

Early and Periodic Screening Diagnostic and Treatment (EPSDT) Program

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Early and Periodic Screening Diagnostic and Treatment (EPSDT) Program

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 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children and youth ages 20 and under, who are enrolled in Medicaid. EPSDT is key to ensuring that children and youth receive appropriate preventive, dental, mental health, developmental and specialty services.

Early	Assessing and identifying problems early
Periodic	Checking children's health at periodic, age-appropriate intervals
Screening	Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
Diagnostic	Performing diagnostic tests to follow up when a risk is identified
Treatment	Control, correct or reduce health problems found

One of the goals of EPSDT is to establish a regular pattern of healthcare through routine health screenings, diagnostic, and treatment services.

All states are required to complete a report to the federal government on April 1 of each year as to the numbers of services received by the EPSDT eligible members. All states have a minimum requirement of 80% of the children and youth receiving at least one screening visit per year.



Providers should refer to the Code of Colorado Regulations, [Program Rules](#) (10 CCR 2505-10.8.280), for specific information when providing EPSDT care.

General Billing Information

National Provider Identifier (NPI)

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



Paper Claims

Electronic claims format shall be required unless hard copy claims submittals are specifically authorized by the Department of Health Care Policy and Financing (the Department). Requests may be sent to Affiliated Computer Services (ACS), P.O. Box 90, Denver, CO 80201-0090. The following claims can be submitted on paper and processed for payment:

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

Paper claims do not require an NPI, but do require the Colorado Medical Assistance Program provider number. Electronically mandated claims submitted on paper are processed, denied, and marked with the message “Electronic Filing Required”.

Electronic Claims

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

- X12N Technical Report 3 (TR3) for the 837P, 837I, or 837D (<http://www.wpc-edi.com/>)
- Companion Guides for the 837P, 837I, or 837D in the Provider Services [Specifications](#) section of the Department’s Web site.
- 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. For additional electronic information, please refer to the Medicaid Provider Information manual located on the Department’s website (Colorado.gov/hcpf) → For Our Providers → Provider Services → [Billing Manuals](#).

General Program Provisions

EPSDT Services

EPSDT is made up of the following screening, diagnostic, and treatment services:

Screening Services

Comprehensive health and developmental history

Comprehensive unclothed physical exam

Appropriate immunizations (according to the Advisory Committee on Immunization Practices)

Laboratory tests (including lead toxicity testing)

Health Education (anticipatory guidance including child development, healthy lifestyles, and accident and disease prevention)

Vision Services At a minimum, diagnosis and treatment for defects in vision, including eyeglasses.

Dental Services At a minimum, dental services include relief of pain and infections, restoration of teeth, and Maintenance of dental health, including examinations, cleanings and fluoride treatments.

Hearing Services At a minimum, diagnosis and treatment for defects in hearing, including hearing aids.

Other Necessary Health Care Services Additional health care services that are coverable under the Federal Medicaid program and found to be medically necessary to treat, correct or reduce illnesses and conditions discovered regardless of whether the service is covered in a state’s Medicaid plan. It is the responsibility of states to determine medical necessity on a case-by-case basis (see medical necessity below for more information).

Diagnostic Services

When a screening indicates the need for further evaluation, diagnostic services must be provided.

Treatment Necessary health care services must be made available for treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedures.

Lead Screening

Lead screening is a requirement for all Medicaid eligible children at 12 and 24 months or between the ages of 36 and 72 months if not previously tested. Colorado has not received an exemption from this requirement from CMS, therefore all contracted providers are required to provide and report testing for lead at the appropriate physicals at 12 and 24 months and between 36 and 72 months if not previously tested.

Medical Necessity

All Medicaid coverable, medically necessary, services must be provided even if the service is not available under the State plan to other Medicaid eligibles. Benefits not listed are not considered to be a state plan benefit and therefore outside of EPSDT coverage and exceptions. No arbitrary limitations on services are allowed, e.g., one pair of eyeglasses or 10 physical therapy visits per year.

Colorado makes the final determination of medical necessity and it is determined on a case-by-case basis. Provider recommendations will be taken in to consideration, but are not the sole determining factor in coverage. Colorado determines which treatment it will cover among equally effective, available alternative treatments.

EPSDT Medical Necessity Does NOT include:

- Experimental or investigational treatments
- Services or items not generally accepted as effective; and/or not within the normal course and duration of treatment; and/or those without clinical guidelines
- Services for caregiver or providers convenience

Services for which Colorado has a waiver are also not considered to be state plan benefits, and therefore are not a benefit under EPSDT. Items such as respite, behavioral interventions, in-home support services, and home modifications are examples of waiver services.

To request services that a provider feels are medically necessary but are not currently covered by the state plan, a prior authorization request must be completed as well as a letter of medical necessity. Both should be sent to the authorizing agent listed in Appendix D located in the [Billing Manuals](#) section of the Department's website.

The provider will receive an initial denial of the benefit, but will then receive a subsequent approval or denial based on the EPSDT review.

Dental Inspection

The mouth must be examined as part of the physical examination. Providers can provide services under the Cavity Free by Three program and bill Colorado Medicaid for appropriate and covered services when they have been certified to do so. Please visit the [Cavity Free at Three](#) web page under Children's Dental on the Department's website.

Children ages one and older, or at the eruption of their first tooth, should be referred to a dentist twice a year for preventive care.

Laboratory Tests

As appropriate for age or medical necessity, perform the following screening tests:

- Anemia
- Tuberculosis



- Sickle-cell trait
- Diabetes
- Lead poisoning
- Other infectious conditions

Administer lab tests according to the *Recommendations for Preventive Pediatric Health Care Schedule*. The Colorado Medical Assistance Program provider is required to test all children for a blood lead level at 12 months **and** 24 months of age and at 36-72 months if age, if not previously tested.

Diagnosis and Follow-Up for Lead Poisoning

If a child is found to have blood lead levels equal to or greater than 10 ug/dL, the laboratory will report results back to the provider and to the Colorado Department of Public Health and Environment. For guidelines covering patient management and treatment, including follow-up blood tests and initiation of investigations to the source of lead where indicated, providers should contact the Colorado Department of Public Health and Environment (Lead Poisoning Prevention Program 1-800-886-7689, Press 1).

Screening Frequency

The State has adopted the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule for physicians in rendering screening examinations.

Screening examinations rendered more frequently are subject to medical review.

Types of EPSDT Provider Visits



1) Periodic Screen

The periodic screen includes comprehensive health assessments that are performed soon after birth or as early as possible in a child’s life. It is repeated at prescribed intervals until the age of 20, as described in the AAP Bright Futures Periodicity Schedule.

2) Inter-periodic visit

An inter-periodic visit is any other healthcare visit the child may need, such as visits for an ear ache, fever or injury.

Outreach and Case Management – Healthy Communities Program

Each family or member is assigned to a Family Health Coordinator in their local area. The Family Health Coordinator’s services are a part of the member’s Medicaid benefit and offers support services, including the following:

- Ensures that members are informed of program benefits
- Assists child in accessing health care services within a reasonable time period
- Offers assistance in identifying participating Colorado Medical Assistance Program doctors, dentists, other medical specialists and managed care programs or Accountable Care Programs
- Assists in making and reminds members of appointments, if requested
- Follows up on appointments that may have been missed, if requested by a provider
- Assists with connecting child with non-medical community resources



Coordinate the following types of health care services wherever possible:

- Newborn or well-baby check-ups
- Day care or Head Start physicals
- Routine well child physical exams

- Dental Screenings
- Behavioral Health screenings
- Developmental screenings

Visit the [Healthy Communities](#) web page on the Department’s website to find a [Family Health Coordinator](#) in your area.

Diagnosis and Treatment

A presumptive diagnosis may be made at the time of screening, but it is usually necessary to advise the member of the need for further diagnosis and treatment. Necessary treatments may be rendered by the PCP or MCO practitioner or by referral to an authorized Colorado Medical Assistance Program specialist.

Benefits

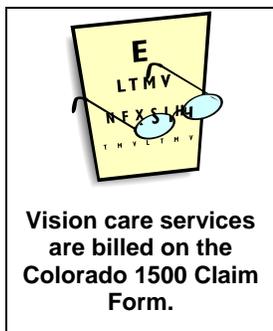
Dental Benefits

A non-emergency oral examination, dental prophylaxis, and fluoride topical application once every six months are benefits of the EPSDT program. The Colorado Medical Assistance Program recommends regular periodic examinations by a dentist with eruption of the first tooth or at age one, and continuing every six (6) months or as recommended by a dentist. Referral from the PCP is **not** required for EPSDT dental services.

Orthodontia is available for children who have been diagnosed with a severely handicapping malocclusion.

Dentally necessary radiographs, restorations, endodontics, periodontics, prosthodontics and oral surgery are also benefits. Dental services are billed on the 2006 American Dental Association (ADA) claim form or the 837 D. Complete billing instructions for dental services are included in DentaQuest Provider Office Reference Manual (ORM) found under DentaQuest Resources section of DentaQuest’s [website](#). Colorado Medicaid dental providers can also call DentaQuest’s Provider Relations/Services at 1-855-225-1731 (for TTY assistance, please call AT&T’s TTY line at 711).

Vision Care Benefits



Vision diagnostic and treatment services may be performed by an ophthalmologist or optometrist. Referral is **not** required for vision care. Single and multifocal vision lenses and frames, as well as repair or replacement of broken lenses or frames, are benefits of EPSDT and may be provided by an ophthalmologist, optometrist, or optician. Contact lenses are available in some medically necessary situations and require prior authorization.

Vision care services are billed on the Colorado 1500 Health Insurance claim form or the 837 P. Complete billing instructions for vision services are included in the vision billing manual.

Hearing Assisted Device Benefits

Audiological benefits include identification, diagnostic evaluation, and treatment for children with hearing impairments. Benefits include hearing aids and other assisted devices, auditory training in the use of hearing aids, therapy for children with hearing impairments, and family-focused home based early language intervention for children, (birth to three years of age), with hearing loss through the Colorado Home Intervention Program (CHIP).

EPSDT Billing

Providers submitting claims electronically must use the 837P.

Providers submitting claims on paper must use the EPSDT paper claim form.

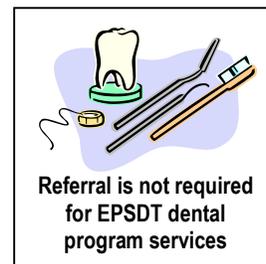
The EPSDT claim form is used by primary care providers who bill fee-for-service for EPSDT periodic screens.

The Department tracks the EPSDT periodic screens by procedure and diagnosis codes appropriate for the screen. Other children’s health care services are billed on the Colorado 1500, using national standard codes.

Providers must identify if a visit is a result of a referral from an EPSDT Screen

If a provider is seeing a child as a result of a referral from the EPSDT periodic screen for further diagnosis or treatment, the provider should enter a **“Yes” in Box # L** on the Colorado 1500.

If the visit is a referral from an EPSDT periodic screen for further diagnosis and treatment, enter a **“Yes” in the service line** (Loop 2400, Segment SV1, Element SV111). It is important to identify these services as they are reported on the Annual EPSDT Participation Report (416) to the Centers for Medicare and Medicaid Services (CMS) along with the number of EPSDT periodic screens.



- Dental benefits are billed on the ADA claim form or the 837 D.
- Vision benefits are billed on the Colorado 1500 claim form or 837 P.
- If the child is ill, services related to the illness should be billed on the Colorado 1500 claim form. An appointment for an EPSDT screening should be made at a later date.
- Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) complete the UB-04 claim form for EPSDT-rendered services. Refer to the FQHC/RHC Billing Manual for specific UB-04 billing instructions. FQHCs and RHCs use V72.0 to bill for the EPSDT Periodic Screen.

EPSDT benefits may include medically necessary covered benefits available for children enrolled in the Medical Assistance Program.

A comprehensive EPSDT Periodic Screening examination includes the following components

- | | |
|--|---|
| <ul style="list-style-type: none"> ▪ Comprehensive health & developmental history ▪ Comprehensive unclothed physical examination ▪ Assessment of physical, emotional & developmental growth ▪ Assessment of mouth, oral cavity and teeth, including referral to a dentist ▪ Assessment of nutritional status ▪ Vision assessment | <ul style="list-style-type: none"> ▪ Immunizations <i>appropriate to age & health history</i> ▪ Laboratory tests (including lead blood level assessment appropriate to age & risk) ▪ Assessment of mental/behavioral health ▪ Hearing assessment ▪ Health education (including anticipatory guidance) ▪ Family planning services and adolescent maternity care ▪ Treatment and referrals for any medically necessary further diagnosis and treatment |
|--|---|

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 Current Procedural Terminology (CPT), a numeric coding system maintained by the American Medical Association (AMA). The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals.

Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter followed by 4 numeric digits, while CPT codes are identified using 5 numeric digits.

HIPAA requires providers to comply with the coding guidelines of the AMA CPT Procedure Codes and the International Classification of Disease, Clinical Modification Diagnosis Codes. If there is no time designated in the official descriptor, the code represents one unit or session. Providers should regularly consult monthly bulletins 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.

EPSDT Procedure Coding

Procedure Code(s)	Description
Periodic Screening: Preventive Medicine Codes*	
99381 – 99385	New Patient (age specific)
99391 – 99395	Established Patient (age specific)
99431	History and examination
99432	Normal newborn care
Periodic Screening: Evaluation and Management Codes	
99203 – 99205	New Patient
99214 – 99215	Established Patient
Note: These codes must be used in conjunction with diagnosis codes for a well-child exam including V20.0 – V20.2 and V70.0, V70.3 and V70.8.	
Inter-periodic Visit Codes	
Range 99201 – 99350	
Note: Used in conjunction with the appropriate diagnosis codes excluding the well-child diagnosis codes: V20.0 – V20.2 and V70.0, V70.3 and V70.8	

Paper Claim Instructions

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

Field Label	Completion format	Instructions
Invoice/Pat Acct Number	Up to 12 characters: Letters, numbers or hyphens	Optional Enter information that identifies the patient or claim in the provider's billing system. Submitted information appears on the Provider Claim Report (PCR).
1. Client Name	Up to 25 characters: Letters & spaces	Required Enter the client's last name, first name and middle initial.
2. Client ID(entification)Number	7 characters, a letter prefix followed by six numbers	Required Enter the client's Medical Assistance Program ID number exactly as it appears on the eligibility verification response. Each person has his/her own unique Colorado Medical Assistance Program ID number. Example: A123456
3. Date of Birth	Date of Birth 6 digits MMDDYY	Required Enter the patient's birth date using two digits for the month, two digits for the date, and two digits for the year (MMDDYY format). Use the birth date that as it appears on the eligibility verification response. Example: 070105 for July 1, 2005
4. Sex	Check box Male <input type="checkbox"/> Female <input type="checkbox"/>	Required Enter a check mark or an "x" in the correct box to indicate the client's sex.
5. Screening	Letters: N, A, T, R indicators	Required Enter N, A, T, or R for each item to indicate if the test was <u>N</u> ormal, <u>A</u> bnormal, <u>T</u> reated, or <u>R</u> eferred. If the item was not performed, leave that line blank.
6. Other Insurance	Check box <input type="checkbox"/> Yes <input type="checkbox"/> No	Required Enter a check mark or an "x" in the correct box to indicate that the client has other insurance. If Yes is checked, complete the insurance information requested.

Field Label	Completion format	Instructions
Insurance Paid/Denied	Check Box <input type="checkbox"/> Paid <input type="checkbox"/> Denied	Conditional Complete if client has commercial health insurance. Enter a check mark or an “x” in the correct box to indicate whether the other insurance paid or denied.
Date Insurance Paid/Denied	6 digits MMDDYY	Conditional Enter the date the commercial insurance paid or denied the claim using two digits for the month, two digits for the date, and two digits for the year (MMDDYY format). Example: 08/08/08
Insurance Company Name/Address	Text	Conditional Complete if client has commercial health insurance coverage. Enter name, address, policy number, and telephone numbers (if known) of the commercial health care insurer.
Insurance Policy Number	Text	Conditional Complete if client has commercial health insurance. Enter the policy number.
Insurance Group Number	Text	Conditional Complete if client has commercial health insurance. Enter the group number.
Policyholder Name/Address	Text	Conditional Complete if client has commercial health insurance. Enter the policyholder’s name and address.
Employer Name	Text	Conditional Complete if the client is covered by health insurance available through an employer as either the employee or as a dependent of an employee. Enter the name and address of the employer.
7. Diagnosis Code	ICD-9-CM Diagnosis Codes Codes: 3, 4, or 5 characters. 1st character may be a letter.	Required At least one diagnosis code must be entered. Enter up to four ICD-9-CM diagnosis codes starting at the far left side of the coding area. <i>Do not enter the decimal point. Do not enter zeros to fill the spaces when the diagnosis code is fewer than 5 numbers.</i>
Description(s)	Text	Optional Written description is not required. If entered, the written description must match the code(s).
8. Line Number Preprinted	None	Do not alter preprinted line numbers.

Field Label	Completion format	Instructions
<p>9. Date of Service</p>	<p>6 digits MMDDYY</p>	<p>Required All dates of service must be the same date as screening. Example: 070109 for July 1, 2009</p>
<p>10. Place of Service</p>	<p>2 digits</p>	<p>Required Enter the Place of Service (POS) code that describes the location when services were rendered. The Colorado Medical Assistance Program accepts the Centers for Medicare & Medicaid Services (CMS) POS codes. Note: CMS POS codes do not have a generic clinic designation. Practitioners who have been using POS 4 to identify clinic services should use POS 11-Office. <u>The only valid POS Codes Are:</u> 11 Office 12 Home 21 Inpatient Hospital 22 Outpatient Hospital 32 Nursing Facility 99 Other Unlisted</p>
<p>11. Procedure Codes</p>	<p>5 characters: 5 digits or 1 letter plus 4 digits or 2 letters plus 3 digits</p>	<p>Required Enter the procedure code for the medical screening examination on line 01. Enter codes for additional services on subsequent lines: <ul style="list-style-type: none"> ▪ Bill screening-related services (immunizations, testing) rendered on the same day on the same EPSDT claim form. ▪ Do not bill E/M codes on the EPSDT claim format. ▪ Treatment services for conditions discovered during the screening and provided the day screening is performed are submitted on the EPSDT claim form. All procedures must be identified with codes in <ul style="list-style-type: none"> ▪ The current edition of Physicians Current Procedural Terminology (CPT). CPT is updated annually. ▪ The current Medical Assistance Program CMS codes publication. </p>

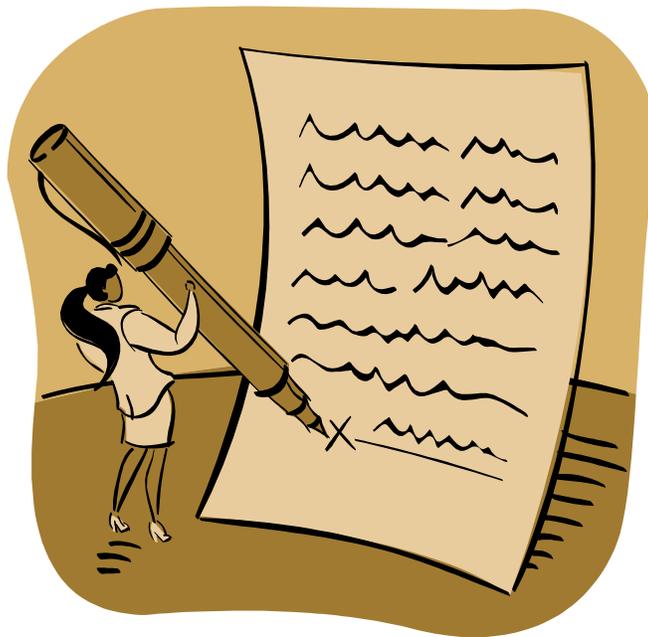
Field Label	Completion format	Instructions
<p>12. Modifier</p>	<p>2 characters: Letters, or digits</p>	<p>Conditional Complete if a procedure related modifier is necessary. Two modifiers may be entered.</p>
	<p>-24</p> <p>Evaluation/Management (E/M) service during the postoperative period Use with E/M codes to report unrelated services by the same physician during the postoperative period. Claim diagnosis code(s) must identify a condition unrelated to the surgical procedure.</p> <p>-26</p> <p>Professional component Use with diagnostic codes to report professional component services (reading and interpretation) billed separately from technical component services. Report separate professional and technical component services <u>only</u> if different providers perform the professional and technical portions of the procedure. Read CPT descriptors carefully. Do not use modifiers if the descriptor specifies professional or technical components.</p> <p>-47</p> <p>Anesthesia by surgeon Use with surgical procedure codes to report general or regional anesthesia by the surgeon. Local anesthesia is included in the surgical reimbursement.</p> <p>-50</p> <p>Bilateral procedures Use to identify the bilateral (second) surgical procedure performed at the same operative session. Read CPT descriptions carefully. Do not use modifier -50 if the procedure descriptor states "Unilateral or bilateral" services.</p> <p>-51</p> <p>Multiple Procedures Use to identify additional procedures that are performed on the same day or at the same session by the same provider. Do not use to designate "add-on" codes.</p>	

Field Label	Completion format	Instructions
12. Modifier (continued)	<p>-59</p> <p>-76</p> <p>-77</p> <p>-79</p> <p>-80</p>	<p>Multiple Procedures Use to indicate a service that is distinct or independent from other services that are performed on the same day. These services are not usually reported together but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system or separate lesion or injury.</p> <p>Repeat procedure by <u>same</u> physician/provider Use to identify subsequent occurrences of the same service on the same day by the same provider. Not valid with E/M codes.</p> <p>Repeat procedure by <u>another</u> physician/provider Use to identify subsequent occurrences of the same service on the same day by different rendering providers.</p> <p>Unrelated procedure or service by surgeon Unrelated procedures or services (other than E/M services) by the surgeon during the postoperative period. Use to identify unrelated services by the operating surgeon during the postoperative period. Claim diagnosis code(s) must identify a condition unrelated to the surgical procedure.</p> <p>Assistant surgeon Use with surgical procedure codes to identify assistant surgeon services. Note: Assistant surgeon services by non-physician practitioners, physician assistants, perfusionists, etc. are not reimbursable.</p>

Field Label	Completion format	Instructions
12. Modifier (continued)	-55	<p>Postoperative Management only Use with eyewear codes (lenses, lens dispensing, frames, etc.) to identify eyewear provided after eye surgery. Benefit for eyewear, including contact lenses, for clients over age 20 must be related to surgery. Modifier -55 takes the place of the required claim comment that identifies the type and date of eye surgery. The provider must retain and, upon request, furnish records that identify the type and date of surgery.</p>
13. Diagnosis Related	Letter 1,2,3,4	<p>Required Enter the number from field 7 (Diagnosis Code) to indicate the diagnosis related to each procedure billed on each line. Do not repeat the ICD-9-CM diagnosis code.</p>
14. Units of Service	4 digits	<p>Required Enter the number of services provided for each procedure code.</p> <ul style="list-style-type: none"> ▪ Enter whole numbers only. ▪ Do not enter fractions or decimals. ▪ Do not enter a decimal point followed by a zero for whole numbers.
15. Charges	7 digits: Currency 99999.99	<p>Required Enter your usual and customary charge for each procedure or service billed.</p>
16. Comments	Text	<p>Conditional Complete if documenting the Late Bill Override Date (LBOD) for timely filing. Other comments are optional.</p>
17. Name Physician or Agency	Text	<p>Required Enter the name and address of the provider who will receive payment for these services.</p>
18. Billing Provider ID	8 Digits	<p>Required Enter the eight-digit Medical Assistance Program provider number of the provider or agency who will receive payment for these services. Payment is made to the enrolled provider or agency that is assigned this number.</p>

Field Label	Completion format	Instructions
19. Signature	Text	<p>Required</p> <p>Each claim must be signed by the enrolled provider or a registered authorized agent.</p> <ul style="list-style-type: none"> ▪ A signature stamp may be used <u>if</u> authorization is on file with the fiscal agent. ▪ An authorized agent 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>Unacceptable signature alternatives:</p> <ul style="list-style-type: none"> ▪ 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.
20. Date Signed	6 Digits, MMDDYY Format	<p>Required</p> <p>Enter the date the claim is signed using the MMDDYY format. The date of signature cannot precede the date of service shown on the claim.</p>
21. Total Charges	7 digits: Currency 99999.99	<p>Required</p> <p>Enter the sum of all charges listed in field 15 (Charges).</p>
22. Insurance Amount Paid	7 digits: Currency 99999.99	<p>Conditional</p> <p>Complete if the client has commercial health insurance and the third party resource has made payment on the billed services. Enter the amount of the third party payment shown on the third party payment voucher.</p>
23. Net Charge	7 digits: Currency 99999.99	<p>Required</p> <p>Enter the net amount submitted by subtracting the amount in field 23 (Insurance Amount Paid) from field 21 (Total Charges).</p>
24. Rendering Provider ID	8 Digits	<p>Required</p> <p>Enter the eight-digit Medical Assistance Program provider number assigned to the <i>individual</i> who actually performed or rendered the billed service. This number cannot be assigned to a group or clinic.</p>

Field Label	Completion format	Instructions
25. Referring Provider ID	8 Digits	Conditional Enter the PCP's eight digit Medical Assistance Program provider number. Entry of the PCP's provider number represents the provider's declaration that he/she has a referral from the PCP.
26. Supervising Provider ID	8 Digits	Conditional Complete if the rendering provider is a non-physician practitioner who requires on-premises supervision by a licensed physician. (See Provider Participation) Enter the eight digit Medical Assistance Program provider number assigned to the on-premises supervising physician.



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>Colorado 1500</i>: Indicate “LBOD” and the date in box 30 - Remarks. ➤ <i>2006 ADA Dental</i>: Indicate “LBOD” and the date in box 35 - Remarks
Adjusting Paid Claims	<p>If the initial timely filing period has expired and a previously submitted claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was paid and now needs to be adjusted, resulting in additional payment to the provider.</p> <p>Adjust the claim within 60 days of the claim payment. Retain all documents that prove compliance with timely filing requirements.</p> <p><i>Note: There is no time limit for providers to adjust paid claims that would result in repayment to the Colorado Medical Assistance Program.</i></p> <p>LBOD = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the payment.</p>

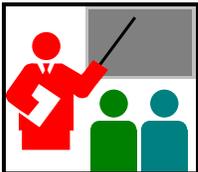
Billing Instruction Detail	Instructions
<p>Denied Paper Claims</p>	<p>If the initial timely filing period has expired and a previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was denied.</p>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

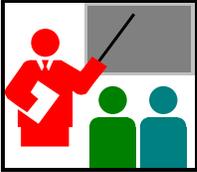
Billing Instruction Detail	Instructions
<p>Delayed Notification of Eligibility</p>	<p>The provider was unable to determine that the patient had Colorado Medical Assistance Program coverage until after the timely filing period expired.</p> <p>File the claim within 60 days of the date of notification that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

Billing Instruction Detail	Instructions
	denial or rejection, and continue filing in compliance with the 60-day rule until insurance processing information is available. LBOD = the date commercial insurance paid or denied.
Correspondence LBOD Authorization	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. File the claim within 60 days of the date on the authorization letter. Retain the authorization letter. LBOD = the date on the authorization letter.
Member Changes Providers during Obstetrical Care	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. 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. LBOD = the last date of OB care by the billing provider.



Sterilizations, Hysterectomies and Abortions

Billing Instruction Detail	Instructions
<p style="text-align: center;">Sterilizations, Hysterectomies, and Abortions</p> 	<p>Voluntary sterilizations</p> <p>Sterilization for the purpose of family planning is a benefit of the Colorado Medical Assistance Program in accordance with the following procedures:</p> <p>General requirements</p> <p>The following requirements must be followed precisely or payment will be denied. These claims must be filed on paper. A copy of the sterilization consent form (MED-178) must be attached to each related claim for service including the hospital, anesthesiologist, surgeon, and assistant surgeon.</p> <ul style="list-style-type: none"> ➤ The individual must be at least 21 years of age at the time the consent is obtained. ➤ The individual must be mentally competent. An individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose cannot consent to sterilization. The individual can consent if she has been declared competent for purposes that include the ability to consent to sterilization. ➤ The individual must voluntarily give "informed" consent as documented on the MED-178 consent form (see illustration) and specified in the "Informed Consent Requirements" described in these instructions. ➤ At least 30 days but not more than 180 days must pass between the date of informed consent and the date of sterilization with the following exceptions: <p>Emergency Abdominal Surgery:</p> <p>An individual may consent to sterilization at the time of emergency abdominal surgery if at least 72 hours have passed since he/she gave informed consent for the sterilization.</p> <p>Premature Delivery:</p> <p>A woman may consent to sterilization at the time of a premature delivery if at least 72 hours have passed since she gave informed consent for the sterilization and the consent was obtained at least 30 days prior to the expected date of delivery.</p>

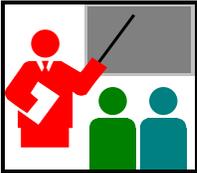
Billing Instruction Detail	Instructions
<p style="text-align: center;">Sterilizations, Hysterectomies, and Abortions</p> 	<p>The person may not be an "institutionalized individual".</p> <p>Institutionalized includes:</p> <ul style="list-style-type: none"> • Involuntarily confinement or detention, under a civil or criminal statute, in a correctional or rehabilitative facility including a mental hospital or other facility for the care and treatment of mental illness. • Confinement under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness. <p>If any of the above requirements are not met, the claim will be denied. Unpaid or denied charges resulting from clerical errors such as the provider's failure to follow the required procedures in obtaining informed consent or failure to submit required documentation with the claim may not be billed to the member.</p> <p>Informed consent requirements</p> <p>The person obtaining informed consent must be a professional staff member who is qualified to address all the consenting individual's questions concerning medical, surgical, and anesthesia issues.</p> <p>Informed consent is considered to have been given when the person who obtained consent for the sterilization procedure meets all of the following criteria:</p> <ul style="list-style-type: none"> ➤ Has offered to answer any questions that the individual who is to be sterilized may have concerning the procedure ➤ Has provided a copy of the consent form to the individual ➤ Has verbally provided all of the following information or advice to the individual who is to be sterilized: <ul style="list-style-type: none"> • Advice that the individual is free to withhold or withdraw consent at any time before the sterilization is done without affecting the right to any future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled • A description of available alternative methods of family planning and birth control • Advice that the sterilization procedure is considered to be irreversible • A thorough explanation of the specific sterilization procedure to be performed • A full description of the discomforts and risks that may accompany or follow the performing of the procedure including an explanation of the type and possible effects of any anesthetic to be used.

Billing Instruction Detail	Instructions
<p style="text-align: center;">Sterilizations, Hysterectomies, and Abortions</p> 	<ul style="list-style-type: none"> • A full description of the benefits or advantages that may be expected as a result of the sterilization • Advice that the sterilization will not be performed for at least 30 days except in the case of premature delivery or emergency abdominal surgery • Suitable arrangements have been made to ensure that the preceding information was effectively communicated to an individual who is blind, deaf, or otherwise handicapped. • The individual to be sterilized was permitted to have a witness of his or her choice present when consent was obtained. • The consent form requirements (noted below) were met. • Any additional requirement of the state or local law for obtaining consent was followed. • Informed consent may <u>not</u> be obtained while the individual to be sterilized is: <ul style="list-style-type: none"> ▪ In labor or childbirth; ▪ Seeking to obtain or is obtaining an abortion; and/or ▪ Under the influence of alcohol or other substances that may affect the individual's sense of awareness. <p>MED-178 consent form requirements</p> <p>Evidence of informed consent must be provided on the MED-178 consent form. The MED-178 form is available on the Department's website (colorado.gov/hcpf)→Provider Services→Forms→Sterilization Consent Forms. The fiscal agent is required to assure that the provisions of the law have been followed before Colorado Medical Assistance Program payment can be made for sterilization procedures.</p> <p>A copy of the MED-178 consent form must be attached to every claim submitted for reimbursement of sterilization charges including the surgeon, the assistant surgeon, the anesthesiologist, and the hospital or ambulatory surgical center. The surgeon is responsible for assuring that the MED-178 consent form is properly completed and providing copies of the form to the other providers for billing purposes.</p> <p>Spanish forms are acceptable.</p> <p>A sterilization consent form initiated in another state is acceptable when the text is complete and consistent with the Colorado form.</p>

Billing Instruction Detail	Instructions
<p style="text-align: center;">Sterilizations, Hysterectomies, and Abortions</p> 	<p>Completion of the MED-178 consent form</p> <p>Please refer to the MED-178 Instructions for completion on the Department’s website (colorado.gov/hcpf)→Provider Services→Forms→Sterilization Consent Forms. Information entered on the consent form must correspond directly to the information on the submitted Colorado Medical Assistance Program claim form.</p> <p>Federal regulations require strict compliance with the requirements for completion of the MED-178 consent form or claim payment is denied. Claims that are denied because of errors, omissions, or inconsistencies on the MED-178 may be resubmitted if corrections to the consent form can be made in a legally acceptable manner.</p> <p>Any corrections to the patient's portion of the sterilization consent must be approved and initialed by the patient.</p> <p>Hysterectomies</p> <p>Hysterectomy is a benefit of the Colorado Medical Assistance Program when performed solely for medical reasons. Hysterectomy is <u>not</u> a benefit of the Colorado Medical Assistance Program if the procedure is performed solely for the purpose of sterilization, or if there was more than one purpose for the procedure and it would not have been performed but for the purpose of sterilization.</p> <p>The following conditions must be met for payment of hysterectomy claims under the Colorado Medical Assistance Program. These claims must be filed on paper.</p> <ul style="list-style-type: none"> ➤ Prior to the surgery, the person who secures the consent to perform the hysterectomy must inform the patient and her representative, if any, verbally and in writing that the hysterectomy will render the patient permanently incapable of bearing children. ➤ The patient and her representative, if any, must sign a written acknowledgment that she has been informed that the hysterectomy will render her permanently incapable of reproducing. The written acknowledgment may be any form created by the provider that states specifically that, “I acknowledge that prior to surgery, I was advised that a hysterectomy is a procedure that will render me permanently incapable of having children.” The acknowledgment must be signed and dated by the patient. <p>A written acknowledgment from the patient is not required if:</p> <ul style="list-style-type: none"> ➤ The patient is already sterile at the time of the hysterectomy, or ➤ The hysterectomy is performed because of a life-threatening emergency in which the practitioner determines that prior acknowledgment is not possible.

Billing Instruction Detail	Instructions
<p>Sterilizations, Hysterectomies, and Abortions (continued)</p> 	<p>If the patient's acknowledgment is not required because of the one of the above noted exceptions, the practitioner who performs the hysterectomy must certify in writing, as applicable, one of the following:</p> <ul style="list-style-type: none"> ➤ A signed and dated statement certifying that the patient was already sterile at the time of hysterectomy and stating the cause of sterility; ➤ A signed and dated statement certifying that the patient required hysterectomy under a life-threatening, emergency situation in which the practitioner determined that prior acknowledgment by the patient was not possible. The statement must describe the nature of the emergency. <p>A copy of the patient's written acknowledgment or the practitioner's certification as described above must be attached to all claims submitted for hysterectomy services. A suggested form on which to report the required information is located in Appendix J. Providers may copy this form, as needed, for attachment to claim(s). Providers may substitute any form that includes the required information. The submitted form or case summary documentation must be signed and dated by the practitioner performing the hysterectomy.</p> <p>The surgeon is responsible for providing copies of the appropriate acknowledgment or certification to the hospital, anesthesiologist, and assistant surgeon for billing purposes. Claims will be denied if a copy of the written acknowledgment or practitioner's statement is not attached.</p>



Billing Instruction Detail	Instructions													
<p>Sterilizations, Hysterectomies, and Abortions (continued)</p> 	<p>Abortions</p> <p>Induced abortions</p> <p>Therapeutic legally induced abortions are a benefit of the Colorado Medical Assistance Program when performed to save the life of the mother. The Colorado Medical Assistance Program also reimburses legally induced abortions for pregnancies that are the result of sexual assault (rape) or incest.</p> <p>A copy of the appropriate certification statement must be attached to all claims for legally induced abortions performed for the above reasons. Because of the attachment requirement, claims for legally induced abortions must be submitted on paper and must not be electronically transmitted. Claims for spontaneous abortions (miscarriages), ectopic, or molar pregnancies are not affected by these regulations.</p> <p>The following procedure codes are appropriate for identifying induced abortions:</p> <table border="0" data-bbox="639 816 1299 905"> <tr> <td>59840</td> <td>59841</td> <td>59851</td> <td>59852</td> </tr> <tr> <td>59850</td> <td>59855</td> <td>59856</td> <td>59857</td> </tr> </table> <p>Diagnosis code ranges:</p> <p>635.00-635.92 637.00-637.92</p> <p>Surgical diagnosis codes:</p> <table border="0" data-bbox="553 1192 1357 1226"> <tr> <td>69.01</td> <td>69.51</td> <td>69.93</td> <td>74.91</td> <td>75.0</td> </tr> </table> <p>Providers billing on the Colorado 1500 claim form</p> <p>Use the appropriate procedure/diagnosis code from the list above and the most appropriate modifier from the list below:</p> <p>G7 - Termination of pregnancy resulting from rape, incest, or certified by a physician as life-threatening.</p> <p>In addition to the required coding, all claims must be submitted with the required documentation. Claims submitted for induced abortion-related services submitted without the required documentation will be denied.</p>	59840	59841	59851	59852	59850	59855	59856	59857	69.01	69.51	69.93	74.91	75.0
59840	59841	59851	59852											
59850	59855	59856	59857											
69.01	69.51	69.93	74.91	75.0										

Billing Instruction Detail	Instructions
<p>Sterilizations, Hysterectomies, and Abortions (continued)</p> 	<p>Providers billing on the UB-04 claim form</p> <p>Use the appropriate procedure/diagnosis code from those listed previously and the most appropriate condition code from the list below:</p> <p>AA Abortion Due to Rape AB Abortion Due to Incest AD Abortion Due to Life Endangerment</p> <p>In addition to the required coding, all claims must be submitted with the required documentation. Claims submitted for induced abortion-related services submitted without the required documentation will be denied.</p> <p><i>Induced abortions to save the life of the mother</i></p> <p>Every reasonable effort to preserve the lives of the mother and unborn child must be made before performing an induced abortion. The services must be performed in a licensed health care facility by a licensed practitioner, unless, in the judgment of the attending practitioner, a transfer to a licensed health care facility endangers the life of the pregnant woman and there is no licensed health care facility within a 30 mile radius of the place where the medical services are performed.</p> <p>“To save the life of the mother” means:</p> <p>The presence of a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, as determined by the attending practitioner, which represents a serious and substantial threat to the life of the pregnant woman if the pregnancy is allowed to continue to term.</p> <p>The presence of a psychiatric condition which represents a serious and substantial threat to the life of the pregnant woman if the pregnancy continues to term.</p> <p>All claims for services related to induced abortions to save the life of the mother must be submitted with the following documentation:</p> <ul style="list-style-type: none"> • Name, address, and age of the pregnant woman • Gestational age of the unborn child • Description of the medical condition which necessitated the performance of the abortion • Description of services performed • Name of the facility in which services were performed • Date services were rendered <p>And, at least one of the following forms with additional supporting documentation that confirms life-endangering circumstances:</p> <ul style="list-style-type: none"> • Hospital admission summary • Hospital discharge summary • Consultant findings and reports • Laboratory results and findings

Billing Instruction Detail	Instructions
<p>Sterilizations, Hysterectomies, and Abortions (continued)</p> 	<ul style="list-style-type: none"> • Office visit notes • Hospital progress notes <p>A suggested form on which to report the required information is in Appendix K. Providers may copy this form, as needed, for attachment to claim(s). Providers may substitute any form that includes the required information. The submitted form or case summary documentation must be signed and dated by the practitioner performing the abortion service.</p> <p>For psychiatric conditions lethal to the mother if the pregnancy is carried to term, the attending practitioner must:</p> <ul style="list-style-type: none"> • Obtain consultation with a physician specializing in psychiatry. • Submit a report of the findings of the consultation unless the pregnant woman has been receiving prolonged psychiatric care. <p><i>The practitioner performing the abortion is responsible for providing the required documentation to other providers (facility, anesthetist, etc.) for billing purposes.</i></p> <p><i>Induced abortions when pregnancy is the result of sexual assault (rape) or incest</i></p> <p>Sexual assault (including rape) is defined in the Colorado Revised Statutes (C.R.S.) 18-3-402 through 405, 405.3, or 405.5. Incest is defined in C.R.S. 18-6-301. Providers interested in the legal basis for the following abortion policies should refer to these statutes.</p> <p>All claims for services related to induced abortions resulting from sexual assault (rape) or incest must be submitted with the “Certification Statement for abortion for sexual assault (rape) or incest”. A suggested form is located in Appendix L. This form must:</p> <ul style="list-style-type: none"> • Be signed and dated by the patient or guardian and by the practitioner performing the induced abortion AND • Indicate if the pregnancy resulted from sexual assault (rape) or incest. Reporting the incident to a law enforcement or human services agency is not mandated. If the pregnant woman did report the incident, that information should be included on the Certification form. <p>No additional documentation is required.</p> <p>The practitioner performing the abortion is responsible for providing the required documentation to other providers (facility, anesthetist, etc.) for billing purposes.</p>

Billing Instruction Detail	Instructions
<p>Sterilizations, Hysterectomies, and Abortions (continued)</p> 	<p>Spontaneous Abortion (Miscarriage)</p> <p><i>Ectopic and molar pregnancies</i></p> <p>Surgical and/or medical treatment of pregnancies that have terminated spontaneously (miscarriages) and treatment of ectopic and molar pregnancies are routine benefits of the Colorado Medical Assistance Program. Claims for treatment of these conditions do not require additional documentation. The claim must indicate an ICD-9-CM diagnosis code that specifically demonstrates that the termination of the pregnancy was not performed as a therapeutic legally induced abortion.</p> <p>The following diagnosis codes are appropriate for identifying conditions that may properly be billed for Colorado Medical Assistance Program reimbursement.</p> <p>630 Hydatidiform Mole</p> <p>631 Other Abnormal Products of Conception</p> <p>632 Missed Abortion</p> <p>633-633.9 Ectopic Pregnancy</p> <p>634-639.9 Spontaneous Abortion</p> <p>656.4 Intrauterine Death</p> <p>The following HCPCS (CPT) procedure codes may be submitted for covered abortion and abortion related services.</p> <p>58120 D & C For Hydatidiform Mole</p> <p>59100-59101 Hysterectomy For Removal of Hydatidiform Mole</p> <p>59800-59830 Medical and Surgical Treatment of Abortion</p> <p><i>Fetal anomalies incompatible with life outside the womb</i></p> <p>Therapeutic abortions performed due to fetal anomalies incompatible with life outside the womb are not a Colorado Medical Assistance Program benefit.</p>

EPSDT Claim Example

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

INVOICE/PAT. ACCT NUMBER
Client-04

EPSDT CLAIM

1. CLIENT NAME (LAST, FIRST, M.I.) Client, Ima	2. CLIENT ID NUMBER C444444	3. DATE OF BIRTH MO 07 DAY 04 YR 2004	4. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F
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5. SCREENING		
N = PERFORMED, NORMAL		R = PERFORMED, REFERRED
A = PERFORMED, ABNORMAL		LEAVE BLANK IF NOT PERFORMED.
T = PERFORMED, TREATED		
ITEM NO.	SCREENING ITEMS	RESULTS
01	MEDICAL HISTORY OBTAINED?	N
02	PHYSICAL EXAMINATION?	N
ASSESSMENTS PERFORMED		
03	VISION	R
04	HEARING	A
05	DENTAL	N
06	DEVELOPMENTAL (PHYS. GROWTH/EMOTIONAL DEV./LEARNING)	N
07	NUTRITIONAL/GASTROINTESTINAL	N
08	CARDIOVASCULAR/RESPIRATORY	N
09	GENITAL/URINARY TRACT	N
10	DIABETES	N
11	IMMUNIZATION	T
12	EDUCATION	N
13	OTHER SCREEN	
LAB TESTS PERFORMED		
01	HGB/HCT	N
02	URINALYSIS	
03	SICKLE CELL	
04	BLOOD LEAD	N
05	TB	N
06	OTHER LAB	

6. OTHER INSURANCE	
OTHER INSURANCE?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
INSURANCE PAID / DENIED	<input type="checkbox"/> PAID <input type="checkbox"/> DENIED
DATE INSURANCE PAID / DENIED	
INSURANCE COMPANY NAME/ADDRESS	
INSURANCE POLICY NUMBER	
INSURANCE GROUP NUMBER	
POLICYHOLDER NAME / ADDRESS	
EMPLOYER NAME	

7. DIAGNOSIS ICD-9-CM	DESCRIPTION
1 Y000	_____
2 V721	_____
3 7883	_____
4	_____

IN COLUMN 13, RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE NUMBERS 1, 2, 3, OR 4

8. LINE NO.	9. DATE OF SERVICE			10. PLACE OF SERVICE	11. PROCEDURE CODES			12. MODIFIER		13. DIAGNOSIS RELATED			14. UNITS OF SERVICE	15. CHARGES		16. COMMENTS	
	MO	DAY	YR		1	2	P	S	T	1	2	3					
01	08	10	08	11	9	9	3	9	3		1			1	30	00	
02	08	10	08	11	9	0	7	0	5		1			1	25	00	
03	08	10	08	11	6	9	2	1	0		1	3		1	10	00	
04																	
05																	
06																	
07																	
08																	
09																	
10																	

17. NAME PHYSICIAN OR AGENCY ABC Clinic	DIAGNOSIS RELATED: RELATE DIAGNOSIS IN FIELD 7 TO PROCEDURE BY REFERRING TO NUMBERS 1, 2, 3, OR 4. 18. BILLING PROVIDER ID 98765432	21. TOTAL CHARGES 65 00	24. RENDERING PROVIDER ID 89765120
19. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE SIDE) <i>Authorized Signature</i>	20. DATE SIGNED 08 12 08	22. INS AMOUNT PAID 65 00	25. REFERRING PROVIDER ID 26. SUPERVISING PROVIDER ID

EPSDT Revisions Log

Revision Date	Additions/Changes	Pages	Made by
04/21/2009	Drafted Manual	All	jg
07/06/2009	Accepted changes and verified TOC	Throughout	jg
10/19/2009	LBOD	23	jg
01/12/2010	Updated Web site links	Throughout	jg
02/10/2010	Changed EOMB to SPR	25	jg
03/04/2010	Added link to Program Rules	2	jg
12/05/2011	Replaced 997 with 999 Replaced http://www.wpc-edi.com/hipaa with http://www.wpc-edi.com/ Replaced Implementation Guide with Technical Report 3 (TR3)	4 2 2	ss
05/08/2013	Deleted duplicate GY modifier information	19	jg
09/27/2013	Removed electronic billing and referenced the CO-1500 General billing manual Removed MED-178 instructions and example. Referenced location of form and instructions on p.30	3 30-35	cc
10/03/2013	Formatted Updated TOC	Throughout i	jg
02/03/2014	Updated abortion information	29 & 30	jg
05/14/2014	Updated Billing Manual for removal of the Primary Care Physical Program	Throughout	Mm
8/8/14	Updated all references of Client to Member	Throughout	ZS
8/11/14	Updated all weblinks to reflect Department's new site	Throughout	Mm
8/20/2014	Revised General Program Provisions per benefit manager	3-4	GR, MM
8/20/2014	Added Cavity Free at Three information	4	GR, MM
8/20/2014	Added all references to DentaQuest, new Dental ASO	6, Throughout	GR, MM
8/20/2014	Revised Outreach and Case Management to include Healthy Living Program	5	GR, MM
8/20/2014	Removed immunization references	8-10, throughout	GR, MM

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.