

Telemedicine

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Telemedicine

Program Overview

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

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

The Colorado Medical Assistance Program reimburses providers for medically necessary medical and surgical services furnished to eligible members.

Telemedicine is not itself a unique service but a means of providing selected services approved by the Colorado Medical Assistance Program. Telemedicine involves two collaborating providers: an "originating provider" and a "distant provider". The provider where the member is located is the "originating site" or "originating provider". In most cases the "distant provider" is a clinician who acts as a consultant to the originating provider. However, in some cases – mental health services, for example – the distant provider may be the only provider involved in the service.



Providers should refer to the Code of Colorado Regulations, [Program Rules](#) (10 CCR 2505-10, Section 8.200.4), for specific information when providing telemedicine services. For further questions please contact:

Telemedicine Program Coordinator
Colorado Department of Health Care Policy and Financing
800-221-3943

Billing Information

National Provider Identifier (NPI)

The Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities (i.e., health plans, health care clearinghouses, and those health care providers who transmit any health information electronically in connection with a transaction for which the Secretary of Health and Human Services has adopted a standard) use NPIs in standard transactions.

Paper Claims

Electronic claims format shall be required unless hard copy claims submittals are specifically prior authorized by the Department of Health Care Policy and Financing (the Department). Requests for paper claim submission may be sent to the Department's fiscal agent, Xerox State Healthcare, P.O. Box 90, Denver, CO 80201-0090. The following claims can be submitted on paper and processed for payment:

- Claims from providers who consistently submit 5 claims or fewer per month (requires prior approval)
- Claims that by policy require attachments
- Reconsideration claims

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 are available on the Department’s website in the Provider Services [Specifications](#) section
- Web Portal User Guide (via within the Web Portal)

The Colorado Medical Assistance Program collects electronic claim information interactively through the [Colorado Medical Assistance Program Secure Web Portal](#) (Web Portal) or via batch submission through a host system. Please refer to the Medicaid Provider Information found on [Billing Manuals](#) web page of the Department’s website Medicaid Reimbursement for Telemedicine

As of October 1, 2007, the Colorado Medical Assistance Program began accepting telemedicine claims. This enables providers to be reimbursed for selected services provided via telecommunications equipment.

To receive Medicaid reimbursement, telemedicine services must be provided “live”. The patient and the distant provider interact with one another in real time through an **audio-video** communications circuit. Peripherals may be included, such as transmission of a live ultrasound exam.

Exclusions

“Telemedicine” **does not** include:

- Consultations provided by telephone (interactive audio)
- Facsimile machines

Does Telemedicine Add New Services?

- Providers may only bill procedure codes which they are already eligible to bill.
- Services appropriately billed to managed care should continue to be billed to managed care. All managed care requirements must be met for services billed to managed care. Managed care may or may not reimburse telemedicine costs.
- Colorado Medicaid does not pay for provider or patient education when education is the only service provided via telemedicine.
- Services not otherwise covered by Colorado Medicaid are not covered when delivered via telemedicine.
- The use of telecommunications equipment for delivery of services does not change prior authorization requirements established for the services being provided.

Telemedicine and Managed Care



No enrolled managed care organization may require face-to-face contact between a provider and a member for services appropriately provided through telemedicine if:

- The member resides in a county with a population of 150,000 or fewer residents.
- and**
- The county has the technology necessary to provide telemedicine services.

The use of telemedicine is not required when in-person care by a participating provider is available to an enrolled member within a reasonable distance. Please refer to 10 CCR 2505-10, Section 8.200.4.B. for more information.

When Should A Provider Choose Telemedicine?

The Colorado General Assembly considers a primary purpose of telemedicine is to bring providers to people living in rural areas. Providers should weigh this advantage against quality of care and member safety considerations. They should also consider the provider's liability. Members may choose which is more convenient for them when providers make telemedicine available.

However, telemedicine should not be selected when face-to-face services are medically necessary. Members should establish relationships with primary care providers who are available on a face-to-face basis.

Telemedicine Confidentiality Requirements

All Medicaid providers using telemedicine to deliver Medicaid services must employ existing quality-of-care protocols and member confidentiality guidelines when providing telemedicine services. Health benefits provided through telemedicine must meet the same standard of care as in-person care. Record-keeping should comply with Medicaid requirements in 10 CCR 2505-10, Section 8.130.

Transmissions must be performed on dedicated secure lines or must utilize an acceptable method of encryption adequate to protect the confidentiality and integrity of the transmission. Transmissions must employ acceptable authentication and identification procedures by both the sender and the receiver.



Providers of telemedicine services must implement confidentiality procedures that include, but are not limited to:

- Specifying the individuals who have access to electronic records.
- Using unique passwords or identifiers for each employee or other person with access to the member records.
- Ensuring a system to routinely track and permanently record such electronic medical information.

Waiving the Face-to-Face Requirement

The Medicaid requirement for face-to-face contact between provider and member may be waived prior to treating the member through telemedicine for the first time. The rendering provider must furnish each member with all of the following written statements which must be signed by the member or the member's legal representative:



- The member retains the option to refuse the delivery of health care services via telemedicine at any time without affecting the member's right to future care or treatment and without risking the loss or withdrawal of any program benefits to which the member would otherwise be entitled.
- All applicable confidentiality protections shall apply to the services.
- The member shall have access to all medical information resulting from the telemedicine services as provided by applicable law for member access to his or her medical records.

These requirements do not apply in an emergency. [C. R. S. 2006, 25.5-5-320 (4) & (5)].

General Billing Instructions



Billing Providers

Telemedicine services will only be reimbursed for providers who are enrolled in the Colorado Medical Assistance Program at the time service.

The availability of services through telemedicine in no way alters the scope of practice of any health care provider; or authorizes the delivery of health care services in a setting or manner not otherwise authorized by law. [C. R. S. 2006, 25.5-5-414 (7)(a) & (b)].

Originating Site Billing

All telemedicine services are billed on the CMS 1500 paper claim form or as an 837P transaction regardless of provider type.

The originating provider may bill for an office, outpatient or inpatient Evaluation & Management (E&M) service that precedes a telemedicine consultation and for other Medicaid-covered services. In some cases, the originating provider site will not be providing clinical services, but only providing a site and telecommunications equipment.

Originating providers bill as follows:

- If the originating provider is making a room and telecommunications equipment available but is not providing clinical services, the originating provider bills Q3014, the procedure code for the telemedicine originating site facility fee.
- If the originating provider also provides clinical services to the member, the provider bills the rendering provider’s appropriate procedure code and bills Q3014.
- The originating provider may also bill, as appropriate, on the UB-04 paper claim form or as an 837I transaction for any clinical services provided on-site on the same day that a telemedicine originating site claim is made. The originating provider must submit two separate claims for the member’s two separate services.

The following provider types may bill procedure code Q3014 (telemedicine originating site facility fee):



Physician	05
Clinic	16
Osteopath	26
Federally Qualified Health Center	32
Psychologist	37
MA Psychologist	38
Physician Assistant	39
Nurse Practitioner	41
Rural Health Clinic	45

If practitioners at both the originating site and the distant site provide the same service to the member, both providers submit claims using the same procedure code with modifier 77. (Repeat procedure by another physician.)

The originating site may not bill for assisting the distant site provider with an examination.

Distant Provider Billing

All distant site rendering providers bill the appropriate procedure code using modifier GT (interactive communication) on the CMS 1500 paper claim form or as an 837P transaction. The previously listed provider types may bill using modifier GT. The procedure codes for billing telemedicine are listed below.

Using modifier GT adds \$5.00 to the fee for the procedure code billed.

Rendering Providers

If a rendering provider's number is required on the claim for a face-to-face visit, it is required on the claim for a telemedicine visit.



Rural Health Clinics should leave field 19D on the CMS 1500 paper claim form blank. Federally Qualified Health Centers, Clinics and the other provider types are required to enter the rendering provider's Colorado Medical Assistance Program provider number in field 19D.

When an originating site bills Q3014 (originating site facility fee), there is generally no rendering provider actually involved in the service at the originating site.

However, a rendering provider number is still required and must be affiliated with the billing provider. The facility may enter either the patient's usual provider's number; or another provider number affiliated with that site as the rendering provider.

When the patient sees a rendering provider at the originating site and also uses the site as the telemedicine originating site, the facility bills the rendered service procedure code and Q3014 for the use of the telemedicine facility. The same rendering provider number is entered in field 19D.

Procedure/HCPCS Codes Overview

The Department accepts 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 CPT (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA). The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, 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 completing and submitting a publication preference form.

Bulletins include updates on approved procedures codes as well as the maximum allowable units billed per procedure.

Telemedicine Procedure Coding

The following procedure codes, when billed with modifier GT by appropriate providers, pay the telemedicine transmission fee. Any other procedure codes billed with modifier GT will not pay the telemedicine transmission fee.

Procedure Codes	Description	Comments	Prior Authorization Required
Outpatient Mental Health			
90791	Diagnostic evaluation	If interactive complexity then report with add on code 90785	
90832	Psychotherapy, 30 min (actual time can be 16-37 min)	If interactive complexity then report with add on code 90785	
90833	Add on Psychotherapy 30 min (actual time can be 16-37 min) Use in conjunction with appropriate E/M code	If interactive complexity then report with add on code 90785	
90834	Psychotherapy 45 min (actual time can be 38-52 min)	If interactive complexity then report with add on code 90785	
90836	Add on Psychotherapy 45 min (actual time can be 38-52 min) Use in conjunction with appropriate E/M code	If interactive complexity then report with add on code 90785	
90837	Psychotherapy 60 min (actual time can be 53+)	Medicare crossover only	
90838	Add on Psychotherapy 60 min (actual time can be 53+ Use in conjunction with appropriate E/M code	Medicare crossover only	
90863	Add on Pharmacologic management code	can be added to primary psychotherapy code	
90846	Family therapy – patient not present		
90847	Family therapy – patient present		
Evaluation & Management			
99201	Office or other outpatient visit, new patient, 10 minutes		
99202	Office or other outpatient visit, new patient, 20 minutes		
99203	Office or other outpatient visit, new patient, 30 minutes		
99204	Office or other outpatient visit, new patient, 45 minutes		
99205	Office or other outpatient visit, new patient, 60 minutes		
99211	Office or other outpatient visit, established patient, 5 minutes		

Procedure Codes	Description	Comments	Prior Authorization Required
99212	Office or other outpatient visit, established patient, 10 minutes		
99213	Office or other outpatient visit, established patient, 15 minutes		
99214	Office or other outpatient visit, established patient, 25 minutes		
99215	Office or other outpatient visit, established patient, 40 minutes		
Speech Therapy			
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual, per encounter		
97532	Development of cognitive skills, direct one-on-one patient contact, 15 minutes		
Obstetrical Ultrasounds			
76801	Ultrasound, pregnant uterus, real time first trimester		
76802	Each additional gestation		
76805	Ultrasound, pregnant uterus, real time after first trimester		
76810	Each additional gestation		
76811	Ultrasound, pregnant uterus, real time plus detailed fetal anatomical exam, single or first gestation		
76812	Each additional gestation		
76813	Ultrasound, pregnant uterus real time first trimester fetal nuchal translucency measurement		
76814	Each additional gestation		
76815	Ultrasound, pregnant uterus, real time, limited, one or more fetuses		
76816	Ultrasound, pregnant uterus, real time, follow-up		
76817	Ultrasound, pregnant uterus, real time, transvaginal		
Other			
96116	Neurobehavior status exam		

CMS 1500 Paper Claim Reference Table

The following paper claim form reference table shows required, optional, and conditional fields and detailed field completion instructions.

CMS Field #	Field Label	Field is?	Instructions
1	Insurance Type	Required	Place an "X" in the box marked as Medicaid.
1a	Insured's ID Number	Required	Enter the member's Colorado Medical Assistance Program seven-digit Medicaid ID number as it appears on the Medicaid Identification card. Example: A123456.
2	Patient's Name	Required	Enter the member's last name, first name, and middle initial.
3	Patient's Date of Birth / Sex	Required	Enter the patient's birth date using two digits for the month, two digits for the date, and two digits for the year. Example: 070114 for July 1, 2014. Place an "X" in the appropriate box to indicate the sex of the member.
4	Insured's Name	Conditional	Complete if the member is covered by a Medicare health insurance policy. Enter the insured's full last name, first name, and middle initial. If the insured used a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name.
5	Patient's Address	Not Required	
6	Patient's Relationship to Insured	Conditional	Complete if the member is covered by a commercial health insurance policy. Place an "X" in the box that identifies the member's relationship to the policyholder.
7	Insured's Address	Not Required	
8	Reserved for NUCC Use		

CMS Field #	Field Label	Field is?	Instructions
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.
11a	Insured's Date of Birth, Sex	Conditional	Complete if the member is covered by a Medicare health insurance policy. Enter the insured's birth date using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. Place an "X" in the appropriate box to indicate the sex of the insured.
11b	Other Claim ID	Not Required	

CMS Field #	Field Label	Field is?	Instructions
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	<p>Complete if information is known. Enter the date of illness, injury or pregnancy, (date of the last menstrual period) using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014.</p> <p>Enter the applicable qualifier to identify which date is being reported</p> <p>431 Onset of Current Symptoms or Illness 484 Last Menstrual Period</p>
15	Other Date	Not Required	
16	Date Patient Unable to Work in Current Occupation	Not Required	
17	Name of Referring Physician	Not Required	
18	Hospitalization Dates Related to Current Service	Not Required	
19	Additional Claim Information	Conditional	<p>LBOD</p> <p>Use to document the Late Bill Override Date for timely filing.</p>

CMS Field #	Field Label	Field is?	Instructions
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
22	Medicaid Resubmission Code	Conditional	List the original reference number for resubmitted claims. When resubmitting a claim, enter the appropriate bill frequency code in the left-hand side of the field. 7 Replacement of prior claim 8 Void/Cancel of prior claim This field is not intended for use for original claim submissions.
23	Prior Authorization	Conditional	Enter the six character prior authorization number from the approved Prior Authorization Request (PAR). Do not combine services from more than one approved PAR on a single claim form. Do not attach a copy of the approved PAR unless advised to do so by the authorizing agent or the fiscal agent.
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

CMS Field #	Field Label	Field is?	Instructions																		
			<p>the date and two digits for the year. Example: 010114 for January 1, 2014</p> <p>From To</p> <table border="1" data-bbox="914 348 1247 401"> <tr> <td>01</td><td>01</td><td>15</td><td></td><td></td><td></td> </tr> </table> <p>Or</p> <p>From To</p> <table border="1" data-bbox="914 485 1247 537"> <tr> <td>01</td><td>01</td><td>15</td><td>01</td><td>01</td><td>15</td> </tr> </table> <p>Span dates of service</p> <p>From To</p> <table border="1" data-bbox="914 621 1247 674"> <tr> <td>01</td><td>01</td><td>15</td><td>01</td><td>31</td><td>15</td> </tr> </table> <p>Practitioner claims must be consecutive days. <u>Single Date of Service</u>: Enter the six digit date of service in the "From" field. Completion of the "To" field is not required. Do not spread the date entry across the two fields. <u>Span billing</u>: permissible if the same service (same procedure code) is provided on consecutive dates.</p> <p>Supplemental Qualifier To enter supplemental information, begin at 24A by entering the qualifier and then the information.</p> <p>ZZ Narrative description of unspecified code</p> <p>N4 National Drug Codes</p> <p>VP Vendor Product Number</p> <p>OZ Product Number</p> <p>CTR Contract Rate</p> <p>JP Universal/National Tooth Designation</p> <p>JO Dentistry Designation System for Tooth & Areas of Oral Cavity</p>	01	01	15				01	01	15	01	01	15	01	01	15	01	31	15
01	01	15																			
01	01	15	01	01	15																
01	01	15	01	31	15																
24B	Place of Service	Required	<p>Enter the Place of Service (POS) code that describes the location where services were rendered. The Colorado Medical Assistance Program accepts the CMS place of service codes.</p> <p>04 Homeless Shelter</p> <p>11 Office</p> <p>12 Home</p>																		

CMS Field #	Field Label	Field is?	Instructions
			15 Mobile Unit 20 Urgent Care Facility 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room Hospital 25 Birthing Center 26 Military Treatment Center 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Transportation – Land 51 Inpatient Psychiatric Facility 52 Psychiatric Facility Partial Hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility – MR 60 Mass Immunization Center 61 Comprehensive IP Rehab Facility 62 Comprehensive OP Rehab Facility 65 End Stage Renal Dialysis Trtmt Facility 71 State-Local Public Health Clinic 99 Other Unlisted
24C	EMG	Not Required	
24D	Procedures, Services, or Supplies	Required	Enter the HCPCS procedure code that specifically describes the service for which payment is requested. All procedures must be identified with codes in the current edition of Physicians Current Procedural Terminology (CPT). CPT is updated annually. HCPCS Level II Codes The current Medicare coding publication (for Medicare crossover claims only).

CMS Field #	Field Label	Field is?	Instructions
			<p>Only approved codes from the current CPT or HCPCS publications will be accepted.</p> <p>Telemedicine</p> <p>For originating provider use procedure code Q3014 with no modifier.</p> <p>For distant provider use an approved telemedicine procedure code + modifier.</p>
24D	Modifier	Conditional	<p>Enter the appropriate procedure-related modifier that applies to the billed service. Up to four modifiers may be entered when using the paper claim form.</p> <p>GT Via Ineract Audio/Video System</p>
24E	Diagnosis Pointer	Required	<p>Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis.</p> <p>At least one diagnosis code reference letter must be entered.</p> <p>When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow.</p> <p>This field allows for the entry of 4 characters in the unshaded area.</p>
24F	\$ Charges	Required	<p>Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.</p> <p>Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one procedure from the same group is billed, special multiple pricing rules apply.</p> <p>The base procedure is the procedure with the highest allowable amount. The base code is used to determine the allowable amounts for additional CPT surgical procedures when more than one procedure from the same grouping is performed.</p> <p>Submitted charges cannot be more than charges made to non-Colorado Medical Assistance Program covered individuals for the same service.</p>

CMS Field #	Field Label	Field is?	Instructions
			Do not deduct Colorado Medical Assistance Program 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	<p>EPSDT (shaded area) For Early & Periodic Screening, Diagnosis, and Treatment related services, enter the response in the shaded portion of the field as follows:</p> <p>AV Available- Not Used S2 Under Treatment ST New Service Requested NU Not Used</p> <p>Family Planning (unshaded area) Not Required</p>
24I	ID Qualifier	Not Required	
24J	Rendering Provider ID #	Required	In the shaded portion of the field, enter the eight-digit Colorado Medical Assistance Program provider number assigned to the <u>individual</u> who actually performed or rendered the billed service. This number cannot be assigned to a group or clinic. NOTE: When billing a paper claim form, do not use the individual's NPI.
25	Federal Tax ID Number	Not Required	
26	Patient's Account Number	Optional	Enter information that identifies the patient or claim in the provider's billing system. Submitted information appears on the Provider Claim Report (PCR).
27	Accept Assignment?	Required	The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.

CMS Field #	Field Label	Field is?	Instructions
28	Total Charge	Required	Enter the sum of all charges listed in field 24F. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
29	Amount Paid	Conditional	Enter the total amount paid by Medicare or any other commercial health insurance that has made payment on the billed services. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
30	Rsvd for NUCC Use		
31	Signature of Physician or Supplier Including Degrees or Credentials	Required	<p>Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent.</p> <p>A holographic signature stamp may be used <u>if</u> authorization for the stamp is on file with the fiscal agent.</p> <p>An authorized agent or representative may sign the claim for the enrolled provider <u>if</u> the name and signature of the agent is on file with the fiscal agent.</p> <p>Each claim must have the date the enrolled provider or registered authorized agent signed the claim form. Enter the date the claim was signed using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014.</p> <p>Unacceptable signature alternatives:</p> <p>Claim preparation personnel may not sign the enrolled provider’s name.</p> <p>Initials are not acceptable as a signature.</p> <p>Typed or computer printed names are not acceptable as a signature.</p> <p>“Signature on file” notation is not acceptable in place of an authorized signature.</p>
32	32- Service Facility Location Information 32a- NPI Number	Conditional	<p>Complete for services provided in a hospital or nursing facility in the following format:</p> <p>1st Line Name</p> <p>2nd Line Address</p> <p>3rd Line City, State and ZIP Code</p>

CMS Field #	Field Label	Field is?	Instructions
	32b- Other ID #		32a- NPI Number Enter the NPI of the service facility (if known). 32b- Other ID # Enter the eight-digit Colorado Medical Assistance Program provider number of the service facility (if known). The information in field 32, 32a and 32b is not edited.
33	33- Billing Provider Info & Ph # 33a- NPI Number 33b- Other ID #	Required	Enter the name of the individual or organization that will receive payment for the billed services in the following format: 1 st Line Name 2 nd Line Address 3 rd Line City, State and ZIP Code 33a- NPI Number Enter the NPI of the billing provider 33b- Other ID # Enter the eight-digit Colorado Medical Assistance Program provider number of the individual or organization.



Late Bill Override Date

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

Valid Delay Reason Codes

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



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

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

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

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

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

Billing Instruction Detail	Instructions
<p>Commercial Insurance Processing</p>	<p>The claim has been paid or denied by commercial insurance.</p> <p>File the claim within 60 days of the insurance payment or denial. Retain the commercial insurance payment or denial notice that identifies the patient, rendered services, and shows the payment or denial date.</p> <p>Claims must be filed within 365 days of the date of service. No exceptions are allowed. If the claim is nearing the 365-day limit and the commercial insurance company has not completed processing, file the claim, receive a denial or rejection, and continue filing in compliance with the 60-day rule until insurance processing information is available.</p> <p>LBOD = the date commercial insurance paid or denied.</p>
<p>Correspondence LBOD Authorization</p>	<p>The claim is being submitted in accordance with instructions (authorization) from the Colorado Medical Assistance Program for a 60 day filing extension for a specific member, claim, services, or circumstances.</p> <p>File the claim within 60 days of the date on the authorization letter. Retain the authorization letter.</p> <p>LBOD = the date on the authorization letter.</p>
<p>Member Changes Providers during Obstetrical Care</p>	<p>The claim is for obstetrical care where the patient transferred to another provider for continuation of OB care. The prenatal visits must be billed using individual visit codes but the service dates are outside the initial timely filing period.</p> <p>File the claim within 60 days of the last OB visit. Maintain information in the medical record showing the date of the last prenatal visit and a notation that the patient transferred to another provider for continuation of OB care.</p> <p>LBOD = the last date of OB care by the billing provider.</p>



Telemedicine Originator Claim Example



HEALTH INSURANCE CLAIM FORM

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

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>	
1. MEDICARE (Medicare #) <input checked="" type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE (ID/DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input type="checkbox"/>			1a. INSURED'S I.D. NUMBER (For Program in item 1) D444444								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Client, Ima A				3. PATIENT'S BIRTH DATE MM DD YY 10 16 45 M F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)				6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? PLACE (State) YES <input type="checkbox"/> NO <input type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. RESERVED FOR LOCAL USE		11. INSURED'S POLICY GROUP OR FECA NUMBER * INSURED'S DATE OF BIRTH MM DD YY SEX M F b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> # yes, complete items 9, 9a and 9d.					
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED Signature on File DATE 1/1/15										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL			15. OTHER DATE MM DD YY QUAL			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE			17a. NPI			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD-9 9										22. RESUBMISSION CODE ORIGINAL REF. NO.	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. I.D. QUAL. I. RENDING PROVIDER ID. #										23. PRIOR AUTHORIZATION NUMBER	
1 01 01 15 01 01 15 11 Q3014 A 21 73 1 12345678 NPI 0123456789											
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	
25. FEDERAL TAX I.D. NUMBER SSN EIN			26. PATIENT'S ACCOUNT NO. Optional		27. ACCEPT ASSIGNMENT? (For gov. plans, see 26C) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 21 73		29. AMOUNT PAID \$		30. Rwd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Signature DATE 1/1/15			32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH# () ABC Telemedicine Clinic 100 Any Street Any City a. 1234567890 b. 04567890				

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PHYSICIAN OR SUPPLIER INFORMATION

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Telemedicine Distant Claim Example



HEALTH INSURANCE CLAIM FORM

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

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>					
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> (Medicaid #) (DW/CoDR) <input type="checkbox"/> TRECARE <input type="checkbox"/> (DW/CoDR) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (ID#) <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> (ID#) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID#) <input type="checkbox"/>	1a. INSURED'S I.D. NUMBER (For Program in Item 1)														
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Client, Ima A										3. PATIENT'S BIRTH DATE MM DD YY 10 16 45		SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER			
10a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>										10b. AUTO ACCIDENT? PLACE (State) YES <input type="checkbox"/> NO <input type="checkbox"/>		10c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		11a. INSURED'S DATE OF BIRTH MM DD YY M SEX F	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED Signature on File DATE 1/1/15										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL	15. OTHER DATE QUAL	16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 77a. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input type="checkbox"/>	21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind: 9	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. EFFECT Party Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #						
01 01 15 01 01 15 11	90801	GT	A	100 00	1			12345678	NPI 0123456789						
25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO. Optional	27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	28. TOTAL CHARGE \$ 100 00	29. AMOUNT PAID \$	30. Reserved for NUCC Use										
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Signature DATE 1/1/15	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # () ABC Telemedicine Clinic 100 Any Street Any City													
		a. 1234567890	b. 04567890												

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Telemedicine Revisions Log

Revision Date	Section	Pages/ Action	Made by
01/05/2009	<i>Drafted Manual</i>	All	jg
02/22/2010	<i>General updates and revisions</i>	Throughout	vr
03/04/2010	<i>Final revisions</i>	Throughout	vr/jg
07/12/2010	<i>Updated date examples for field 19A</i> <i>Updated claim examples</i>	16 26 & 27	jg
07/14/2010	<i>Added Electronic Remittance Advice (ERA) to Special Instructions for Medicare SPR Date field and to Electronic Medicare Crossover Claims & to Medicare Denied Services in Late Bill Override Date section.</i>	19 24	jg
08/30/2011	<i>Changed authorizing agent to authorizing agency.</i>	14	crc
08/31/2011	<i>Updated hyperlink for colorado.gov/hcpf</i>	4	dc
08/31/2011	<i>Updated hyperlink for edifecs.com</i>	5	dc
08/31/2011	<i>Updated client date of birth and Medicaid ID</i>	10 & 11	dc
08/31/2011	<i>Updated diagnosis code</i>	14 & 17	dc
08/31/2011	<i>Deleted SPR/ERA when spelled out</i>	24	dc
12/06/2011	<i>Replaced 997 with 999</i> <i>Replaced wpc-edi.com/hipaa with wpc-edi.com/</i> <i>Replaced Implementation Guide with Technical Report 3 (TR3)</i>	4 3 3	ss
05/14/2013	<i>Consolidated electronic billing information</i> <i>HCPCS Added:</i> <ul style="list-style-type: none"> • 90791, 90832, 90833, 90834, 90836, 90837, 90838, 90863 <i>Deleted:</i> <ul style="list-style-type: none"> • 90801, 90804, 90805, 90806, 90807, 90808, 90809, 90862 	3 8-9	cc
05/15/2013	<i>Reformatted</i> <i>Updated TOC</i>	Throughout i	jg
09/23/2013	<i>Deleted. Codes no longer covered 99243, 99244, 99245, 99251, 99252, 99253, 99254, and 99255</i>	6-7	db
09/23/2013	<i>Reformatted</i> <i>Updated TOC</i> <i>Replaced "dually eligible" with "Medicare-Medicaid enrollees"</i>	Throughout I 7	Jg
8/15/14	<i>Replaced all CO 1500 references with CMS 1500</i>	Throughout	ZS

<i>8/15/14</i>	<i>Updated Professional Claim Billing Instructions section with CMS 1500 information.</i>		<i>ZS</i>
<i>8/15/14</i>	<i>Replaced all client references with member</i>	<i>Throughout</i>	<i>ZS</i>
<i>8/22/2014</i>	<i>Updated all weblinks for the Department's new website</i>	<i>Throughout</i>	<i>MM</i>
<i>12/08/2014</i>	<i>Removed Appendix H information, added Timely Filing document information</i>	<i>19</i>	<i>mc</i>
<i>04/28/2015</i>	<i>Changed the word unshaded to shaded</i>	<i>24J</i>	<i>Bl</i>
<i>7/28/15</i>	<i>ICD-10 Audit revealed no current ICD-9 codes in manual. Removed the ICD-9 reference for CMS field 21.</i>	<i>Throughout</i>	<i>JH</i>
<i>8/19/15</i>	<i>Added column to Procedure code table to indicate Prior Authorization. Changed font to Tahoma. Reviewed for mention of Carewebqi but none.</i>	<i>6-7 Throughout Throughout.</i>	<i>JH</i>
<i>09/08/2015</i>	<i>Accepted changes and updated TOC</i>	<i>Throughout</i>	<i>bl</i>

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