work order for the IFSP.)
6. Pursuant to the Affordable Care Act's requirements that State Medicaid Agencies ensure correct ordering, prescribing, and referring (OPR) National Provider Identification (NPI) numbers be on the claim form (42 CFR §455.440):
    - All Outpatient Speech Therapy claims must contain the valid NPI number of the OPR physician, physician assistant, nurse practitioner, or provider associated with an Individualized Family Service Plan (IFSP), in accordance with Program Rule 8.125.8.A.
    - All physicians, physician assistants, nurse practitioners, or providers associated with an IFSP who order, prescribe, or refer Outpatient Speech Therapy services for Health First Colorado members must be enrolled in Health First Colorado (42 CFR §455.410), in accordance with Program Rule 8.125.7.D. OPR Providers can begin enrollment on Health First Colorado's website.
        - The new enrollment requirement for OPR providers does not include a requirement to see Health First Colorado members or to be listed as a Health First Colorado provider for member assignments or referrals.

- Physicians or other eligible professionals who are already enrolled in Health First Colorado as participating providers and who submit claims to Health First Colorado are not required to enroll separately as OPR providers.

7. The term "valid OPR NPI number" means the registered NPI number of the provider that legitimately orders, prescribes, or refers the Outpatient Speech Therapy service being rendered, as indicated by the procedure code on the claim.
    - Claims without a valid OPR NPI number which are paid will then be subject to recovery.
    - Medical documentation must be kept on file to substantiate the order, prescription, or referral for Outpatient Speech Therapy. Claims lacking such documentation on file will be subject to recovery.
8. Health First Colorado recognizes that Outpatient Speech Therapy ordered in conjunction with an approved IFSP for Early Intervention may not necessarily have an ordering provider. Under this circumstance alone the rendering provider must use their own NPI number as the OPR NPI number.
    - Early Intervention Outpatient Speech Therapy claims must have modifier 'TL' attached on the procedure line item for Health First Colorado to identify that the services rendered were associated with an approved IFSP.
        - Any claim with modifier 'TL' attached must be for a service ordered by an approved IFSP and delivered within the time span noted in the IFSP.
        - If the OPR NPI on the claim is that of the rendering provider, and the claim does not have modifier 'TL' attached, the claim is subject to recovery.
9. Educational, personal need, and comfort therapies are not covered speech therapy benefits for any member regardless of age.
10. Therapies provided as part of a member's IEP (individualized education program) by a therapist in the school setting are not separately reimbursable. These services are paid for by the school district which is reimbursed by the Department. Providers may not submit claims for services performed in the school setting.
11. Reference the Speech-language and Hearing Services Benefit Coverage Standard found on our website for further coverage and policy information.

Payment for Covered Services

Regardless of whether Health First Colorado has actually reimbursed the provider, billing members for covered services is strictly prohibited. Balance billing is prohibited. If reimbursement is made, providers must accept this payment as *payment in full* (see Program Rule 8.012). The provider may only bill the member for services not covered by Health First Colorado.

- Members may be billed for non-covered services in accordance with C.R.S. 25.5-4-301(1)(a)(I).
    - *(1) (a) (I) Except as provided in section 25.5-4-302 and subparagraph (III) of this paragraph (a), no recipient or estate of the recipient shall be liable for the cost or the cost remaining after payment by medicaid, medicare, or a private insurer of medical benefits authorized by Title XIX of the social security act, by this title, or by rules promulgated by the state board, which benefits are rendered to the recipient by a provider of medical services authorized to render such service in the state of Colorado, except those contributions required pursuant to section 25.5-4-209 (1). However, a recipient may enter into a documented agreement with a provider under which the recipient agrees to pay for*

items or services that are nonreimbursable under the medical assistance program. Under these circumstances, a recipient is liable for the cost of such services and items.

- If Prior Authorization Requests (PAR) for services are required, the following policy applies:
  - Technical/lack of information (LOI) denial does not mean those services are not covered. Members may not be billed for services denied for LOI.
  - Services partially approved are still considered covered services. Members may not be billed for the denied portion of the request.
  - Services totally denied for not meeting medical necessity criteria are considered non-covered services.

For detailed coverage and service limitations, please refer to the Speech-language and Hearing Services Benefit Coverage Standard on the Department's website.

Rehabilitative Speech Therapy

In accordance with 10 CCR 2505-10 8.200.3.D.2.d.i, Rehabilitative speech therapy is a covered benefit under the following conditions. "Rehabilitative" means therapy that treats acute injuries and illnesses which are non-chronic conditions. Rehabilitative is therefore short-term in nature.

Member Eligibility

1. Adult Policy
   a. All Health First Colorado members age 21 and over may receive Rehabilitative speech therapy to treat non-chronic conditions and acute illness and injury.
2. Child Policy
   a. All Health First Colorado members age 20 and under may receive Rehabilitative speech therapy to treat non-chronic conditions and acute illness and injury.
3. The acute condition must be documented in all medical/treatment session notes, and must be accompanied by an order/referral/prescription by a licensed Health First Colorado enrolled physician, physician assistant, or nurse practitioner.

Habilitative Speech Therapy

In accordance with 10 CCR 2505-10 8.017.B, Habilitative speech therapy is a covered benefit under the following conditions. The Colorado Division of Insurance has defined "Habilitative" services to be:

Services that help a person retain, learn, or improve skills and functioning for daily living that are offered in parity with, and in addition to, any rehabilitative services offered in Colorado's Essential Health Benefits (EHB) benchmark plan. Parity in this context means of like type and substantially equivalent in scope, amount, and duration.

"Habilitative" means therapy that treats chronic conditions with the purpose of helping the member retain or improve skills and functioning that are affected by the chronic condition. Habilitative therapy may therefore be long-term in nature.

Member Eligibility

1. Adult Policy
   a. All Health First Colorado members ages 21 and over are considered adults. Only adults who are on the Alternative Benefit Plan (ABP), the ACA Adult Health First Colorado Benefit Plan, may receive Habilitative speech therapy.

i. When checking a member's ID in the eligibility portal, adult expansion members will have the coverage of "ABP – Alternative Benefit Plan – HR" listed in the coverage details box. Eligible members may receive outpatient PT, OT, and ST for the purposes of habilitation in addition to rehabilitation. If the adult member **only** has the benefit coverage of "TXIX – Medicaid State Plan – HR", they are not eligible for Habilitative speech therapy services.

b. Prior Authorization Requests for Habilitative speech therapy are required for adults. See the prior authorization section of this manual for details on this process.

c. The chronic condition must be documented in all medical/treatment session notes, as well as in the Prior Authorization Request, and must be accompanied by an order/referral/prescription by a licensed Health First Colorado enrolled physician, physician assistant, or nurse practitioner.

d. Eligible members may receive Habilitative speech therapy in addition to Rehabilitative speech therapy.

2. Child Policy

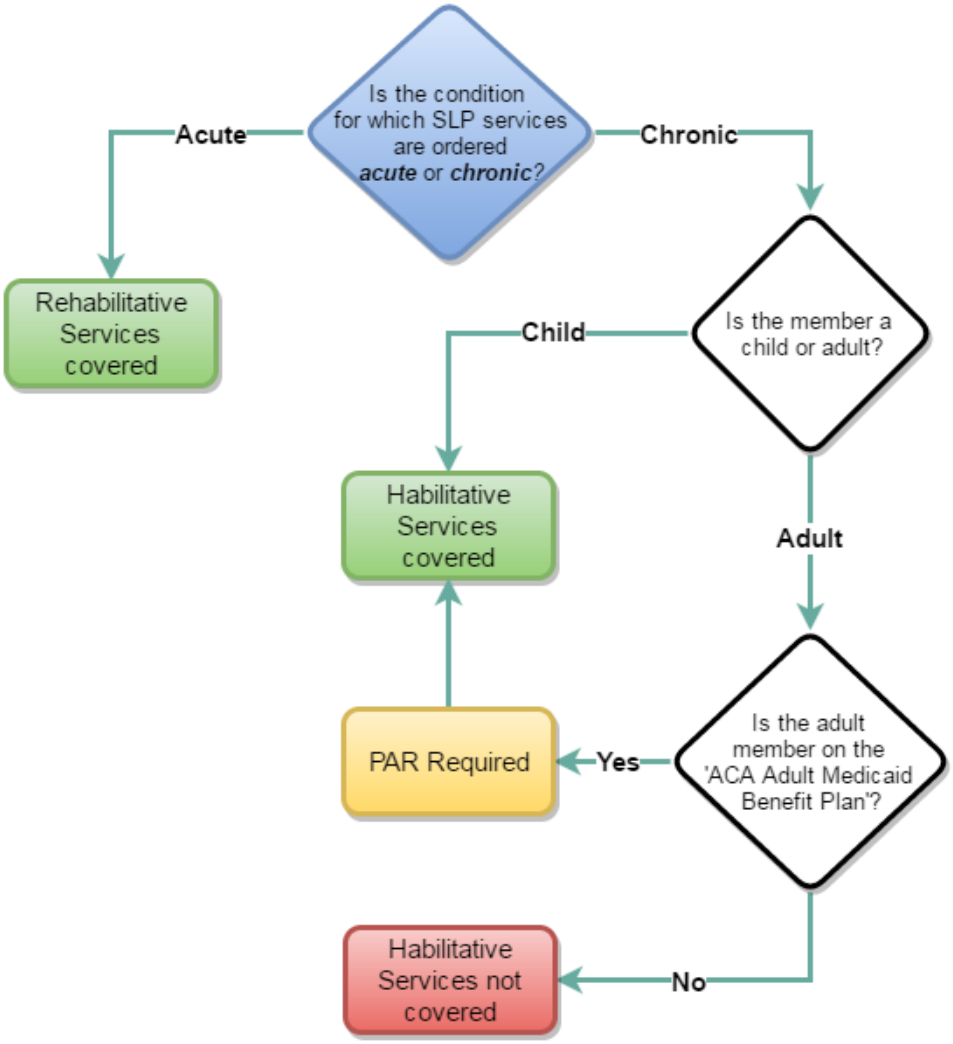
a. All Health First Colorado members ages 20 and under may receive Habilitative speech therapy to treat a chronic condition which requires ongoing speech therapy to prevent against the loss of functional ability.

b. The chronic condition must be documented in all medical/treatment session notes and must be accompanied by an order/referral/prescription by a licensed Health First Colorado enrolled physician, physician assistant, or nurse practitioner.

c. Prior Authorization Requests are not required for children.

d. Eligible members may receive Habilitative speech therapy in addition to Rehabilitative speech therapy.

Coverage Diagram



Benefit Limitations

1. Rehabilitative and Habilitative speech therapy is limited to five (5) units of service per date of service.
2. Eligible members may not receive both Rehabilitative and Habilitative speech therapy services on the same date of service.

Additional Limitations and Notes

- Habilitative therapies are not categorized as an Inpatient or Home Health benefit. 'Acute' and 'Long-term' therapies remain benefits per Home Health coverage.
- Habilitative therapies are not a benefit if provided in nursing facilities; Rehabilitative PT, OT, ST will remain benefits.
- Habilitative therapies should not to be confused with Habilitation services found within Home and Community Based Services (HCBS) waivers.

Assistive Technology Assessments

The following billing policies are effective for CPT procedure code **97755** to accommodate HB14-1211. HB14-1211 requires that all Health First Colorado members seeking complex rehabilitation technology must have an initial Assistive Technology Assessment (complex rehabilitative technology evaluation/assessment) prior to receiving complex rehabilitation technology, and follow-up assessments, as needed. Only licensed speech, physical, and occupational therapists may render this specialty evaluation.

All providers using procedure code **97755** must follow these guidelines. The Department recognizes that only a portion of Assistive Technology Assessments will be used for complex rehabilitation technology evaluation/assessment. Providers will be asked upon PAR submission if the service is for a complex rehabilitation technology assessment.

Policy	**Notes**
Complex rehabilitation technology evaluations / assessments are billed using **only 97755**.	Combinations of procedure codes, including procedure code **97542**, for the purposes of complex rehabilitation technology evaluation / assessment are not allowed.
97755 always requires a Prior Authorization Request (PAR).	PARs must be submitted electronically using ColoradoPAR. Details are found here.
Member daily limit of **97755** is 20 units.	Up to five hours of assessment is allowed per date of service.
Member yearly limit of **97755** is 60 units.	Members may have up to 60 units of procedure code **97755** per State Fiscal Year (July 1 – June 30). This limit will reset with the start of each new State Fiscal Year.

PARs for **97755** must comply with the following policies:

- Must have a current prescription/referral for an Assistive Technology Assessment from the member's primary care physician.
- May indicate up to one year duration.
- May indicate initial/new assessments or follow-up assessment visits.
- Only one active PAR for **97755** is allowed per member, per span of time. Overlapping **97755** PAR requests will be denied.
- Initial speech therapy evaluation services, such as **92521**, are not required prior to requesting **97755**.
- **97755** is **separate** from physical and occupational therapy (PT/OT) and is not part of the PT/OT benefit limitation.
- PARs for **97755** should be submitted independently from other services. The Medical PAR type should be selected for **97755** at ColoradoPAR.com.
- **97755** performed by a Speech Therapist is considered Rehabilitative speech therapy and is covered for both adults and children.

If a member requires further assessment by a different provider not indicated on the original PAR, and that PAR is still active, then it must be closed by the original requesting provider. Once closed a new PAR can be submitted. Members may request a 'change of provider' on their PAR by contacting the vender directly. Please see the Prior Authorization Request section of this manual.

Daily Unit Limits

- Speech Therapy is limited to five (5) units of service per date of service. Some specific daily limits per procedure code apply. Please see the table below.
- While a maximum of five units of service is allowed per date of service, providers are required to consult the American Medical Association's (AMA) Current Procedural Terminology (CPT) manual for each coded service. Some codes represent a treatment session without regard to its length of time (one unit maximum) while other codes may be billed incrementally as "timed" units.
- Members determined to need a speech generating device (HCPCS codes E2500, E2502, E2504, E2510, E2211, E2512, and E2599) should be referred to a Health First Colorado participating medical supplier to be prior authorized.
- All claims must meet eligibility and claim submission requirements (e.g. timely filing, third party resources payment pursued, required attachments included, etc.) before payment can be made.

Coding Tables

Required Billing Modifier Code Table	
Benefit	**Required Modifiers**
Speech Therapy - Rehabilitative	GN
Speech Therapy – Habilitative (non-Early Intervention)	GN + HB
Speech Therapy – Early Intervention	GN + TL

Covered Speech Therapy Procedure Codes			
Brief Description	**Procedure Code**	**Unit Limits** **Max # units per member, per provider, per DOS**	**Prior Authorization Required**
Evaluation of speech fluency (e.g. stuttering, cluttering)	**92521**	1	Adult-Habilitative Only
Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)	**92522**	1	Adult-Habilitative Only
Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language	**92523**	1	Adult-Habilitative Only

Covered Speech Therapy Procedure Codes			
Brief Description	**Procedure Code**	**Unit Limits** **Max # units per member, per provider, per DOS**	**Prior Authorization Required**
comprehension and expression (eg, receptive and expressive language)			
Behavioral and qualitative analysis of voice and resonance	**92524**	1	Adult-Habilitative Only
Treatment of speech, language, voice, communication and/or auditory disorder; individual.	**92507**	1	Adult-Habilitative Only
Speech/hearing treatment, group, 2 or more individuals	**92508**	1	Adult-Habilitative Only
Laryngeal function studies	**92520**	1	Adult-Habilitative Only
Treatment of swallowing dysfunction or oral.	**92526**	1	Adult-Habilitative Only
Oral speech device evaluation	**92597**	1	Adult-Habilitative Only
Evaluate for device	**92605**	1	Adult-Habilitative Only
Non-speech device service	**92606**	1	Adult-Habilitative Only
Evaluation for speech generating device, first hour	**92607**	1	Adult-Habilitative Only
Additional 30 minutes of evaluation for 92607	**92608**	1	Adult-Habilitative Only
Use of speech device service	**92609**	1	Adult-Habilitative Only
Evaluation of oral and pharyngeal swallowing function	**92610**	1	Adult-Habilitative Only
Motion fluoroscopic evaluation of swallowing function	**92611**	1	Adult-Habilitative Only
Flexible fiber optic endoscopic evaluation by cine or video recording	**92612**	1	Adult-Habilitative Only
Flexible fiber optic endoscopic laryngeal sensory testing by cine or video recording	**92614**	1	Adult-Habilitative Only

Covered Speech Therapy Procedure Codes			
Brief Description	**Procedure Code**	**Unit Limits** **Max # units per member, per provider, per DOS**	**Prior Authorization Required**
Evaluation of auditory rehab status; first hour	**92626**	1	Adult-Habilitative Only
Each additional 15 minutes of 92626	**92627**	4	Adult-Habilitative Only
Assessment of aphasia, per hour	**96105**	2	Adult-Habilitative Only
Developmental testing; extended with interpretation and report, per hour	**96111**	1	Adult-Habilitative Only
Development of cognitive skills, per 15 minutes	**97532**	3	Adult-Habilitative Only
Assistive technology assessment, each unit 15 minutes	**97755**	20 per day, 60 per fiscal year	Always
Telehealth, originating site facility fee	**Q3014**	1	Adult-Habilitative Only

National Correct Coding Initiative (NCCI)

National Correct Coding Initiative Procedure-To-Procedure (PTP) and Medically Unlikely Edits (MUE) edits apply to certain combinations of speech therapy procedure codes. Please refer to the Medicaid.gov website on NCCI edits for the NCCI Policy Manual, a complete list of impacted codes, guidance on bypass modifier use, and general information.

- Policy guidance for NCCI provided in this manual does not supersede Federal NCCI policy. It is published to assist providers in understanding how the Health First Colorado Speech Therapy benefit is affected by NCCI edits and policy.
- Although every effort is made to guide providers accordingly, this manual may not always reflect the most up to date NCCI policies, nor is it an exhaustive list of any edit/policy that may affect the speech therapy benefit. Providers should always reference the Medicaid.gov website for the most current NCCI policies as those policies may change.
- Health First Colorado does not create NCCI policy.
- All providers are required to comply with NCCI policy.

  Pursuant to the NCCI Policy Manual (Current Revision 1-1-2016, Chapter XI – Page 14):

  - Speech language pathologists may perform services coded as CPT codes **92507**, **92508**, or **92526**. They do not perform services coded as CPT codes **97110**, **97112**, **97150**, or **97530**, which are generally performed by physical or occupational therapists. Speech language pathologists should not report CPT codes **97110**, **97112**, **97150**, **97530**, or **97532** as unbundled services included in the services coded as **92507**, **92508**, or **92526**.

  - A single practitioner should not report CPT codes **92507** (treatment of speech, language, voice . . .; individual) and/or **92508** (treatment of speech, language, voice . . .; group) on the same date of service as CPT codes **97532** (development of cognitive skills to improve . . .) or **97533** (sensory integrative techniques to enhance . . .).
- However, if the two types of services are performed by different types of practitioners on the same date of service, they may be reported separately by a single billing entity. For example, if a speech language pathologist performs the procedures described by CPT codes **92507** and/or **92508** on the same date of service that an occupational therapist performs the procedures described by CPT codes **97532** and/or **97533**, a provider entity that employs both types of practitioners may report both services utilizing an NCCI PTP-associated modifier.
- Treatment of swallowing dysfunction and/or oral function for feeding (CPT code **92526**) may utilize electrical stimulation. The HCPCS code **G0283** (electrical stimulation (unattended), to one or more areas for indication(s) other than wound care...) should not be reported with CPT code **92526** for electrical stimulation during the procedure. The NCCI PTP edit (**92526**/**G0283**) for practitioner service claims does not allow use of NCCI PTP-associated modifiers with this edit because the same provider would never perform both of these services on the same date of service. However, the same edit for outpatient hospital facility claims does allow use of NCCI PTP-associated modifiers because two separate practitioners in the same outpatient hospital facility or institutional therapy provider might perform the two procedures for different purposes at different member encounters on the same date of service.

Billing Information

National Provider Identifier (NPI)

T 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. Certain Provider Types are not able to obtain an NPI. Those providers will be assigned a Health First Colorado provider number.

Paper Claims

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

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

Paper claims require an NPI for those provider types that can obtain one. Providers that cannot obtain an NPI are required to use an assigned Health First Colorado provider number on their claims. Electronically mandated claims submitted on paper are processed, denied, and marked with the message "Electronic Filing Required".

Electronic Claims

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

- X12N Technical Report 3 (TR3) for the 837P, 837I, or 837D (wpc-edi.com/)
- Companion Guides for the 837P, 837I, or 837D in the EDI support section of the Department's website (edi-support)
- Online Portal User Guide (via within the Online Portal)

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

Interactive Claim Submission and Processing

Interactive claim submission through the Online Portal is a real-time exchange of information between the provider and the Health First Colorado. Health First Colorado providers may create and transmit HIPAA compliant 837P (Professional), 837I (Institutional), and 837D (Dental) claims electronically one at a time. These claims are transmitted through the Health First Colorado Online Portal (OP).

The Online Portal contains training, user guides and help that describe claim completion requirements, edits that verify the format and validity of the entered information, and edits that assure that required fields are completed.

The Health First Colorado OP reviews the claim information for compliance with Health First Colorado billing policy and passes the claim to the Colorado interChange system for adjudication and reporting on the Health First Colorado Provider Remittance Advice (RA).

The OP immediately returns a response to the provider about that single transaction indicating whether the claim will be rejected, suspended or paid.

- If the claim is rejected, the OP sends a rejection response that identifies the rejection reason. The rejected claim can immediately be resubmitted.
- If the claim is suspended then it needs additional manual review by the Fiscal Agent.
- If the claim is accepted, the provider receives a message indicating that the claim is will be paid.

The Online Portal provides immediate feedback directly to the submitter. All claims are processed to provide a weekly Health Care Claim Payment/Advice (Accredited Standards Committee [ASC] X12N 835) transaction and/or Remittance Advice to providers. The Online Portal also provides access to reports and transactions generated from claims submitted via paper and through electronic data submission methods other than the Online Portal. The reports and transactions include:

- Accept/Reject Report
- Remittance Advice
- Health Care Claim Payment/Advice (ASC X12N 835)
- Managed Care Reports such as Primary Care Physician Rosters
- Eligibility Inquiry (interactive and batch)
- Claim Status Inquiry

Claims may be adjusted, edited and resubmitted, and voided in real time through the Online Portal. Access the Online Portal through Secured Site at colorado.gov/hcpf. For help with claim submission via the Online Portal, please choose the *User Guide* option available for each Online Portal transaction.

For additional electronic billing information, please refer to the appropriate Companion Guide located in the Provider Services Specifications section of the Department's website.

Procedure/HCPCS Code Overview

The codes used for submitting claims for services provided to Health First Colorado members represent services that are approved by the Centers for Medicare and Medicaid Services (CMS) and services that may be provided by an enrolled Health First Colorado 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 CPT, a numeric coding system maintained by the 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.

Prior Authorization Requests (PARs) – Habilitative Speech Therapy Only

Independent speech therapists and outpatient hospital based therapy clinics providing Habilitative speech therapy for adults must submit, and have approved, PARs for medically necessary services prior to rendering the services.

Prior Authorization Requests are approved for up to a twelve (12) month period (depending on medical necessity determined by the authorizing agency).

- Retroactive PAR requests will not be accepted.
- Overlapping PAR request dates for same provider types will not be accepted.
- Incomplete, incorrect or insufficient member information on a PAR request form will not be accepted.

Submit PARs for the number of units for each specific procedure code requested, not for the number of services. Modifiers must be included on both the PAR and claim submission. When submitting a PAR for either rehabilitative or habilitative services, the procedure codes must include GN + HB modifiers (e.g. 92507+GN+HB).

PAR Requests Must Include:

- Legibly written and signed ordering practitioner prescription, to include diagnosis (preferably with ICD-10 code) and reason for therapy, the number of requested therapy sessions per week and total duration of therapy.
- The member's Physical or Occupational treatment history, including current assessment and treatment. Include duration of previous treatment and treating diagnosis.
- Documentation indicating if the member has received PT or OT under the Home Health Program or inpatient hospital treatment.
- Current treatment diagnosis.
- Course of treatment, measurable goals and reasonable expectation of completed treatment.
- Documentation supporting medical necessity for the course and duration of treatment being requested.
- Assessment or progress notes submitted for documentation, must not be more than sixty (60) days prior to submission of PAR request.
- If the PAR is submitted for services delivered by an independent therapist, the name and address of the individual therapist providing the treatment must be present in field #24 of the PAR.
- The billing provider name and address needs to be present in field #25 on the PAR.
- The Health First Colorado provider number of the independent therapist must be present in PAR field #28.
- The billing provider's Health First Colorado number must be present in field #29 of the PAR.

The authorizing agency reviews all completed PARs and approves or denies, by individual line item, each requested service or supply listed on the PAR. PAR status inquiries can be made through the Web Portal and results are included in PAR letters sent to both the provider and the member. **Read the results carefully as some line items may be approved and others denied. Do not render or bill for services until the PAR has been processed.**

The claim must contain the PAR number for payment.

Approval of a PAR does not guarantee Health First Colorado payment and does not serve as a timely filing waiver. Prior authorization only assures that the service is considered a benefit of the Health First Colorado. All claims, including those for prior authorized services, must meet eligibility and claim submission requirements (e.g. timely filing, third party resources payment pursued, required attachments included, etc.) before payment can be made.

If the PAR is denied, providers should direct inquiries to the authorizing agency:

ColoradoPAR Program
Provider Prior Authorization (PAR) Vendor for the Health First Colorado
Provider PAR Line: 888-801-9355
PAR Fax Line: 866-940-4288

The Health First Colorado PAR forms are available in the Provider Services Forms section or by contacting the ColoradoPAR Program at 888-801-9355 (toll free).

Providers can fax documents to the ColoradoPAR Program at 866-940-4288. Documents that may be compromised by faxing can be mailed to:

PAR Revisions

Please print "REVISION" in bold letters at the top and enter the PAR number being revised in box #7. Do not enter the PAR number being revised anywhere else on the PAR.

Paper Prior Authorization Request Instructional Reference

Field Label	Completion Format	Instructions
The upper margin of the PAR form must be left blank. This area is for authorizing agency use only.		
Invoice/Pat Account Number	Text	Optional Enter up to 12 characters (numbers, letters, hyphens) that help identify the claim or member.
Does Client Have Primary Insurance?	Check box ☐ Y ☐ N	Optional Enter an "X" in the appropriate box.
1. Client Name	Text	Required Enter the member's last name, first name, and middle initial.
2. Client Identification Number	1 letter followed by 6 numbers	Required Enter the member's state identification number. This number consists of a letter prefix followed by six numbers. Example: A123456.
3. Sex	Check box ☐ Y ☐ N	Required Enter an "X" in the appropriate box.
4. Date of Birth	6 digits (MMDDYY)	Required Enter the member's birth date using MMDDYY format. Example: January 1, 2015 = 010115.
5. Client Address	Characters: numbers and letters	Required Enter the member's full address: Street, City, State, and Zip code.
6. Client Telephone Number	Text	Optional Enter the member's telephone number.
7. Prior Authorization Number		System assigned Leave blank
8. Dates Covered by this Request	6 digits for From date and 6 digits for Through date (MMDDYY)	Optional Enter the date(s) within which service(s) will be provided. If left blank, dates are entered by the authorizing agency. Authorized services must be provided within these dates.

Field Label	Completion Format	Instructions
9. Does Client Reside in a Nursing Facility?	Check box ☐ Y ☐ N	Required Check the appropriate box.
10. Group Home Name if Patient Resides in a Group Home	Text	Not applicable.
11. Diagnosis	Text	Required Enter the medical/physiological diagnosis code and sufficient relevant diagnostic information to justify the request. Include the prognosis. Provide relevant clinical information, other drugs or alternative therapies tried to treating the condition, results of tests, etc. to justify a Health First Colorado determination of medical necessity. Approval of necessity. Attach documents as required.
12. Requesting Authorization for Repairs	Text	Not applicable
13. Indicate Length of Necessity	Text	Not applicable
14. Estimated Cost of Equipment	Digits	Not applicable
15. Services to be Authorized	None	Preprinted Do not alter preprinted lines. No more than five items can be requested on one form.
16. Describe Procedure, Supply, or Drug to be Provided	Text	Required Enter the description of the service/procedure to be provided.
17. Procedure, Supply or Drug Code Required	HCPCS code	Enter the procedural code for each item that will be billed on the claim form. The authorized agency may change any code. The approved code(s) on the PAR form must be used on the claim form.
18. Requested Number of Services	Digits	Required Enter the number of units for supplies, services or equipment requested. If this field is blank, the authorizing agency will complete with one unit.

Field Label	Completion Format	Instructions
19. Authorized No. of Services	None	Leave blank The authorizing agency indicates the number of services authorized which may be more not equal number of requested in Field 18 (Number of Services).
20. A = Approved **D = Denied**	None	Leave blank Check the PAR on-line or refer to the PAR letter.
21. Primary Care Physician (PCP) Name	Text	Conditional Complete if member has a PCP.
Telephone Number	Text	Optional Enter the PCP's telephone number.
22. Primary Care Physician Address	Text	Conditional Complete if member has a PCP. Enter the PCP's complete address.
23. PCP Provider Number	8 Digits	Conditional Complete if member has a PCP. Enter the PCP's eight-digit Health First Colorado provider number. This number must be obtained by contacting the PCP for the necessary authorization.
24. Name and Address of Physician Referring for Prior Authorization	Text	Required Enter the complete name and address of the physician requesting prior authorization (the physician ordering/writing the prescription).
25. Name and Address of Provider Who will Bill Service	Text	Required Enter the name and telephone number of the provider who will be billing for the service.
26. Requesting Physician Signature	Text	Required The requesting provider must sign the PAR and must be the physician ordering the service. Under unusual circumstances, when the prescribing physician is not available, a legible copy of a signed prescription may be attached in place of the signature of the requesting provider. The written diagnosis must be entered in Field 11 (Diagnosis), even if a prescription form is attached. Do not send the original

Field Label	Completion Format	Instructions
		prescription; send a photocopy on an 8 ½ x 11 sheet. A rubber stamp facsimile signature is not acceptable on the PAR.
27. Date Signed	6 Digits	Required Enter the date the PAR form is signed by the requesting provider.
Telephone Number	Text	Required Enter the telephone number of the requesting provider.
28. Requesting Physician Provider Number	8 Digits	Required Enter the eight-digit Health First Colorado provider number of the requesting provider.
29. Billing Provider Number	8 Digits	Required Enter the eight-digit Health First Colorado provider number of the billing provider. All rendering and billing providers must be Health First Colorado providers.
30. Comments	Text	Leave Blank This field is completed by the authorizing agency. Refer to the PAR response for comments submitted by the authorizing agent.
31. PA Number Being Revised	Text	Leave Blank This field is completed by the authorizing agency.

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.

Instructions for completing and submitting electronic claims are available through the X12N Technical Report 3 (TR3) for the 837P (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).

CMS Field #	Field Label	Field is?	Instructions
1	**Insurance Type**	Required	Place an "X" in the box marked as Medicaid.
1a	**Insured's ID Number**	Required	Enter the member's Health First Colorado seven-digit Medicaid ID number as it appears on the Medicaid Identification card. Example: A123456.
2	**Patient's** Name	Required	Enter the member's last name, first name, and middle initial.
3	**Patient's** Date of Birth **/ Sex**	Required	Enter the member's birth date using two digits for the month, two digits for the date, and two digits for the year. Example: 070115 for July 1, 2015. Place an "X" in the appropriate box to indicate the sex of the member.
4	**Insured's Name**	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	

CMS Field #	Field Label	Field is?	Instructions
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.
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.

CMS Field #	Field Label	Field is?	Instructions
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: 070115 for July 1, 2015. 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	
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: 070115 for July 1, 2015. 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	

CMS Field #	Field Label	Field is?	Instructions
16	**Date Patient Unable to Work in Current Occupation**	Not Required	
17	**Name of Referring Physician**	Conditional	
17.b	**NPI of referring physician**	Required	Required in accordance with Program Rule 8.125.8.A
18	**Hospitalization Dates Related to Current Service**	Conditional	Complete for services provided in an inpatient hospital setting. Enter the date of hospital admission and the date of discharge using two digits for the month, two digits for the date and two digits for the year. Example: 070115 for July 1, 2015. If the member is still hospitalized, the discharge date may be omitted. This information is not edited.
19	**Additional Claim Information**	Conditional	
20	**Outside Lab?** **$ Charges**	Not Required	
21	**Diagnosis or Nature of Illness or Injury**	Required	Enter at least one but no more than twelve diagnosis codes based on the member's diagnosis/condition. Enter applicable ICD indicator to identify which version of ICD codes is being reported. 0 ICD-10-CM (DOS 10/1/15 and after) 9 ICD-9-CM (DOS 9/30/15 and before)
22	**Medicaid Resubmission Code**	Conditional	List the original reference number for adjusted claims. When resubmitting a claim as a replacement or a void, enter the appropriate bill frequency code in the left-hand side of the field. 7 Replacement of prior claim

CMS Field #	Field Label	Field is?	Instructions
			8 Void/Cancel of prior claim This field is not intended for use for original claim submissions.
23	**Prior Authorization**	Not Required	
24	**Claim Line Detail**	Information	The paper claim form allows entry of up to six detailed billing lines. Fields 24A through 24J apply to each billed line. **Do not enter more than six lines of information** on the paper claim. If more than six lines of information are entered, the additional lines will not be entered for processing. Each claim form must be fully completed (totaled). **Do not file continuation claims** (e.g., Page 1 of 2).
24A	**Dates of Service**	Required	The field accommodates the entry of two dates: a "From" date of services and a "To" date of service. Enter the date of service using two digits for the month, two digits for the date and two digits for the year. Example: 010116 for January 1, 2016 From To **01 01 16** | | | | | | Or From To **01 01 16 01 01 16** Span dates of service From To **01 01 16 01 31 16** Single Date of Service: 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. Span billing: permissible if the same service (same procedure code) is provided on consecutive dates. **Supplemental Qualifier**

CMS Field #	Field Label	Field is?	Instructions
			To enter supplemental information, begin at 24A by entering the qualifier and then the information. 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
24B	**Place of Service**	Required	Enter the Place of Service (POS) code that describes the location where services were rendered. The Health First Colorado accepts the CMS place of service codes. 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

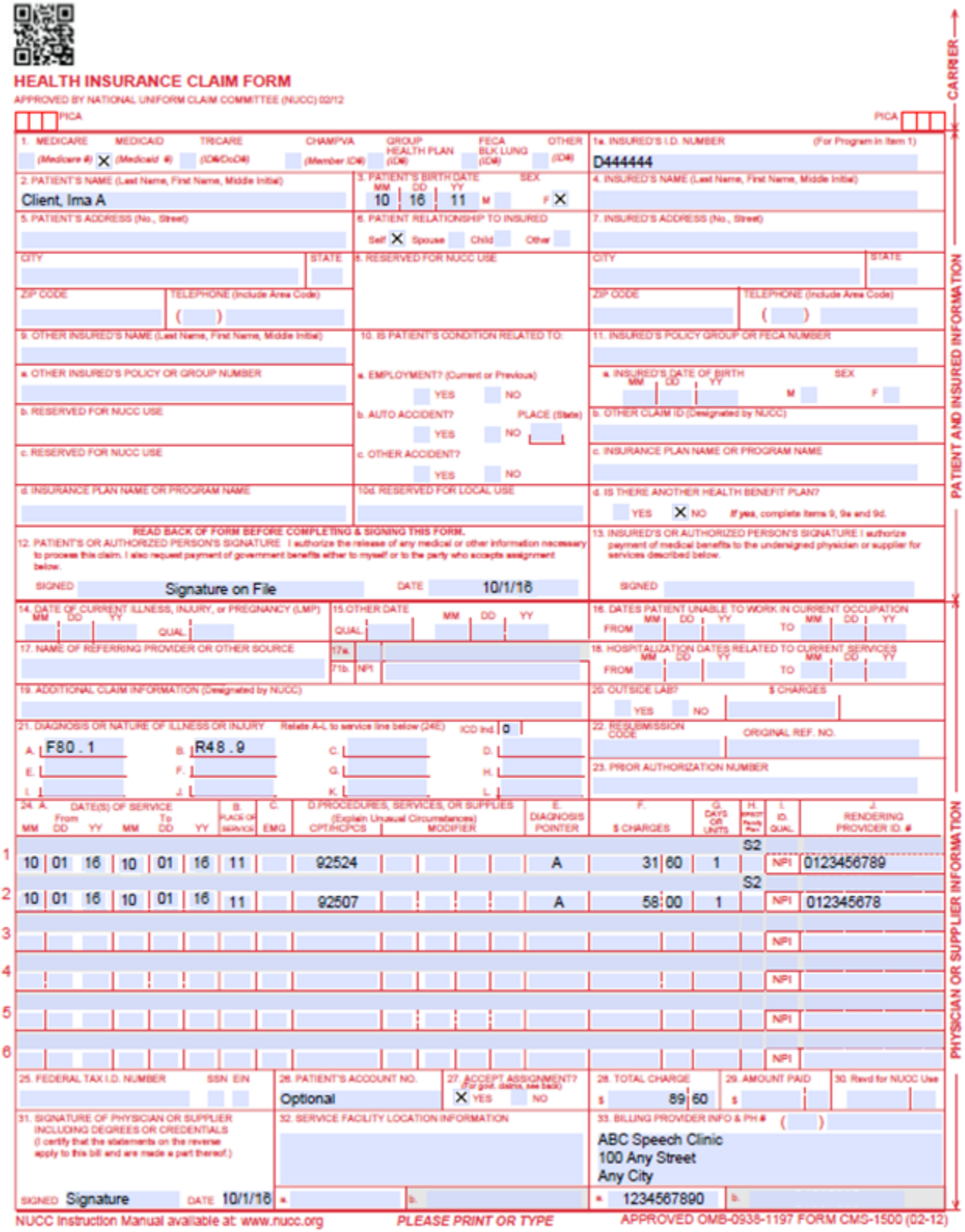
CMS Field #	Field Label	Field is?	Instructions
			65 End Stage Renal Dialysis Trtmt Facility 71 State-Local Public Health Clinic 99 Other Unlisted
24C	**EMG**	Conditional	Enter a "Y" for YES or leave blank for NO in the bottom, unshaded area of the field to indicate the service is rendered for a life-threatening condition or one that requires immediate medical intervention. If a "Y" for YES is entered, the service on this detail line is exempt from co-payment requirements.
24D	**Procedures, Services, or Supplies**	Required	Enter the HCPCS procedure code that specifically describes the service for which payment is requested. All procedures must be identified with codes in the current edition of Physicians Current Procedural Terminology (CPT). CPT is updated annually. HCPCS Level II Codes The current Medicare coding publication (for Medicare crossover claims only). Only approved codes from the current CPT or HCPCS publications will be accepted.
24D	**Modifier**	Required	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. GN **Service By Speech/Language Pathologist** HB **Habilitative therapy service** TL **Early Intervention service**
24E	**Diagnosis Pointer**	Required	Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis. At least one diagnosis code reference letter must be entered.

CMS Field #	Field Label	Field is?	Instructions
			When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. This field allows for the entry of 4 characters in the unshaded area.
24F	$ **Charges**	Required	Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number. Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one procedure from the same group is billed, special multiple pricing rules apply. The base procedure is the procedure with the highest allowable amount. The base code is used to determine the allowable amounts for additional CPT surgical procedures when more than one procedure from the same grouping is performed. Submitted charges cannot be more than charges made to non-Health First Colorado covered individuals for the same service. Do not deduct Health First Colorado co-payment or commercial insurance payments from the usual and customary charges.
24G	**Days or Units**	Required	Enter the number of services provided for each procedure code. Enter whole numbers only- do not enter fractions or decimals.
24H	**EPSDT/Family Plan**	Conditional	**EPSDT** (shaded area) For Early & Periodic Screening, Diagnosis, and Treatment related services, enter the response in the shaded portion of the field as follows: AV Available- Not Used S2 Under Treatment ST New Service Requested NU Not Used **Family Planning** (unshaded area) Not Required

CMS Field #	Field Label	Field is?	Instructions
24I	**ID Qualifier**	Not Required	
24J	**Rendering Provider ID #**	Required	In the shaded portion of the field, enter the NPI of the Health First Colorado provider number assigned to the individual who actually performed or rendered the billed service. This number cannot be assigned to a group or clinic.
25	**Federal Tax ID Number**	Not Required	
26	**Patient's Account Number**	Optional	Enter information that identifies the member or claim in the provider's billing system. Submitted information appears on the Remittance Advice (RA).
27	**Accept Assignment?**	Required	The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.
28	**Total Charge**	Required	Enter the sum of all charges listed in field 24F. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
29	**Amount Paid**	Conditional	Enter the total amount paid by Medicare or any other commercial health insurance that has made payment on the billed services. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
30	**Rsvd for NUCC Use**		
31	**Signature of Physician or Supplier Including Degrees or Credentials**	Required	Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent. A holographic signature stamp may be used if authorization for the stamp is on file with the fiscal agent. An authorized agent or representative may sign the claim for the enrolled provider if the

CMS Field #	Field Label	Field is?	Instructions
			name and signature of the agent is on file with the fiscal agent. Each claim must have the date the enrolled provider or registered authorized agent signed the claim form. Enter the date the claim was signed using two digits for the month, two digits for the date and two digits for the year. Example: 070116 for July 1, 2016. **Unacceptable signature alternatives:** Claim preparation personnel may not sign the enrolled provider's name. Initials are not acceptable as a signature. Typed or computer printed names are not acceptable as a signature. "Signature on file" notation is not acceptable in place of an authorized signature.
32	**32- Service Facility Location Information** **32a- NPI Number** **32b- Other ID #**	Conditional	Complete for services provided in a hospital or nursing facility in the following format: 1st Line Facility Name 2nd Line Address 3rd Line City, State and ZIP Code 32a- NPI Number Enter the NPI of the service facility (if known).
33	**33- Billing Provider Info & Ph #** **33a- NPI Number** **33b- Other ID #**	Required	Enter the name of the individual or organization that will receive payment for the billed services in the following format: 1st Line Name 2nd Line Address 3rd Line City, State and ZIP Code 33a- NPI Number Enter the NPI of the billing provider

CMS 1500 Speech Therapy Claim Example



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare #) X MEDICAID (Medicaid #) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): D444444

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Client, Ima A

3. PATIENT'S BIRTH DATE MM DD YY: 10 16 11 SEX M F X

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED Signature on File DATE 10/1/16

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

SIGNED

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

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

A. F80.1 B. R48.9 C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10	01	16	10	01	16	11		92524			A	31 60	1	S2	NPI	0123456789
2	10	01	16	10	01	16	11		92507			A	58 00	1	S2	NPI	012345678
3																NPI	
4																NPI	
5																NPI	
6																NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. Optional

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

28. TOTAL CHARGE $ 89 60

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED Signature DATE 10/1/16

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

ABC Speech Clinic
100 Any Street
Any City

a. 1234567890 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

UB-04 Paper Claim Reference Table

Speech therapy outpatient hospital paper claims must be submitted on the UB-04 claim form.

The information in the following table provides instructions for completing Form Locators (FL) as they appear on the UB-04 paper 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 FLs on the UB-04 have the same attributes (specifications) for the Health First Colorado as those indicated in the *NUBC UB-04 Reference Manual*.

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

The UB-04 certification must be completed and attached to all claims submitted on the UB-04. A copy of the certification form is included with this manual. Completed UB-04 paper Health First Colorado claims, including hardcopy Medicare claims, should be mailed to the correct fiscal agent address located in Appendix A of the Appendices section in Provider Services Billing Manuals.

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 electronically.

The Paper Claim Reference Table below lists the required, optional and/or conditional form locators for submitting the UB-04 paper claim form to the Health First Colorado for speech therapy services.

Instructions for completing and submitting electronic claims are available through the X12N Technical Report 3 (TR3) for the 837I (wpc-edi.com), 837I Companion Guide (in the Provider Services Specifications section of the Department's website), and in the Web Portal 837I User Guide (via within the portal).

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 using standard post office abbreviations. Enter the telephone number.
2. Pay-to Name, Address, City, State	Text	Required 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

Form Locator and Label	Completion Format	Instructions
		Zip Code Abbreviate the state using standard post office abbreviations. Enter the telephone number.
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 Remittance Advice (RA).
3b. Medical Record Number	17 digits	Optional Enter the number assigned to the member to assist in retrieval of medical records.
4. Type of Bill	3 digits	Required 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): **Digit 1** — **Type of Facility** 1 Hospital 2 Skilled Nursing Facility 3 Home Health 4 Religious Non-Medical Health Care Institution Hospital Inpatient 5 Religious Non-Medical Health Care Institution Post-Hospital Extended Care Services 6 Intermediate Care 7 Clinic (Rural Health/FQHC/Dialysis Center) 8 Special Facility (Hospice, RTCs) **Digit 2** — **Bill Classification (Except clinics & special facilities):** 1 Inpatient (Including Medicare Part A) 2 Inpatient (Medicare Part B only) 3 Outpatient 4 Other (for hospital referenced diagnostic services or home health not under a plan of treatment)

Form Locator and Label	Completion Format	Instructions
		5 Intermediate Care Level I 6 Intermediate Care Level II 7 Sub-Acute Inpatient (revenue code 19X required with this bill type) 8 Swing Beds 9 Other **Digit 2** **Bill Classification (Clinics Only):** 1 Rural Health/FQHC 2 Hospital Based or Independent Renal Dialysis Center 3 Freestanding 4 Outpatient Rehabilitation Facility (ORF) 5 Comprehensive Outpatient Rehabilitation Facilities (CORFs) 6 Community Mental Health Center **Digit 2** **Bill Classification (Special Facilities Only):** 1 Hospice (Non-Hospital Based) 2 Hospice (Hospital Based) 3 Ambulatory Surgery Center 4 Freestanding Birthing Center 5 Critical Access Hospital 6 Residential Facility **Digit 3** **Frequency:** 00 Non-Payment/Zero Claim 01 Admit through discharge claim 02 Interim - First claim 03 Interim - Continuous claim 04 Interim - Last claim 07 Replacement of prior claim 08 Void of prior claim

Form Locator and Label	Completion Format	Instructions
5. Federal Tax Number	None	Not required 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 (Note: OP claims cannot span over a month's end) Enter the From (beginning) date and Through (ending) date of service covered by this bill. *Example:* 01012016 = January 1, 2016 This form locator must reflect the beginning and ending dates of service. When span billing for multiple dates of service and multiple procedures, complete FL 45 (Service Date). Providers not wishing to span bill following these guidelines, must submit one claim per date of service. "From" and "Through" dates must be the same. All line item entries must represent the same date of service.
8a. Patient Identifier		Not required 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.
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	Digits	Optional

Form Locator and Label	Completion Format	Instructions
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. *Example*: 01012015 = January 1, 2015
11. Patient Sex	1 letter	Required Enter an M (male) or F (female) to indicate the member's sex.
12. Admission Date	6 digits	Conditional Required for observation holding beds only
13. Admission Hour	6 digits	Conditional Required for observation holding beds only
14. Admission Type	1 digit	Required Enter the following to identify the admission priority: **1 – Emergency** Member requires immediate intervention as a result of severe, life threatening or potentially disabling conditions. Exempts inpatient hospital & clinic claims from co-payment and PCP referral. Exempts outpatient hospital claims from co-payment and PCP only if revenue code 450 or 459 is present. This is the only benefit service for an undocumented alien. If span billing, emergency services cannot be included in the span bill and must be billed separately from other outpatient services. **2 - Urgent** The member requires immediate attention for the care and treatment of a physical or mental disorder. **3 - Elective** The member's condition permits adequate time to schedule the availability of accommodations. **4 - Newborn** Required for inpatient and outpatient hospital. **5 - Trauma Center** Visit to a trauma center/hospital as licensed or designated by the state or local government authority

Form Locator and Label	Completion Format	Instructions
		authorized to do so, or as verified by the American College of Surgeons and involving trauma activation. **Clinics** Required only for emergency visit.
15. Source of Admission	1 digit	Required Enter the appropriate code for co-payment exceptions on claims submitted for outpatient services. (To be used in conjunction with FL 14, Type of Admission). 1 Physician referral 2 Clinic referral 4 Transfer from a hospital 5 Transfer from a skilled nursing facility (SNF) 6 Transfer from another health care facility 8 Court/Law Enforcement 9 Information not available E Transfer from an Ambulatory Surgery Center F Transfer from a Hospice Agency **Newborns** 5 Baby born inside this hospital 6 Baby born outside this hospital
16. Discharge Hour	2 digits	Not Required
17. Patient Discharge Status	2 digits	Conditional Enter member status as of discharge date. 01 Discharged to Home or Self Care (Dialysis is limited to code 01) 02 Discharged/transferred to another short term hospital 03 Discharged/transferred to a Skilled Nursing Facility (SNF) 04 Discharged/transferred to an Intermediate Care Facility (ICF) 05 Discharged/transferred to another type institution

Form Locator and Label	Completion Format	Instructions
		06 Discharged/transferred to home under care of organized Home and Community Based Services Program (HCBS) 07 Left against medical advice or discontinued care 08 Discharged/transferred to home under care of a Home Health provider 09 Admitted as an inpatient to this hospital 20 Expired 30** Still a member or expected to return for outpatient services 31** Still a member - Awaiting transfer to long term psychiatric hospital 32** Still a Member - Awaiting placement by Health First Colorado 50 Hospice – Home 51 Hospice - Medical Facility 61 Discharged/transferred within this institution to hospital based Medicare approved swing bed 62 Discharged/transferred to an inpatient rehabilitation hospital. 63 Discharged/transferred to a Medicare certified long term care hospital. 65 Discharge/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital 66 Transferred/Discharged to Critical Access Hospital CAH 70 Discharged/Transferred to Other HC Institution 71 Discharged/transferred/referred to another institution for outpatient services 72 Discharged/transferred/referred to this institution for outpatient services Use code 02 for a PPS hospital transferring a member to another PPS hospital. Code 05, Discharged to Another Type Institution, is the most appropriate code to use for a PPS hospital transferring a member to an exempt hospital. **A PPS hospital cannot use Member Status codes 30, 31 or 32 on any claim submitted for DRG

Form Locator and Label	Completion Format	Instructions
		reimbursement. The code(s) are valid for use on exempt hospital claims only. Interim bills may be submitted for Prospective Payment System (PPS) -DRG claims, but must meet specific billing requirements. For exempt hospitals use the appropriate code from the codes listed. Note: Refer to the "Interim" billing instruction in this section of the manual.
18-28. Condition Codes	2 Digits	Conditional Complete with as many codes necessary to identify conditions related to this bill that may affect payer processing. **Condition Codes** 01 Military service related 02 Employment related 04 HMO enrollee 05 Lien has been filed 06 ESRD member - First 18 months entitlement 07 Treatment of non-terminal condition/hospice member 17 Member is homeless 25 Member is a non-US resident 39 Private room medically necessary 42 Outpatient Continued Care not related to Inpatient 44 Inpatient CHANGED TO Outpatient 51 Outpatient Non-diagnostic Service unrelated to Inpatient admit 60 DRG (Day outlier) **Renal dialysis settings** 71 Full care unit 72 Self care unit 73 Self care training 74 Home care 75 Home care - 100 percent reimbursement 76 Back-up facility **Special Program Indicator Codes** A1 EPSDT/CHAP

Form Locator and Label	Completion Format	Instructions
		A2 Physically Handicapped Children's Program A4 Family Planning A6 PPV/Medicare A9 Second Opinion Surgery AA Abortion Due to Rape AB Abortion Done Due to Incest AD Abortion Due to Life Endangerment AI Sterilization B3 Pregnancy Indicator B4 Admission Unrelated to Discharge **PRO Approval Codes** C1 Approved as billed C2 Automatic approval as billed - Based on focused review C3 Partial approval C4 Admission/Services denied C5 Post payment review applicable C6 Admission preauthorization C7 Extended authorization
29. Accident State		Optional
31-34. Occurrence Code/Date	2 digits and 6 digits	Conditional Complete both the code and date of occurrence. Enter the appropriate code and the date on which it occurred. Enter the date using MMDDYY format. **Occurrence Codes:** 01 Accident/Medical Coverage 02 Auto Accident - No Fault Liability 03 Accident/Tort Liability 04 Accident/Employment Related 05 Other Accident/No Medical Coverage or Liability Coverage 06 Crime Victim 20 Date Guarantee of Payment Began 24* Date Insurance Denied 25* Date Benefits Terminated by Primary Payer

Form Locator and Label	Completion Format	Instructions
		26 Date Skilled Nursing Facility Bed Available 27 Date of Hospice Certification or Re-certification 40 Scheduled Date of Admission (RTD) 50 Medicare Pay Date 51 Medicare Denial Date 53 Late Bill Override Date 55 Insurance Pay Date A3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer A indicated in FL 50 B3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer B indicated in FL 50 C3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer C indicated in FL 50 **Other Payer occurrence codes 24 and 25 must be used when applicable. The claim must be submitted with the third party information.*
35-36. Occurrence Span Code From/ Through	2 digits and 6 digits	Leave blank
38. Responsible Party Name/ Address	None	Not required Submitted information is not entered into the claim processing system.
39-41. Value Code-Code Value Code-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. If a value code is entered, a dollar amount or numeric value related to the code must always be entered. 01 Most common semiprivate rate (Accommodation Rate) 06 Medicare blood deductible 14 No fault including auto/other

Form Locator and Label	Completion Format	Instructions
		15 Worker's Compensation 30 Preadmission testing 31 Member Liability Amount 32 Multiple Member Ambulance Transport 37 Pints of Blood Furnished 38 Blood Deductible Pints 40 New Coverage Not Implemented by HMO 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 58 Arterial Blood Gas (PO2/PA2) 68 EPO-Drug 80 Covered Days 81 Non-Covered Days Enter the deductible amount applied by indicated payer: A1 Deductible Payer A B1 Deductible Payer B C1 Deductible Payer C Enter the amount applied to member's co-insurance by indicated payer: A2 Coinsurance Payer A B2 Coinsurance Payer B C2 Coinsurance Payer C Enter the amount paid by indicated payer: A3 Estimated Responsibility Payer A B3 Estimated Responsibility Payer B C3 Estimated Responsibility Payer C Enter the amount paid by member FC Member Paid Amount For Rancho Coma Score bill with appropriate diagnosis for head injury. Medicare & TPL - See A1-A3, B1-B3, & C1-C3 above
42. Revenue Code	3 digits	Required

Form Locator and Label	Completion Format	Instructions
		Enter the revenue code which identifies the specific accommodation or ancillary service provided. List revenue codes in ascending order. A revenue code must appear only once per date of service. If more than one of the same service is provided on the same day, combine the units and charges on one line accordingly. When billing outpatient hospital radiology, the radiology revenue code may be repeated, but the corresponding HCPCS code cannot be repeated for the same date of service. Refer to instructions under FL 44 (HCPCS/Rates). Psychiatric step down Use the following revenue codes: 114 Psychiatric Step Down 1 124 Psychiatric Step Down 2
43. Revenue Code Description	Text	Required Enter the revenue code description or abbreviated description. When reporting an NDC Enter the NDC qualifier of "N4" in the first two positions on the left side of the field. Enter the 11-digit NDC numeric code Enter the NDC unit of measure qualifier (examples include): F2 – International Unit GR – Gram ML – Milliliter UN – Units Enter the NDC unit of measure quantity
44. HCPCS/Rates /HIPPS Rate Codes	5 digits	Conditional Enter only the HCPCS code for each detail line. Use approved modifiers listed in this section for hospital based transportation services. Complete for laboratory, radiology, physical therapy, occupational therapy, and hospital based transportation. When billing HCPCS codes, the appropriate revenue code must also be billed. HCPCS codes must be identified for the following revenue codes: ▪ 30X LABORATORY

Form Locator and Label	Completion Format	Instructions
		▪ 32X RADIOLOGY – DIAGNOSTIC ▪ 33X RADIOLOGY – THERAPEUTIC ▪ 34X NUCLEAR MEDICINE ▪ 35X CT SCAN ▪ 40X OTHER IMAGING SERVICES ▪ 42X PHYSICAL THERAPY ▪ 43X OCCUPATIONAL THERAPY ▪ 44X SPEECH THERAPY ▪ 54X AMBULANCE ▪ 61X MRI HCPCS codes cannot be repeated for the same date of service. Combine the units in FL 46 (Service Units) to report multiple services. The following revenue codes always require a HCPCS code. Please reference the Provider Services Bulletins section of the Department's Web site for a list of physician-administered drugs that also require an NDC code. When a HCPCS code is repeated more than once per day and billed on separate lines, use modifier 76 to indicate this is a repeat procedure and not a duplicate. 0252 Non-Generic Drugs 0253 Take Home Drugs 0255 Drugs Incident to Radiology 0257 Non-Prescription 0258 IV Solutions 0259 Other Pharmacy 0260 IV Therapy General Classification 0261 Infusion Pump 0262 IV Therapy/Pharmacy Services 0263 IV Therapy/Drug/Supply Delivery 0264 IV Therapy/Supplies 0269 Other IV Therapy 0631 Single Source Drug 0632 Multiple Source Drug 0633 Restrictive Prescription 0634 Erythropoietin (EPO) <10,000 0635 Erythropoietin (EPO) >10,000 0636 Drugs Requiring Detailed Coding

Form Locator and Label	Completion Format	Instructions
45. Service Date	6 digits	Required For span bills only Enter the date of service using MMDDYY format for each detail line completed. Each date of service must fall within the date span entered in the "Statement Covers Period" (FL 6). Not required for single date of service claims.
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) The grand total line (Line 23) does not require a unit value. For span bills, the units of service reflect only those visits, miles or treatments provided on dates of service in FL 45.
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	9 digits	Conditional Enter incurred charges that are not payable by the Health First Colorado. Non-covered charges must be entered in both FL 47 (Total Charges) and FL 48 (Non-Covered Charges). Each column requires a grand total. Non-covered charges cannot be billed for outpatient hospital laboratory or hospital based transportation services.
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. At least one line must indicate The Health First Colorado. Source Payment Codes

Form Locator and Label	Completion Format	Instructions
		B Workmen's Compensation C Medicare D Health First Colorado 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 Health First Colorado 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		Not required Submitted information is not entered into the claim processing system.
53. Assignment of Benefits		Not required 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 Health First Colorado after provider has received other third party, Medicare or member liability amount. **Medicare Crossovers** Enter the sum of the Medicare coinsurance plus Medicare deductible less third party payments and member payments.

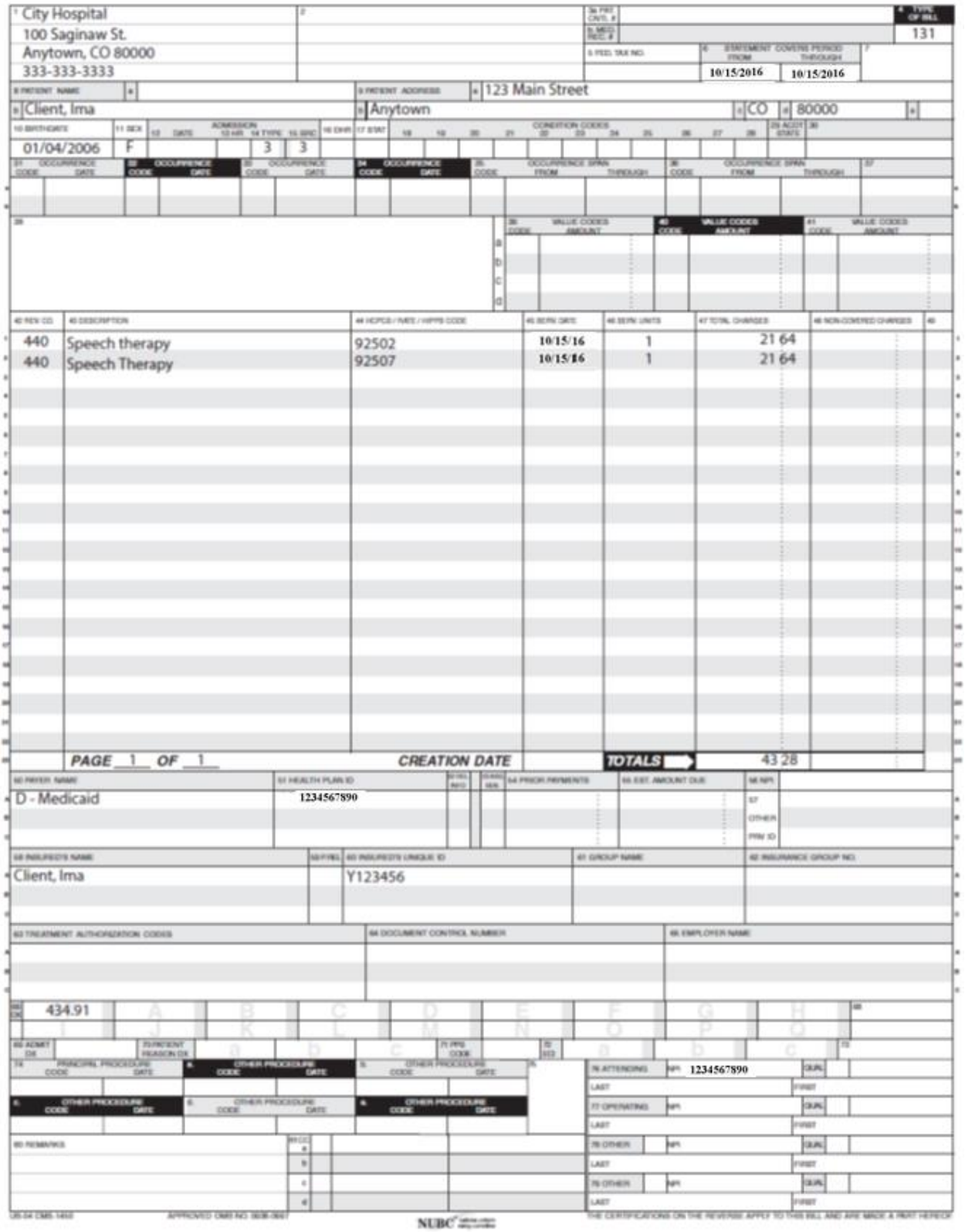
Form Locator and Label	Completion Format	Instructions
56. National Provider Identifier (NPI)	10 digits	Optional Enter the billing provider's 10-digit National Provider Identifier (NPI).
57. Other Provider ID		Not required Submitted information is not entered into the claim processing system.
58. Insured's Name	Up to 30 characters	Required Enter the member's name on the Health First Colorado 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 exactly as it appears on the health insurance card. Include letter prefixes or suffixes shown on the card.
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 exactly as it appears on the health insurance card.
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 carried.
63. Treatment Authorization Code	Up to 18 characters	Conditional Complete when the service requires a PAR. Enter the authorization number in this FL if a PAR is required and has been approved for services.
64. Document Control Number		Conditional

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		Not required 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	Up to 6 digits	Conditional 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	Up to 6 digits	Optional Enter the diagnosis code as stated by the physician at the time of admission.
70. Patient Reason Diagnosis		Not required Submitted information is not entered into the claim processing system.
71. PPS Code		Not required Submitted information is not entered into the claim processing system.
72. External Cause of Injury Code (E-code)	Up to 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	Up to 7 characters or Up to 6 digits	Conditional Enter the procedure code for the principal procedure performed during this billing period and the date on which procedure was performed. Enter the date using MMDDYY format. Apply the following criteria to determine the principle procedure:

Form Locator and Label	Completion Format	Instructions
		The principal procedure is not performed for diagnostic or exploratory purposes. This code is related to definitive treatment; and The principal procedure is most related to the primary diagnosis.
74A. Other Procedure Code/Date	Up to 7 characters or Up to 6 digits	Conditional Complete when there are additional significant procedure codes. Enter the procedure codes identifying all significant procedures other than the principle procedure and the dates on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principle diagnosis. Enter the date using MMDDYY format.
76. Attending **NPI – Conditional** **QUAL - Conditional** **ID - (Health First Colorado Provider #) – Required** **Attending- Last/ First Name**	NPI - 10 digits QUAL – Text Medicaid ID - 8 digits Text	Health First Colorado ID Required NPI - Enter the 10-digit NPI number assigned to the physician having primary responsibility for the member's medical care and treatment. This number is obtained from the physician, and cannot be a clinic or group number. (If the attending physician is not enrolled in the Health First Colorado or if the member leaves the ER before being seen by a physician, the hospital may enter their individual numbers.) Hospitals may enter the member's regular physician's 10-digit NPI in the Attending Physician ID form locator if the locum tenens physician is not enrolled in the Health First Colorado. QUAL – Enter "1D " for Medicaid Enter the attending physician's last and first name. This form locator must be completed for all services.
77. Operating- NPI/QUAL/ID		Not required Submitted information is not entered into the claim processing system.
78-79. Other ID **NPI – Conditional** **QUAL - Conditional**	NPI - 10 digits QUAL – Text Medicaid ID - 8 digits	Conditional – Complete when attending physician is not the PCP or to identify additional physicians. NPI - Enter up to two 10-digit NPI numbers, when applicable. This form locator identifies physicians other than the attending physician. If the attending physician is not the PCP or if a clinic is a PCP agent, enter the PCP

Form Locator and Label	Completion Format	Instructions
ID - (Health First Colorado Provider #) – Conditional		NPI number as the referring physician. The name of the Health First Colorado member's PCP appears on the eligibility verification. Review either for eligibility and PCP. The Health First Colorado does not require that the PCP number appear more than once on each claim submitted. The attending physician's last and first name are optional.
80. Remarks	Text	Optional Enter specific additional information necessary to process the claim or fulfill reporting requirements.
81. Code-Code QUAL/CODE/VALUE (a-d)		Optional Submitted information is not entered into the claim processing system.

UB-04 Outpatient Speech Therapy Claim Example



1 City Hospital
100 Saginaw St.
Anytown, CO 80000
333-333-3333

4 TYPE OF BILL: 131

6 STATEMENT COVERS PERIOD: FROM 10/15/2016 THROUGH 10/15/2016

8 PATIENT NAME: b Client, Ima

9 PATIENT ADDRESS: a 123 Main Street; b Anytown; c CO; d 80000

10 BIRTHDATE: 01/04/2006

11 SEX: F

14 TYPE: 3

15 SRC: 3

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
440	Speech therapy	92502	10/15/16	1	21 64	
440	Speech Therapy	92507	10/15/16	1	21 64	
	PAGE 1 OF 1	CREATION DATE		TOTALS	43 28	

50 PAYER NAME: D - Medicaid

51 HEALTH PLAN ID: 1234567890

60 INSURED'S NAME: Client, Ima

62 INSURED'S UNIQUE ID: Y123456

66 DX: 434.91

76 ATTENDING NPI: 1234567890

NUBC

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.

Timely Filing

The Health First Colorado allows providers to document compliance with timely filing requirements when the initial timely filing period has expired. Health First Colorado providers have 120 days from the date of service to submit their claim. For information on the 60-day resubmission rule for denied/rejected claims, 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.

Speech Therapy Revisions Log

Revision Date	Additions/Changes	Pages	Made by
12/01/2016	*Manual revised for interChange implementation. For manual revisions prior to 12/01/2016, please refer to Archive.*	*All*	*HPE (now DXC)*
12/27/2016	*Updates based on Colorado iC Stage II Provider Billing Manual Comment Log v0_2.xlsx*	*Multiple*	*HPE (now DXC)*
1/10/2017	*Updates based on Colorado iC Stage Provider Billing Manual Comment Log v0_3.xlsx*	*Multiple*	*HPE (now DXC)*
1/19/2017	*Updates based on Colorado iC Stage Provider Billing Manual Comment Log v0_4.xlsx*	*Multiple*	*HPE (now DXC)*
1/26/2017	*Updates based on Department 1/20/2017 approval email*	*Accepted tracked changes throughout*	*HPE (now DXC)*
3/7/2017	*Clarified billing for assistants, clinical fellows. Clarified PAR documentation requirements. Updated eligibility message for HPE response.*	*Multiple*	*AW*
5/26/2017	*Updates based on Fiscal Agent name change from HPE to DXC*	*11*	*DXC*

***Note**: In many instances when specific pages are updated, the page numbers change for the entire section. Page numbers listed above are the page numbers on which the updates/changes occur.*