

Hospice Care

Hospice

Providers must be enrolled as a Colorado Medical Assistance Program provider in order to:

- Treat a Colorado Medical Assistance Program client
- Submit claims for payment to the Colorado Medical Assistance Program

Hospice services are available to Colorado Medical Assistance Program clients with a terminal illness (life expectancy of six months or less). The palliative treatment includes services and interventions that are not curative but provide the greatest degree of relief and comfort for the symptoms of the terminal illness.



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

Billing Information

National Provider Identifier (NPI)

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

Paper Claims



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

- Claims from providers who consistently submit 5 claims or fewer per month (requires prior 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. In addition, the UB-04 Certification document must be completed and attached to all claims submitted on the paper UB-04. 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 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.

Interactive Claim Submission and Processing

Interactive claim submission through the Web Portal is a real-time exchange of information between the provider and the Colorado Medical Assistance Program. Colorado Medical Assistance Program providers may create and transmit HIPAA compliant 837P (Professional), 837I (Institutional), and 837D (Dental) claims electronically one at a time. These claims are transmitted through the Colorado Medical Assistance Program OnLine Transaction Processor (OLTP).



The Colorado Medical Assistance Program OLTP reviews the claim information for compliance with Colorado Medical Assistance Program billing policy and returns a response to the provider's personal computer about that single transaction. If the claim is rejected, the OLTP sends a rejection response that identifies the rejection reason.

If the claim is accepted, the provider receives an acceptance message and the OLTP passes accepted claim information to the Colorado Medical Assistance Program claim processing system for final adjudication and reporting on the Colorado Medical Assistance Program Provider Claim Report (PCR).



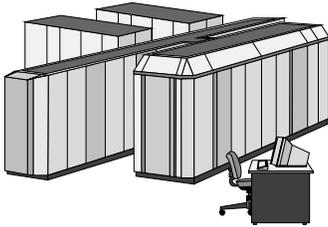
The Web Portal contains online training, user guides and help that describe claim completion requirements, a mechanism that allows the user to create and maintain a data base of frequently used information, edits that verify the format and validity of the entered information, and edits that assure that required fields are completed.

Because a claim submitter connects to the Web Portal through the Internet, there is no delay for "dialing up" when submitting claims. The Web Portal provides immediate feedback directly to the submitter. All claims are processed to provide a weekly Health Care Claim Payment/Advice (Accredited Standards Committee [ASC] X12N 835) transaction and/or Provider Claim Report to providers. The Web Portal also provides access to reports and transactions generated from claims submitted via paper and through electronic data submission methods other than the Web Portal. The reports and transactions include:

- Accept/Reject Report
- Provider Claim Report
- Health Care Claim Payment/Advice (ASC X12N 835)
- Managed Care Reports such as Primary Care Physician Rosters
- Eligibility Inquiry (interactive and batch)
- Claim Status Inquiry

Claims may be adjusted, edited and resubmitted, and voided in real time through the Web Portal. Access the Web Portal through Secured Site at colorado.gov/hcpf. For help with claim submission via the Web Portal, please choose the *User Guide* option available for each Web Portal transaction. For additional electronic billing information, please refer to the appropriate Companion Guide located in the Provider Services [Specifications](#) section.

Batch Electronic Claims Submission



Batch billing refers to the electronic creation and transmission of several claims in a group. Batch billing systems usually extract information from an automated accounting or patient billing system to create a group of claim transactions. Claims may be transmitted from the provider's office or sent through a billing vendor or clearinghouse.

All batch claim submission software must be tested and approved by the Colorado Medical Assistance Program fiscal agent.

Any entity sending electronic claims to ACS Electronic Data Interchange (EDI) Gateway for processing where reports and responses will be delivered must complete an EDI enrollment package. This provides ACS EDI Gateway the information necessary to assign a Logon Name, Logon ID, and Trading Partner ID, which are required to submit electronic claims. You may obtain an EDI enrollment package by contacting the Medical Assistance Program fiscal agent or by downloading it from the Provider Services [EDI Support](#) section.

The X12N 837 Professional, Institutional, or Dental transaction data will be submitted to the EDI Gateway, which validates submission of American National Standards Institute (ANSI) X12N format(s). The TA1 Interchange Acknowledgement reports the syntactical analysis of the interchange header and trailer. If the data is corrupt or the trading partner relationship does not exist within the Medicaid Management Information System (MMIS), the interchange will reject and a TA1 along with the data will be forwarded to the ACS State Healthcare Clearinghouse (SHCH) Technical Support for review and follow-up with the sender. An X12N 999 Functional Acknowledgement is generated when a file that has passed the header and trailer check passes through the ACS SHCH.

If the file contains syntactical error(s), the segment(s) and element(s) where the error(s) occurred will be reported. After validation, the ACS SHCH will then return the X12N 835 Remittance Advice containing information related to payees, payers, dollar amount, and payments. These X12N transactions will be returned to the Web Portal for retrieval by the trading partner, following the standard claims processing cycle.

Testing and Vendor Certification

Completion of the testing process must occur prior to submission of electronic batch claims to ACS EDI Gateway. Assistance from ACS EDI business analysts is available throughout this process. Each test transmission is inspected thoroughly to ensure no formatting errors are present. Testing is conducted to verify the integrity of the format, not the integrity of the data; however, in order to simulate a production environment, EDI requests that providers send real transmission data.

The number of required test transmissions depends on the number of format errors on a transmission and the relative severity of these errors. Additional testing may be required in the future to verify any changes made to the MMIS system have not affected provider submissions. Also, changes to the ANSI formats may require additional testing.

In order to expedite testing, ACS EDI Gateway requires providers to submit all X12N test transactions to EDIFECS prior to submitting them to ACS EDI Gateway. The EDIFECS service is free to providers to certify X12N readiness. EDIFECS offers submission and rapid result turnaround 24 hours a day, 7 days a week. For more information, go to <http://www.edifecs.com>.



Hospice Benefits

The client may receive Colorado Medical Assistance Program Hospice Benefit (MHB) services in a:



- Private residence
- Residential care facility (Alternative Care)
- Licensed hospice facility
- Intermediate Care Facility for the Mentally Retarded (ICFMR)
- Skilled Nursing Facility (SNF)
- Nursing Facility (NF)

Colorado Medical Assistance Program Hospice Benefit clients residing in a nursing facility must meet hospice level of care and financial Colorado Medical Assistance Program eligibility criteria.

Hospice SNF/NF room and board reimbursement is made to the hospice provider for each home care level day (routine or continuous care).

- The client must choose MHB services.
- The client's attending physician must certify that the client is terminal.
- Both the client and the attending physician must agree to the plan of care developed by the hospice provider.
- A participating MHB provider must provide all MHB services.
- Hospice services are co-payment exempt.
- Physician services are not a covered MHB; they are billed by the physician as a regular physician service.
- The SNF/NF provides the hospice with the room and board per diem amount for hospice clients residing in an SNF/NF. The hospice bills room and board on behalf of the client to the Colorado Medical Assistance Program which reimburses 95% of the per diem amount. and the hospice passes the room and board payment through to the SNF/NF.



The patient liability amount may apply when a hospice client resides in a NF. This is payment made by the client for NF care, after the personal needs allowance and other approved expenses are deducted from client income. The personal needs allowance and other approved deductions are determined by County Income Maintenance Technicians. The patient liability amount must be applied to the client's care.

When reporting the patient liability amount for the entire month, regardless of the number of days in that month, apply the total patient liability.

Example:

Bill the full \$100.00 (Per Diem Rate) amount

The processing system automatically deducts 5% – $\$100 \times .95 = \95.00

$\$95.00 \times 31 = \$2,945.00$

$\$2,945.00 - \$500.00 = \$2,445.00$ (NF R & B)

$\$2,445.00 + \$3,500.00$ (routine home care amount) = \$5,945.00 Total Reimbursement.



42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NONCOVERED CHARGES	49
651	Hospice Routine Home Care		01/01/08	31	3500.00		
659	Nursing Facility R & B Per Diem		01/01/08	31	3100.00		
TOTALS					6600.00		

50 PAYER NAME D - Medicaid	51 HEALTH PLAN ID 12345678	52 REL INFO	53 ADJ BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE 6100.00	56 NPI	57 OTHER PRV ID
58 INSURED'S NAME Client, Ima D.	59 P REL	60 INSURED'S UNIQUE ID A123456	61 GROUP NAME		62 INSURANCE GROUP NO.		

69 ADMIT DX 1534	70 PATIENT REASON DX 1974	71 PPS CODE 492	72 ECI	73
74 PRINCIPAL PROCEDURE CODE	75 OTHER PROCEDURE CODE	76 ATTENDING NPI	77 OPERATING NPI	78 OTHER NPI
79 OTHER NPI	80 REMARKS	81 CC a	81 CC b	81 CC c

Patient Liability

**Est. Amount Due
Total Charges-Patient Liability**

SNF Provider ID



Use the per diem calculation to calculate the correct amount when reporting the patient liability amounts for less than one full month of NF care. The per diem calculation is the number of days in the facility, excluding the date of discharge, times the facility's per diem rate.

To calculate NF partial patient liability:

1. Calculate the Colorado Medical Assistance amount by multiplying the number of days for payment times the per diem amount.
2. If the Colorado Medical Assistance amount exceeds the patient liability amount, the partial month's patient liability amount remains the same as the regular patient liability amount.
3. If the patient liability is more than the Colorado Medical Assistance amount, the partial month's patient liability is the same as the Colorado Medical Assistance amount. The excess of the patient liability over the partial month's patient liability belongs to the resident and, if it has already been paid to the facility, shall be refunded to the resident.



It is the SNF's/NF's responsibility to collect patient liability. The hospice does not have to collect patient liability. The hospice may choose to collect this amount and pay the SNF/NF.

Revenue Coding

Bill Hospice services with the following revenue codes:

Service	Revenue Code	Description
Hospice Routine Home Care	651	One Unit = 1 day
Continuous Home Care	652	One Unit=1 hour (must be at least 8 hours in a 24 hour period with more than half provided by a nurse)
Hospice Inpatient Respite	655	One Unit = 1 day
Hospice General Inpatient Care	656	One Unit = 1 day
Hospice Physician Service (Visit)	657	One Unit = 1 visit Non-covered MHB service (Non-covered charges must be shown in both FL 53 and 54)
Hospice NF Room and Board Per/Diem	659	One unit = 1 day

Post Eligibility Treatment of Income (PETI)

Nursing Facility Supplemental Benefits

Post Eligibility Treatment of Income (PETI) is defined as the reduction of resident payment to a nursing facility for costs of care provided to an individual for services not covered by the Medical Assistance Program, by the amount that remains after certain approved deductions are applied, and paid to the providers to reduce the individual's total payment.

- The individual is liable to pay the remaining amount to the institution.
- Clients who reside in a nursing facility, are receiving hospice services and who are making a patient liability payment must have a letter from their primary care physician stating why these additional services are medically necessary and requested by the resident.
- These requests will be considered individually and the Department will determine whether or not to approve the request.
- The Long Term Care (LTC) facility or the family determines the need for Non-Medical Assistance Program covered services.
- The facility or family arranges for the client to see the provider.



All PETI expenses must be prior authorized by the Department. **Prior Authorization Requests (PARs) should be sent to:**

PETI Program
 Department of Health Care Policy & Financing
 1570 Grant Street
 Denver, CO 80203

PETI Revenue Codes			
479	Hearing	969	Dental
962	Vision	999	Health insurance/other

Hospice agencies are responsible for adding PETI codes to their claims for Medical Assistance Program clients living in nursing facilities and who also make a patient liability payment. Once the charges are approved, the hospice agency may submit claims for the PETI payment on the claim with the client's room and board minus patient liability amount. The claims processing system will automatically complete the calculations.

Bill PETI charges in units. One unit equals one dollar.

Example: If a client has been approved for the purchase of eyeglasses at a cost of \$175, the PETI amount equals 175 units at \$1.00 each. Do not bill partial units or cents.

46 REV. CD.	48 DESCRIPTION	49 HCPCS / RATE / ICD9 CODE	44 SERI. DATE	45 SERI. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
651	Hospice Routine Home Care		01/06/08	8	624.00		
652	Hospice Continuous Home Care		01/18/08	24	480.00		
652	Hospice Continuous Home Care		01/19/08	16	320.00		
652	Hospice Continuous Home Care		01/20/08	8	160.00		
655	Hospice Inpatient Respite		01/21/08	3	249.00		
656	Hospice General Inpatient Care		01/24/08	1	350.00		
651	Hospice Routine Home Care		01/25/08	9	702.00		
659	Nursing Facility R & B Per Diem		01/06/08	20	1100.00		
962	Vision and Eye Care		01/06/08	175	175.00		
TOTALS					4160.00		

UB-04 Paper Claim Reference Table

Hospice services must be provided and billed only by a certified Hospice provider.

The information in the following table provides instructions for completing form locators (FL) as they appear on the paper UB-04 claim form. Instructions for completing the UB-04 claim form are based on the current *National Uniform Billing Committee (NUBC) UB-04 Reference Manual*. Unless otherwise noted, all data form locators on the UB-04 have the same attributes (specifications) for the Colorado Medical Assistance Program as those indicated in the *NUBC UB-04 Reference Manual*.

All code values listed in the *NUBC UB-04 Reference Manual* for each form locator **may not** be used for submitting paper claims to the Colorado Medical Assistance Program. The appropriate code values listed in this manual must be used when billing the Colorado Medical Assistance Program.

The UB-04 Certification document (located after the Late Bill Override instructions and in the Provider Services [Forms](#) section) must be completed and attached to all claims submitted on the paper UB-04. Completed UB-04 paper Colorado Medical Assistance Program claims, including hardcopy Medicare claims, should be mailed to the correct fiscal agent address located in Appendix A of the Appendices in the Provider Services [Billing Manuals](#) section.

Do not submit “continuation” claims. Each claim form has a set number of billing lines available for completion. Do not crowd more lines on the form. Billing lines in excess of the designated number are not processed or acknowledged. Claims with more than one page may be submitted through the Web Portal.

The Paper Claim Reference Table below lists the required, optional and/or conditional form locators for submitting the paper UB-04 claim form to the Colorado Medical Assistance Program for hospice care services.

Form Locator and Label	Completion Format	Instructions
1. Billing Provider Name, Address, Telephone Number	Text	Required Enter the provider or agency name and complete mailing address of the provider who is billing for the services: Street/Post Office box City State Zip Code Abbreviate the state in the address to the standard post office abbreviations. Enter the telephone number.
2. Pay-to Name, Address, City, State	Text	Required on if different from FL 1. Enter the provider or agency name and complete mailing address of the provider who will receive payment for the services: Street/Post Office box City State Zip Code Abbreviate the state in the address to the standard post office abbreviations.
3a. Patient Control Number	Up to 20 characters: Letters, numbers or hyphens	Optional Enter information that identifies the client or claim in the provider’s billing system. Submitted information appears on the Provider Claim Report.

Form Locator and Label	Completion Format	Instructions
3b. Medical Record Number	17 digits	Optional Enter the number assigned to the patient to assist in retrieval of medical records.
4. Type of Bill	3 digits	<p>Required</p> <p><u>Use the following code range for Hospice:</u></p> <p>811-815 for non-hospital based Hospice services</p> <p>821-825 for hospital based Hospice services</p> <p>The three-digit code requires one digit from each of the sequences (Type of facility, Bill classification, & Frequency).</p> <p>Enter the three-digit number indicating the specific type of bill. The three-digit code requires one digit each in the following sequences:</p> <p><u>Digit 1 - Type of Facility:</u></p> <p>8 - Special Facility (Hospice)</p> <p><u>Digit 2 - Bill Classification (Special facilities Only):</u></p> <p>1 - Hospice (Non-Hospital Based)</p> <p>2 - Hospice (Hospital Based)</p> <p><u>Digit 3 - Frequency:</u></p> <p>0 - Non-Payment/Zero Claim</p> <p>1 - Admit Through Discharge Claim</p> <p>2 - Interim - First Claim</p> <p>3 - Interim - Continuous Claim</p> <p>4 - Interim - Last Claim</p> <p>5 - Late Charge(s) Only Claim</p>
5. Federal Tax Number	None	Submitted information is not entered into the claim processing system.
6. Statement Covers Period – From/Through	<p>From: 6 digits MMDDYY</p> <p>Through: 6 digits MMDDYY</p>	<p>Required</p> <p>"From" date is the actual start date of services.</p> <p>"From" date cannot be prior to the start date reported on the initial prior authorization, if applicable, or is the first date of an interim bill.</p> <p>"Through" date is the actual discharge date, or final date of an interim bill.</p>

Form Locator and Label	Completion Format	Instructions
6. Statement Covers Period – From/Through (continued)	From: 6 digits MMDDYY Through: 6 digits MMDDYY	“From” and “Through” dates cannot exceed a calendar month (e.g., bill 01/15/08 thru 01/30/08 and 02/01/08 thru 02/15/08, not 01/15/08 thru 02/15/08). Match dates to the prior authorization if applicable. If patient is admitted and discharged the same date, that date must appear in both fields. Detail dates of service must be within the “Statement Covers Period” dates.
8a. Patient Identifier		Submitted information is not entered into the claim processing system.
8b. Patient Name	Up to 25 characters: Letters & spaces	Required Enter the client’s last name, first name and middle initial.
9a. Patient Address – Street	Characters Letters & numbers	Required Enter the client's street/post office box exactly as it appears on the eligibility verification or as determined at the time of admission.
9b. Patient Address – City	Text	Required Enter the client's city exactly as it appears on the eligibility verification or as determined at the time of admission.
9c. Patient Address – State	Text	Required Enter the client's state exactly as it appears on the eligibility verification or as determined at the time of admission.
9d. Patient Address – Zip	Digits	Required Enter the client's zip code exactly as it appears on the eligibility verification or as determined at the time of admission.
9e. Patient Address – Country Code	Digits	Optional
10. Birthdate	8 digits (MMDDCCYY)	Required Enter the client’s birthdate using two digits for the month, two digits for the date, and four digits for the year (MMDDCCYY format). Example: 07012007 for July 1, 2007. Use the birthdate that appears on the eligibility verification.

Form Locator and Label	Completion Format	Instructions
11. Patient Sex	1 letter	Required Enter an M (male) or F (female) to indicate the client's sex.
12. Admission Date	6 digits	Required Enter the date care originally started from any funding source (e.g., Medicare, Colorado Medical Assistance Program, Third Party Resource, etc.).
13. Admission Hour	6 digits	Not Required
14. Admission Type	1 digit	Not Required
15. Source of Admission	1 digit	Optional
16. Discharge Hour	2 digits	Not Required
17. Patient Discharge Status	2 digits	<p>Required</p> <p>Enter client status as ongoing patient (code 30) or as of discharge date. Agencies are limited to the following codes:</p> <ul style="list-style-type: none"> 01 Discharged to Home 03 Discharged/Transferred to SNF 04 Discharged/Transferred to ICF 05 Discharged/Transferred to Another Type of Institution 06 Discharged/Transferred to organized Home Health Care Program (HCBS) 07 Left Against Medical Advice 20 Expired (Deceased - Not for Hospice use) 30 Still patient (ongoing) 40* Expired at home 41* Expired in hospital, SNF, ICF, or free-standing hospice 42* Expired - place unknown 50 Hospice - Home 51 Hospice - Medical Facility <p>* Hospice use only</p>

Form Locator and Label	Completion Format	Instructions
18-28. Condition Codes	2 Digits	Required <u>Z4 necessary for paper claims.</u> Enter the code that matches the program and the prior authorization. <u>Condition Codes (as applicable):</u> 04 - HMO Medicare enrollee 07 - Treatment of non-terminal condition/hospice patient 17 - Patient over 100 years old 39 - Private room medically necessary
29. Accident State		Submitted information is not entered into the claim processing system.
31-34. Occurrence Code/Date	2 digits and 6 digits	Required Enter the appropriate code and the date on which it occurred. Enter the date using MMDDYY format. <u>Occurrence Codes</u> 27 - Date Hospice Plan Established 42 - Date of Discharge (Hospice Benefit Termination)
35-36. Occurrence Span Code From/ Through	2 digits	Not Required
38. Responsible Party Name/ Address	None	Leave blank
39-41. Value Code and Amount	2 characters and 9 digits	Conditional Enter appropriate codes and related dollar amounts to identify monetary data or number of days using whole numbers, necessary for the processing of this claim. Never enter negative amounts. Fields and codes must be in ascending order. If a value code is entered, a dollar amount or numeric value related to the code <u>must</u> always be entered.

Form Locator and Label	Completion Format	Instructions
<p>39-41. Value Code and Amount (continued)</p>	<p>2 characters and 9 digits</p>	<p>01 Most common semiprivate rate (Accommodation Rate)</p> <p>06 Medicare blood deductible</p> <p>14 No fault including auto/other</p> <p>15 Worker's Compensation</p> <p>31 Patient Liability Amount (see below)*</p> <p>32 Multiple Patient Ambulance Transport</p> <p>37 Pints of Blood Furnished</p> <p>38 Blood Deductible Pints</p> <p>40 New Coverage Not Implemented by HMO</p> <p>45 Accident Hour Enter the hour when the accident occurred that necessitated medical treatment. Use the same coding used in FL 18 (Admission Hour).</p> <p>49 Hematocrit Reading - EPO Related</p> <p>58 Arterial Blood Gas (PO2/PA2)</p> <p>68 EPO-Drug</p> <p>80 Covered Days</p> <p>81 Non-Covered Days</p> <p><i>Enter the deductible amount applied by indicated payer:</i></p> <p>A1 Deductible Payer A</p> <p>B1 Deductible Payer B</p> <p>C1 Deductible Payer C</p> <p><i>Enter the amount applied to client's co-insurance by indicated payer:</i></p> <p>A2 Coinsurance Payer A</p> <p>B2 Coinsurance Payer B</p> <p>C2 Coinsurance Payer C</p> <p><i>Enter the amount paid by indicated payer:</i></p> <p>A3 Estimated Responsibility Payer A</p> <p>B3 Estimated Responsibility Payer B</p> <p>C3 Estimated Responsibility Payer C</p> <p>Medicare & TPL - See A1-A3, B1-B3, & C1-C3 above</p>

Form Locator and Label	Completion Format	Instructions
<p>39-41. Value Code and Amount (continued)</p>		<p>* Patient Liability Amount is payment made by the client for care, after the personal needs allowance and other approved expenses are deducted. The personal needs allowance and other approved deductions are determined by County Income Maintenance Technicians. This patient liability must be applied to the client's care.</p> <p>When reporting patient liability for the entire month, regardless of the number of days in that month, apply the total patient liability.</p> <p>When reporting patient liability amounts for less than one full month of care, use the per diem calculation to calculate the correct amount.</p> <p>The per diem calculation is the number of days in the facility, excluding the date of discharge, times the facility's per diem rate.</p> <p>The claim will be denied if the billed amount exceeds this allowed amount.</p> <p>To calculate patient liability:</p> <ol style="list-style-type: none"> 1. Calculate the Colorado Medical Assistance amount by multiplying the number of days for payment times the per diem amount. 2. If the Colorado Medical Assistance amount exceeds the patient liability, the partial month's patient liability remains the same as the regular patient liability amount. 3. If the patient liability is more than the Colorado Medical Assistance Program amount, the partial month's patient liability is the same as the Colorado Medical Assistance amount. The excess of the patient liability over the partial month's patient liability belongs to the resident and, if it has already been paid to the facility, shall be refunded to the resident. <p>When client has Medicare "Part B only" coverage, and the provider is billing for the Colorado Medical Assistance Program Accommodation Per Diem and the payer source code is H, enter the "Part B only" ancillary services payment in this field on the Medicare line.</p>
<p>42. Revenue Code</p>	<p>3 digits</p>	<p>Required</p> <p>If billing for nursing facility per diem charges (Revenue Code 659 or 651), the nursing facility provider number must be entered in FL 78 (Other Phys. ID)</p> <p>See Revenue Code table</p>
<p>43. Revenue Code Description</p>	<p>Text</p>	<p>Required</p> <p>Enter the revenue code description or abbreviated description.</p>
<p>44. HCPCS/Rates/ HIPPS Rate Codes</p>		

Form Locator and Label	Completion Format	Instructions
45. Service Date	6 digits	<p>Required</p> <p>For span bills only Enter the date of service using MMDDYY format for each detail line completed.</p> <p>Each date of service must fall within the date span entered in FL 6 (Statement Covers Period).</p>
46. Service Units	3 digits	<p>Required</p> <p>Enter a unit value on each line completed. Use whole numbers only. Do not enter fractions or decimals and do not show a decimal point followed by a 0 to designate whole numbers.</p> <p>Example: Do not enter 1.0 to signify one unit.</p> <p>For span bills, the units of service reflect only those visits, miles or treatments provided on dates of service in FL 45.</p>
47. Total Charges	9 digits	<p>Required</p> <p>Enter the total charge for each line item.</p> <p>Calculate the total charge as the number of units multiplied by the unit charge. Do not subtract Medicare or third party payments from line charge entries. Do not enter negative amounts.</p> <p>A grand total in line 23 is required for all charges.</p>
48. Non-Covered Charges	9 digits	<p>Conditional</p> <p>Enter incurred charges that are not payable by the Colorado Medical Assistance Program.</p> <p>Non-covered charges must be entered in both FL 47 (Total Charges) and FL 48 (Non-Covered Charges.) Each column requires a grand total.</p>
50. Payer Name	1 letter and text	<p>Required</p> <p>Enter the payment source code followed by name of each payer organization from which the provider might expect payment.</p> <p>At least one line must indicate The Colorado Medical Assistance Program.</p>

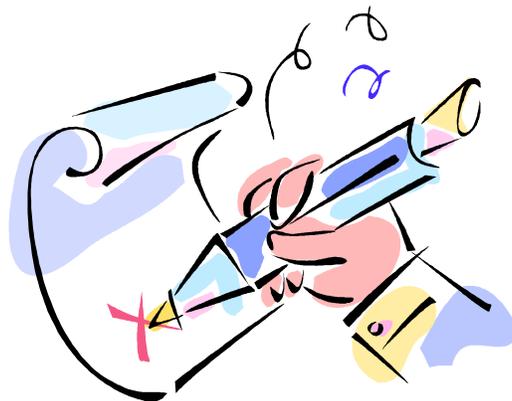
Form Locator and Label	Completion Format	Instructions
50. Payer Name (continued)	1 letter and text	Source Payment Codes B Workmen's Compensation C Medicare D Colorado Medical Assistance Program E Other Federal Program F Insurance Company G Blue Cross, including Federal Employee Program H Other - Inpatient (Part B Only) I Other Line A Primary Payer Line B Secondary Payer Line C Tertiary Payer
51. Health Plan ID	8 digits	Required Enter the provider's Health Plan ID for each payer name. Enter the eight digit Colorado Medical Assistance Program provider number assigned to the billing provider . Payment is made to the enrolled provider or agency that is assigned this number.
52. Release of Information	None	Submitted information is not entered into the claim processing system.
53. Assignment of Benefits	None	Submitted information is not entered into the claim processing system.
54. Prior Payments	Up to 9 digits	Conditional Complete when there are Medicare or third party payments. Enter third party and/or Medicare payments.
55. Estimated Amount Due	Up to 9 digits	Conditional Complete when there are Medicare or third party payments. Enter the net amount due from The Colorado Medical Assistance Program after provider has received other third party, Medicare or patient liability.

Form Locator and Label	Completion Format	Instructions
55. Estimated Amount Due (continued)	Up to 9 digits	Medicare Crossovers Enter the sum of the Medicare coinsurance plus Medicare deductible less third party payments and patient liability.
56. National Provider Identifier (NPI)	10 digits	Optional Enter the billing provider's 10-digit National Provider Identifier (NPI).
57. Other Provider ID		Submitted information is not entered into the claim processing system.
58. Insured's Name	Up to 30 characters	Required Enter the client's name on the Colorado Medical Assistance Program line. Other Insurance/Medicare Complete additional lines when there is third party coverage. Enter the policyholder's last name, first name, and middle initial exactly as it appears on the eligibility verification or on the health insurance card.
60. Insured's Unique ID	Up to 20 characters	Required Enter the insured's unique identification number assigned by the payer organization exactly as it appears on the eligibility verification or on the health insurance card. Include letter prefixes or suffixes shown on the card.
61. Insurance Group Name	14 letters	Conditional Complete when there is third party coverage. Enter the name of the group or plan providing the insurance to the insured exactly as it appears on the health insurance card.
62. Insurance Group Number	17 digits	Conditional Complete when there is third party coverage. Enter the identification number, control number, or code assigned by the carrier or fund administrator identifying the group under which the individual is carried.

Form Locator and Label	Completion Format	Instructions
63. Treatment Authorization Code	Up to 18 characters	Conditional Complete when the service requires a PAR. Enter the PAR/authorization number in this field, if a PAR is required and has been approved for services.
64. Document Control Number		Submitted information is not entered into the claim processing system.
65. Employer Name	Text	Conditional Complete when there is third party coverage. Enter the name of the employer that provides health care coverage for the individual identified in FL 58 (Insured Name).
66. Diagnosis Version Qualifier		Submitted information is not entered into the claim processing system.
67. Principal Diagnosis Code	Up to 6 digits	Required Enter the exact ICD-9-CM diagnosis code describing the principal diagnosis that exists at the time of admission or develops subsequently and affects the length of stay. Do not add extra zeros to the diagnosis code.
67A- 67Q. Other Diagnosis	6 digits	Optional Enter the exact ICD-9-CM diagnosis code corresponding to additional conditions that co-exist at the time of admission or develop subsequently and which effect the treatment received or the length of stay. Do not add extra zeros to the diagnosis code.
69. Admitting Diagnosis Code	6 digits	Optional Enter the ICD-9-CM diagnosis code as stated by the physician at the time of admission.
70. Patient Reason Diagnosis		Not Required
71. PPS Code		Not Required
72. External Cause of Injury Code (E-code)	6 digits	Optional Enter the ICD-9-CM diagnosis code for the external cause of an injury, poisoning, or adverse effect. This code must begin with an "E".

Form Locator and Label	Completion Format	Instructions
74. Principal Procedure Code/ Date	7 characters and 6 digits	Not Required
74A. Other Procedure Code/Date	7 characters and 6 digits	<p>Conditional</p> <p>Complete when there are additional significant procedure codes.</p> <p>Enter the ICD-9-CM procedure codes identifying all significant procedures other than the principle procedure and the dates on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principle diagnosis. Enter the date using MMDDYY format.</p>
<p>76. Attending NPI – Conditional QUAL - Conditional ID - (Colorado Medical Assistance Provider #) – Required</p> <p>Attending- Last/ First Name</p>	<p>NPI - 10 digits QUAL – Text Medicaid ID - 8 digits</p> <p>Text</p>	<p>NPI - Enter the 10-digit NPI assigned to the physician having primary responsibility for the patient's medical care and treatment.</p> <p>QUAL – Enter “1D“ for Medicaid followed by the provider’s eight-digit Colorado Medical Assistance Program provider ID.</p> <p>Medicaid ID - Enter the eight-digit Colorado Medical Assistance Program provider number assigned to the physician having primary responsibility for the patient's medical care and treatment.</p> <p>Numbers are obtained from the physician, and <u>cannot</u> be a clinic or group number. (If the attending physician is not enrolled in the Colorado Medical Assistance Program or if the client leaves the ER before being seen by a physician, the hospital may enter their individual numbers.)</p> <p>Enter the attending physician’s last and first name.</p> <p>This form locator must be completed for all services.</p>
77. Operating- NPI/QUAL/ID		Submitted information is not entered into the claim processing system.

Form Locator and Label	Completion Format	Instructions
<p>78-79. Other ID NPI – Conditional QUAL - Conditional ID - (Colorado Medical Assistance Provider #) – Conditional</p>	<p>NPI - 10 digits QUAL – Text Medicaid ID - 8 digits</p>	<p>Conditional</p> <p>Complete when attending physician is not the PCP or to identify additional physicians.</p> <p>Enter up to two 10-digit NPI and eight digit physician Colorado Medical Assistance Program provider numbers, when applicable. This form locator identifies physicians other than the attending physician. If the attending physician is not the primary care physician (PCP) or if a clinic is a PCP agent, enter the PCP eight digit Colorado Medical Assistance Program provider number in FL 78. The name of the Colorado Medical Assistance Program client's PCP appears on the eligibility verification. The Colorado Medical Assistance Program does not require that the primary care physician number appear more than once on each claim submitted.</p> <p>The “other” physician’s last and first name are optional.</p>
<p>80. Remarks</p>	<p>Text</p>	<p>Enter specific additional information necessary to process the claim or fulfill reporting requirements.</p>
<p>81. Code-Code-QUAL/CODE/VALUE (a-d)</p>		<p>Submitted information is not entered into the claim processing system.</p>



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 a fine and imprisonment under state and/or federal law.

Billing Instruction Detail	Instructions
LBOD Completion Requirements	<ul style="list-style-type: none"> • Electronic claim formats provide specific fields for documenting the LBOD. • Supporting documentation must be kept on file for 6 years. • For paper claims, follow the instructions appropriate for the claim form you are using. <ul style="list-style-type: none"> ➤ <i>UB-04</i>: Occurrence code 53 and the date are required in FL 31-34. ➤ <i>Colorado 1500</i>: Indicate “LBOD” and the date in box 30 - Remarks. ➤ <i>2006 ADA Dental</i>: Indicate “LBOD” and the date in box 35 - Remarks.
Adjusting Paid Claims	<p>If the initial timely filing period has expired and a previously submitted claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was paid and now needs to be adjusted, resulting in additional payment to the provider.</p> <p>Adjust the claim within 60 days of the claim payment. Retain all documents that prove compliance with timely filing requirements.</p> <p><i>Note: There is no time limit for providers to adjust paid claims that would result in repayment to the Colorado Medical Assistance Program.</i></p> <p>LBOD = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the payment.</p>

Billing Instruction Detail	Instructions
Denied Claims	<p>If the initial timely filing period has expired and a previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was denied.</p> <p>Correct the claim errors and refile within 60 days of the claim denial or rejection. Retain all documents that prove compliance with timely filing requirements.</p> <p>LBOD = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the denial.</p>
Returned Paper Claims	<p>A previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was returned for additional information.</p> <p>Correct the claim errors and re-file within 60 days of the date stamped on the returned claim. Retain a copy of the returned claim that shows the receipt or return date stamped by the fiscal agent.</p> <p>LBOD = the stamped fiscal agent date on the returned claim.</p>
Rejected Electronic Claims	<p>An electronic claim that was previously entered within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was rejected and information needed to submit the claim was not available to refile at the time of the rejection.</p> <p>Correct claim errors and refile within 60 days of the rejection. Maintain a printed copy of the rejection notice that identifies the claim and date of rejection.</p> <p>LBOD = the date shown on the claim rejection report.</p>
Denied/Rejected Due to Client Eligibility	<p>An electronic eligibility verification response processed during the original Colorado Medical Assistance Program timely filing period states that the individual was not eligible but you were subsequently able to verify eligibility. Read also instructions for retroactive eligibility.</p> <p>File the claim within 60 days of the date of the rejected eligibility verification response. Retain a printed copy of the rejection notice that identifies the client and date of eligibility rejection.</p> <p>LBOD = the date shown on the eligibility rejection report.</p>
Retroactive Client Eligibility	<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"> • Identifies the patient by name • States that eligibility was backdated or retroactive • Identifies the date that eligibility was added to the state eligibility system. <p>LBOD = the date shown on the county letter that eligibility was added to or first appeared on the state eligibility system.</p>

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

Billing Instruction Detail	Instructions
<p>Commercial Insurance Processing</p>	<p>The claim has been paid or denied by commercial insurance.</p> <p>File the claim within 60 days of the insurance payment or denial. Retain the commercial insurance payment or denial notice that identifies the patient, rendered services, and shows the payment or denial date.</p> <p>Claims must be filed within 365 days of the date of service. No exceptions are allowed. If the claim is nearing the 365-day limit and the commercial insurance company has not completed processing, file the claim, receive a denial or rejection, and continue filing in compliance with the 60-day rule until insurance processing information is available.</p> <p>LBOD = the date commercial insurance paid or denied.</p>
<p>Correspondence LBOD Authorization</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>File the claim within 60 days of the date on the authorization letter. Retain the authorization letter.</p> <p>LBOD = the date on the authorization letter.</p>
<p>Client Changes Providers during Obstetrical Care</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>File the claim within 60 days of the last OB visit. Maintain information in the medical record showing the date of the last prenatal visit and a notation that the patient transferred to another provider for continuation of OB care.</p> <p>LBOD = the last date of OB care by the billing provider.</p>





Colorado Medical Assistance Program

Institutional Provider Certification

This is to certify that the foregoing information is true, accurate and complete.

This is to certify that I understand that payment of this claim will be from Federal and State funds and that any falsification, or concealment of material fact, may be prosecuted under Federal and State Laws.

Signature: _____ *Date:* _____

This document is an addendum to the UB-04 claim form and is required per 42 C.F.R. 445.18 (a)(1-2) to be attached to paper claims submitted on the UB-04.

Hospice Claim without Nursing Facility Room and Board with Physician Charges Example

1 Hospice Agency 100 Saginaw Street Anytown, CO 80201 303-333-3333		2		3a PAT. CNTL. # SM000123		4 TYPE OF BILL 812	
8 PATIENT NAME a Client, Ima D.		9 PATIENT ADDRESS a 123 Main Street		5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM 01/06/08	
10 BIRTHDATE 02/13/1980		11 SEX F		12 DATE 12/06/03		7 THROUGH 01/31/08	
31 OCCURRENCE DATE 27 01/06/08		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
35 OCCURRENCE DATE		36 OCCURRENCE DATE		37 OCCURRENCE DATE		38	
42 REV. CD.		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
651 Hospice Routine Home Care				01/06/08		8 624:00	
652 Hospice Continuous Home Care				01/18/08		24 480:00	
652 Hospice Continuous Home Care				01/19/08		16 320:00	
652 Hospice Continuous Home Care				01/20/08		8 160:00	
655 Hospice Inpatient Respite				01/21/08		3 249:00	
656 Hospice General Inpatient Care				01/24/08		1 350:00	
651 Hospice Routine Home Care				01/25/08		9 702:00	
657 Hospice Physician Service				01/06/08		3 165:00 165:00	
PAGE 1 OF 1		CREATION DATE		TOTALS		3050:00 165:00	
50 PAYER NAME D - Medicaid		51 HEALTH PLAN ID 12345678		52 REL. INFO.		53 ASG. BEN.	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE 2885:00		56 NPI		57 OTHER PRV ID	
58 INSURED'S NAME Client, Ima D.		59 P. REL.		60 INSURED'S UNIQUE ID A123456		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66 DX 1531 1971 492		67		68		69	
74 PRINCIPAL PROCEDURE CODE DATE		70 PATIENT REASON DX a		71 FPS CODE b		72 ECI c	
76 ATTENDING NPI LAST Provider		77 OPERATING NPI		78 OTHER NPI		79 OTHER NPI	
QUAL ID 87654321		QUAL		QUAL		QUAL	
FIRST Ima		FIRST		FIRST		FIRST	
LAST		LAST		LAST		LAST	
80 REMARKS		81 CC a		82		83	
		b		c		d	

UB-04 CMS-1450

APPROVED OMB NO. 0938-0997

NUBC[®] National Uniform Billing Committee

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Hospice Claim with Nursing Facility Room and Board Example

1 Hospice Agency 100 Saginaw Street Anytown, CO 80201 303-333-3333		2		3a PAT. CNTL # SM000123		4 TYPE OF BILL 812	
8 PATIENT NAME a Client, Ima D.		9 PATIENT ADDRESS a 123 Main Street		b Anytown		c CO d 88888 e	
10 BIRTHDATE 02/13/1980	11 SEX F	12 DATE 12/06/03	13 HR 1	14 TYPE 1	15 SRC 30	16 DHR Z4	17 STAT 30
31 OCCURRENCE DATE 27 01/01/08		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
35 OCCURRENCE DATE		36 OCCURRENCE DATE		37 OCCURRENCE DATE		38	
39 CODE		40 CODE		41 CODE		42	
43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE		46 SERV. UNITS	
47 TOTAL CHARGES		48 NON-COVERED CHARGES		49		50	
651 Hospice Routine Home Care				01/06/08		8	
652 Hospice Continuous Home Care				01/18/08		24	
652 Hospice Continuous Home Care				01/19/08		16	
652 Hospice Continuous Home Care				01/20/08		8	
655 Hospice Inpatient Respite				01/21/08		3	
656 Hospice General Inpatient Care				01/24/08		1	
651 Hospice Routine Home Care				01/25/08		7	
659 Nursing Facility R & B Per Diem				01/06/08		26	
PAGE 1 OF 1		CREATION DATE		TOTALS		3985.00	
50 PAYER NAME D - Medicaid		51 HEALTH PLAN ID 12345678		52 REL INFO		53 ASG BEN.	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE 3985.00		56 NPI		57 OTHER PRV ID	
58 INSURED'S NAME Client, Ima D.		59 P.REL.		60 INSURED'S UNIQUE ID A123456		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66 DX 1539 1974 492		67		68		69	
70 PATIENT REASON DX		71 FPS CODE		72 ECI		73	
74 PRINCIPAL PROCEDURE CODE DATE		75 OTHER PROCEDURE CODE DATE		76 OTHER PROCEDURE CODE DATE		77 ATTENDING NPI QUAL ID 87654321 LAST Provider FIRST Ima	
78 OPERATING NPI QUAL		79 OTHER NPI QUAL ID 01234567 LAST Nursing Facility FIRST Ima		80 REMARKS		81 CC a b c d	

UB-04 CMS-1450 APPROVED CMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

Hospice Claim with Patient Pay Example

1 Hospice Agency 100 Saginaw Street Anytown, CO 80201 303-333-3333		2		38 PAT. CRTL. # SM000123		4 TYPE OF BILL 812	
8 PATIENT NAME a Client, Ima D.		9 PATIENT ADDRESS a 123 Main Street		c CO		d 88888	
10 BIRTHDATE 02/13/1980		11 SEX F		12 DATE ADMISSION 12/06/03		13 HR 14 TYPE 15 SRC 16 DHR 17 STAT 18 19 20 21	
31 OCCURRENCE DATE 27 01/01/08		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
35 OCCURRENCE DATE		36 OCCURRENCE DATE		37 OCCURRENCE DATE		38	
39 CODE a 31		40 VALUE CODES AMOUNT 129:00		41 CODE		42 VALUE CODES AMOUNT	
43 REV. CD.		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NONCOVERED CHARGES		49	
651 Hospice Routine Home Care		01/06/08		8		624:00	
652 Hospice Continuous Home Care		01/18/08		24		480:00	
652 Hospice Continuous Home Care		01/19/08		16		320:00	
652 Hospice Continuous Home Care		01/20/08		8		160:00	
655 Hospice Inpatient Respite		01/21/08		3		249:00	
656 Hospice General Inpatient Care		01/24/08		1		350:00	
651 Hospice Routine Home Care		01/25/08		9		702:00	
659 Nursing Facility R & B Per Diem		01/06/08		20		1100:00	
PAGE 1 OF 1		CREATION DATE		TOTALS		3985:00	
50 PAYER NAME D - Medicaid		51 HEALTH PLAN ID 12345678		52 REL. INFO		53 ASG. BEN.	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE 3856:00		56 NPI		57 OTHER PRV ID	
58 INSURED'S NAME Client, Ima D.		59 P.REL.		60 INSURED'S UNIQUE ID A123456		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66 DX 1534 1974 492		67		68		69	
69 ADMIT DX		70 PATIENT REASON DX		71 FPS CODE		72 ECI	
74 PRINCIPAL PROCEDURE CODE		75 OTHER PROCEDURE CODE		76 ATTENDING NPI		77 QUAL ID	
78 LAST PROVIDER		79 FIRST IMA		77 OPERATING NPI		78 QUAL	
79 LAST		79 FIRST		78 OTHER NPI		79 QUAL ID	
80 REMARKS		81 CC		82 LAST PHYSICIAN		83 FIRST IMA	
84		85		86 OTHER NPI		87 QUAL	
88		89		90 LAST		91 FIRST	

Note: Bill services with Medicaid rates or usual and customary charges, whichever is greater.

All detail line days must be equal to or be less than day in FL 6. Do not include revenue code 659 units.

Nursing Facility room and board "day" values of revenue codes.

- Line 1 = 1st date of 8 days
- Line 2 = 1 day (date specific)
- Line 3 = 1 day (date specific)
- Line 4 = 1 day (date specific)
- Line 5 = 3 days (1st date of 3 days)
- Line 6 = 1 day (1st date of 1 day)
- Line 7 = 9 days (1st date of 9 days)
- FL 6 = 24 days

- 651 = 8 days
- 652 = 1 day
- 652 = 1 day
- 652 = 1 day
- 655 = 0 days
- 655 = 0 days
- 651 = 9 days
- 659 = 20 days

Hospice Revisions Log

Revision Date	Additions/Changes	Pages	Made by
02/13/2008	<i>Electronic Claims – Updated first two paragraphs with bullets</i>	3	<i>pr-z</i>
11/05/2008	<i>Updated web addresses</i>	<i>Throughout</i>	<i>jg</i>
03/25/2009	<i>General updates</i>	<i>Throughout</i>	<i>jg</i>
01/19/2010	<i>Updated Web site links</i>	<i>Throughout</i>	<i>jg</i>
02/17/2010	<i>Changed EOMB to SPR</i>	25	<i>jg</i>
03/04/2010	<i>Added link to Program Rules</i>	1	<i>Jg</i>
12/06/2011	<i>Replaced 997 with 999</i>	3	ss
	<i>Replaced www.wpc-edi.com/hipaa with www.wpc-edi.com/</i>	1	
	<i>Replaced Implementation Guide with Technical Report 3 (TR3)</i>	1	

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.