Colorado 1500 Specialty Manuals

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Colorado Medical Assistance Managed Care Programs

Some Colorado Medical Assistance Program clients obtain Medicaid through enrollment in a Colorado Medical Assistance Managed Care Organization (MCO). The Colorado Medical Assistance Program offers several Managed Care options described in this section.

- Primary Care Physician Program (PCP)
- Managed Care Organizations (MCOs)
  - Denver Health & Hospital Authority
  - Colorado Access
  - Rocky Mountain Hosp & Med
- Program of All-Inclusive Care for the Elderly (PACE)
- Mental Health Capitation Program (MHCP)

Identifying Colorado Medical Assistance Program Managed Care Enrollment

Colorado Medical Assistance Managed Care enrollment may be identified through verifying eligibility.

- An inquiry response through the Colorado Medical Assistance Program Secure Web Portal (Web Portal) will first display client information under “Client Details”, followed by the client’s eligibility status under “Client Eligibility Details.” Please note that a client may show as Medicaid “eligible” on the Web Portal response, but not be eligible for Medicaid medical assistance payments. It is important to review the entire response. If the Web Portal displays “Third Party Liability” and Medicare is listed, the message “Client has Medicare covered services only, no drug benefits” means that the client is eligible only for premium assistance. All provider billings to Medicaid will be denied for lack of coverage. Only Medicare will pay for services (in essence, Medicaid purchases Medicare services for the client, but does not provide any direct Medicaid medical benefits at all.
- Co-payment information is displayed next under “Co-payment”.
- If the client is enrolled in Managed Care, that information is displayed under the title “Prepaid Health Plan.” Almost all Medicaid clients are enrolled in the mandatory Mental Health Capitation Program. The client’s behavioral health organization is usually displayed first with the message “MHPROV Services” in large bold letters to identify the Managed Care plan as a mental health plan.

Managed Care enrollment information (if any) is often displayed last under the “Prepaid Health Plan” title. A bolded message reminds providers to get authorization from the plan before providing “non-exempt services.” (See section below for a list of Services that can be provided without managed care approval).

Providers must always verify eligibility information, including managed care participation, *before* providing services. Failure to verify eligibility information increases the risk of not receiving payment for rendered services. Fee-for-service claims for clients who are enrolled in Colorado Medical Assistance MCO will be denied.

Providers must comply with the requirements of the applicable Managed Care Program.

- For MCOs, service providers must be enrolled in the MCO network or have authorization to provide non-exempt services (see information below under Managed Care Organizations). The name and telephone number of the MCO is identified on the eligibility verification response.
- For PCPs (an FFS Managed Care Program), if the service provider is not the PCP, the services must be PCP-referral exempt or the rendering provider must have a referral or authorization from the PCP. The name and telephone number of the PCP is identified on the eligibility verification response.

Enrollment Services

Clients who wish to enroll in managed care can receive counseling and enrollment assistance from Health Colorado. Clients can call 303-839-2120 in the Denver Metro area, or 1-888-367-6557 outside the metro area, or visit the Health Colorado website at www.healthcolorado.net.

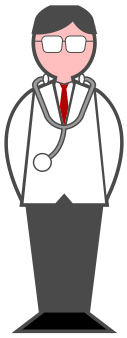
Managed care support services for providers

Questions about the policies and billing procedures for a specific MCO should be directed to that MCO.

Primary Care Physician Program (PCP)

The PCP is a FFS Managed Care Program. Enrolled clients select a PCP to serve as medical case manager.

PCP Case Management Responsibilities



- Provide primary health care services.
- Arrange 24-hour medical coverage for their Colorado Medical Assistance Program clients.
- Make referrals for specialty care and other services when necessary.
- Authorize referrals or coverage services.

PCP Gatekeeper Functions

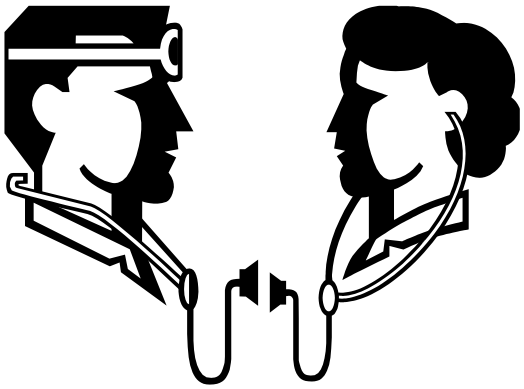
Colorado Medical Assistance Program clients are expected to obtain services from the PCP. Except for the exempt services noted below, clients must first seek care from the PCP.

PCP Referrals

- Referrals may be made verbally or in writing.
- Referrals are not an open-ended transfer of care. PCPs must specify the problem for which referral is made and the period of time allowed for the referral.
- Retroactive referrals are not allowed for non-emergency services in the emergency room or outpatient hospital setting.
- Retroactive referrals are granted for client-referred, non-emergency services and **only** in exceptional circumstances.

PCP Changes

If the client changes PCPs, services resulting from referrals from the previous PCP will be honored for 45 days following the PCP change.



Use of the PCP number

Unauthorized use of a PCP provider number to obtain claim payment is false reporting and may be subject to legal penalties.

PCP referrals are given on a case-by-case basis. Using a maintained list of PCP provider numbers to improperly indicate that the PCP has authorized a referral is not allowed. Unauthorized use of the PCP's provider number to obtain claim payment is prohibited and may be considered false reporting and subject to legal penalties.

Except for referral-exempt services, specialty providers should instruct clients to contact their PCP for medical care.

Referral-Exempt Services

The following services do not require PCP referral. In specifying these exemptions, the PCP does not intend to discourage referral of these services by the PCP.

- Psychiatric care*
- Vision care
- Non-emergency transportation
- Laboratory and radiology services
- Services provided to child abuse victims
- Family planning
- EPSDT dental services
- Anesthesia
- Pharmaceuticals
- Obstetrical services

**Psychiatric care is a benefit of the MHCP. All psychiatric services must be provided in compliance with the rules of the MHCP.*

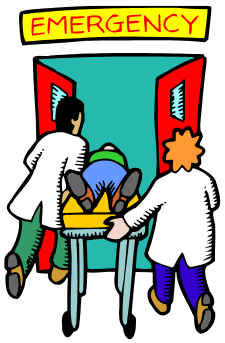
Emergency Services

Emergency services do not require PCP approval or authorization. The PCP Program uses the definition of emergency in the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

An emergency is any medical condition (including active labor and delivery) manifested by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably expect to result in:

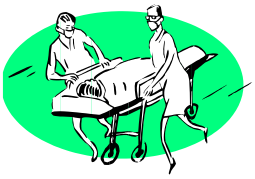
- Placing the patient's health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious life threatening condition or when immediate medical intervention is required.

Medical care in the hospital emergency department setting



- Non-emergency care in an Emergency Room (ER) setting is not a covered Colorado Medical Assistance Program benefit except as noted in these policies.
- Except for emergency conditions, services in the ER setting must be authorized by a PCP.
- Before treatment is initiated in the ER, the ER professional must conduct a medical screening examination on all PCP-enrolled clients.
  - To assess the nature and severity of the medical condition.
  - To determine the appropriateness of treatment in the ER.

The medical screening examination does not require PCP referral.



- If an emergency exists, the ER provider may treat and stabilize the client without PCP referral.
- If presenting circumstances do not constitute an emergency, the ER professional must contact the PCP to coordinate medical care and to obtain treatment authorization for hospital admission and certain specialty referrals.

PCP failure to respond

PCPs must respond to an ER request within 30 minutes. If the PCP does not respond within 30 minutes, the ER may render and be paid for treatment services.

The ER professional can contact the Department of Health Care Policy and Financing's (Department's) Customer Service Contact Center at at 1-800-221-3943 (toll free) to report PCP's failure to respond.

Disputed PCP denials

If the PCP refuses treatment authorization and the ER physician and PCP disagree about the clinical assessment, management, and appropriateness of follow-up treatment or the timing of a follow-up appointment, the ER physician may provide and be paid for treatment services.

- The ER physician must report the disputed denial to the Colorado Medical Assistance Program Provider Services Managed Care Assistance Line. The Colorado Medical Assistance Program Provider Services phone number is located in Appendix B.
- If the ER physician disagrees with a non-physician provider's denial of PCP authorization, the PCP must be available as a backup to speak with the ER physician about the dispute.
- Claims for disputed denials are subject to retrospective review and payment recovery.

Non-benefit services in the ER

Non-emergency care in an ER setting is not a benefit for PCP-enrolled clients. If the PCP client insists upon treatment in the ER setting without PCP authorization, the client is financially responsible for treatment-related fees. Clients are not responsible for screening examination charges.

Before non-benefit treatment services are provided, the client should sign an acknowledgment that he or she has been advised that the services are not covered by the Colorado Medical Assistance Program and that he/she accepts financial responsibility for related charges.

Billing instructions for ER services

Type of Service	PCP Referral	UB-04	Colorado 1500 emergency indicator
Emergency Care	Not Required	▪ Admission Type 1, ▪ Revenue Code 450 or 459	▪ Paper: "check mark" or "**x**" each detail
Screening Examination (Triage Only)	Not Required	▪ Admission Type 1 ▪ Revenue Code 459	▪ Paper: "check mark" or "**x**"
Disputed PCP Denial	Not Required	▪ Admission Type 1	▪ Paper: "check mark" or "**x**" each detail
PCP Failure to Respond	Not Required	▪ Admission Type 1	▪ Paper: "check mark" or "**x**" each detail
PCP Authorized ER Care	Required	▪ PCP's provider number must appear as the Other Physician. Admission Type 2 or 3	▪ PCP's provider number must appear as the Referring Provider Paper: blank

Client Over Utilization Program (COUP)

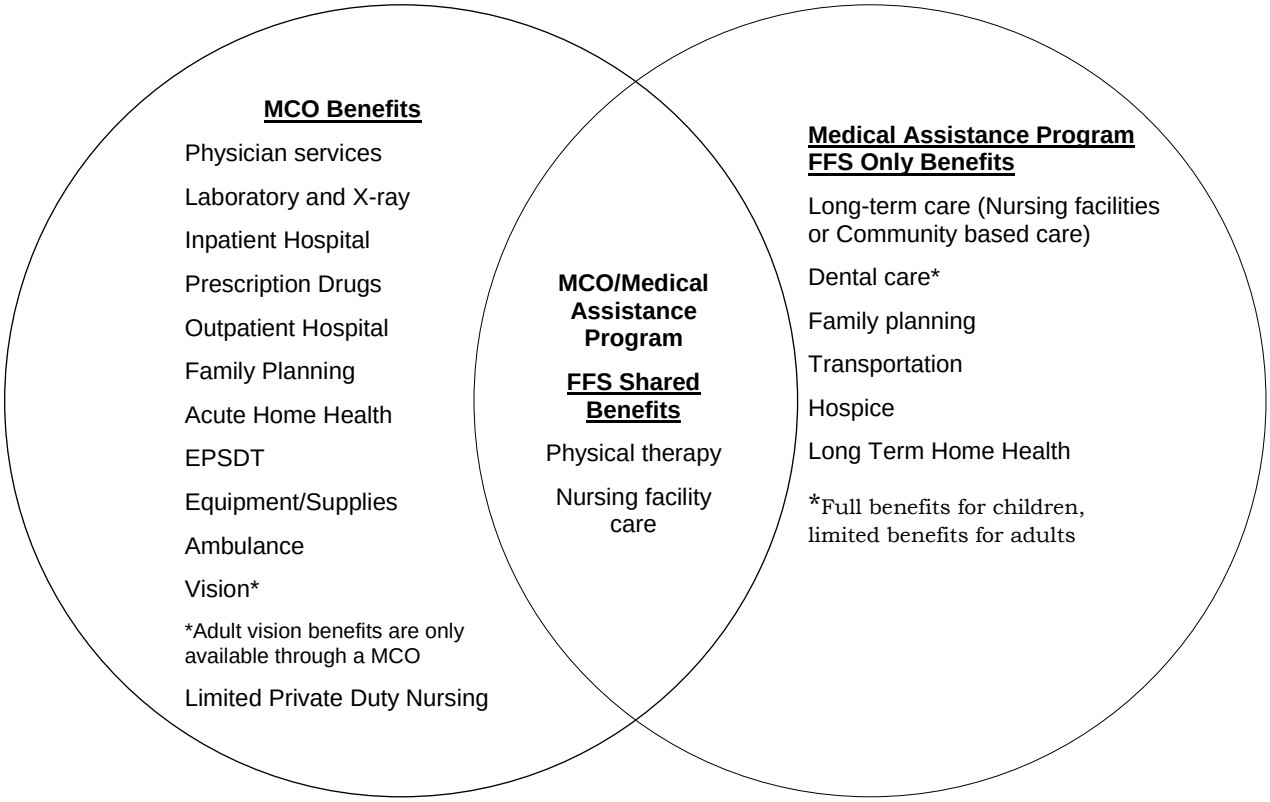
The COUP is a more restrictive application of the PCP for clients with a documented history of inappropriate service utilization.

- Over utilization clients are restricted to a designated PCP and a designated pharmacy.
- Over utilization referrals must be made in writing.
- Emergency care does not require referral.
- All prescriptions must be written by the PCP.
- Psychiatric care for over utilization clients requires PCP referral.

Managed Care Organizations (MCOs)

The Colorado Medical Assistance Program contracts with MCOs to provide benefits to Medical Assistance Program clients enrolled in the MCO. MCO-enrolled clients must obtain available services from the MCO.

Benefit availability



MCO enrolled clients are entitled to the same Colorado Medical Assistance Program benefits as clients who are not enrolled in managed care.

- MCOs provide most of the Colorado Medical Assistance Program benefits available to enrolled clients.
- Some benefits are not available from the MCO and these benefits are provided through FFS reimbursement.
- If the MCO offers a limited benefit, MCO enrolled clients must obtain available services from the MCO. When the MCO benefit is exhausted, additional medically necessary services are provided through FFS reimbursement.

Fee-for-Service Benefits for MCO-Enrolled Clients

The Colorado Medical Assistance Program pays FFS claims for MCO-enrolled clients under the following circumstances:

- When a Colorado Medical Assistance Program benefit is not provided by the MCO,
- When the client has exhausted MCO benefits and requires additional Colorado Medical Assistance Program benefit services.

When the service is one of the following exempt-from-authorization services:

- Emergency Services
- Emergency Transportation
- Non-emergency transportation
- EPSDT dental services
- Obstetrical services
- Family Planning Services

FFS claims for services provided to MCO enrolled clients must have the following attachments:

- A benefits exhausted statement (explanation of benefits) for MCO exhausted benefits.
- A statement from the MCO indicating the service is not a provided MCO benefit. If the MCO routinely does not provide a specific service (e.g., nursing facility, physical therapy, etc.), the non-benefit statement is optional. Benefit coverage may vary from one MCO to another.

MCO Benefits by Non-MCO Providers

Always contact the PHP before providing services to PHP clients to determine the billing procedures

The Colorado Medical Assistance Program will not pay claims for services provided to a MCO enrolled client that are available through the MCO. Providers should always contact the client's MCO before providing services to determine the extent of benefits available through the MCO. Direct questions about MCO covered benefits and billing instructions to the MCO listed on the eligibility verification response.

Emergency Care

Emergency care and out-of-area URGENT care provided by a non-MCO provider is the responsibility of the MCO. The non-MCO provider must comply with all MCO notification requirements.

- The non-MCO provider must contact the MCO within 48 hours of providing services.
- The non-MCO provider must contact the MCO for authorization before providing non-emergency services.
- The MCO may not pay for services determined to be non-emergent.

Inquiries

Inquiries about MCO payments or denials should be directed to the MCO.

Inquiries about claims submitted to the fiscal agent, Xerox State Healthcare at 1-800-237-0757, for exhausted MCO benefits or non-covered MCO services should be directed to the fiscal agent.

Program of All-Inclusive Care for the Elderly (PACE)

What is PACE?

The Program of All-Inclusive Care for the Elderly (PACE) is a Medicare/Medicaid managed care system that provides health care and support services to persons 55 years of age and older. The goal of PACE is to assist frail individuals to live in their communities as independently as possible by providing services depending on their needs. PACE-enrolled clients obtain **all** medical care services—acute as well as nursing facility care through the PACE provider. There are several PACE providers with service areas in the Denver Metropolitan area, and Delta, Montrose and El Paso Counties.

Who is Eligible?

- Persons age 55 or older.
- Persons must meet nursing facility level of care. This is determined by a State Medicaid agency.
- Persons must live in the area of the PACE organization.
- Persons must be able to live in a community setting without jeopardizing his or her health or safety.

PACE Benefits

All PACE providers provide adult day health care, home care, in-home support services, acute hospital care, and nursing facility care. A multidisciplinary team coordinates and plans all services based on each participant's individual medical and supportive care needs. The PACE PCP authorizes all health care services and supplies provided to PACE clients.

Services provided by hospitals, nursing facilities, medical specialists, and other selected health providers are delivered by contract between the service provider and the PACE site/provider.

The fiscal agent denies claims submitted for services to PACE clients.

Community Mental Health Services Program (Mental Health Program)

The Colorado Medical Assistance Program mental health benefits are provided through the Community Mental Health Services Program (Mental Health Program). State contracted Behavioral Health Organizations (BHOs), are responsible for Colorado Medical Assistance Program psychiatric benefit services provided to enrolled clients who reside in the BHOs geographical area. Mental health providers must apply to become a network provider with the BHO in their area. If the network is not accepting new providers, mental health providers are limited to providing services to Medicaid clients with diagnoses that are not covered under the BHO contract. The BHOs contact information is located in the Behavioral Health Organizations section of the Department's website at colorado.gov/hcpf.

Enrollment and Participation

Almost all Colorado Medical Assistance Program clients are enrolled in the Mental Health Program. Colorado Medical Assistance Program clients in the following aid categories are automatically enrolled in the Mental Health Program.

- Old Age Pension, Part A and Part B
- Aid to the Needy Disabled
- Aid to the Blind
- Temporary Aid to Needy Families
- Baby Care Kids Care
- Foster Care

Mental Health Program Benefits

The BHOs are responsible for the cost of mental health benefit services provided to enrolled clients in their geographical area.

Mental health providers should always determine Mental Health Program eligibility before providing services.

Note: The Colorado Medical Assistance Program does not pay FFS claims for Mental Health Program -covered benefits. The BHOs do not pay for unauthorized services.

All mental health services benefits for Mental Health Program clients must be obtained through the BHO (with the exception of Medicare-covered mental health services provided to Medicare/Colorado Medical Assistance eligible clients and emergency care as listed below).

Refer to Appendix T in the Department's Provider Services Billing Manuals section to determine if a specific procedure or diagnosis must be provided through the BHO.

Emergency Care

- Non-network providers who render emergency mental health services must bill the BHO.
- The non-network practitioner and the BHO negotiate payment rates and billing procedures.

- BHOs may deny payment for non-emergency services and follow up care provided without prior authorization from the BHO.

Client Enrollment

With the exception of some select populations/individuals, essentially all Colorado Medical Assistance Program clients are automatically enrolled in the Community Mental Health Program. Exceptions can found in the Code of Colorado Regulations 10 CCR 2505-10 8.212.

Medicare-Medicaid Enrollees

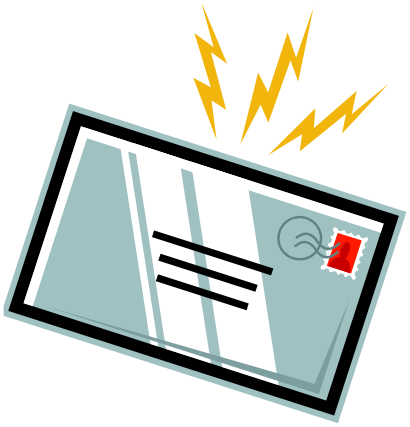
- Medicare-Medicaid enrollees may obtain Medicare-covered services from either BHO or non-BHO providers. The fiscal agent accepts and processes submitted Medicare crossover claims.
- If the mental health service is covered by the Colorado Medical Assistance Program only, the Medicare-Medicaid enrollee must obtain the service from the BHO.

Mental Health Program Non-included Services

- Mental health-related prescription drugs. Claims for prescription drugs are submitted to the Department's fiscal agent under the FFS Reimbursement Program or to the MCO for MCO-enrolled clients.
- Nursing facility residential care. Nursing facility claims are submitted to the Department's fiscal agent for FFS reimbursement.

  Services in a Residential Treatment Center (RTC). RTC claims are submitted to the Department's fiscal agent for FFS reimbursement.
- Claims submitted to the Department's fiscal agent, Xerox State Healthcare, should be addressed to:

Fiscal Agent for the Colorado Medical Assistance Program
Claims and PARs Submission
P.O. Box 30
Denver, CO 80201



School Health Services

The Colorado School Health Services Program is a state program that allows school districts and Boards Of Cooperative Education Services (BOCES) to access federal Medicaid funds for delivering Medicaid allowable school health services to Medicaid eligible children. Reimbursement received by a district through the School Health Services Program shall be used by the district to provide additional and expanded health services.

School Health Services Program Manual

For an in depth look at the policy requirements of Medicaid School Health Services Program please refer to the School Health Services Program Manual that is located on the Department's Web Site. The manual includes information on covered services, provider enrollment, random moment time study, reimbursement and administrative claiming.

Prior authorization requirements

There are no prior authorization requirements for School Health Services.

Procedure Codes

The School Health Services Program uses procedure codes that are approved by the Centers for Medicare & Medicaid Services (CMS). The codes are used for submitting claims for services provided to Colorado Medical Assistance Program clients and represent services that may be provided by enrolled certified Colorado Medical Assistance Program providers.

The Healthcare Common Procedural Coding System (HCPCS) is divided into two principal subsystems, referred to as level I and level II of the HCPCS. Level I of the HCPCS is comprised of Current Procedural Terminology (CPT), a numeric coding system maintained by the American Medical Association (AMA). The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter followed by 4 numeric digits, while CPT codes are identified using 5 numeric digits.
Valid codes and descriptions for the School Health Services Program are listed below.

PROCEDURE CODE	PROCEDURE CODE DESCRIPTIONS	MODIFIER	
		1	2
Behavioral Health Services			
96150	Mental Health/Behavioral Assessment – LPC/MFT		
96150	Mental Health/Behavioral Assessment – PSY	AH	
96150	Mental Health/Behavioral Assessment – SW	AJ	
96151	Mental Health/Behavior Re-Assessment – LPC/MFT		
96151	Mental Health/Behavior Re-Assessment – PSY	AH	
96151	Mental Health/Behavior Re-Assessment – SW	AJ	
H0004	Behavioral Health Counseling/Therapy – LPC/MFT		
H0004	Behavioral Health Counseling/Therapy – PSY	AH	
H0004	Behavioral Health Counseling/Therapy – SW	AJ	
H0004	Behavioral Health Counseling/Therapy, Group – LPC/MFT	HQ	
H0004	Behavioral Health Counseling/Therapy, Group – PSY	AH	HQ
H0004	Behavioral Health Counseling/Therapy, Group – SW	AJ	HQ
Motor Therapy Services			
97001	Physical Therapy Evaluation (1 unit per evaluation)		
97002	Physical Therapy Re-Evaluation (1 unit per evaluation)		
97110	Physical Therapy – PT	GP	
97110	Physical Therapy – PTA	HM	
97150	Physical Therapy, Group – PT	GP	
97150	Physical Therapy, Group – PTA	HM	
97003	Occupational Therapy Evaluation (1 unit per evaluation)		
97004	Occupational Therapy Re-Evaluation (1 unit per evaluation)		
97530	Occupational Therapy – OT	GO	
97530	Occupational Therapy –COTA	HM	
97139	Occupational Therapy, Group – OT	GO	
97139	Occupational Therapy, Group – COTA	HM	
T1023	Orientation & Mobility Evaluation		

PROCEDURE CODE	PROCEDURE CODE DESCRIPTIONS	MODIFIER	
		1	2
T1023	Orientation & Mobility Re-Evaluation	52	
97116	Gait Training (O&M only)		
97116	Gait Training, Group (O&M only)	HQ	
97533	Sensory Integration (O&M only)		
97533	Sensory Integration, Group (O&M only)	HQ	
Nursing Services			
T1001	Nursing Assessment/Evaluation (RN only)		
T1002	RN Services, Up To 15 Min		
T1002	RN Services, Group, Up To 15 Min	HQ	
T1003	LPN Services, Up To 15 Min (delegated RN service)		
T1003	LPN Services, Group, Up To 15 Min (delegated RN service)	HQ	
T1004	Qualified Nursing Aide, Up To 15 Min (delegated RN service)		
T1004	Qualified Nursing Aide, Group, Up To 15 Min (delegated RN service)	HQ	
Personal Care Services			
T1019	Personal Care Services, Individual (per 15 minutes)		
S5125	Personal Care Services, Group (per 15 min) – Safety/Behavior Monitoring Only		
Physician Services			
99201	New Patient Evaluation and Management (10 minutes)		
99202	New Patient Evaluation and Management (20 minutes - expanded)		
99203	New Patient Evaluation and Management (30 minutes - detailed)		
99204	New Patient Evaluation and Management (45 minutes - comprehensive)		
99205	New Patient Evaluation and Management (60 minutes – high complexity)		
99212	Established Patient Eval/Management (10 minutes – straightforward)		
99213	Established Patient Eval/Management (15 minutes – low complexity)		
99214	Established Patient Eval/Management (25 minutes – moderate complexity)		

PROCEDURE CODE	PROCEDURE CODE DESCRIPTIONS	MODIFIER	
		1	2
99215	Established Patient Eval/Management (40 minutes – high complexity)		
Speech and Audiology Services			
92506	Speech Evaluation – SLP	GN	
92507	Speech Language Therapy, Individual		
92508	Speech Language Therapy, Group		
V5008	Audiology Screening/Evaluation (Audiologist only)		
V5299	Audiology Services		
V5299	Audiology Services, Group	HQ	
Targeted Case Management Services			
T1017	Targeted Case Management		
Transportation Services			
T2001	Non-Emergency Transportation - Patient Attendant/Escort/Aide (per 15 minutes)		
T2001	Non-Emergency Transportation, Group - Patient Attendant/Escort/Aide (per 15 minutes)	HQ	
T2003	Non-Emergency Transportation – Trip Encounter (per one-way trip)		

Acronyms

SLP - Speech Language Pathologist

LPC - Licensed Practical Counselor

MFT - Marriage & Family Therapist

PSY - Psychologist

SW - Social Worker

OT - Occupational Therapist

RN - Registered Nurse

LPN - Licensed Practical Nurse

PT - Physical Therapist

PTA - Physical Therapy Assistant

OT - Occupational Therapist

COTA - Certified Occupational Therapy Assistant

Paper Claim Reference Table

The paper claim reference table lists required and conditional fields for the Colorado 1500 paper claim form for School Health Services. For complete Colorado 1500 paper claim instructions, see the Paper Claim Instructional Reference in the Colorado 1500 General Billing Information manual.

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

School Health Services' claims shall be billed as a single date of service, using the specific date a service is provided. Use number of units to identify repeated services by the same provider, on the same date.

Field Label	Special Instructions
1. Client Name	Required
2. Client Date of Birth	Required
3. Medicaid ID Number (Client ID Number)	Required
5. Client Sex	Required
6. Medicare ID Number	Conditional Complete if the client is eligible for Medicare benefits.
7. Client Relationship to Insured	Conditional Complete if the client is covered by a commercial health care insurance policy.
8. Client Is Covered By Employer Health Plan	Conditional Complete if the client is covered by an employer health plan as policyholder or dependent.
9. Other Health Insurance Coverage	Conditional Complete if the client has commercial health insurance coverage.
9A. Policyholder Name and Address	Conditional Complete if the client has commercial health insurance.
10. Was Condition Related To	Conditional Complete if the condition being treated is a result of employment, an automobile accident, or other accident.
11. CHAMPUS Sponsors Service/SSN	Conditional Complete if the client is covered under the Civilian Health And Medical Plan of the Uniformed Services (CHAMPUS).

Field Label	Special Instructions
12. Pregnancy	Conditional Complete if the client is in the maternity cycle (Pregnant or within 6 weeks postpartum).
HMO	Conditional Complete if the client is enrolled in a Colorado Medical Assistance Program Managed Care Organization (MCO).
NF	Conditional Complete if the client is a nursing facility resident.
14. Medicare Denial	Conditional Complete if the client has Medicare coverage and Medicare denied benefits or does not cover the billed services
14A. Other Coverage Denied	Conditional Complete if the client has commercial health insurance coverage.
15. Name of supervising physician	Conditional Complete if the individual who performs the service (rendering provider) is a non-physician practitioner who requires on-premises supervision by a licensed physician.
16. For services related to hospitalization	Conditional Complete for services provided in an inpatient hospital setting.
17. Name and address of facility where services rendered	Conditional Complete for services provided in a hospital or nursing facility.
Provider Number	Conditional Complete for services provided in a hospital or nursing facility.
17A. Check box if laboratory work performed outside physician office	Conditional Complete if all laboratory work was referred to and performed by an outside laboratory.
18. ICD-9-CM	Required
19A. Date of Service	Required
19B. Place of Service	Required
19C. Procedure Code (HCPCS)	Required
Modifiers	Conditional Complete if a modifier applies to the billed procedure.
19D. Rendering Provider Number	Required

Field Label	Special Instructions
19E. Referring Provider Number	Conditional Complete for clients enrolled in the Primary Care Physician (PCP) program if: The rendering or billing provider is not the primary care provider - and The billed service requires PCP referral.
19F. Diagnosis	Required
19G. Charges	Required
19H. Days or Units	Required
19I. COPAY	Conditional Complete if co-payment is required of this client for this service.
19J. Emergency	Conditional Complete if the service is rendered for a life-threatening condition or one that requires immediate medical intervention.
19K. Family Planning	Conditional Complete if the service is rendered for family planning.
19L. EPSDT	Conditional Complete if the service is provided as a follow-up to or referral from an EPSDT screening examination.
20. Total Charges	Required
21. Medicare Paid	Conditional Complete for Medicare crossover claims.
22. Third Party Paid	Conditional Complete if the client has commercial health insurance and the third party resource has made payment on the billed services.
23. Net Charge	Required
24. Medicare Deductible	Conditional Complete for Medicare crossover claims.
25. Medicare Coinsurance	Conditional Complete for Medicare crossover claims.
26. Medicare Disallowed	Conditional Complete for Medicare crossover claims.
27. Signature	Required
28. Billing Provider Name	Required
29. Billing Provider Number	Required

Field Label	Special Instructions
30. Remarks	Conditional As an example, use to document the Late Bill Override Date (LBOD) for timely filing.

Colorado 1500 Specialty Manuals Revisions Log

Revision Date	Section/Action	Pages	Made by
03/09/2007	*EPSDT – Replaced Immunization Schedules*	*28-31*	*jg*
03/09/2007	*Medical/Surgical – Corrected crossover claim*	*62*	*jg*
03/09/2007	*Obstetrical Care – Updated PE information*	*71*	*jg*
03/09/2007	*Outpatient Substance Abuse Treatment – Added no PCP referral required*	*99*	*jg*
03/09/2007	*Outpatient Substance Abuse Treatment – Updated claim example*	*106*	*jg*
03/29/2007	*Outpatient Substance Abuse Treatment – Corrected typo on page 100*	*100*	*jg*
03/30/2007	*Updated Appendices references*	*Throughout*	*jg*
09/10/2007	*Outpatient Substance Abuse Treatment – Added procedure codes on page 104*	*104*	*jg*
09/21/2007	*Added Telemedicine section*	*133-141*	*jg*
11/29/2007	*Corrected Telemedicine Originator claim example*	*140*	*jg*
11/30/2007	*Obstetrical Care – Changed MID to MIC*	*67*	*jg*
03/18/2008	*EPSDT – Revised Immunization Schedule statement*	*23*	*jg*
04/15/2008	*PT/OT/S&LT – Updated introduction and Benefits and Limitations*	*79-80*	*jg*
05/22/2008	*PACE – Updated information*	*65*	*jg*
02/04/2010	*Updated TOC and Web site links*	*1-4, Throughout*	*jg*
02/26/2010	*Verified TOC and Relabeled Telemedicine claim examples*	*1-4 136 & 137*	*jg*
03/29/2010	*Change field number for Client Sex from 4 to 5*	*101*	*jg*
07/01/2011	*Removed the completed specialty manuals (Audiology, ASCs, EPSDT, Independent Lab, Medical/Surgical Services, OP Substance Abuse Treatment, Supplies & DME, Telemedicine and Vision and Eyewear)* *Spelled out Colorado 1500* *Updated PE reference* *Updated narrative for codes 59400 & 59510* *Updated narrative for codes 59410 &59409* *Added X for 4th & 5th digit in diagnosis examples* *Deleted code example in second sentence under anesthesia* *Deleted and added new code 99460-99463 range in first paragraph under Examination and evaluation of healthy newborn*	*Throughout* *TOC* *10* *11* *12* *13* *14* *16*	*dc*

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07/01/2011	*Deleted instructions and added no longer a benefit criteria under Routine or ritual circumcision, added code 54161* *Deleted and added new code 99465 under Newborn resuscitation or care of the high risk newborn at delivery* *Spelled out Colorado in 1500 Paper Claim Reference Table* *Deleted last sentence in under Paper Claim Reference Table and spelled out Colorado 1500 for TRCCF required fields* *Spelled out Colorado 1500* *Spelled out Colorado 1500 on Transportation Claim example* *Changed the UB92 to UB-04 on the Paper UB-04 Transportation Instructional Reference* *Renamed the Form Locator and Label names for numbers: 1, 6, 8b, 9a, 10, 11, 18-28, 42, 45, 46, 50, 60, 67, 76* *Deleted 82, 85, and 86 as form locators* *Added the Institutional Provider Certification*	*17* *17* *42* *42* *56* *59* *62* *62* *63* *65*	*dc*
01/31/2012	*Changed authorizing agent to authorizing agency*	*50, 51, 53, 54, 57*	*jg*
09/18/2012	*Added link to Colorado Access* *Changed link from Billing Information to Colorado 1500 General Billing Information in Paper Claim Reference Table descriptions* *Updated RCCF claim form* *Added UB-04 Transportation Claim example*	*1* *18, 27, 32 & 49* *35* *57*	*jg*
09/26/2012	*Updated Transportation claim examples*	*52-54*	*cc*
09/28/2012	*Added new Colorado 1500 Transportation claim examples* *Checked formatting* *Updated TOC*	*50-52* *All* *i & ii*	*jg*
12/05/2012	*Replaced Dually Eligible with Medicare-Medicaid enrollee*	*9*	*jg*
03/03/2013	*Removed RCCF Program information into the RCCF Billing Manual*	*31-36*	*cc*
07/26/2013	*Updated BHO information per Provider Enrollment documents*	*8-11*	*cc*
09/27/2013	*Added links to the MED-178 instructions and form*	*15*	*cc*
10/14/2013	*Removed Department's Customer Service 303-866-3513 number*	*4*	*jg*
01/25/2014	*Removed Obstetrical Care – Moved to the Obstetrical Care Billing Manual*	*10-22*	*jg*
01/27/2014	*Removed Tranportation – Moved to Transportation Manual*	*18-38*	*jg*

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