

# Home and Community Based Services Billing Manual

## Children’s Home and Community Based Services (CHCBS), Children with Life Limiting Illness (CLLI) Children with Autism (CWA)

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# Home and Community Based Services (HCBS) Overview

## Children’s Home and Community Based Services (CHCBS) Waiver

## Children with a Life Limiting Illness (CLLI) Waiver

## Children with Autism (CWA) Waiver

Medicaid is a health care program for low income Coloradans. Applicants must meet eligibility criteria for one of the Medicaid Program categories in order to qualify for benefits. Major program categories include:

- Aid to Families with Dependent Children/Medicaid Only
- Aid to the Needy Disabled
- Baby Care/Kids Care
- Colorado Works/TANF (Temporary Assistance for Needy Families)
- Aid to the Blind
- Old Age Pension

Waiver programs provide additional Medicaid benefits to specific populations who meet special eligibility criteria.

Level of care determinations are made annually by the case management agencies (aka Single Entry Points and Community Center Boards). Clients must meet financial, medical, and program criteria to access services under a waiver. The applicant must be at risk of placement in a nursing facility, hospital, or ICF/IID (intermediate care facility for Individuals with an Intellectual Disability). To utilize waiver benefits, clients must be willing to receive services in their homes or communities. A client who receives



services through a waiver is also eligible for all basic Medicaid covered services except nursing facility and long-term hospital care. When a client chooses to receive services under a waiver, the services must be provided by certified Medicaid providers or by a Medicaid contracting managed care organization (MCO).

Each waiver has an enrollment limit. Applicants may apply for more than one waiver, but may only receive services through one waiver at a time.



### **Prior Authorization Requests (PARs)**

Unless otherwise noted, all HCBS services require prior approval before they can be reimbursed by the Colorado Medical Assistance Program. Case Management Agencies (CMA) complete the Prior Approval and/or Cost Containment requests for their specific programs according to instructions published in the regulations for the Department of Health Care Policy and Financing (the Department).



Providers may contact the CMA for the status of the PAR or inquire electronically through the Colorado Medical Assistance Program Web Portal.

The CMAs responsibilities include, but are not limited to:

- Informing clients and/or legal guardian of the eligibility process.
- Submitting a copy of the approved Enrollment Form to the County department of human/social services for a Colorado Medical Assistance Program client identification number.
- Developing the appropriate Prior Approval and/or Cost Containment Record Form of services and projected costs for approval.
- Submitting a copy of the Prior Authorization and/or Cost Containment document to the authorizing agent. A list of authorizing agents can be found in Appendix D of the Appendices in the Provider Services [Billing Manuals](#) section.
- Assessing the client’s health and social needs.
- Arranging for face-to-face contact with the client.
- Monitoring and evaluating services.
- Reassessing each client annually or upon change in condition.
- Demonstrating continued cost effectiveness whenever services increase or decrease.

**Approval of prior authorization does not guarantee Colorado Medical Assistance Program payment and does not serve as a timely filing waiver.**



Prior authorization only assures that the approved service is a medical necessity and is considered a benefit of the Colorado Medical Assistance Program. All claims, including those for prior authorized services, must meet eligibility and claim submission requirements (e.g., timely filing, provider information completed appropriately, required attachments included, etc.) before payment can be made.

**Prior approvals must be completed thoroughly and accurately.** If an error is noted on an approved request, it should be brought to the attention of the client’s case manager for corrections. Procedure codes, quantities, etc., may be changed or entered by the client’s case manager.

The authorizing agent or CMA is responsible for timely submission and distribution of copies of approvals to agencies and providers contracted to provide services.

## PAR Submission

The following PAR (CHCBS, CLLI, and CWA) forms are fillable electronically and are located in the Provider Services [Forms](#) section of the Department’s website. The use of the forms is strongly encouraged due to the complexity of the calculations.

Send all New, Continued Stay Reviews (CSR), and Revised PARs for CHCBS, CLLI, and CWA to the Department’s fiscal agent:

Xerox State Healthcare  
PARs  
P.O. Box 30  
Denver, CO 80201-0030

**Note:** If submitted to the Department’s fiscal agent, the following correspondence will not be returned to case managers, outreach will not be performed to fulfill the requests, and all such requests will be recycled: 1) Paper PAR forms that do not clearly identify the case management agency in the event the form(s) need to be returned and/or 2) PAR revision requests not submitted on Department approved PAR forms, including typed letters with revision instructions. Should questions arise about what fiscal agent staff can process, please contact the appropriate Department Waiver manager.

## PAR Form Instructional Reference Table

| Field Label                            | Completion Format   | Instructions   |
|--|---|--|
| <b>PA Number being revised</b>         |   | Conditional<br>Complete if PAR is a revision. Indicate original PAR number assigned.   |
| <b>Revision</b>                        | Check box<br><input type="checkbox"/> Yes <input type="checkbox"/> No | Required<br>Check the appropriate box.   |
| <b>Client Name</b>                     | Text  | Required<br>Enter the client's last name, first name and middle initial.<br>Example: Adams, Mary A.  |
| <b>Client ID</b>                       | 7 characters, a letter prefix followed by six numbers                 | Required<br>Enter the client's state identification number. This number consists of a letter prefix followed by six numbers.<br>Example: A123456 |
| <b>Sex</b>                             | Check box<br><input type="checkbox"/> M <input type="checkbox"/> F    | Required<br>Check the appropriate box.   |
| <b>Birthdate</b>                       | 6 numbers<br>(MM/DD/YY)   | Required<br>Enter the client's birth date using MM/DD/YY format.<br>Example: January 1, 2010 = 01/01/10.   |
| <b>Requesting Physician Provider #</b> | 8 numbers   | Required<br>Enter the eight-digit Colorado Medical Assistance Program provider number of the requesting provider.                                |
| <b>Client's County</b>                 | Text  | Required<br>Enter the client's county of residence   |
| <b>Case Number (Agency Use)</b>        | Text  | Optional<br>Enter up to 12 characters, (numbers, letters, hyphens) which helps identify the claim or client.                                     |
| <b>Dates Covered (From/Through)</b>    | 6 numbers for from date and 6 numbers for through date<br>(MM/DD/YY)  | Required<br>Enter PAR start date and PAR end date.   |

| Field Label  | Completion Format  | Instructions  |
|--|--|---|
| <b>Services Description</b>  | Text   | N/A<br>List of approved procedure codes for qualified and demonstration services.   |
| <b>Provider</b>  | Text   | Optional (CMA use)<br>Enter up to 12 characters to identify provider.   |
| <b>Modifier</b>  | 2 Letters  | Required<br>The alphanumeric values in this column are standard and static and cannot be changed.   |
| <b>Max # Units</b>   | Number   | Required<br>Enter the number of units next to the services being requested for reimbursement.   |
| <b>Cost Per Unit</b>   | Dollar Amount  | Required<br>Enter cost per unit of service.   |
| <b>Total \$ Authorized</b>   | Dollar Amount  | Required<br>The dollar amount authorized for this service automatically populates.  |
| <b>Comments</b>  | Text   | Optional<br>Enter any additional useful information. For example, if a service is authorized for different dates than in "Dates Covered" field, please include the HCPCS procedure code and date span here. |
| <b>Total Authorized HCBS Expenditures</b>  | Dollar Amount  | Required<br>Total automatically populates.  |
| <b>Number of Days Covered</b>  | Number   | Required<br>The number of days covered automatically populates.   |
| <b>Average Cost Per Day</b>  | Dollar Amount  | Required<br>The client's maximum authorized cost divided by number of days in the care plan period automatically populates.   |
| <b>Immediately prior to HCBS enrollment, this client was in one of the following facility types:</b> | Check box<br><input type="checkbox"/> Nursing Facility <input type="checkbox"/> Hospital | Required<br>Check the appropriate box.  |

| Field Label                   | Completion Format          | Instructions  |
|-------------------------------|----------------------------|---|
| <b>Case Manager Name</b>      | Text                       | Required<br>Enter the name of the Case Manager.           |
| <b>Case Manager Signature</b> | Text                       | Required<br>Signature of Case Manager.                    |
| <b>Agency</b>                 | Text                       | Required<br>Enter the name of the case management agency. |
| <b>Phone #</b>                | 10 Numbers<br>123-456-7890 | Required<br>Enter the phone number of the Case Manager.   |
| <b>Email</b>                  | Text                       | Required<br>Enter the email address of the Case Manager.  |
| <b>Date</b>                   | 6 Numbers<br>(MM/DD/YY)    | Required<br>Enter the date completed.                     |



# HCBS-CHCBS PAR Example

| STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING  |                    |                             |                 |   |   |  |
|---|--------------------|-----------------------------|-----------------|---|---|--|
| REQUEST FOR CHILDREN HOME AND COMMUNITY BASED SERVICES (HCBS) PRIOR APPROVAL AND COST CONTAINMENT                         |                    |                             |                 | <b>CHCBS-U5</b>   |   |  |
| <b>HCBS - Children's Home and Community Based Services (CHCBS) Waiver</b>   |                    |                             |                 | PA Number being revised:  |   |  |
|   |                    |                             |                 | Revision? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 1. CLIENT NAME  |                    | 2. CLIENT ID                |                 | 3. SEX  |   |  |
| Client, Ima   |                    | A11111                      |                 | <input type="checkbox"/> M <input checked="" type="checkbox"/> F              |   |  |
|   |                    |                             |                 | 4. BIRTHDATE  |   |  |
|   |                    |                             |                 | 7/7/2007  |   |  |
| 5. REQUESTING PROVIDER #  | 6. CLIENT'S COUNTY | 7. CASE NUMBER (AGENCY USE) |                 | 8. DATES COVERED  |   |  |
| 00112233  |                    |                             |                 | From: 07/05/13 Through: 07/04/14  |   |  |
| STATEMENT OF REQUESTED SERVICES   |                    |                             |                 |   |   |  |
| 9. Description  | 10. Provider       | 11. Modifier                | 12. Max # Units | 13. Cost Per Unit   | 14. Total \$ Authorized                   | 15. Comments:                                |
| T1016 CHCBS Case Management (U5)  |                    |                             | 90              | \$8.43  | \$758.70                                  |  |
| H0038 IHHS Health Maintenance Activities (U5)   |                    |                             | 4928            | \$7.09  | \$34,939.52                               |  |
| A   |                    |                             |                 |   |   |  |
| B   |                    |                             |                 |   |   |  |
| 16. TOTAL AUTHORIZED HCBS EXPENDITURES (SUM OF AMOUNTS IN COLUMN 14 ABOVE)  |                    |                             |                 |   | <b>\$35,698.22</b>                        |  |
| 17. NUMBER OF DAYS COVERED (FROM FIELD 8 ABOVE)   |                    |                             |                 |   | <b>365</b>                                |  |
| 18. AVERAGE COST PER DAY (Client's maximum authorized cost divided by number of days in the care plan period)             |                    |                             |                 |   | <b>\$97.80</b>                            |  |
| A. Monthly State Cost Containment Amount  |                    |                             |                 |   | <b>\$0.00</b>                             |  |
| B. Divided by 30.42 days = Daily Cost Containment Ceiling   |                    |                             |                 |   | <b>\$0.00</b>                             |  |
| 19. Immediately prior to HCBS enrollment, this client was in one of the following facility types:                         |                    |                             |                 |   | <input type="checkbox"/> Nursing Facility | <input checked="" type="checkbox"/> Hospital |
| 20. CASE MANAGER NAME   |                    | 21. AGENCY                  |                 | 22. PHONE #   | 23. EMAIL                                 | 24. DATE                                     |
| Jane Doe  |                    | AAA                         |                 | 333-111-2222  | Jane.Doe@AAA.com                          | 7/15/2013                                    |
| 20A. CASE MANAGER SIGNATURE:<br><i>Jane Doe</i>   |                    |                             |                 |   |   |  |
| DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY   |                    |                             |                 |   |   |  |
| 25. CASE PLAN: <input type="checkbox"/> Approved Date: <input type="checkbox"/> Denied Date: Return for correction- Date: |                    |                             |                 |   |   |  |
| 26. REGULATION(S) upon which Denial or Return is based:   |                    |                             |                 |   |   |  |
| 27. DEPARTMENT APPROVAL SIGNATURE:  |                    |                             |                 |   | 28. DATE:                                 |  |

# HCBS-CLLI PAR Example

| STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING   |                    |  |  |                   |                         |   |
|--|--------------------|--|--|-------------------|-------------------------|---|
| REQUEST FOR CHILDREN HOME AND COMMUNITY BASED SERVICES (HCBS) PRIOR APPROVAL AND COST CONTAINMENT  |                    |  |  |                   |                         | CLLHUD  |
| <b>HCBS - Children with Life Limiting Illness (CLLI) Waiver</b>  |                    |  |  |                   |                         | PA Number being reviewed  |
|  |                    |  |  |                   |                         | Revision? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 1. CLIENT NAME   | 2. CLIENT ID       | 3. SEX   | 4. BIRTHDATE   |                   |                         |   |
| Client, Ima  | 1212121            | <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 1/1/2010   |                   |                         |   |
| 5. REQUESTING PROVIDER #   | 6. CLIENT'S COUNTY | 7. CASE NUMBER (AGENCY USE)                                      |  | 8. DATES COVERED  |                         |   |
| 0101010101   | Jefferson          |  |  | From: 06/01/14    | Through: 05/31/15       |   |
| STATEMENT OF REQUESTED SERVICES  |                    |  |  |                   |                         |   |
| 9. Description   | 10. Provider       | 11. Modifier   | 12. Max # Units  | 13. Cost Per Unit | 14. Total \$ Authorized | 15. Comments:   |
| H2032 Art and Play Therapy (UD)  |                    | HA   | 30   | \$15.41           | \$462.30                |   |
| H2032 Art and Play Therapy Group (UD)  |                    |  |  |                   |                         |   |
| H2032 Music Therapy (UD)   |                    |  |  |                   |                         |   |
| H2032 Music Therapy Group (UD)   |                    | HQ   | 30   | \$8.63            | \$258.90                |   |
| 97124 Massage Therapy (UD)   |                    |  |  |                   |                         |   |
| G9012 Care Coordination (UD)   |                    |  |  |                   |                         |   |
| S9123 Pain and Symptom Management (UD)   |                    |  |  |                   |                         |   |
| S5150 Respite Care - Unskilled (4 hours or less) (UD)  |                    |  |  |                   |                         |   |
| S5151 Respite Care - Unskilled (4 hours or more) (UD)  |                    |  |  |                   |                         |   |
| T1005 Respite Care - CNA (4 hours or less) (UD)  |                    |  |  |                   |                         |   |
| S9125 Respite Care - CNA (4 hours or more) (UD)  |                    |  |  |                   |                         |   |
| T1005 Respite Care - Skilled RN, LPN (4 hours or less) (UD)  |                    |  |  |                   |                         |   |
| S9125 Respite Care - Skilled RN, LPN (4 hours or more) (UD)  |                    |  |  |                   |                         |   |
| S0257 Bereavement Counseling (UD)  |                    |  |  |                   |                         |   |
| S0257 Therapeutic Life Limiting Illness Support - Individual (UD)  |                    |  |  |                   |                         |   |
| S0257 Therapeutic Life Limiting Illness Support - Family (UD)  |                    |  |  |                   |                         |   |
| S0257 Therapeutic Life Limiting Illness Support - Group (UD)   |                    |  |  |                   |                         |   |
| A  |                    |  |  |                   |                         |   |
| B  |                    |  |  |                   |                         |   |
| 16. TOTAL AUTHORIZED HCBS EXPENDITURES (SUM OF AMOUNTS IN COLUMN 14 ABOVE)   |                    |  |  |                   | \$721.20                |   |
| 17. NUMBER OF DAYS COVERED (FROM FIELD 8 ABOVE)  |                    |  |  |                   | 365                     |   |
| 18. AVERAGE COST PER DAY (Client's maximum authorized cost divided by number of days in the care plan period)                                    |                    |  |  |                   | \$1.98                  |   |
| A. Monthly State Cost Containment Amount   |                    |  |  |                   | \$0.00                  |   |
| B. Divided by 30.42 days = Daily Cost Containment Ceiling  |                    |  |  |                   | \$0.00                  |   |
| 19. CASE MANAGER NAME  | 20. AGENCY         | 21. PHONE #  | 22. EMAIL  | 23. DATE          |                         |   |
| John Doe   | BBB                | 222-111-4444   | <a href="mailto:John.Doe@BBB.com">John.Doe@BBB.com</a> | 6/2/2013          |                         |   |
| <b>DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY</b>   |                    |  |  |                   |                         |   |
| 24. CASE PLAN: <input type="checkbox"/> Approved Date: <input type="checkbox"/> Denied Date: <input type="checkbox"/> Return for correction-Date |                    |  |  |                   |                         |   |
| 25. REGULATION(S) upon which Denial or Return is based:  |                    |  |  |                   |                         |   |
| 26. DEPARTMENT APPROVAL SIGNATURE:   |                    |  |  |                   |                         | 27. DATE:   |

# HCBS-CWA PAR Example

| STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING   |                    |                             |   |   |  |              |
|--|--------------------|-----------------------------|---|---|--|--------------|
| REQUEST FOR CHILDREN HOME AND COMMUNITY BASED SERVICES (HCBS) PRIOR APPROVAL AND COST CONTAINMENT  |                    |                             |   | CWA-LL  |  |              |
|   |                    |                             | <b>HCBS - Children with Autism (CWA) Waiver</b> |   |  |              |
|  |                    |                             |   | PA Number being revised:  |  |              |
|  |                    |                             |   | Revision? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |              |
| 1. CLIENT NAME   |                    | 2. CLIENT ID                |   | 3. SEX  |  |              |
| Client, Irma   |                    | A4444444                    |   | <input type="checkbox"/> M <input checked="" type="checkbox"/> F              |  |              |
|  |                    |                             |   | 4. BIRTHDATE  |  |              |
|  |                    |                             |   | 10/1/2010   |  |              |
| 5. REQUESTING PROVIDER #   | 6. CLIENT'S COUNTY | 7. CASE NUMBER (AGENCY USE) |   | 8. DATES COVERED  |  |              |
| 555 5555 55  | Adams              |                             |   | From: 07/01/13 Through: 06/30/14  |  |              |
| STATEMENT OF REQUESTED SERVICES  |                    |                             |   |   |  |              |
| 9. Description   | 10. Provider       | 11. Modifier                | 12. Max # Units                                 | 13. Cost Per Unit   | 14. Total \$ Authorized                                | 15. Comments |
| H0004 Behavior Therapies, Lead Therapist (UL)  |                    |                             | 196   | \$23.31   | \$4,568.76   |              |
| H0004 Behavior Therapies, Senior Therapist (UL)  |                    | HN                          | 1600  | \$12.14   | \$19,424.00  |              |
| H2019 Behavior Therapies, Line Staff (UL)  |                    |                             |   |   |  |              |
| H2000 Ongoing Treatment Evaluations (UL)   |                    |                             |   |   |  |              |
| H2000 Post Service Evaluation (UL)   |                    | TS                          |   |   |  |              |
| A  |                    |                             |   |   |  |              |
| B  |                    |                             |   |   |  |              |
| 16. TOTAL AUTHORIZED HCBS EXPENDITURES (SUM OF AMOUNTS IN COLUMN 14 ABOVE)   |                    |                             |   |   | \$23,992.76  |              |
| 17. NUMBER OF DAYS COVERED (FROM FIELD 8 ABOVE)  |                    |                             |   |   | 365  |              |
| 18. AVERAGE COST PER DAY (Client's maximum authorized cost divided by number of days in the care plan period)                              |                    |                             |   |   | \$65.73  |              |
| A. Monthly State Cost Containment Amount   |                    |                             |   |   | \$0.00   |              |
| B. Divided by 30.42 days = Daily Cost Containment Ceiling  |                    |                             |   |   | \$0.00   |              |
| 19. CASE MANAGER NAME  |                    | 20. AGENCY                  |   | 21. PHONE #   | 22. EMAIL  | 23. DATE     |
| Jane Doe   |                    | CCC                         |   | 111-222-3333  | <a href="mailto:Jane.Doe@CCC.com">Jane.Doe@CCC.com</a> | 7/1/2014     |
| 19A. CASE MANAGER SIGNATURE:<br><i>Jane Doe</i>  |                    |                             |   |   |  |              |
| DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY  |                    |                             |   |   |  |              |
| 24. CASE PLAN: <input type="checkbox"/> Approved Date: _____ <input type="checkbox"/> Denied Date: _____ Return for correction- Date _____ |                    |                             |   |   |  |              |
| 25. REGULATION(S) upon which Denial or Return is based:  |                    |                             |   |   |  |              |
| 26. DEPARTMENT APPROVAL SIGNATURE:   |                    |                             |   |   |  | 27. DATE:    |

## **Claim Submission**

### **Paper Claims**

Electronic claims format shall be required unless hard copy claims submittals are specifically authorized by the Department. Requests 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 approval)
- Claims that, by policy, require attachments
- Reconsideration claims

For more detailed Colorado 1500 billing instructions, please refer to the Colorado 1500 General Billing Information manual in the Provider Services [Billing Manuals](#) section.

### **Electronic Claims**

Instructions for completing and submitting electronic claims are available through the 837 Professional (837P) Web Portal User guide via the Web Portal and also on the [Department's Colorado Medical Assistance Program Web Portal](#) page.

Electronically mandated claims submitted on paper are processed, denied, and marked with the message "Electronic Filing Required."

The Special Program Indicator (SPI) must be completed on claims submitted electronically. Claims submitted electronically and on paper are identified by using the specific national modifiers along with the procedure code. The appropriate procedure codes and modifiers for each HCBS waiver are noted throughout this manual. When the services are approved, the claim may be submitted to the Department's fiscal agent. For more detailed billing instructions, please refer to the Colorado 1500 General Billing Information in the Provider Services [Billing Manuals](#) section.

### **Procedure/HCPCS Codes Overview**

The Department develops procedure codes that are approved by the Centers for Medicare & Medicaid Services (CMS). The codes are used to submit claims for services provided to Colorado Medical Assistance Program clients. The procedure codes 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. These include ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DME/Supplies) 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. CPT codes are identified using 5 numeric digits.

# Children’s Home and Community Based Services (CHCBS)

The Children’s Home and Community Based Services (CHCBS) waiver program is for disabled children who are at risk of institutionalization in a hospital or nursing facility. These children would not otherwise qualify for Colorado Medical Assistance due to parental income and/or resources. All state plan Colorado Medical Assistance benefits and case management are provided to children birth through age 17. The children must meet the established minimum criteria for hospital or nursing facility level of care. Clients meeting program eligibility requirements are certified as medically eligible for CHCBS by the case manager.



## **CHCBS Procedure Code Table**

Providers may bill the following procedure codes for HCBS-CHCBS services:

| <b>HCBS-CHCBS Procedure Code Table (Special Program Code 88)</b> |                                     |    |                     |
|--|-------------------------------------|----|---------------------|
| <b>Case Management (HCBS – CM)</b>                               |                                     |    |                     |
| <b>Description</b>   | <b>Procedure Code + Modifier(s)</b> |    | <b>Units</b>        |
| Case Management  | T1016                               | U5 | 1 unit = 15 minutes |

## **In-Home Support Services (IHSS)**

IHSS is limited to health maintenance activities, which include support for activities of daily living or instrumental activities of daily living. Additionally, IHSS providers must provide core independent living skills.

| <b>HCBS-CHCBS Procedure Code Table (Special Program Code 88)</b> |                                     |    |                     |
|--|-------------------------------------|----|---------------------|
| <b>In-Home Support (HCBS-IHSS)</b>                               |                                     |    |                     |
| <b>Description</b>   | <b>Procedure Code + Modifier(s)</b> |    | <b>Units</b>        |
| Health Maintenance Activities                                    | H0038                               | U5 | 1 unit = 15 minutes |

## **CHCBS, CLLI, and CWA Paper Claim Reference Table**

The following paper form reference table gives required and/or conditional fields for the paper Colorado 1500 claim form for HCBS-CHCBS, CLLI, and CWA claims:

| <b>Field Label</b>             | <b>Completion format</b>                         | <b>Special Instructions</b>   |
|--------------------------------|--|---|
| <b>Invoice/Pat Acct Number</b> | Up to 12 characters: letters, numbers or hyphens | Optional<br>Enter information that identifies the patient or claim in the provider’s billing system.<br>Submitted information appears on the Provider Claim Report. |
| <b>Special Program Code</b>    | 2 digits   | Required<br>Code 88 identifies the CHCBS waiver.<br>Code 97 identifies the HCBS-CLLI waiver.<br>Code 96 identifies the HCBS-CWA waiver.                             |

| Field Label  | Completion format   | Special Instructions   |
|--|---|--|
| 1. <b>Client Name</b>  | Up to 25 characters: letters & spaces   | Required<br>Enter the client's last name, first name, and middle initial.  |
| 2. <b>Client Date of Birth</b>   | Date of Birth<br>8 digits (MMDDCCYY)<br>Example: 01/01/2010   | Required<br>Enter the patient's birth date using two digits for the month, two digits for the date, two digits for the century, and two digits for the year. Example: 07012010 for July 1, 2010. |
| 3. <b>Colorado Medical Assistance Program ID Number (Client ID Number)</b> | 7 characters, a letter prefix followed by six numbers   | Required<br>Enter the client's Colorado Medical Assistance Program ID number. Each person has his/her own unique Colorado Medical Assistance Program ID number. Example: A123456                 |
| 4. <b>Client Address Telephone Number</b>                                  | Characters: numbers and letters   | Not Required<br>Submitted information is not entered into the claim processing system.   |
| 5. <b>Client Sex</b>   | Check box<br>Male <input type="checkbox"/><br>Female <input type="checkbox"/>   | Required<br>Enter a check mark or an "x" in the correct box to indicate the client's sex.  |
| 6. <b>Medicare ID Number (HIC or SSN)</b>                                  | Up to 11 characters: numbers and letters  | Not Required   |
| 7. <b>Client relationship to Insured</b>                                   | Check box<br>Self    Spouse<br><input type="checkbox"/> <input type="checkbox"/><br>Child    Other<br><input type="checkbox"/> <input type="checkbox"/> | Not Required   |
| 8. <b>Client is covered by Employer Health Plan</b>                        | Text  | Not Required   |
| 9. <b>Other Health Insurance Coverage</b>                                  | Text  | Conditional<br>Complete if the client has commercial health insurance coverage. Enter the name, address, policy number, and telephone numbers, if known, of the commercial health care insurer.  |
| 9A. <b>Policyholder Name and Address</b>                                   | Text  | Conditional<br>Complete if the client has commercial health insurance coverage. Enter the name, address, and telephone number, if known, of the policyholder.                                    |

| Field Label   | Completion format   | Special Instructions                         |
|---|---|--|
| <b>10. Was condition related to</b>   | Check box A <input type="checkbox"/><br>Client employment<br>Check box B <input type="checkbox"/><br>Accident<br>6 digits:<br>MMDDYY<br>C. Date of<br>accident<br>6 digits:<br>MMDDYY | Not Required                                 |
| <b>11. CHAMPUS Sponsors Service/SSN</b>   | 10 digits   | Not Required                                 |
| <b>12. Pregnancy PHP Nursing Facility Resident</b>                              | Check box <input type="checkbox"/><br>Check box <input type="checkbox"/><br>Check box <input type="checkbox"/>  | Not Required<br>Not Required<br>Not Required |
| <b>13. Date of illness or injury or pregnancy</b>                               | 6 digits:<br>MMDDYY   | Not Required                                 |
| <b>14. Medicare Denial</b>  | Check box<br><input type="checkbox"/> Benefits Exhausted<br><input type="checkbox"/> Non-covered services   | Not Required                                 |
| <b>14A. Other Coverage Denied</b>   | Check box<br>No <input type="checkbox"/><br>Yes <input type="checkbox"/><br>Pay/Deny Date<br>6 digits:<br>MMDDYY  | Not Required                                 |
| <b>15. Name of supervising physician Provider Number</b>                        | Text<br>8 digits  | Not Required                                 |
| <b>16. For services related to hospitalization</b>                              | 6 digits:<br>MMDDYY   | Not Required                                 |
| <b>17. Name and address of facility where services rendered Provider Number</b> | Text<br>(address is optional)<br>8 digits   | Not Required                                 |

| Field Label  | Completion format  | Special Instructions   |
|--|--|--|
| <b>18. ICD-9-CM</b>  | 1 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/><br>2 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/><br>3 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/><br>4 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/><br>Codes: 3, 4, or 5 characters.<br>1 <sup>st</sup> character may be a letter. | Required<br>At least one diagnosis code must be entered.<br>CHCBS and CLLI may use 7999.<br>CWA must use 299.00.   |
| <b>Diagnosis or nature of illness or injury</b>                        | Text   | Not Required<br>If entered the written description must match the code(s).   |
| <b>Transportation Certification attached</b>                           | Check box <input type="checkbox"/>   | Not Required   |
| <b>Durable Medical Equipment Model/serial number (unlabeled field)</b> | 20 characters  | Not Required   |
| <b>Prior Authorization No.</b>   | 6 characters:<br>Letter plus 5 digits  | Conditional<br>Enter the 6 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.<br>Complete when the service requires prior authorization. |



| Field Label                                    | Completion format  | Special Instructions  |    |    |      |  |  |  |    |    |      |    |    |      |    |    |      |    |    |      |
|--|--|---|----|----|------|--|--|--|----|----|------|----|----|------|----|----|------|----|----|------|
| <p><b>19A. Date of Service</b></p>             | <p>From:<br/>6 digits<br/>MMDDYY</p> <p>To:<br/>6 digits<br/>MMDDYY</p>                  | <p>Required</p> <p>The field accommodates the entry of two dates: a “beginning” or “from” date of service and an “ending” or “to” date of service.</p> <p>Single date of service</p> <p>From To</p> <table border="1" data-bbox="889 478 1222 520"> <tr> <td>01</td> <td>01</td> <td>2013</td> <td></td> <td></td> <td></td> </tr> </table> <p>Or</p> <p>From To</p> <table border="1" data-bbox="889 604 1222 646"> <tr> <td>01</td> <td>01</td> <td>2013</td> <td>01</td> <td>01</td> <td>2013</td> </tr> </table> <p>Span dates of service</p> <table border="1" data-bbox="889 688 1222 730"> <tr> <td>01</td> <td>01</td> <td>2013</td> <td>01</td> <td>31</td> <td>2013</td> </tr> </table> <p>Single Date of Service: Enter the six digit date of service in the “From” field. Completion of the “To” field is not required. Do not spread the date entry across the two fields.</p> <p>Span billing: Span billing is permissible if the same service (same procedure code) is provided on consecutive dates..</p> | 01 | 01 | 2013 |  |  |  | 01 | 01 | 2013 | 01 | 01 | 2013 | 01 | 01 | 2013 | 01 | 31 | 2013 |
| 01   | 01   | 2013  |    |    |      |  |  |  |    |    |      |    |    |      |    |    |      |    |    |      |
| 01   | 01   | 2013  | 01 | 01 | 2013 |  |  |  |    |    |      |    |    |      |    |    |      |    |    |      |
| 01   | 01   | 2013  | 01 | 31 | 2013 |  |  |  |    |    |      |    |    |      |    |    |      |    |    |      |
| <p><b>19B. Place of Service</b></p>            | <p>2 digits</p>  | <p>Required</p> <p>Enter place of service code:</p> <p><b>03</b> - School</p> <p><b>11</b> - Office</p> <p><b>12</b> - Patient’s residence</p> <p><b>34</b> - Hospice</p>   |    |    |      |  |  |  |    |    |      |    |    |      |    |    |      |    |    |      |
| <p><b>19C. Procedure Code (HCPCS code)</b></p> | <p>5 characters:<br/>5 digits or 1 letter plus 4 digits or 2 letters plus 3 digits</p>   | <p>Required</p> <p>Refer to the CHCBS, CLLI, or CWA procedure code tables.</p>  |    |    |      |  |  |  |    |    |      |    |    |      |    |    |      |    |    |      |
| <p><b>Modifier(s)</b></p>                      | <p>2 characters:<br/>Letters or digits<br/>May enter up to two 2 character modifiers</p> | <p>Required</p> <p>Refer to the modifiers listed in the CHCBS, CLLI, or CWA procedure code table.</p>   |    |    |      |  |  |  |    |    |      |    |    |      |    |    |      |    |    |      |
| <p><b>19D. Rendering Provider No.</b></p>      | <p>8 digits</p>  | <p>Not Required</p>   |    |    |      |  |  |  |    |    |      |    |    |      |    |    |      |    |    |      |
| <p><b>19E. Referring Provider No.</b></p>      | <p>8 digits</p>  | <p>Not Required</p>   |    |    |      |  |  |  |    |    |      |    |    |      |    |    |      |    |    |      |

| Field Label  | Completion format   | Special Instructions  |   |   |   |   |         |  |  |  |  |   |  |  |  |  |       |   |  |        |   |  |  |   |  |        |   |  |  |  |  |        |   |  |  |
|--|---|---|---|---|---|---|---------|--|--|--|--|---|--|--|--|--|-------|---|--|--------|---|--|--|---|--|--------|---|--|--|--|--|--------|---|--|--|
| <p><b>19F. Diagnosis</b><br/>Each billed line must have at least one primary diagnosis referenced.</p> | <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px; height: 20px; text-align: center;">P</td> <td style="width: 20px; height: 20px; text-align: center;">S</td> <td style="width: 20px; height: 20px; text-align: center;">T</td> </tr> </table> <p>1 digit per column</p> | P   | S | T | <p>Required<br/>At least one diagnosis code must be entered.<br/>Enter up to four diagnosis codes starting at the far left side of the coding area.<br/>Do not enter the decimal point. Do not enter zeros to fill the spaces when the diagnosis code is fewer than 5 digits.</p> <p>From field 18 <span style="margin-left: 100px;">To field(s) 19F</span></p> <table style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px;">1</td> <td style="width: 40px; border: 1px solid black; text-align: center;">7 9 9 9</td> <td style="width: 100px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> </tr> <tr> <td>2</td> <td style="border: 1px solid black; text-align: center;">         </td> <td></td> <td></td> <td></td> <td style="border: 1px solid black; text-align: center;">P S T</td> </tr> <tr> <td>3</td> <td style="border: 1px solid black; text-align: center;">         </td> <td>Line 1</td> <td style="border: 1px solid black; text-align: center;">1</td> <td style="border: 1px solid black; text-align: center;"> </td> <td style="border: 1px solid black; text-align: center;"> </td> </tr> <tr> <td>4</td> <td style="border: 1px solid black; text-align: center;">         </td> <td>Line 2</td> <td style="border: 1px solid black; text-align: center;">1</td> <td style="border: 1px solid black; text-align: center;"> </td> <td style="border: 1px solid black; text-align: center;"> </td> </tr> <tr> <td></td> <td></td> <td>Line 3</td> <td style="border: 1px solid black; text-align: center;">1</td> <td style="border: 1px solid black; text-align: center;"> </td> <td style="border: 1px solid black; text-align: center;"> </td> </tr> </table> | 1 | 7 9 9 9 |  |  |  |  | 2 |  |  |  |  | P S T | 3 |  | Line 1 | 1 |  |  | 4 |  | Line 2 | 1 |  |  |  |  | Line 3 | 1 |  |  |
| P  | S   | T   |   |   |   |   |         |  |  |  |  |   |  |  |  |  |       |   |  |        |   |  |  |   |  |        |   |  |  |  |  |        |   |  |  |
| 1  | 7 9 9 9   |   |   |   |   |   |         |  |  |  |  |   |  |  |  |  |       |   |  |        |   |  |  |   |  |        |   |  |  |  |  |        |   |  |  |
| 2  |   |   |   |   | P S T   |   |         |  |  |  |  |   |  |  |  |  |       |   |  |        |   |  |  |   |  |        |   |  |  |  |  |        |   |  |  |
| 3  |   | Line 1  | 1 |   |   |   |         |  |  |  |  |   |  |  |  |  |       |   |  |        |   |  |  |   |  |        |   |  |  |  |  |        |   |  |  |
| 4  |   | Line 2  | 1 |   |   |   |         |  |  |  |  |   |  |  |  |  |       |   |  |        |   |  |  |   |  |        |   |  |  |  |  |        |   |  |  |
|  |   | Line 3  | 1 |   |   |   |         |  |  |  |  |   |  |  |  |  |       |   |  |        |   |  |  |   |  |        |   |  |  |  |  |        |   |  |  |
| <p><b>19G. Charges</b></p>   | <p>7 digits: Currency<br/>99999.99</p>  | <p>Required<br/>Enter the usual and customary charge for the service represented by the procedure code on the detail line.<br/>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.<br/>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.<br/>Submitted charges cannot be more than charges made to non-Colorado Medical Assistance Program covered individuals for the same service.<br/>Do not deduct Colorado Medical Assistance Program co-payment or commercial insurance payments from usual and customary charges</p> |   |   |   |   |         |  |  |  |  |   |  |  |  |  |       |   |  |        |   |  |  |   |  |        |   |  |  |  |  |        |   |  |  |

| Field Label                 | Completion format                  | Special Instructions  |
|-----------------------------|------------------------------------|---|
| <b>19H. Days or Units</b>   | 4 digits                           | Required<br>Enter the number of services provided for each procedure code.<br>Enter whole numbers only.<br>Do not enter fractions or decimals.<br>See special instructions for Anesthesia and Psychiatric services.               |
| <b>19I. Copay</b>           | 1 digit                            | Conditional<br>Complete if co-payment is required of this client for this service. Enter one of the following codes:<br>1-Refused to pay co-payment<br>2-Paid co-payment<br>3-Co-payment not requested                            |
| <b>19J. Emergency</b>       | Check box <input type="checkbox"/> | Conditional<br>Enter a check mark or an "x" in the column to indicate the service is rendered for a life-threatening condition or one that requires immediate medical intervention.   |
| <b>19K. Family Planning</b> | Check box <input type="checkbox"/> | Conditional<br>Enter a checkmark or an "x" in the column to indicate the service is rendered for family planning.   |
| <b>19L. EPSDT</b>           | Check box <input type="checkbox"/> | Conditional<br>Enter a check mark or an "x" in the column to indicate the service is provided as a follow-up to or referral from an EPSDT screening examination.  |
| <b>20. Total Charges</b>    | 7 digits: Currency<br>99999.99     | Required<br>Enter the sum of all charges listed in the field 19G (Charges).<br>Each claim form must be completed as a full document. Do not use the claim form as a continuation billing (e.g., Page 1 of 2, etc).                |
| <b>21. Medicare Paid</b>    | 7 digits: Currency<br>99999.99     | Conditional<br>Complete for Medicare crossover claims.<br>Enter the Medicare payment amount shown on the Medicare payment voucher.  |
| <b>22. Third Party Paid</b> | 7 digits: Currency<br>99999.99     | Conditional<br>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. |

| Field Label                            | Completion format                      | Special Instructions   |
|--|--|--|
| <p><b>23. Net Charge</b></p>           | <p>7 digits: Currency<br/>99999.99</p> | <p>Required</p> <p><b>Colorado Medical Assistance Program claims (Not Medicare Crossover)</b><br/>                     Claims without third party payment. Net charge equals the total charge (field 20).<br/>                     Claims with third party payment. Net charge equals the total charge (field 20) minus the third party payment (field 22) amount.</p> <p><b>Medicare Crossover claims</b><br/>                     Crossover claims without third party payment. Net charge equals the sum of the Medicare deductible amount (field 24) plus the Medicare coinsurance (field 25) amount.<br/>                     Crossover claims with third party payment. Net charge equals the sum of the Medicare deductible amount (field 24) plus the Medicare coinsurance (field 25) amount minus the third party payment (field 22) amount.</p>          |
| <p><b>24. Medicare Deductible</b></p>  | <p>7 digits: Currency<br/>99999.99</p> | <p>Not Required</p>  |
| <p><b>25. Medicare Coinsurance</b></p> | <p>7 digits: Currency<br/>99999.99</p> | <p>Not Required</p>  |
| <p><b>26. Medicare Disallowed</b></p>  | <p>7 digits: Currency<br/>99999.99</p> | <p>Not Required</p>  |
| <p><b>27. Signature</b></p>            | <p>Text</p>                            | <p>Required</p> <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>Unacceptable signature alternatives:<br/>                     Claim preparation personnel may not sign the enrolled provider's name.<br/>                     Initials are not acceptable as a signature.<br/>                     Typed or computer printed names are not acceptable as a signature.<br/>                     "Signature on file" notation is not acceptable in place of an authorized signature.</p> |

| Field Label                        | Completion format | Special Instructions  |
|------------------------------------|-------------------|---|
| 28. <b>Billing Provider Name</b>   | Text              | Required<br>Enter the name of the individual or organization that will receive payment for the billed services.   |
| 29. <b>Billing Provider Number</b> | 8 digits          | Required<br>Enter the eight-digit Colorado Medical Assistance Program provider number assigned to the individual or organization that will receive payment for the billed services. |
| 30. <b>Remarks</b>                 | Text              | Conditional<br>Use to document Late Bill Override Date for timely filing.   |



# CHCBS Claim Example

**STATE OF COLORADO  
DEPARTMENT OF  
HEALTH CARE POLICY AND  
FINANCING**

INVOICE/PAT ACCT NUMBER

SPECIAL PROGRAM CODE

## HEALTH INSURANCE CLAIM

### PATIENT AND INSURED (SUBSCRIBER) INFORMATION

|   |   |  |
|---|---|--|
| 1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL)<br><b>Client, Ima</b>  | 2. CLIENT DATE OF BIRTH<br><b>07/07/2007</b>  | 3. MEDICAID ID NUMBER (CLIENT ID NUMBER)<br><b>A111111</b>   |
| 4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)   | 5. CLIENT SEX<br>MALE <input type="checkbox"/> FEMALE <input checked="" type="checkbox"/>   | 6. MEDICARE ID NUMBER (HIC OR SSN)   |
| TELEPHONE NUMBER  | 7. CLIENT RELATIONSHIP TO INSURED<br>SELF <input checked="" type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>   | 8. <input type="checkbox"/> CLIENT IS COVERED BY EMPLOYER HEALTH PLAN AS EMPLOYEE OR DEPENDENT       |
| 9. OTHER HEALTH INSURANCE COVERAGE — INSURANCE COMPANY NAME, ADDRESS, PLAN NAME, AND POLICY NUMBER(S)         | 10. WAS CONDITION RELATED TO:<br>A. CLIENT EMPLOYMENT<br>YES <input type="checkbox"/><br>B. ACCIDENT<br>AUTO <input type="checkbox"/> OTHER <input type="checkbox"/><br>C. DATE OF ACCIDENT<br><input type="text"/> | EMPLOYER NAME: _____<br>POLICYHOLDER NAME: _____<br>GROUP: _____<br>11. CHAMPUS SPONSORS SERVICE/SSN |
| TELEPHONE NUMBER  | 9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)   |  |
| TELEPHONE NUMBER  |   |  |
| 12. PREGNANCY <input type="checkbox"/> HMO <input type="checkbox"/> NURSING FACILITY <input type="checkbox"/> |   |  |

### PHYSICIAN OR SUPPLIER INFORMATION

|   |   |   |
|---|---|---|
| 13. DATE OF: <input type="checkbox"/> ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR FIRST PREGNANCY (LMP) | 14. MEDICARE DENIAL (ATTACH THE MEDICARE STANDARD PAPER REMITTANCE (SPR) IF EITHER BOX IS CHECKED)<br><input type="checkbox"/> BENEFITS EXHAUSTED <input type="checkbox"/> NON-COVERED SERVICES | 14A. OTHER COVERAGE DENIED<br><input type="checkbox"/> NO <input type="checkbox"/> YES PAY/DENY DATE: _____   |
| 15. NAME OF SUPERVISING PHYSICIAN   | PROVIDER NUMBER   | 16. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES<br>ADMITTED: _____ DISCHARGED: _____  |
| 17. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (IF OTHER THAN HOME OR OFFICE)                | PROVIDER NUMBER   | 17A. CHECK BOX IF LABORATORY WORK WAS PERFORMED OUTSIDE THE PHYSICIANS OFFICE<br><input type="checkbox"/> YES |

|  |  |
|--|--|
| 18. ICD-9-CM DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. IN COLUMN F, RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE NUMBERS 1, 2, 3, OR 4 | TRANSPORTATION CERTIFICATION ATTACHED <input type="checkbox"/> YES |
| 1. <b>7999</b>   | DURABLE MEDICAL EQUIPMENT<br>Line # Make Model Serial Number       |
| 2. _____   | PRIOR AUTHORIZATION #  |
| 3. _____   |  |
| 4. _____   |  |

| 19A. DATE OF SERVICE FROM TO | B. PLACE OF SERVICE | C. PROCEDURE CODE (HCPCS) | MODIFIERS | D. RENDERING PROVIDER NUMBER | E. REFERRING PROVIDER NUMBER | F. DIAGNOSIS |   |   | G. CHARGES | H. DAYS OR UNITS | I. COPAY | J. EMERG ENCY            | K. FAMILY PLANNING       | L. EPSDT                 |
|------------------------------|---------------------|---------------------------|-----------|------------------------------|------------------------------|--------------|---|---|------------|------------------|----------|--------------------------|--------------------------|--------------------------|
|                              |                     |                           |           |                              |                              | P            | S | T |            |                  |          |                          |                          |                          |
| 07/08/2013 07/08/2013        | 12                  | T1016                     | U5        |                              |                              | 1            |   |   | \$33.72    | 4                |          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                              |                     |                           |           |                              |                              |              |   |   |            |                  |          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                              |                     |                           |           |                              |                              |              |   |   |            |                  |          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                              |                     |                           |           |                              |                              |              |   |   |            |                  |          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                              |                     |                           |           |                              |                              |              |   |   |            |                  |          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                              |                     |                           |           |                              |                              |              |   |   |            |                  |          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE, AND COMPLETE. I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS AND THAT ANY FALSIFICATION OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS.

|   |                                    |   |
|---|------------------------------------|---|
| 27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE<br><b>Children's Health Management Agency 07/08/13</b> | 20. TOTAL CHARGES → <b>\$33.72</b> | LESS ↓  |
| 28. BILLING PROVIDER NAME<br><b>Children's Health Management Agency</b>   | 30. REMARKS                        | 21. MEDICARE PAID<br><input type="text"/>               |
| 28. BILLING PROVIDER NUMBER<br><b>04444444</b>  |                                    | 22. THIRD PARTY PAID<br><input type="text"/> \$0.00     |
| COL-101   |                                    | 23. NET CHARGE<br><input type="text"/> \$33.72          |
| FORM NO. 94320 (REV. 02/99)<br>ELECTRONIC APPLICATION   |                                    | 24. MEDICARE DEDUCTIBLE<br><input type="text"/> \$0.00  |
|   |                                    | 25. MEDICARE COINSURANCE<br><input type="text"/> \$0.00 |
|   |                                    | 26. MEDICARE DISALLOWED<br><input type="text"/>         |

**COLORADO 1500**

## Home and Community Based Services for Children with Life Limiting Illness (CLLI)



The Home and Community Based Services for Children with Life Limiting Illness (CLLI) Waiver formerly known as the Pediatric Hospice Waiver (PHW) is for children from birth to age 18 with a medical diagnosis of a life-limiting illness who meet the institutional level of care for inpatient hospitalization. Level of care determinations are conducted annually by the single entry point case management agencies. Services include Bereavement Counseling, Expressive Therapy (Art, Play, and Music), Massage Therapy, Palliative/Supportive Care (Care Coordination and Pain and Symptom Management), Respite Care, and Therapeutic Life Limiting Illness Support Services. Clients that are enrolled in the waiver also have access to all state plan Colorado Medical Assistance benefits, including curative care. There is no requirement for a nine-month terminal prognosis.

### HCBS-CLLI Procedure Code Table

Providers may bill the following procedure codes for HCBS-CLLI services:

| <b>HCBS-CLLI Procedure Code Table (Special Program Code 97)</b> |                              |            |  |                     |
|---|------------------------------|------------|--|---------------------|
| Description   | Procedure Code + Modifier(s) |            | Place of Service                         | Units               |
| Art and Play Therapy  | H2032                        | UD, HA     | 11 - Office<br>12 - Home                 | 1 unit = 15 minutes |
| Art and Play Therapy - Group                                    | H2032                        | UD, HA, HQ | 11 - Office<br>12 - Home                 | 1 unit = 15 minutes |
| Music Therapy   | H2032                        | UD         | 11 - Office<br>12 - Home                 | 1 unit = 15 minutes |
| Music Therapy - Group   | H2032                        | UD, HQ     | 11 - Office<br>12 - Home                 | 1 unit = 15 minutes |
| Massage Therapy   | 97124                        | UD         | 11 - Office<br>12 - Home                 | 1 unit = 15 minutes |
| Care Coordination   | G9012                        | UD         | 11 - Office<br>12 - Home                 | 1 unit = 15 minutes |
| Pain and Symptom Management                                     | S9123                        | UD         | 12 – Home<br>11 - Office<br>34 - Hospice | 1 unit = 1 hour     |
| Respite Care – Unskilled (4 hours or less)                      | S5150                        | UD         | 12 - Home                                | 1 unit = 15 minutes |
| Respite Care – Unskilled (4 hours or more)                      | S5151                        | UD         | 12 - Home                                | 1 unit = 1 day      |

| <b>HCBS-CLLI Procedure Code Table (Special Program Code 97)</b> |                                     |        |                          |                     |
|---|-------------------------------------|--------|--------------------------|---------------------|
| <b>Description</b>  | <b>Procedure Code + Modifier(s)</b> |        | <b>Place of Service</b>  | <b>Units</b>        |
| Respite Care – CNA (4 hours or less)                            | T1005                               | UD     | 12 - Home                | 1 unit = 15 minutes |
| Respite Care – CNA (4 hours or more)                            | S9125                               | UD     | 12 - Home                | 1 unit = 1 day      |
| Respite Care - Skilled RN, LPN (4 hours or less)                | T1005                               | UD, TD | 12 - Home                | 1 unit = 15 minutes |
| Respite Care - Skilled RN, LPN (4 hours or more)                | S9125                               | UD, TD | 12 - Home                | 1 unit = 1 day      |
| Bereavement Counseling  | S0257                               | UD, HK | 12 – Home<br>11 - Office | 1 unit = lump sum   |
| Therapeutic Life Limiting Illness Support – Individual          | S0257                               | UD     | 12 – Home<br>11 - Office | 1 unit = 15 minutes |
| Therapeutic Life Limiting Illness Support – Family              | S0257                               | UD, HR | 12 – Home<br>11 - Office | 1 unit = 15 minutes |
| Therapeutic Life Limiting Illness Support - Group               | S0257                               | UD, HQ | 12 – Home<br>11 - Office | 1 unit = 15 minutes |

### Service Limitations

Reimbursement for HCBS-CLLI Therapeutic Life Limiting Illness Support services (S0257 with any “UD” modifier) shall be limited to 98 hours per annual certification. Reimbursement for HCBS-CLLI respite care services (T1005, S9125, S5150 and S5151) shall be limited to 30 days (unique dates of service) per annual certification. Reimbursement for HCBS-CLLI respite care services (T1005, S9125, S5150 and S5151) shall not be duplicated at the same time of service as state plan Home Health or Palliative/Supportive Care services (S9123) and shall be denied.



# HCBS-CLLI Claim Example

**STATE OF COLORADO  
DEPARTMENT OF  
HEALTH CARE POLICY AND  
FINANCING**

|                         |
|-------------------------|
| INVOICE/PAT ACCT NUMBER |
| SPECIAL PROGRAM CODE    |

## HEALTH INSURANCE CLAIM

**PATIENT AND INSURED (SUBSCRIBER) INFORMATION**

|   |  |  |
|---|--|--|
| 1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL)<br><b>Client, Ima</b>                                    | 2. CLIENT DATE OF BIRTH<br><b>01/01/2014</b>   | 3. MEDICAID ID NUMBER (CLIENT ID NUMBER)<br><b>G121212</b>                                     |
| 4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)   | 5. CLIENT SEX<br>MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/>  | 6. MEDICARE ID NUMBER (HIC OR SSN)   |
| TELEPHONE NUMBER  | 7. CLIENT RELATIONSHIP TO INSURED<br>SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>   | 8. <input type="checkbox"/> CLIENT IS COVERED BY EMPLOYER HEALTH PLAN AS EMPLOYEE OR DEPENDENT |
| 9. OTHER HEALTH INSURANCE COVERAGE — INSURANCE COMPANY NAME, ADDRESS, PLAN NAME, AND POLICY NUMBER(S) | 10. WAS CONDITION RELATED TO:<br>A. CLIENT EMPLOYMENT<br>YES <input type="checkbox"/><br>B. ACCIDENT<br>AUTO <input type="checkbox"/> OTHER <input type="checkbox"/><br>C. DATE OF ACCIDENT<br><div style="border: 1px solid black; width: 50px; height: 20px; margin: 5px auto;"></div> | EMPLOYER NAME: _____<br>POLICYHOLDER NAME: _____<br>GROUP: _____                               |
| TELEPHONE NUMBER  | 9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)  | 11. CHAMPUS SPONSORS SERVICE/SSN   |
| TELEPHONE NUMBER  | 12. PREGNANCY <input type="checkbox"/> HMO <input type="checkbox"/> NURSING FACILITY <input type="checkbox"/>  |  |

**PHYSICIAN OR SUPPLIER INFORMATION**

|  |   |   |
|--|---|---|
| 13. DATE OF: <input type="checkbox"/> ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR FIRST PREGNANCY (LMP)                          | 14. MEDICARE DENIAL (ATTACH THE MEDICARE STANDARD PAPER REMITTANCE (SPR) IF EITHER BOX IS CHECKED)<br><input type="checkbox"/> BENEFITS EXHAUSTED <input type="checkbox"/> NON-COVERED SERVICES | 14A. OTHER COVERAGE DENIED<br><input type="checkbox"/> NO <input type="checkbox"/> YES<br>PAYMENT DATE: _____ |
| 15. NAME OF SUPERVISING PHYSICIAN  | PROVIDER NUMBER   | 16. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES<br>ADMITTED: _____ DISCHARGED: _____  |
| 17. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (IF OTHER THAN HOME OR OFFICE)   | PROVIDER NUMBER   | 17A. CHECK BOX IF LABORATORY WORK WAS PERFORMED OUTSIDE THE PHYSICIANS OFFICE<br><input type="checkbox"/> YES |
| 18. ICD-9-CM DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. IN COLUMN F, RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE NUMBERS 1, 2, 3, OR 4 | TRANSPORTATION CERTIFICATION ATTACHED <input type="checkbox"/> YES  |   |
| 1. <b>7999</b>   | DURABLE MEDICAL EQUIPMENT<br>Line #    Make    Model    Serial Number   |   |
| 2. _____   | PRIOR AUTHORIZATION #:  |   |
| 3. _____   |   |   |
| 4. _____   |   |   |

| 19A. DATE OF SERVICE FROM | 19B. DATE OF SERVICE TO | 19C. PLACE OF SERVICE | 19D. PROCEDURE CODE (HCPCS) | 19E. MODIFIERS | 19F. RENDERING PROVIDER NUMBER | 19G. REFERRING PROVIDER NUMBER | 19H. DIAGNOSIS P I S T | 19I. CHARGES | 19J. DAYS OR UNITS | 19K. COPAY | 19L. EMERG ENCY          | 19M. FAMILY PLANNING     | 19N. EPSDT               |
|---------------------------|-------------------------|-----------------------|-----------------------------|----------------|--------------------------------|--------------------------------|------------------------|--------------|--------------------|------------|--------------------------|--------------------------|--------------------------|
| 6/04/2014                 | 06/04/2014              | 12                    | S9125                       | UD             |                                |                                | 1                      | \$155.29     | 1                  |            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                           |                         |                       |                             |                |                                |                                |                        |              |                    |            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                           |                         |                       |                             |                |                                |                                |                        |              |                    |            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                           |                         |                       |                             |                |                                |                                |                        |              |                    |            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                           |                         |                       |                             |                |                                |                                |                        |              |                    |            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                           |                         |                       |                             |                |                                |                                |                        |              |                    |            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                           |                         |                       |                             |                |                                |                                |                        |              |                    |            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

|   |   |
|---|---|
| <p style="font-size: small; margin: 0;">THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE, AND COMPLETE. I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS.</p> <p>27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE<br/><i>Children's Health Management Agency 06/04/14</i></p> <p>28. BILLING PROVIDER NAME<br/><b>Children's Health Management Agency</b></p> <p>29. BILLING PROVIDER NUMBER<br/><b>01010101</b></p> <p style="font-size: x-small;">COL-101<br/>FORM NO. 54320 (REV. 02/95)<br/>ELECTRONIC APPLICATION</p> | <p style="text-align: center;">20. TOTAL CHARGES → <b>\$155.29</b></p> <p>21. MEDICARE PAID <input type="text" value="\$0.00"/></p> <p>22. THIRD PARTY PAID <input type="text" value="\$0.00"/></p> <p>23. NET CHARGE <input type="text" value="\$155.29"/></p> <p>24. MEDICARE DEDUCTIBLE <input type="text" value="\$0.00"/></p> <p>25. MEDICARE COINSURANCE <input type="text" value="\$0.00"/></p> <p>26. MEDICARE DISALLOWED <input type="text" value=""/></p> <p style="text-align: center;"><b>COLORADO 1500</b></p> |
|---|---|

# Home and Community Based Services for Children with Autism (HCBS-CWA)



The Home and Community Based Services for Children with Autism (HCBS-CWA) waiver program is for children from birth to age six (6) with a medical diagnosis of Autism. The children must meet the institutional level of care for an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID). Level of care determinations are made annually by the case management agency. Eligible children qualify for behavioral therapies provided through the waiver as well as for all state plan Colorado Medical Assistance benefits.



## HCBS-CWA Procedure Code Table

Providers may bill the following procedure codes for HCBS-CWA services:

| <b>HCBS-CWA Procedure Code Table (Special Program Code 96)</b> |                              |        |                     |
|--|------------------------------|--------|---------------------|
| Description  | Procedure Code + Modifier(s) |        | Units               |
| Behavioral Therapies, Lead Therapist                           | H0004                        | UL     | 1 unit = 15 minutes |
| Behavioral Therapies, Senior Therapist                         | H0004                        | UL, HN | 1 unit = 15 minutes |
| Behavioral Therapies, Line Staff                               | H2019                        | UL     | 1 unit = 15 minutes |
| Initial/ Ongoing Treatment Evaluation                          | H2000                        | UL     | 1 unit = 15 minutes |
| Post Service Evaluation  | H2000                        | UL, TS | 1 unit = 15 minutes |



# HCBS-CWA Claim Example

**STATE OF COLORADO  
DEPARTMENT OF  
HEALTH CARE POLICY AND  
FINANCING**

|                         |
|-------------------------|
| INVOICE/PAT ACCT NUMBER |
| SPECIAL PROGRAM CODE    |

## HEALTH INSURANCE CLAIM

### PATIENT AND INSURED (SUBSCRIBER) INFORMATION

|   |   |   |
|---|---|---|
| 1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL)<br><b>Client, Ima</b>                                    | 2. CLIENT DATE OF BIRTH<br><b>10/30/2007</b>  | 3. MEDICAID ID NUMBER (CLIENT ID NUMBER)<br><b>A444444</b>  |
| 4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)   | 5. CLIENT SEX<br>MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/>   | 6. MEDICARE ID NUMBER (HIC OR SSN)  |
| TELEPHONE NUMBER  | 7. CLIENT RELATIONSHIP TO INSURED<br>SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>  | 8. <input type="checkbox"/> CLIENT IS COVERED BY EMPLOYER HEALTH PLAN AS EMPLOYEE OR DEPENDENT                |
| 9. OTHER HEALTH INSURANCE COVERAGE — INSURANCE COMPANY NAME, ADDRESS, PLAN NAME, AND POLICY NUMBER(S) | 10. WAS CONDITION RELATED TO<br>A. CLIENT EMPLOYMENT<br>YES <input type="checkbox"/><br>B. ACCIDENT<br>AUTO <input type="checkbox"/> OTHER <input type="checkbox"/><br>C. DATE OF ACCIDENT<br><input style="width: 50px;" type="text"/> | EMPLOYER NAME _____<br>POLICYHOLDER NAME _____<br>GROUP _____<br>11. CHAMPUS SPONSORS SERVICE/SSN _____       |
| TELEPHONE NUMBER  | 9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)   | 12. PREGNANCY <input type="checkbox"/> HMO <input type="checkbox"/> NURSING FACILITY <input type="checkbox"/> |
| TELEPHONE NUMBER  | 13. DATE OF: <input type="text"/> ILLNESS (FIRST SYMPTON) OR INJURY (ACCIDENT) OR FIRST PREGNANCY (LMP)   |   |

### PHYSICIAN OR SUPPLIER INFORMATION

|   |  |   |
|---|--|---|
| 14. MEDICARE DENIAL (ATTACH THE MEDICARE STANDARD PAPER REMITTANCE (SPR) IF EITHER BOX IS CHECKED)<br><input type="checkbox"/> BENEFITS EXHAUSTED <input type="checkbox"/> NON-COVERED SERVICES | 14A. OTHER COVERAGE DENIED<br><input type="checkbox"/> NO <input type="checkbox"/> YES<br>PAY/DENY DATE: _____ | 16. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES<br>ADMITTED: _____ DISCHARGED: _____  |
| 15. NAME OF SUPERVISING PHYSICIAN   | PROVIDER NUMBER  | 17A. CHECK BOX IF LABORATORY WORK WAS PERFORMED OUTSIDE THE PHYSICIANS OFFICE<br><input type="checkbox"/> YES |
| 17. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (IF OTHER THAN HOME OR OFFICE)  | PROVIDER NUMBER  | 18. ICD-9-CM<br>1. <b>7999</b><br>2. _____<br>3. _____<br>4. _____  |

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. IN COLUMN F, RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE NUMBERS 1, 2, 3, OR 4

TRANSPORTATION CERTIFICATION ATTACHED  YES

DURABLE MEDICAL EQUIPMENT  
Line #      Make      Model      Serial Number

PRIOR AUTHORIZATION #:

| 19A. DATE OF SERVICE FROM | 19A. DATE OF SERVICE TO | B. PLACE OF SERVICE | C. PROCEDURE CODE (HCPCS) | D. MODIFIERS | D. RENDERING PROVIDER NUMBER | E. REFERRING PROVIDER NUMBER | F. DIAGNOSIS | G. CHARGES | H. DAYS OR UNITS | I. COPAY | J. EMERG ENCY            | K. FAMILY PLANNING       | L. EPSDT                 |
|---------------------------|-------------------------|---------------------|---------------------------|--------------|------------------------------|------------------------------|--------------|------------|------------------|----------|--------------------------|--------------------------|--------------------------|
| 08/05/2013                | 08/09/2013              | 12                  | H0004                     | ul hn        |                              |                              | 1            | \$72.84    | 6                |          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                           |                         |                     |                           |              |                              |                              |              |            |                  |          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                           |                         |                     |                           |              |                              |                              |              |            |                  |          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                           |                         |                     |                           |              |                              |                              |              |            |                  |          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                           |                         |                     |                           |              |                              |                              |              |            |                  |          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                           |                         |                     |                           |              |                              |                              |              |            |                  |          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE, AND COMPLETE. I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS.

20. TOTAL CHARGES → **\$72.84**

LESS ↓ MEDICARE SPR DATE

27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE  
*Children's Health Management Agency 08/05/13*

28. BILLING PROVIDER NAME  
**Children's Health Management Agency**

29. BILLING PROVIDER NUMBER  
**01010101**

30. REMARKS

|  |  |
|--|--|
| 21. MEDICARE PAID<br><input style="width: 50px;" type="text"/>                   | 24. MEDICARE DEDUCTIBLE<br><input style="width: 50px;" type="text" value="\$0.00"/>  |
| 22. THIRD PARTY PAID<br><input style="width: 50px;" type="text" value="\$0.00"/> | 25. MEDICARE COINSURANCE<br><input style="width: 50px;" type="text" value="\$0.00"/> |
| 23. NET CHARGE<br><input style="width: 50px;" type="text" value="\$72.84"/>      | 26. MEDICARE DISALLOWED<br><input style="width: 50px;" type="text"/>                 |

## 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   |
|-------------------------------------|--|
| <b>LBOD Completion Requirements</b> | <ul style="list-style-type: none"> <li>• Electronic claim formats provide specific fields for documenting the LBOD.</li> <li>• Supporting documentation must be kept on file for 6 years.</li> <li>• For paper claims, follow the instructions appropriate for the claim form you are using.                             <ul style="list-style-type: none"> <li>➤ <i>UB-04</i>: Occurrence code 53 and the date are required in FL 31-34.</li> <li>➤ <i>Colorado 1500</i>: Indicate “LBOD” and the date in box 30 - Remarks.</li> <li>➤ <i>2006 ADA Dental</i>: Indicate “LBOD” and the date in box 35 - Remarks</li> </ul> </li> </ul>  |
| <b>Adjusting Paid Claims</b>        | <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><b>Adjust the claim within 60 days</b> 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><b>LBOD</b> = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the payment.</p> |

| Billing Instruction Detail                              | Instructions   |
|---|--|
| <p><b>Denied Paper Claims</b></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><b>Correct the claim errors and refile within 60 days</b> of the claim denial or rejection. Retain all documents that prove compliance with timely filing requirements.</p> <p><b>LBOD</b> = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the denial.</p>   |
| <p><b>Returned Paper Claims</b></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><b>Correct the claim errors and re-file within 60 days</b> 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><b>LBOD</b> = the stamped fiscal agent date on the returned claim.</p>  |
| <p><b>Rejected Electronic Claims</b></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><b>Correct claim errors and refile within 60 days</b> of the rejection. Maintain a printed copy of the rejection notice that identifies the claim and date of rejection.</p> <p><b>LBOD</b> = the date shown on the claim rejection report.</p>  |
| <p><b>Denied/Rejected Due to Client Eligibility</b></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><b>File the claim within 60 days</b> of the date of the rejected eligibility verification response. Retain a printed copy of the rejection notice that identifies the client and date of eligibility rejection.</p> <p><b>LBOD</b> = the date shown on the eligibility rejection report.</p>  |
| <p><b>Retroactive Client Eligibility</b></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"> <li>• Identifies the patient by name</li> <li>• States that eligibility was backdated or retroactive</li> <li>• Identifies the date that eligibility was added to the state eligibility system.</li> </ul> <p><b>LBOD</b> = 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><b>Delayed Notification of Eligibility</b></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><b>File the claim within 60 days</b> 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 <a href="#">Billing Manuals</a> section) that identifies the client, indicates the effort made to identify eligibility, and shows the date of eligibility notification.</p> <ul style="list-style-type: none"> <li>• Claims must be filed within 365 days of the date of service. No exceptions are allowed.</li> <li>• This extension is available only if the provider had no way of knowing that the individual had Colorado Medical Assistance Program coverage.</li> <li>• Providers who render services in a hospital or nursing facility are expected to get benefit coverage information from the institution.</li> <li>• The extension does not give additional time to obtain Colorado Medical Assistance Program billing information.</li> <li>• If the provider has previously submitted claims for the client, it is improper to claim that eligibility notification was delayed.</li> </ul> <p><b>LBOD</b> = the date the provider was advised the individual had Colorado Medical Assistance Program benefits.</p> |
| <p><b>Electronic Medicare Crossover Claims</b></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><b>File the claim within 120 days</b> of the Medicare processing/payment date shown on the SPR/ERA. Maintain the original SPR/ERA on file.</p> <p><b>LBOD</b> = the Medicare processing date shown on the SPR/ERA.</p>  |
| <p><b>Medicare Denied Services</b></p>             | <p>The claim is for Medicare denied services (Medicare non-benefit services, benefits exhausted services, or the client 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><b>File the claim within 60 days</b> 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><b>LBOD</b> = the Medicare processing date shown on the SPR/ERA.</p>   |

| Billing Instruction Detail                                     | Instructions   |
|--|--|
| <p><b>Commercial Insurance Processing</b></p>                  | <p>The claim has been paid or denied by commercial insurance.<br/> <b>File the claim within 60 days</b> 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.<br/>                     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.<br/> <b>LBOD</b> = the date commercial insurance paid or denied.</p> |
| <p><b>Correspondence LBOD Authorization</b></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 client, claim, services, or circumstances.<br/> <b>File the claim within 60 days</b> of the date on the authorization letter. Retain the authorization letter.<br/> <b>LBOD</b> = the date on the authorization letter.</p>  |
| <p><b>Client Changes Providers during Obstetrical Care</b></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.<br/> <b>File the claim within 60 days</b> 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.<br/> <b>LBOD</b> = the last date of OB care by the billing provider.</p>   |



***HCBS-CHCBS, CWA, and CLLI Specialty Manuals Revisions Log***

| <b><i>Revision Date</i></b> | <b><i>Section/Action</i></b>  | <b><i>Pages</i></b> | <b><i>Made by</i></b> |
|-----------------------------|---|---------------------|-----------------------|
| <i>05/07/2013</i>           | <i>Created</i>  | <i>All</i>          | <i>kg/cc/sm</i>       |
| <i>12/31/2013</i>           | <i>Added the following services to the CWA waiver: Initial/Ongoing Treatment Evaluation (H2000) and Post Service Evaluation (H2000)</i> | <i>25</i>           | <i>cc</i>             |
| <i>05/08/2014</i>           | <i>Updated CLLI PAR Example</i>   | <i>8</i>            | <i>mm</i>             |
| <i>05/08/2014</i>           | <i>Updated CWA PAR Example</i>  | <i>9</i>            | <i>mm</i>             |
| <i>05/08/2014</i>           | <i>Updated CLLI Procedure Code Table to account for new 7/1 services. Benefit description and limitations also revised</i>              | <i>21-22</i>        | <i>mm</i>             |
| <i>05/08/2014</i>           | <i>Updated CLLI Claim Example</i>   | <i>23</i>           | <i>mm</i>             |
| <i>05/09/2014</i>           | <i>Updated CWA Units for Post Service Eval. Changed from 1 minutes to 15 minutes</i>  | <i>24</i>           | <i>mm</i>             |