

# Children’s Residential Habilitation Program (CHRP) Waiver Program Billing Manual

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# Home and Community Based Services (HCBS) for Persons with Developmental Disabilities (DD) Program

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## Overview

The Home and Community Based Services (HCBS) program provides Colorado Medical Assistance Program benefits to clients for certain services in their homes and communities as an alternative to institutional care. HCBS programs for persons with developmental disabilities include the Children's Habilitation Residential Program (HCBS-CHRP).

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). 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/MR (intermediate care facility for the mentally retarded). 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.

## General Billing Information

### 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 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

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. Please refer to the [Colorado General Billing Information Manual](#) for additional electronic information.

## Children's Residential Habilitation Program (CHRP)

CHRP is a residential service and support program for children and youth birth to 22 years of age. CHRP provides residential services for children and youth in foster care who have a developmental disability and extraordinary needs. The children must be at risk for institutionalization. CHRP serves as an alternative to placement in Intermediate Care Facilities/Individuals with Intellectual Disabilities (ICF/IID). The waiver is designed to assist children/youth to acquire, retain, and/or improve self-help, socialization, and adaptive skills necessary to live in the community with a plan to include services. Placements occur through the Colorado County Departments of Human/Social Services once children meet all of the program eligibility requirements.

The following services are provided through CHRP when deemed appropriate and adequate by the child/youth's physician and they are to be provided in the community, as available:

- Self-Advocacy Training
- Independent Living Training
- Cognitive Services
- Communication Services
- Counseling and Therapeutic Services
- Personal Care Services
- Emergency Assistance Training
- Community Connection Training
- Travel Services
- Supervision Services
- Respite Services



## 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/single entry points complete the Prior Approval and/or Cost Containment requests for their specific programs according to instructions published in the Department of Health Care Policy and Financing's (the Department's) Code of Colorado Regulations, [Program Rules](#) (10 CCR 2505-10, Section 8.500).

The CMAs/SEPs responsibilities include, but 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 by referring to 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 within 30 calendar days of receipt of the referral.
- Monitoring and evaluating services.
- Reassessing each client.
- 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 case management agency/single entry point is responsible for timely submission and distribution of copies of approvals to agencies and providers contracted to provide services.

## PAR Submission

All HCBS-CHRP services must be prior authorized by the County Department of Human Social Services and transmitted electronically to the Medicaid Management Information System (MMIS) by the Division Child Welfare Division. The telephone number for the Child Welfare Division is listed in Appendix A of the Appendices in the Provider Services [Billing Manuals](#) section of the Department's website.

## Claim Submission

### Paper Claims

The electronic claims format is 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.

## CHRP Procedure Code Table

Providers may bill the following procedure codes for CHRP services:

<b>Children’s Habilitation Residential Program (CHRP) (Special Program Code 93)</b>		
<b>Description</b>	<b>Procedure Code + Modifier(s)</b>	
Level (of Care) I	T1015	U9
Level (of Care) II	H0041	U9
Level (of Care) III	T2033	U9
Respite	H0045	U9

## Paper Claim Reference Table

The following paper form reference table describes required fields for the paper Colorado 1500 claim form for HCBS-CHRP claims:

Field Label	Completion format	Special Instructions
<b>Invoice/Pat Acct Number</b>	Up to 12 characters: letters, numbers or hyphens	Optional Enter the information that identifies the patient or claim in the provider’s billing system. Submitted information appears on the Provider Claim Report.
<b>Special Program Code</b>	2 digits	Required Enter the code that identifies the program under which services are being billed. Code 93 identifies the Children’s Habilitation Residential Program (CHRP)
<b>1. Client Name</b>	Up to 25 characters: letters & spaces	Required Enter the client’s last name, first name and middle initial
<b>2. Client Date of Birth</b>	Date of birth 8 digits (MMDDCCYY) Example: 01/01/2010	Required 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.
<b>3. Colorado Medical Assistance Program ID Number (Client ID Number)</b>	7 characters, a letter prefix followed by six numbers	Required 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
<b>4. Client Address Telephone Number</b>	Characters: numbers and letters	Not Required Submitted information is not entered into the claim processing system
<b>5. Client Sex</b>	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.
<b>6. Medicare ID Number (HIC or SSN)</b>	Up to 11 characters: numbers and letters	Not required Complete if the client is eligible for Medicare benefits. Enter the individual’s Medicare health insurance claim number.

Field Label	Completion format	Special Instructions
7. <b>Client relationship to insured</b>	Check box Self    Spouse <input type="checkbox"/> <input type="checkbox"/> Child    Other <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	Not required
10. <b>Was condition related to</b>	Check box A. Client employment <input type="checkbox"/> Check box B. Accident <input type="checkbox"/> 6 digits: MMDDYY C. Date of accident 6 digits: MMDDYY	Not required
11. <b>CHAMPUS Sponsors Service/SSN</b>	10 digits	Not required
<b>Durable Medical Equipment Model/serial number (unlabeled field)</b>	20 characters	Not required
12. <b>Pregnancy PHP Nursing Facility Resident</b>	Check box <input type="checkbox"/> Check box <input type="checkbox"/> Check box <input type="checkbox"/>	Not required Not required Not required
13. <b>Date of illness or injury or pregnancy</b>	6 digits: MMDDYY	Not required
14. <b>Medicare Denial</b>	Check box <input type="checkbox"/> Benefits Exhausted <input type="checkbox"/> Non-covered services	Not required

Field Label	Completion format	Special Instructions
<b>14A. Other Coverage Denied</b>	Check box No <input type="checkbox"/> Yes <input type="checkbox"/> Pay/Deny Date 6 digits: MMDDYY	Not required
<b>15. Name of supervising physician Provider Number</b>	Text 8 digits	Not required
<b>16. For services related to hospitalization</b>	6 digits: MMDDYY	Not required
<b>17. Name and address of facility where services rendered Provider Number</b>	Text (address is optional) 8 digits	Not required
<b>18. ICD-9-CM</b>	1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/> Codes: 3, 4, or 5 characters. 1 <sup>st</sup> character may be a letter.	Required At least one diagnosis code must be entered. CHRP must enter 7999
<b>Diagnosis or nature of illness or injury</b>	Text	Not required
<b>Transportation Certification attached</b>	Check box <input type="checkbox"/>	Not required
<b>Prior authorization No.</b>	6 characters: Letter plus 5 digits	Conditional 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. Complete when the service requires prior authorization

Field Label	Completion format	Special Instructions																		
<b>19A. Date of Service</b>	From: 6 digits MMDDYY  To: 6 digits MMDDYY	Required The field accommodates the entry of two dates: a “beginning” or “from” date of service and an “ending” or “to” date of service. Single date of service From To <table border="1" data-bbox="889 510 1224 558"> <tr> <td>10</td> <td>01</td> <td>2013</td> <td></td> <td></td> <td></td> </tr> </table> Or From To <table border="1" data-bbox="889 642 1224 690"> <tr> <td>10</td> <td>01</td> <td>2013</td> <td>10</td> <td>01</td> <td>2013</td> </tr> </table> Span dates of service <table border="1" data-bbox="889 737 1224 785"> <tr> <td>10</td> <td>01</td> <td>2013</td> <td>10</td> <td>31</td> <td>2013</td> </tr> </table> Single Date of Service: Enter the six digit date of service in the “From” field. Completion of the “To” field is not required. Do not spread the date entry across the two fields. Span billing: Span billing is permissible if the same service (same procedure code) is provided on consecutive dates.	10	01	2013				10	01	2013	10	01	2013	10	01	2013	10	31	2013
10	01	2013																		
10	01	2013	10	01	2013															
10	01	2013	10	31	2013															
<b>19B. Place of Service</b>	2 digits	Required Enter place of service code <b>12</b> – Home																		
<b>19C. Procedure Code MOD</b>	5 characters: 5 digits or 1 letter plus 4 digits or 2 letters plus 3 digits	Required Refer to the CHRP procedure code table.																		
<b>Mod(ifier)</b>	2 characters: Letters or digits May enter up to two, 2 character, modifiers	Required Refer to the modifiers list in the CHCBS procedure code table.																		
<b>19D. Rendering Provider No.</b>	8 digits	Not required																		
<b>19E. Referring</b>	8 digits	Not required																		



Field Label	Completion format	Special Instructions
<b>19I. Copay</b>	1 digit	Conditional Complete if co-payment is required of this client for this service. Enter one of the following codes: 1-Refused to pay co-payment 2-Paid co-payment 3- Co-payment not requested
<b>19J. Emergency</b>	Check box <input type="checkbox"/>	Conditional 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 Enter a check mark 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 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	Required Enter the sum of all charges listed in the field 19G (charges). 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 99999.99	Not required
<b>22. Third Party Paid</b>	7 digits: Currency 99999.99	Not required



Field Label	Completion format	Special Instructions
<p><b>23. Net Charge</b></p>	<p>7 digits: Currency 99999.99</p>	<p>Required</p> <p><b>Colorado Medical Assistance Program claims (Not Medicare Crossover)</b>                      Claims without third party payment. Net charge equals the total charge (field 20).                      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>                      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.                      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 99999.99</p>	<p>Not required</p> <p>Complete for Medicare crossover claims. Enter the Medicare deductible amount shown on the Medicare payment voucher.</p>
<p><b>25. Medicare Coinsurance</b></p>	<p>7 digits: Currency 99999.99</p>	<p>Not required</p> <p>Complete for Medicare crossover claims. Enter the Medicare coinsurance amount shown on the Medicare payment voucher.</p>
<p><b>26. Medicare Disallowed</b></p>	<p>7 digits: Currency 99999.99</p>	<p>Not required</p> <p>Complete for Medicare crossover claims. Enter the amount Medicare disallowed, if any, shown on the Medicare payment voucher.</p>



Field Label	Completion format	Special Instructions
<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 if 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 if the name and signature of the agent is on file with the fiscal agent.</p> <p><b>Unacceptable signature alternatives:</b></p> <p>Claim preparation personnel may not sign the enrolled provider’s name.</p> <p>Initials are not acceptable as a signature.</p> <p>Typed or computer printed names are not acceptable as a signature.</p> <p>“Signature on file” notation is not acceptable in place of an authorized signature.</p>
<p><b>28. Billing Provider Name</b></p>	<p>Text</p>	<p>Required</p> <p>Enter the name of the individual or organization that will receive payment for the billed services.</p>
<p><b>29. Billing Provider Number</b></p>	<p>8 digits</p>	<p>Required</p> <p>Enter the eight-digit Colorado Medical Assistance Program provider number assigned to the individual or organization that will receive payment for the billed services.</p>
<p><b>30. Remarks</b></p>	<p>Text</p>	<p>Conditional</p> <p>Use to document Late Bill Override for timely filing.</p> <p>When applicable, enter the word “CLIA” followed by the number.</p>



# CHRP 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) <b>Client, Ima</b>	2. CLIENT DATE OF BIRTH <b>09/25/1999</b>	3. MEDICAID ID NUMBER (CLIENT ID NUMBER) <b>A123456</b>
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. CLIENT SEX MALE <input type="checkbox"/> FEMALE <input checked="" type="checkbox"/>	6. MEDICARE ID NUMBER (HIC OR SSN)
TELEPHONE NUMBER	7. CLIENT RELATIONSHIP TO INSURED 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 EMPLOYER NAME: _____
9. OTHER HEALTH INSURANCE COVERAGE — INSURANCE COMPANY NAME, ADDRESS, PLAN NAME, AND POLICY NUMBER(S)	10. WAS CONDITION RELATED TO: A. CLIENT EMPLOYMENT YES <input type="checkbox"/> B. ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/> C. DATE OF ACCIDENT <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0;"></div>	POLICYHOLDER NAME: _____ 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: <span style="font-size: 2em;">←</span>	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) <input type="checkbox"/> BENEFITS EXHAUSTED <input type="checkbox"/> NON-COVERED SERVICES	14A. OTHER COVERAGE DENIED <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 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 <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 1. <b>7999</b>	TRANSPORTATION CERTIFICATION ATTACHED <input type="checkbox"/> YES
2. _____	DURABLE MEDICAL EQUIPMENT Line # Make Model Serial Number
3. _____	PRIOR AUTHORIZATION #:
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	19I. DIAGNOSIS S	19J. DIAGNOSIS T	19K. CHARGES	19L. DAYS OR UNITS	19M. COPAY	19N. EMERG ENCY	19O. FAMILY PLANNING	19P. EPSDT
10/01/2013	10/15/2013	12	T2033	U4			1			\$7,061.10	15	3	<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 → <b>\$7,058.10</b>	LESS ↓	MEDICARE SPR DATE
27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE <i>Authorized Signature November 7, 2013</i>	30. REMARKS		21. MEDICARE PAID \$0.00
28. BILLING PROVIDER NAME Children's Habilitation Center			24. MEDICARE DEDUCTIBLE \$0.00
29. BILLING PROVIDER NUMBER 12345678			25. MEDICARE COINSURANCE \$0.00
COL-101 FORM NO. 94320 (REV. 02/99) ELECTRONIC APPLICATION			26. MEDICARE DISALLOWED

**COLORADO 1500**

## 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.</p> <p><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.</p> <p>Claims must be filed within 365 days of the date of service. No exceptions are allowed. If the claim is nearing the 365-day limit and the commercial insurance company has not completed processing, file the claim, receive a denial or rejection, and continue filing in compliance with the 60-day rule until insurance processing information is available.</p> <p><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.</p> <p><b>File the claim within 60 days</b> of the date on the authorization letter. Retain the authorization letter.</p> <p><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.</p> <p><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.</p> <p><b>LBOD</b> = the last date of OB care by the billing provider.</p>



***CHRP Specialty Manual 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>
06/17/2013	<i>Split DD, SLS, CES, CHRP and TCM from the combined HCBS manual</i>	All	cc/sm/jg