

# Early Intervention Program

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# **Program Overview**

## **Early Intervention Services (EI)**

Early Intervention Services provides developmental supports and services to children birth to three (3) years of age who have either a significant developmental delay or a diagnosed condition that has a high probability of resulting in a developmental delay and are determined to be eligible for the program.

Targeted Case Management (TCM) Services are provided through the Community Centered Boards (CCB) for children actively enrolled in Early Intervention Services program and the Colorado Medical Assistance Program.



## **Allowable Early Intervention Services**

### **General Definition**

Allowable Early Intervention Services are those services that are:

1. Designed to meet the developmental needs of an infant or toddler with a significant developmental delay or the needs of the family related to enhancing the infant's or toddler's development;
2. Selected in collaboration with the infant's or toddler's family;
3. Provided in conformity with an Individualized Family Service Plan (IFSP);
4. Based on appropriate evidence-based practices and related to functional outcomes;
5. Provided under public supervision to assure, through monitoring, that services are provided in accordance with these requirements;
6. Provided by qualified personnel as defined in Colorado's Part C State Plan;
7. Provided in the natural environments of the infant or toddler and the family including the family's home and/or community settings in which infants and toddlers without disabilities participate, unless otherwise justified on the IFSP; and
8. Provided in a culturally relevant manner, including the use of an interpreter if needed.

### **Role of Service Providers**

All Early Intervention service providers are responsible for:

1. Consulting with parents, service coordinators, other service providers and representatives of other community agencies where the infant or toddler participates to ensure the effective provision and coordination of Early Intervention Services;
2. Billing Medicaid appropriately for services rendered when the service is a benefit of Colorado Medicaid.
3. Completing all required Prior Authorization requests for Medicaid covered services in a timely manner;
4. Collaborating with service coordinators when recommending referrals for other professional services.

## Allowable Early Intervention Providers

Community Centered Boards (CCBs) can become billing agents, if they choose, for EI service providers. The Department does not regulate who can act in the capacity of billing agent. To bill a fee-for-service code, the provider must be approved to provide that service.

Once the provider has provided a service, the billing agent can bill using the rendering provider's Medicaid NPI number in both the billing and rendering fields. The CCBs cannot pay additional money to the providers for the service that they are billing Medicaid for (e.g. if the reimbursement for a code is \$60 from Medicaid and the CCB generally pays \$75 to non-Medicaid providers, they can't pay the \$15 difference to the provider). When a provider signs up to become a Medicaid provider, he/she signs a contract agreeing to accept the Medicaid payment for the services he/she bills. However, if the CCB wants to pay for additional services not covered by Medicaid, such as transportation to and/or from the member's house that is up to each CCB and provider to decide between them.

Medicaid does not regulate who can fill out the provider application. CCB staff can choose to fill out the Medicaid application for providers. The provider is still responsible for reading the application and signing it.

## Targeted Case Management (TCM)

Targeted Case Management is an optional Colorado Medical Assistance Program benefit for members who have been determined by a CCB to have a developmental disability and are actively enrolled in Early Intervention Services. The purpose of case management is:

- ✓ Facilitate Enrollment
- ✓ Service Plan Development
- ✓ Service Monitoring
- ✓ Coordination of Services/Benefits which include but is not limited to: Educational; Mental Health; Emotional; Social; Medical
- ✓ Ensure Non Duplication of Services

These activities include, but are not limited to:

- Locating, coordinating, and monitoring needed developmental disabilities services;
- Coordinating with other non-developmental disabilities funded services to ensure non-duplication of services; and
- Monitoring the effective and efficient provision of services across multiple funding sources.

Activities will not:

- ✓ Restrict members to a limited provider set. Members may choose any willing Medicaid provider for Medicaid services.
- ✓ Limit case management services provided in a manner consistent with the member's best interest.
- ✓ Be used to restrict a member's access to other services.
- ✓ Compel members to receive case management services.
- ✓ Be used as a reason for case managers to deny other State Plan services.

## Billable Activities

### Comprehensive Assessment and Periodic Reassessment

- ✓ Determine need for: Medical, Educational, Social, or other EI Services

### Service Plan Development based on information collected through assessment

- ✓ Specifies goals for meeting all service needs
- ✓ Activities to ensure member participation
- ✓ Work with individual and others to develop goals

### Service and Support Coordination

- ✓ Coordination of the services being provided in the Service Plan to ensure continuity of service provision
- ✓ Help individuals obtain needed services and activities and link them to the appropriate provider

### Activity TCM activity that is being performed

- ✓ Multiple related activities or activities performed within a single day should be entered into a single log note
- ✓ Must be a billable activity
- ✓ Type of contact can be Direct or Indirect, however, length of activity must be at least 7.5 minutes in order to bill one unit. Voice mails left or received or emails sent and received are not an acceptable way to bill for one unit.

## Non-Reimbursable Targeted Case Management Services

Activities that may be a service coordination responsibility, but are not reimbursed as TCM services are those activities either paid through the "Early Intervention Contract," personnel costs, indirect costs, a service to be paid by third party or activities that are built into the rate structure for TCM services. The list below is not exhaustive:

- Intake and initial eligibility determination for the EI Colorado Program;
- Preparation for and participation in the dispute resolution processes in accordance with Federal Part C Regulations of the IDEA (34 C.F.R. Part 303) procedural safeguards;
- Assessment costs for determining the individual's need for a physical or psychological examination or evaluation;
- Payment for the costs of the administration of other services or programs to which a recipient is referred (e.g. educational services), general administrative programs of the Medicaid program;
- The provision of any medical treatment or service;
- Service coordination staff meetings not related to individual child and family reviews;
- Completing time sheets or billing documents; billing Medicaid for services which are included in the cost of doing normal business;
- Discharge planning from an institution or hospital;
- Administrative activities such as eligibility determination, screening, intake outreach and utilization review;
- Care coordination or case management activities covered by Medicaid in the ACC and Healthy Communities programs;
- Formal policy advocacy and developing new provider resources;

- Service coordination training and personnel development;
- Prior authorization of services;
- Recreational events provided by the Broker when no service coordination activity is provided;
- Fund raising activities for the Broker.
- Voice mail messages (should be combined together with other approved activities to form one note);
- Multiple case managers or supervisors in a single meeting, only one person can bill for the meeting.
- Supervisors cannot bill for TCM time, only a service coordinator can bill for TCM services

## **Other Medicaid Covered Services**

Other services which can be billed to Medicaid include, but are not limited to:

- ✓ Occupational Therapies
- ✓ Physical Therapies
- ✓ Speech Therapies
- ✓ Assistive Technology
- ✓ Audiology or hearing services
- ✓ Developmental Screenings, including but not limited to: the M-CHAT and Ages and Stages

These Medicaid covered services should always be billed to Medicaid by a contracted Colorado Medicaid provider. Any Medicaid covered services must be billed prior to accessing CORE Early Intervention dollars for the same services. Please visit our website at [www.colorado.gov/pacific/hcpf/billing-manuals](http://www.colorado.gov/pacific/hcpf/billing-manuals) for the billing instructions for these and other covered services.

## **Natural Environments**

Part C of IDEA requires *"to the maximum extent appropriate to the needs of the child, early intervention services must be provided in natural environments, including the home and community settings in which children without disabilities participate."* (34 CFR §303.12(b))

By definition, natural environments mean *"settings that are natural or normal for the child's age peers who have no disabilities."* (34 CFR §303.18)

The exception to the rule reads *"the provision of early intervention services for any infant or toddler with a disability occurs in a setting other than a natural environment that is most appropriate, as determined by the parent and the individualized family service plan team, only when early intervention cannot be achieved satisfactorily for the infant or toddler in a natural environment."*

The provision of early intervention services taking place in natural environments is not just a guiding principle or suggestion, it is a legal requirement.

# 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, or
- Reconsideration claims.

For more detailed CMS 1500 billing instructions, please refer to the CMS 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 CMS 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 members. 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.

## Early Intervention Procedure Code Table

Providers may bill procedure codes for Early Intervention Services as follows:

*It is important to remember that State General Funds and Federal Part C Funds can be used for the reimbursement of provider travel time when billing Medicaid. Generally provider's travel time is included in their negotiated hourly rate, however, in situations where providers are being asked to travel significant distances the Community Centered Board may decide to reimburse this cost to providers. This would be considered a related cost aligned with the service.*

<b>Early Intervention (Special Code 87)</b>			
<b>Description</b>	<b>Proc Code</b>	<b>Modifier(s)</b>	<b>Notes</b>
Any Medicaid service provided to a child enrolled in Early Intervention	all	TL	All services should be billed with the addition of the TL modifier. This is for identification purposes only. IFSP should be submitted along with any PAR request filed for services.

## TCM Procedure Code Table

<b>Targeted Case Management- Early Intervention (Special Code 87)</b>			
<b>Description</b>	<b>Proc Code</b>	<b>Modifier(s)</b>	<b>Unit Designation</b>
Targeted Case Management – Early Intervention Services	<b>T1017</b>	TL	15 Minutes – the use of the modifier here is required and is not solely for identification purposes.

## Early Intervention Paper Claim Reference Table

The following paper form reference table describes required fields for the paper CMS 1500 claim form for Early Intervention 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 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	None
<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.

Field Label	Completion format	Special Instructions
<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.
<b>7. Client relationship to insured</b>	Check box Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	Not Required
<b>8. Client is covered by Employer Health Plan</b>	Text	Not required
<b>9. Other Health Insurance Coverage</b>	Text	Not required but must be used if there is other health insurance coverage

Field Label	Completion format	Special Instructions
<b>10. 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
<b>11. CHAMPUS Sponsors Service/SSN</b>	10 digits	Not required
<b>Durable Medical Equipment Model/serial number (unlabeled field)</b>	20 characters	Not required
<b>12. 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
<b>13. Date of illness or injury or pregnancy</b>	6 digits: MMDDYY	Not required
<b>14. 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 but must be used to show that private primary insurance was billed for the services and that they were approved or denied
<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-10-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. If none available EI must Enter 7999
<b>Diagnosis or nature of illness or injury</b>	Text	Not required
<b>Transportation Certification attached</b>	Check box	Not required

Field Label	Completion format	Special Instructions																		
<b>Prior authorization No.</b>	6 characters: Letter plus 5 digits	<p>Conditional</p> <p>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.</p> <p>Complete when the service requires prior authorization</p>																		
<b>19A. Date of Service</b>	<p>From: 6 digits MMDDYY</p> <p>To: 6 digits 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 1062 1224 1115"> <tr> <td>01</td> <td>01</td> <td>16</td> <td></td> <td></td> <td></td> </tr> </table> <p>Or</p> <p>From To</p> <table border="1" data-bbox="889 1262 1224 1314"> <tr> <td>01</td> <td>01</td> <td>16</td> <td>01</td> <td>01</td> <td>16</td> </tr> </table> <p>Span dates of service</p> <table border="1" data-bbox="889 1377 1224 1430"> <tr> <td>01</td> <td>01</td> <td>16</td> <td>01</td> <td>31</td> <td>16</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	16				01	01	16	01	01	16	01	01	16	01	31	16
01	01	16																		
01	01	16	01	01	16															
01	01	16	01	31	16															
<b>19B. Place of Service</b>	2 digits	<p>Required</p> <p>Enter place of service code <b>12</b> – Home</p>																		

Field Label	Completion format	Special Instructions						
<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 EI procedure code tables.						
<b>Mod(ifier)</b>	2 characters: Letters or digits May enter up to two, 2 character, modifiers	Required TL required on all Early Intervention requests						
<b>19D. Rendering Provider No.</b>	8 digits	Not required						
<b>19E. Referring Provider No.</b>	8 digits	Not required						
<b>19F. Diagnosis</b> Each billed line must have at least one primary diagnosis referenced.	<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="padding: 2px;"><b>P</b></td> <td style="padding: 2px;"><b>S</b></td> <td style="padding: 2px;"><b>T</b></td> </tr> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table> 1 digit per column	<b>P</b>	<b>S</b>	<b>T</b>				Required At least one diagnosis code must be entered. Enter up to four diagnosis codes starting at the far left side of the coding area. Do not enter the decimal point. Do not enter zeros to fill the spaces when the diagnosis code is fewer than 5 digits. From field 18                      To field(s) 19F 1   7   9   9   9                        ↓ 2                   <b>P   S   T</b> 3                                        Line 1   1           4                                        Line 2   1           <span style="margin-left: 150px;">Line 3   1          </span>
<b>P</b>	<b>S</b>	<b>T</b>						

Field Label	Completion format	Special Instructions
<b>19G. Charges</b>	7 digits: Currency 99999.99	<p>Required</p> <p>Enter the usual and customary charge for the service represented by the procedure code on the detail line.</p> <p>Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one procedure from the same group is billed, special multiple pricing rules apply.</p> <p>The base procedure is the procedure with the highest allowable amount. The base code is used to determine the allowable amounts for additional CPT surgical procedures when more than one procedure from the same grouping is performed.</p> <p>Submitted charges cannot be more than charges made to non-Colorado Medical Assistance Program covered individuals for the same service.</p> <p>Do not deduct Colorado Medical Assistance Program co-payment or commercial insurance payments from usual and customary charges.</p>
<b>19H. Days or Units</b>	4 digits	<p>Required</p> <p>Enter the number of services provided for each procedure code.</p> <p>Enter whole numbers only.</p> <p>Do not enter fractions or decimals.</p> <p>See special instructions for Anesthesia and Psychiatric services.</p>
<b>19I. Copay</b>	1 digit	<p>Conditional</p> <p>Complete if co-payment is required of this client for this service. Enter one of the following codes:</p> <p>1-Refused to pay co-payment 2-Paid co-payment 3- Co-payment not requested</p>

Field Label	Completion format	Special Instructions
<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></p> <p>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></p> <p>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.</p> <p>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>

# Early Intervention Claim Example



## HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> <input type="checkbox"/> PICA										PICA <input type="checkbox"/> <input type="checkbox"/>									
1. MEDICARE (Medicare #) <input checked="" type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE (ID#/DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>A123456</b>									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Client, Ima A</b>										3. PATIENT'S BIRTH DATE MM DD YY <b>10 16 15</b> SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ( )										4. INSURED'S NAME (Last Name, First Name, Middle Initial) 6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME										8. RESERVED FOR NUCC USE 10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? PLACE (State) YES <input type="checkbox"/> NO <input type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. RESERVED FOR LOCAL USE									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED <b>Signature on File</b> DATE <b>1/1/16</b>										7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ( ) 11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>If yes, complete items 9, 9a and 9d.</i>									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI										15. OTHER DATE MM DD YY QUAL 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind <b>0</b> A. <b>G80.9</b> B. C. D. E. F. G. H. I. J. K. L.										19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES 22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER										F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #									
1 <b>01 01 16 01 01 16 12 T1017 A \$100 00 1 NPI 12345678 0123456789</b>										25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. <b>Optional</b> 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 28. TOTAL CHARGE \$ <b>100 00</b> 29. AMOUNT PAID \$ 30. Rsvd for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED <b>Signature</b> DATE <b>1/1/16</b>										32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH# ( ) <b>Provider</b> <b>100 Any Street</b> <b>Any City</b> a. <b>0123456789</b> b. <b>04567890</b>									

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

## **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
<p><b>LBOD Completion Requirements</b></p>	<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 six 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>CMS 1500</i>: Indicate "LBOD" and the date in box 19 – Additional Claim Information.</li> <li>➢ <i>2006 ADA Dental</i>: Indicate "LBOD" and the date in box 35 - Remarks</li> </ul> </li> </ul>
<p><b>Adjusting Paid Claims</b></p>	<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>
<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>

<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>

<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>



## Early Intervention Specialty Manuals Revisions Log

<i><b>Revision Date</b></i>	<i><b>Section/Action</b></i>	<i><b>Pages</b></i>	<i><b>Made by</b></i>
06/16/2016	Publish first version		GR