

# Obstetrical Care

<b>Obstetrical Care .....</b>	<b>1</b>
Billing Information .....	1
National Provider Identifier (NPI) .....	1
Paper Claims.....	1
Electronic Claims.....	1
Presumptive Eligibility (PE) .....	2
Presumptive Eligibility (PE) Card.....	2
Diagnosis Coding.....	2
Procedure Coding.....	3
Global Procedure Codes .....	3
Services not included in global reimbursement:.....	4
Separate Procedures.....	4
Special Provider Considerations.....	9
Paper Claim Reference Table.....	10
OB Claim Example.....	24
Late Bill Override Date.....	25
Sterilizations, Hysterectomies, and Abortions .....	29
Voluntary sterilizations.....	29
General requirements .....	29
Emergency Abdominal Surgery:.....	29
Premature Delivery: .....	29
Informed consent requirements .....	30
MED-178 consent form requirements .....	31
Completion of the MED-178 consent form .....	32
Hysterectomies.....	32
Abortions .....	33
Induced abortions .....	33
Providers billing on the Colorado 1500 claim form .....	34
Providers billing on the UB-04 claim form .....	34
Induced abortions to save the life of the mother.....	34
Spontaneous abortion (Miscarriage) .....	37

# Obstetrical Care

The Department of Health Care Policy and Financing (the Department) periodically modifies billing information. Therefore, the information in this manual is subject to change. The manual is updated as new policies are implemented.

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

Colorado Medical Assistance Program benefits are available for pregnant women and infants meeting Federal income guidelines. Eligibility is determined by the County Department of Human/Social Services in the applicant's county of residence.



## 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. Requests may be sent to 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 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. 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 ([wpc-edi.com/](http://wpc-edi.com/))
- Companion Guides for the 837P, 837I, or 837D in the Provider Services
- Web Portal User Guide (via within the Web Portal)



The Colorado Medical Assistance Program collects electronic claim information interactively through the Colorado Medical Assistance Program Secure Web Portal ([Web Portal](#)) or via batch submission through a host system. Please refer to the [Colorado General Billing Information Manual](#) for additional electronic information.

## Presumptive Eligibility (PE)

Presumptive Eligibility (PE) provides medical assistance benefits to low income pregnant women and their children prior to receiving approval for full Medicaid benefits. This program improves benefit accessibility for pregnant women through the process known as PE.

PE allows a woman temporary Colorado Medical Assistance Program coverage for 60 days. PE clients receive a PE card that identifies them as eligible for ambulatory medical services. Inpatient hospital (e.g., delivery) services are not a PE benefit. After the full eligibility determination process, Colorado Medical Assistance eligible clients receive a Medical Identification Card (MIC).



Colorado Medical Assistance eligible pregnant women have continuous eligibility. The woman remains eligible throughout her pregnancy and until the end of the month in which the 60th day following the end of her pregnancy occurs. Income changes during pregnancy do not affect eligibility. The infant has continuous eligibility until his or her first birthday.

Pregnant women are eligible for all Colorado Medical Assistance Program benefit services determined by their physician to be medically necessary. Pregnant women under age 21 are also eligible for Early and Periodic Screening Diagnosis and Treatment (EPSDT) services, including dental, vision care and EPSDT health checkups.

Woman in the maternity cycle are exempt from co-payment. The provider must mark the co-payment indicator on the paper claim form or on the electronic format.

- Providers must be a CHP+ site to offer services
- Providers must verify CHP+ PE client eligibility through [Colorado Access](#)

### Presumptive Eligibility (PE) Card

Medicaid Presumptive Eligibility  
Medical Card

Name:  
State Id:  
Eligibility Date:  
Expiration Date:

Providers - For billing or authorization questions, call the fiscal agent Provider Services at 1-800-237-0757.

Send Claims to:  
Colorado Medicaid  
PO Box 30  
Denver, CO 80201-0030

## Diagnosis Coding

The Colorado Medical Assistance Program recognizes the *International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)* diagnostic coding reference. The following diagnoses are for reference only. See the ICD-9-CM for a full list of diagnosis codes. When required, use additional digits as indicated.

Diagnosis Code	Description	Diagnosis Code	Description
V22	Normal pregnancy	630-634.99 & 639-676.94	Complications of pregnancy, childbirth, and puerperium
V23	Supervision of high-risk pregnancy		

Diagnosis Code	Description	Diagnosis Code	Description
V24	Postpartum care and examination		
V25	Contraceptive management		



### Procedure Coding

Whenever possible, medical care provided during pregnancy, labor and delivery, and the postpartum period should be billed using the global OB codes. The following CPT codes do not represent an exhaustive list of codes. Medical providers should consult the CPT codebook to ensure correct coding.

### Global Procedure Codes

Global OB code	Description	Units
<b>59400</b>	Global OB care - Vaginal delivery Includes routine antepartum care, labor and vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care. (Requires a minimum of four antepartum visits.) Bill using delivery date as date of service.	1
<b>59510</b>	Global OB care - Cesarean delivery Includes routine antepartum care, and postpartum care. (Requires a minimum of four antepartum visits.) Bill using delivery date as date of service.	1
<b>99201-99215 w/modifier TH</b>	Antepartum care, per visit Each visit must be billed on a separate detail line.	1
<b>59425</b>	Antepartum care, 4-6 visits Bill on one detail line; date of service is the last antepartum visit. Delivery and postpartum care must be billed separately.	1
<b>59426</b>	Antepartum care, 7 or more visits Bill on one detail line; date of service is the last antepartum visit. Delivery and postpartum care must be billed separately.	1
<b>59410</b>	Vaginal delivery including postpartum care Includes (with or without episiotomy, and/or forceps) Bill when the delivering practitioner provides postpartum care for a period of 45 days after birth. Use delivery date as date of service	1
<b>59409</b>	Vaginal delivery without postpartum care Includes,(with or without episiotomy, and/or forceps)	1

Global OB code	Description	Units
59515	Cesarean delivery including postpartum care Bill when the delivering practitioner provides postpartum care for a period of 45 days after birth. Use delivery date as date of service	1
59514	Cesarean delivery without postpartum care	1
59430	Postpartum care (separate procedure) Bill when the postpartum care provider does not deliver the baby, but does provide follow-up postpartum care.	1
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and /or forceps) and postpartum care, after previous cesarean delivery.	1
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and /or forceps); including postpartum care.	1
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery.	1
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care.	1

**Services not included in global reimbursement:**

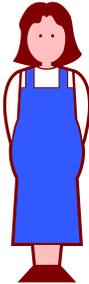
- Unusual circumstances
- Conditions which are unrelated to the pregnancy or delivery
- Complications of pregnancy
- Certain adjunctive services
- Medical/Surgical services unrelated to the pregnancy



**Separate Procedures**

These services should be billed separately from (in addition to) global obstetrical care charges.

Service	Instructions
Prenatal testing 	Bill only for the testing or the portion of the testing performed by the provider Use modifier -TC for technical component services only Use modifier - 26 for professional services only Use no modifier if professional and technical testing services are performed by the same provider
Invasive or non-invasive prenatal testing, including ultrasound	Only one ultrasound per pregnancy is recommended. If the patient’s medical condition requires additional ultrasonography, medical records must be documented.

Service	Instructions
<p>Clinical laboratory testing</p> 	<p>Providers must be CLIA certified</p> <p>Tests performed by an outside lab, must be billed by the lab. Laboratory testing other than routine chemical urinalysis and finger stick hematocrit.</p> <p>Pap smear during pregnancy and a second pap smear during the postpartum period. (This is in addition to the routine annual pap smear.)</p> <p><b>NOTE: Lab tests <i>must</i> be marked "Emergency" for all non-citizens. If the claim is not marked "Emergency", the claim will not be paid.</b></p>
<p>Adjunctive services</p>	<p>For example, Tracheloplasty/trachelorrhaphy, etc.</p>
<p>Initial antepartum visit</p> 	<p>Use CPT E&amp;M codes 99201-99215 for initial visit. Initial visit may involve additional time and attention.</p> <p>Use one of the following diagnosis codes:</p> <p>V22.X- Confirmed pregnancy (No PCP referral required)</p> <p>V23.9</p> <p>V72.4X Pregnancy examination/test, pregnancy unconfirmed (If client has a PCP, referral is required.)</p> <p>626.X Absence of menstruation (If client has a PCP, referral is required.)</p>
<p>Conditions requiring additional management</p> 	<p>59610-59614 Single vaginal delivery of multiple infants</p> <p>Multiple Infants:</p> <p>Use the appropriate vaginal or Cesarean delivery procedure code and bill one unit of service. The additional infants may be billed using 59409 or 59514 with modifier 22 and indicating the number of additional infants in unit field of the claim form. Use the appropriate diagnosis code to indicate multiple infants.</p> <p>The date of service must be the delivery date.</p>
<p>Medical or surgical complications</p>	<p>Bill on an ongoing basis using the appropriate procedure code(s).</p> <p>The diagnosis code must identify the complication or condition.</p>
<p>Conditions unrelated to pregnancy</p>	<p>Medical or surgical services for conditions that are not related to pregnancy should be billed separately. Identify the condition requiring additional care. Services are subject to PCP referral.</p>

Service	Instructions
<p>Anesthesia</p> 	<p>The delivery fee includes local, pudendal, and paracervical blocks by the delivering practitioner.</p> <p>If the delivering practitioner begins block anesthesia for a vaginal delivery that subsequently requires a cesarean, separate charges may be submitted using the appropriate block code.</p> <p>If the delivering practitioner provides general or regional anesthesia (epidural, caudal, spinal, or saddle), bill the service separately using the appropriate delivery code (59409 or 59410) plus modifier -47. Enter units of service as one.</p> <p>Anesthesia by a practitioner other than the delivering practitioner must be billed by the rendering provider.</p>
<p>Epidural anesthesia</p>	<p>Epidural anesthesia by a provider other than the delivering practitioner is a covered benefit. Document patient contact time on the claim. Paper claims for more than 120 minutes (8 or more time units) of direct patient contact epidural time require an attached copy of the anesthesia record. Electronic claims may be submitted (no attachments) but documents verifying extended direct patient contact must be maintained and produced upon request.</p>
<p>Assistant surgeon at cesarean delivery</p>	<p>Modifier - 80 identifies assistant surgeon services. A family practitioner or certified nurse midwife may bill as assistant surgeon at cesarean. Physician assistants, surgical assistants, and nurse practitioners may not bill as assistant surgeon. An assistant surgeon is not allowed on vaginal deliveries.</p>
<p>Family planning</p> 	<p>Colorado Medical Assistance Program enrolled women may receive family planning services during and after pregnancy. Colorado Medical Assistance Program generally covers most methods of birth control. Prior authorization is not required for family planning.</p>



Service	Instructions
<p>Surgical sterilization</p> 	<p>Voluntary sterilization requires strict compliance with Federal informed consent regulations. All sterilization or sterilization-related claims must be submitted on paper with an attached <a href="#">MED-178</a> consent form, completed according to the provider manual.</p> <p>The woman must be at least 21 years old on the date she signs the MED-178 and the form must be completed 30 days in advance of the procedure unless emergency surgery or premature delivery occurs.</p> <p>The surgeon must provide copies of the properly completed MED-178 to the assistant surgeon, anesthesiologist, and hospital. Claims without MED-178 documentation are denied.</p> <p>Sterilization performed at the time of vaginal or cesarean delivery must be billed on paper using the appropriate sterilization code with the required MED-178 form attached.</p> <p>If laparoscopic tubal ligation is performed, bill the base diagnostic laparoscopy on one detail line and the appropriate tubal ligation procedure code on a second detail line.</p> <p>Refer to the MED-178 Instructions for completion and form on the Department’s website (<a href="http://colorado.gov/hcpf/ProviderServices">colorado.gov/hcpf/ProviderServices</a>) → <a href="#">Forms</a> → Sterilization Consent Forms.</p>
<p>Treatment of HIV-infected persons</p> 	<p>Treatment of HIV-infected persons with antiretroviral medications prescribed by a doctor is a Colorado Medical Assistance Program benefit. Medications include, but are not limited to, zidovudine (AZT), didanosine (ddl), and stavudine. Medications to treat HIV related diseases must be FDA approved, listed on the drug formulary, and not classified as experimental. Most drugs do not require prior authorization. For questions on the status of drugs as a covered benefit, call your local pharmacy or Colorado Medical Assistance Program Provider Services.</p>
<p>Treatment for substance abusing pregnant women</p>	<p>Substance abusing pregnant women may be eligible for involvement in Special Connections, a Colorado Medical Assistance Program funded program for substance abuse treatment. The service package includes: Risk assessment, case management, individual counseling, group counseling and health maintenance. Substance abusing pregnant women can refer themselves to Special Connections or be referred by a provider.</p>

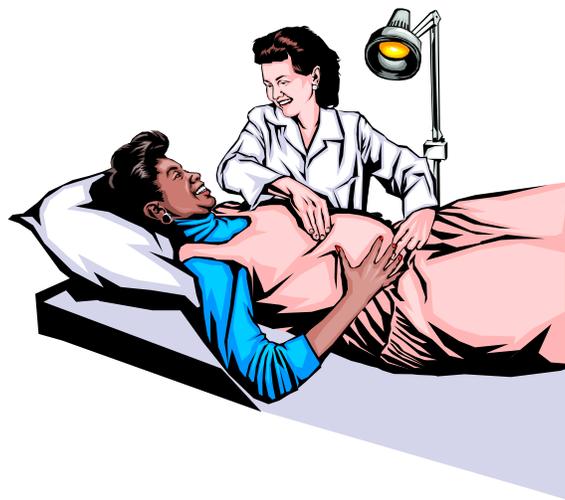


Service	Instructions
<p>Newborn Care in the Hospital</p> 	<p>Practitioner services provided to newborns in the hospital while the mother is also hospitalized may be billed using the mother's Colorado Medical Assistance Program State ID number and date of birth. Any services provided after mother's discharge must be submitted using the child's Colorado Medical Assistance Program State ID number. Under continuous eligibility, babies born to women enrolled in the Colorado Medical Assistance Program are eligible for program benefits until their first birthday as long as the baby remains in the mother's home. The mother or the provider must notify the local county department of human/social services of the infant's birth date, name and sex.</p> <p>Prompt notification avoids billing delays. Upon notification, the county will enroll the infant in the Colorado Medical Assistance Program and assign a State ID number.</p> <p>When billing newborn care under mother's State ID number, complete the claim with mother's name, mother's State ID number, mother's date of birth, and use modifier UK with each procedure code to identify that services were provided while mother and baby were hospitalized.</p> <p>If the infant is transferred to a different hospital or remains hospitalized after mother's discharge, claims must be submitted using the child's Colorado Medical Assistance Program State ID number. Claims for newborn care using the mother's State ID number after the mother's hospital discharge are denied.</p>
<p>Examination and evaluation of the healthy newborn</p>	<p>Use diagnosis code V30.00-V39.21 and a procedure code in the range 99460-99463. Use modifier UK with each submitted code as appropriate.</p> <p>EPSDT Periodicity Guidelines recommend initial newborn screenings at 3-5 days and 2 weeks.</p>
<p>Routine or ritual circumcision</p>	<p>As of July, 1, 2011 circumcision is no longer a benefit of the program. The following CPT codes are no longer being reimbursed 54150, 54160 or 54161. This change does not affect the CHP+ Program.</p>
<p>Newborn resuscitation or care of the high risk newborn at delivery</p>	<p>Includes, for example, inhalation therapy, aspiration, and administration of medication for initial stabilization. Bill using procedure code 99465-UK.</p>



### Special Provider Considerations

Provider	Service
Enrolled Certified Nurse Midwives	May provide OB care in accordance with the Colorado Medical Practice Act. Nurse Midwives submit claims in the same manner as physicians. Certified nurse midwives may act as assistant surgeon at cesarean.
Certified Family Nurse Practitioners or Certified Pediatric Nurse Practitioners 	Must be specifically identified and enrolled according to The Colorado Medical Assistance Program provider enrollment policy. These non-physician practitioners do not require direct and personal supervision of an on-premises, licensed, Colorado Medical Assistance Program-enrolled physician and may receive direct reimbursement.
Physician assistants other nurse practitioners	These providers do not qualify for direct reimbursement. The provider number of the supervising physician must appear in the supervising provider field on the claim record. Physician assistants, surgical assistants, and nurse practitioners may not serve as assistant surgeons.



## Paper Claim Reference Table

The following paper claim reference table shows required, optional, and conditional fields with detailed field completion instructions for submitting Obstetrical Care claims on the Colorado 1500 claim form.

Field Label	Completion format	Special Instructions
<b>Invoice/Pat Acct Number</b>	Up to 12 characters: letters, numbers or hyphens	Optional Enter 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>	N/A	N/A
<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)	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. Use the birth date given on the eligibility verification response. Example: 07012009 for July 1, 2009.
<b>3. Medicaid 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 exactly as it appears on the eligibility verification response. Each person has his/her own unique Colorado Medical Assistance Program ID number. Example: A123456
<b>4. Client Address</b>	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</b>	Up to 11 characters: numbers and letters	Conditional Complete if the client is eligible for Medicare benefits. Enter the individual's Medicare health insurance claim number.  The term "Medicare-Medicaid enrollee" refers to a person who is eligible for both Colorado Medical Assistance Program and Medicare benefits.

Field Label	Completion format	Special Instructions
<b>7. Client Relationship to Insured</b>	Check box Self    Spouse <input type="checkbox"/> <input type="checkbox"/> Child   Other <input type="checkbox"/> <input type="checkbox"/>	Conditional Complete if the client is covered by a commercial health care insurance policy. Enter a check mark or an “x” in the box that identifies the person’s relationship to the policyholder.
<b>8. Client Is Covered By Employer Health Plan</b>	Text	Conditional Complete if the client is covered by an employer health plan as policyholder or as a dependent. Enter the employer name policyholder’s name and group number. Also complete fields 9 and 9A.
<b>9. Other Health Insurance Coverage</b>	Text	Conditional Complete if the client has commercial health insurance coverage. Enter the name, address, policy number, and telephone numbers, if known, of the commercial health care insurer.
<b>9A. Policyholder Name and Address</b>	Text	Conditional Complete if the client has commercial health insurance coverage. Enter the name, address, and telephone number, if known, of the policyholder.
<b>10. Was Condition Related To</b>	Check box A. Client Employment Yes <input type="checkbox"/> B. Accident Auto <input type="checkbox"/> Other <input type="checkbox"/> C. Date of accident 6 digits: MMDDYY	Conditional Complete if the condition being treated is the result of employment, an automobile accident, or other accident. Enter a check mark or an “x” in the appropriate box. Enter the date of the accident in the marked boxes.
<b>11. CHAMPUS Sponsors Service/SSN</b>	Up to 10 characters	Conditional Complete if the client is covered under the Civilian Health And Medical Plan of the Uniformed Services (CHAMPUS). Enter the sponsor’s service number or SSN.
<b>Durable Medical Equipment Model/serial number (unlabeled field)</b>	N/A	N/A

Field Label	Completion format	Special Instructions
<p><b>12. Pregnancy</b></p> <p><b>HMO</b></p> <p><b>NF</b></p>	<p>Check box <input type="checkbox"/></p>	<p>Conditional Complete if the client is in the maternity cycle (i.e., pregnant or within 6 weeks postpartum).</p> <p>Conditional Complete if the client is enrolled in a Colorado Medical Assistance HMO.</p> <p>Conditional Complete if the client is a nursing facility resident.</p>
<p><b>13. Date of illness or injury or pregnancy</b></p>	<p>6 digits: MMDDYY</p>	<p>Optional Complete if information is known. Enter the following information as appropriate to the client's condition:</p> <p>Illness            Date of first symptoms</p> <p>Injury             Date of accident</p> <p>Pregnancy        Date of Last Menstrual Period (LMP)</p>
<p><b>14. Medicare Denial</b></p>	<p>Check box</p> <p><input type="checkbox"/> Benefits Exhausted</p> <p><input type="checkbox"/> Non-covered services</p>	<p>Conditional Complete if the client has Medicare coverage and Medicare denied the benefits or does not cover the billed services.</p> <p>Enter a check mark or an "x" in the Benefits Exhausted box if a Medicare payment voucher shows that Medicare has denied payment because a limited benefit is exhausted. A copy of the Medicare denial notice must be provided upon request.</p> <p>Enter a check mark or an "x" in the Non-covered Services box if a Medicare publication or denial notice shows the billed service(s) is/are not a Medicare covered benefit. A copy of the Medicare denial or Medicare publication showing that the service is not covered must be provided upon request.</p> <p>Bill claims for Medicare denied services and Medicare crossover claims separately.</p>

Field Label	Completion format	Special Instructions
<p><b>14A. Other Coverage Denied</b></p>	<p>Check box                      No <input type="checkbox"/>                      Yes <input type="checkbox"/>                      Pay/Deny Date                      6 digits: MMDDYY</p>	<p>Conditional                      Complete if the client has commercial health care insurance coverage.                      Enter a check mark or an “x” in the “No” box if the other coverage has paid a portion of the billed charges.                      If the other coverage payment amount is the same or more than the Colorado Medical Assistance Program benefit, the Colorado Medical Assistance Program will not make additional payment.                      Enter a check mark or an “x” in the “Yes” box if the other coverage carrier has denied payment or has applied all of the allowed benefit to a deductible.                      Enter the date of the other coverage payment or denial.</p>
<p><b>15. Name of supervising physician</b></p>	<p>Text                      8 digits</p>	<p>Conditional                      Complete if the individual who performs the service (rendering provider) is a non-physician practitioner who requires on-premises supervision by a licensed physician (see Provider Participation).                      Enter the eight digit Colorado Medical Assistance Program provider number assigned to the on-premises supervising physician.</p>
<p><b>16. For services related to hospitalization</b></p>	<p>6 digits: MMDDYY</p>	<p>Admitted <input type="text" value="MM"/> <input type="text" value="DD"/> <input type="text" value="YY"/> Discharged <input type="text" value="MM"/> <input type="text" value="DD"/> <input type="text" value="YY"/>                      Conditional                      Complete for services provided in an inpatient hospital setting. Enter the date of hospital admission and the date of discharge, if known. If the client is still hospitalized, the discharge date may be omitted. This information is not edited</p>
<p><b>17. Name and address of facility where services rendered                      Provider Number</b></p>	<p>Text (address is optional)                      8 digits</p>	<p>Conditional                      Complete for services provided in a hospital or nursing facility. Enter the name of the hospital or nursing facility. This information is not edited.                      Complete for services provided in a hospital or nursing facility. Enter the Colorado Medical Assistance Program provider number of hospital or nursing facility, if known. This information is not edited.</p>

Field Label	Completion format	Special Instructions															
<b>17A. Check box if laboratory work performed outside physician office</b>	Check box <input type="checkbox"/>	Conditional Complete if <u>all</u> laboratory work was referred to and performed by an outside laboratory. Practitioners may not request payment for services performed by an independent or hospital laboratory.															
<b>18. ICD-9-CM</b>	1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/> Codes: 3, 4, or 5 characters. 1 <sup>st</sup> character may be a letter.	Required At least one diagnosis code must be entered. 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. Example (May require 4 <sup>th</sup> or 5 <sup>th</sup> digit): <table border="1" data-bbox="878 842 1435 1083"> <thead> <tr> <th><u>ICD-9-CM description</u></th> <th><u>Code</u></th> <th><u>Claim Entry</u></th> </tr> </thead> <tbody> <tr> <td>Septic shock</td> <td>785.59</td> <td>7   8   5   5   9</td> </tr> <tr> <td>Fractured ankle</td> <td>824</td> <td>8   2   4   X  </td> </tr> <tr> <td>Dehydration</td> <td>276.5</td> <td>2   7   6   5   X</td> </tr> <tr> <td>Normal pregnancy</td> <td>V22</td> <td>V   2   2   X  </td> </tr> </tbody> </table> Independent labs may use diagnosis V71 on all claims.	<u>ICD-9-CM description</u>	<u>Code</u>	<u>Claim Entry</u>	Septic shock	785.59	7   8   5   5   9	Fractured ankle	824	8   2   4   X	Dehydration	276.5	2   7   6   5   X	Normal pregnancy	V22	V   2   2   X
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Dehydration	276.5	2   7   6   5   X															
Normal pregnancy	V22	V   2   2   X															
<b>Diagnosis or nature of illness or injury</b>	Text	Written description is not required. If entered, the written description must match the code(s).															
<b>Transportation Certification attached</b>	Check box <input type="checkbox"/>	Conditional Complete for emergency transportation and wheelchair van services. Enter a check mark or an "x" to certify that you have a transportation certificate or trip sheet on file for this service.															
<b>Prior Authorization No.</b>	6 characters: Letter plus 5 digits	Conditional Enter the 6 character prior authorization number from the approved Prior Authorization Request (PAR). Do not combine services from more than one approved PAR on a single claim form. Do not attach a copy of the approved PAR unless advised to do so by the authorizing agent or the fiscal agent.															

Field Label	Completion format	Special Instructions																														
<p><b>19A.-19L. Detail Billing Lines – Labels</b></p>	<p>At least one detail billing line must be completed fully</p>	<p>Required</p> <p>The paper claim form allows entry of up to six detailed billing lines. Fields 19A through 19L apply to each billed line.</p> <p><b>Do not enter more than six lines of information</b> on the paper claims. If more than six lines of information are entered, the additional lines will not be entered for processing.</p> <p>Each claim form must be fully completed (totaled).</p> <p><b>Do not file continuation claims</b> (e.g., Page 1 of 2).</p>																														
<p><b>19A. Date of Service</b></p>	<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> <table border="1" data-bbox="883 982 1292 1062"> <tr> <td>From</td> <td>To</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>01</td> <td>01</td> <td>2014</td> <td></td> <td></td> <td></td> </tr> </table> <p>Or</p> <table border="1" data-bbox="883 1108 1292 1188"> <tr> <td>From</td> <td>To</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>01</td> <td>01</td> <td>2014</td> <td>01</td> <td>01</td> <td>2014</td> </tr> </table> <p>Span dates of service</p> <table border="1" data-bbox="883 1234 1292 1276"> <tr> <td>01</td> <td>01</td> <td>2014</td> <td>01</td> <td>31</td> <td>2014</td> </tr> </table> <p>Practitioner claims must be consecutive days.</p> <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> <p><b>Global Obstetrical care</b></p> <p>For global obstetrical care, the “From” and “To” dates of service must be entered as the date of delivery.</p>	From	To					01	01	2014				From	To					01	01	2014	01	01	2014	01	01	2014	01	31	2014
From	To																															
01	01	2014																														
From	To																															
01	01	2014	01	01	2014																											
01	01	2014	01	31	2014																											

Field Label	Completion format	Special Instructions
<p><b>19B. Place of Service</b></p>	<p>2 digits</p>	<p>Required</p> <p>Enter the Place Of Service (POS) code that describes the location where services were rendered. The Colorado Medical Assistance Program accepts the CMS place of service codes.</p> <ul style="list-style-type: none"> <li>03 School</li> <li>04 Homeless Shelter</li> <li>05 IHS Free-Standing Facility</li> <li>06 Provider-Based Facility</li> <li>07 Tribal 638 Free-Standing</li> <li>08 Tribal 638 Provider-Based</li> <li>11 Office</li> <li>12 Home</li> <li>15 Mobile Unit</li> <li>20 Urgent Care Facility</li> <li>21 Inpatient hospital</li> <li>22 Outpatient hospital</li> <li>23 Emergency room hospital</li> <li>24 ASC</li> <li>25 Birthing Center</li> <li>26 Military Treatment Center</li> <li>31 Skilled Nursing Facility</li> <li>32 Nursing facility</li> <li>33 Custodial Care Facility</li> <li>34 Hospice</li> <li>41 Transportation Land</li> <li>42 Air or water transportation</li> <li>50 Federally Qualified Health Center</li> <li>51 Inpatient Psychiatric Facility</li> <li>52 Psychiatric Facility Partial Hospitalization</li> <li>53 Community mental health center</li> <li>54 Intermediate Care Facility - MR</li> <li>55 Residential Treatment Facility</li> <li>60 Mass Immunization Center</li> <li>61 Comprehensive IP Rehab Facility</li> <li>62 Comprehensive OP Rehab Facility</li> <li>65 End Stage Renal Dialysis Trtmt Facility</li> <li>71 State-Local Public Hlth Clinic</li> <li>72 Rural Health Clinic</li> <li>81 Independent lab</li> <li>99 Other Unlisted</li> </ul>

Field Label	Completion format	Special Instructions
<p><b>19C. Procedure Code (HCPCS)</b></p>	<p>5 characters: 5 digits or 1 letter plus 4 digits or 2 letters plus 3 digits</p>	<p>Required Enter the HCPCS procedure code that specifically describes the service for which payment is requested. All procedures must be identified with codes in the current edition of Physicians Current Procedural Terminology (CPT). CPT is updated annually. HCPCS Level II Codes The current Medicare coding publication (for Medicare crossover claims only). Only approved codes from the current CPT or HCPCS publications will be accepted.</p>
<p><b>Modifiers</b></p>	<p>2 characters: Letters or digits May enter up to two 2 character modifiers</p>	<p>Conditional Enter the appropriate procedure-related modifier that applies to the billed service. Up to four modifiers may be entered when using the paper claim form.</p> <ul style="list-style-type: none"> <li>-22 Delivery of multiples</li> <li>-26 Professional component</li> <li>-47 Anesthesia by surgeon</li> <li>-80 Assistant surgeon</li> <li>-TC Technical component</li> <li>-TH Obstetrical Treatment/Services, Prenatal or Postpartum</li> <li>-UK Services provided while mother and baby were hospitalized</li> </ul>
<p><b>19D. Rendering Provider Number.</b></p>	<p>8 digits</p>	<p>Required Enter the eight-digit Colorado Medical Assistance Program provider number assigned to the <u>individual</u> who actually performed or rendered the billed service. This number cannot be assigned to a group or clinic.</p>
<p><b>19E. Referring Provider Number.</b></p>	<p>8 digits</p>	<p>Conditional Complete for clients enrolled in the Primary Care Physician (PCP) program if: The rendering or billing provider is not the primary care provider - <u>and</u> The billed service requires PCP referral.</p>



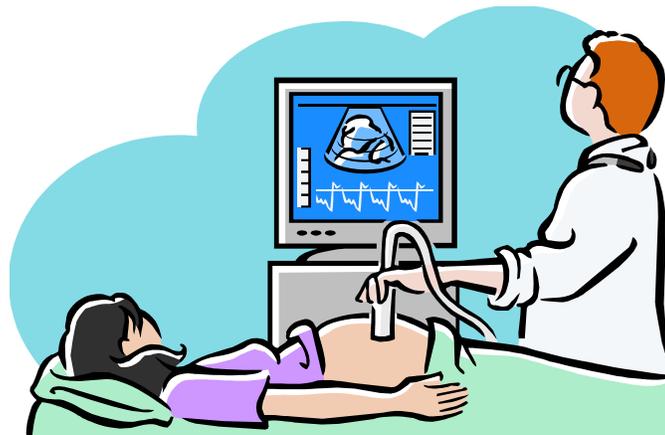
Field Label	Completion format	Special Instructions										
<p><b>19G. Charges</b> (continued)</p>	<p>7 digits: Currency 99999.99</p>	<p>Submitted charges cannot be more than charges made to non-Colorado Medical Assistance Program covered individuals for the same service.</p> <p>Do not deduct Colorado Medical Assistance Program co-payment or commercial insurance payments from usual and customary charges.</p>										
<p><b>19H. Days or Units</b></p>	<p>4 digits</p>	<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> <p><b>General Instructions</b></p> <p>A unit represents the number of times the described procedure or service was rendered.</p> <p>Except as instructed in this manual or in Colorado Medical Assistance Program bulletins, the billed unit must correspond to procedure code description. The following examples show the relationship between the procedure description and the entry of units.</p> <p>Note: The codes used in the examples are not actual CPT codes. They are used for illustration only.</p> <p><b>Codes that define units as inclusive numbers</b></p> <p>Some services such as allergy testing define units by the number of services as an inclusive number, not as additional services.</p> <table border="0"> <thead> <tr> <th><u>Code</u></th> <th><u>Description</u></th> </tr> </thead> <tbody> <tr> <td>11111</td> <td>Patch or application tests, up to 10 tests</td> </tr> <tr> <td>22222</td> <td>11-20 tests</td> </tr> <tr> <td>33333</td> <td>21-30 tests</td> </tr> <tr> <td>44444</td> <td>More than 30 tests</td> </tr> </tbody> </table>	<u>Code</u>	<u>Description</u>	11111	Patch or application tests, up to 10 tests	22222	11-20 tests	33333	21-30 tests	44444	More than 30 tests
<u>Code</u>	<u>Description</u>											
11111	Patch or application tests, up to 10 tests											
22222	11-20 tests											
33333	21-30 tests											
44444	More than 30 tests											

Field Label	Completion format	Special Instructions
<b>19H. Days or Units</b> (continued)	4 digits	<u>Billing example</u> Total tests: 8 Bill 11111 - 1 unit Total tests: 14 Bill 22222 - 1 unit and 22222 - 2 units (Do not bill both 11111 and 22222) Total tests: 35 Bill 44444 - 1 unit
<b>19I. COPAY</b>	1 digit	Conditional Complete if co-payment is required of this client for this service. Enter one of the following codes: 1-Refused to pay co-payment 2-Paid co-payment 3-Co-payment not requested
<b>19J. Emergency</b>	Check box <input type="checkbox"/>	Conditional Enter a check mark or an "x" in the column to indicate the service is rendered for a life-threatening condition or one that requires immediate medical intervention. If checked, the service on this detail line is exempt from co-payment and from PCP Program referral requirements.
<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. If checked, the service on this detail line is exempt from co-payment and from PCP Program referral requirements.
<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.

Field Label	Completion format	Special Instructions
<b>Medicare SPR Date (unlabeled field)</b>	6 digits: MMDDYY	Conditional Complete for Medicare crossover claims. Enter the date of the Medicare Standard Paper Remit (SPR) or Electronic Remittance Advice (ERA). <ul style="list-style-type: none"> <li>▪ Do not complete this field if Medicare denied all benefits.</li> <li>▪ Do not combine items from several SPRs/ERAs on a single claim form.</li> <li>▪ Bill for as many crossover items as appear on a single SPR/ERA up to a maximum of 6 lines. Complete separate claim forms for additional lines on the SPR/ERA.</li> <li>▪ Providers must submit a copy of the SPR/ERA with paper claims. Be sure to retain the original SPR/ERA for audit purposes.</li> </ul>
<b>20. Total Charges</b>	7 digits: Currency 99999.99	Required Enter the sum of all charges listed in 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	Conditional Complete for Medicare crossover claims. Enter the Medicare payment amount shown on the Medicare payment voucher.
<b>22. Third Party Paid</b>	7 digits: Currency 99999.99	Conditional Complete if the client has commercial health insurance and the third party resource has made payment on the billed services. Enter the amount of the third party payment shown on the third party payment voucher. Do <b>not</b> enter Colorado Medical Assistance Program co-payment in this field or anywhere else on the claim form.
<b>23. Net Charge</b>	7 digits: Currency 99999.99	Required <b>Colorado Medical Assistance Program claims (Not Medicare Crossover)</b> Claims without third party payment. Net charge equals the total charge (field 20). Claims with third party payment. Net charge equals the total charge (field 20) minus the third party payment (field 22) amount.

Field Label	Completion format	Special Instructions
<p><b>23. Net Charge</b> (continued)</p>	<p>7 digits: Currency 99999.99</p>	<p><b>Medicare Crossover claims</b> Crossover claims without third party payment. Net charge equals the sum of the Medicare deductible amount (field 24) plus the Medicare coinsurance (field 25) amount.  Crossover claims with third party payment. Net charge equals the sum of the Medicare deductible amount (field 24) plus the Medicare coinsurance (field 25) amount minus the third party payment (field 22) amount.</p>
<p><b>24. Medicare Deductible</b></p>	<p>7 digits: Currency 99999.99</p>	<p>Conditional 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>Conditional 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>Conditional Complete for Medicare crossover claims. Enter the amount Medicare disallowed, if any, shown on the Medicare payment voucher.</p>
<p><b>27. Signature</b></p>	<p>Text</p>	<p>Required Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent. A holographic signature stamp may be used <u>if</u> authorization for the stamp is on file with the fiscal agent. An authorized agent or representative may sign the claim for the enrolled provider <u>if</u> the name and signature of the agent is on file with the fiscal agent <b>Unacceptable signature alternatives:</b> Claim preparation personnel may not sign the enrolled provider’s name. Initials are not acceptable as a signature. Typed or computer printed names are not acceptable as a signature. “Signature on file” notation is not acceptable in place of an authorized signature</p>

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



# OB Claim Example

STATE OF COLORADO  
DEPARTMENT OF  
HEALTH CARE POLICY AND  
FINANCING

INVOICE/PAT ACCT NUMBER
SPECIAL PROGRAM CODE

## HEALTH INSURANCE CLAIM

### PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL) <b>Client Ima</b>	2. CLIENT DATE OF BIRTH <b>01/08/1992</b>	3. MEDICAID ID NUMBER (CLIENT ID NUMBER) <b>A555555</b>
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE) <b>123 Main Street Street Avenue Colorado CO</b>	5. CLIENT SEX MALE <input type="checkbox"/> FEMALE <input checked="" type="checkbox"/>	6. MEDICARE ID NUMBER (HIC OR SSN)
7. CLIENT RELATIONSHIP TO INSURED SELF <input checked="" type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. <input type="checkbox"/> CLIENT IS COVERED BY EMPLOYER HEALTH PLAN AS EMPLOYEE OR DEPENDENT	
9. OTHER HEALTH INSURANCE COVERAGE — INSURANCE COMPANY NAME, ADDRESS, PLAN NAME, AND POLICY NUMBER(S)	10. WAS CONDITION RELATED TO: A. CLIENT EMPLOYMENT YES <input type="checkbox"/> B. ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/> C. DATE OF ACCIDENT <div style="border: 1px solid black; width: 50px; height: 15px; margin: 5px auto;"></div>	
9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)	11. CHAMPUS SPONSORS SERVICE/SSN	
12. PREGNANCY <input checked="" type="checkbox"/> HMO <input type="checkbox"/> NURSING FACILITY <input type="checkbox"/>		

### PHYSICIAN OR SUPPLIER INFORMATION

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

18. ICD-9-CM DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. IN COLUMN F, RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE NUMBERS 1, 2, 3, OR 4 1. <b>V22X Normal pregnancy</b>	TRANSPORTATION CERTIFICATION ATTACHED <input type="checkbox"/> YES
2. _____	DURABLE MEDICAL EQUIPMENT Line # Make Model Serial Number
3. _____	PRIOR AUTHORIZATION #:
4. _____	

19A DATE OF SERVICE FROM	19B DATE OF SERVICE TO	19C PLACE OF SERVICE	19D PROCEDURE CODE (HPCS)	19E MODIFIERS	19F RENDERING PROVIDER NUMBER	19G REFERRING PROVIDER NUMBER	19H DIAGNOSIS P	19I DIAGNOSIS S	19J DIAGNOSIS T	19K CHARGES	19L DAYS OR UNITS	19M COPAY	19N EMERGENCY	19O FAMILY PLANNING	19P EPSDT
12/31/2013	12/31/2013	11	59400				1			\$1,200.00	1		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE <i>Authorized Signature</i> 01/03/2014	20. TOTAL CHARGES → \$1,200.00	21. MEDICARE PAID \$0.00
28. BILLING PROVIDER NAME D. R. Momma, M.D.	22. THIRD PARTY PAID \$0.00	24. MEDICARE DEDUCTIBLE \$0.00
29. BILLING PROVIDER NUMBER 12345678	23. NET CHARGE \$1,200.00	25. MEDICARE COINSURANCE \$0.00
30. REMARKS	26. MEDICARE DISALLOWED	MEDI CARE SPR DATE

COL-101  
FORM NO. 94320 (REV. 02/99)  
ELECTRONIC APPLICATION

**COLORADO 1500**

## Late Bill Override Date

For electronic claims, a delay reason code must be selected and a date must be noted in the “Claim Notes/LBOD” field.

### Valid Delay Reason Codes

- 1 Proof of Eligibility Unknown or Unavailable
- 3 Authorization Delays
- 7 Third Party Processing Delay
- 8 Delay in Eligibility Determination
- 9 Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules
- 11 Other



The Late Bill Override Date (LBOD) allows providers to document compliance with timely filing requirements when the initial timely filing period has expired. Colorado Medical Assistance Program providers have 120 days from the date of service to submit their claim. For information on the 60-day resubmission rule for denied/rejected claims, please see the General Provider Information manual in the Provider Services [Billing Manuals](#) section of the Department’s website.

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

Billing Instruction Detail	Instructions
<p><b>Denied Paper Claims</b></p>	<p>If the initial timely filing period has expired and a previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was denied.</p> <p><b>Correct the claim errors and refile within 60 days</b> of the claim denial or rejection. Retain all documents that prove compliance with timely filing requirements.</p> <p><b>LBOD</b> = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the denial.</p>
<p><b>Returned Paper Claims</b></p>	<p>A previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was returned for additional information.</p> <p><b>Correct the claim errors and re-file within 60 days</b> of the date stamped on the returned claim. Retain a copy of the returned claim that shows the receipt or return date stamped by the fiscal agent.</p> <p><b>LBOD</b> = the stamped fiscal agent date on the returned claim.</p>
<p><b>Rejected Electronic Claims</b></p>	<p>An electronic claim that was previously entered within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was rejected and information needed to submit the claim was not available to refile at the time of the rejection.</p> <p><b>Correct claim errors and refile within 60 days</b> of the rejection. Maintain a printed copy of the rejection notice that identifies the claim and date of rejection.</p> <p><b>LBOD</b> = the date shown on the claim rejection report.</p>
<p><b>Denied/Rejected Due to Client Eligibility</b></p>	<p>An electronic eligibility verification response processed during the original Colorado Medical Assistance Program timely filing period states that the individual was not eligible but you were subsequently able to verify eligibility. Read also instructions for retroactive eligibility.</p> <p><b>File the claim within 60 days</b> of the date of the rejected eligibility verification response. Retain a printed copy of the rejection notice that identifies the client and date of eligibility rejection.</p> <p><b>LBOD</b> = the date shown on the eligibility rejection report.</p>
<p><b>Retroactive Client Eligibility</b></p>	<p>The claim is for services provided to an individual whose Colorado Medical Assistance Program eligibility was backdated or made retroactive.</p> <p>File the claim within 120 days of the date that the individual's eligibility information appeared on state eligibility files. Obtain and maintain a letter or form from the county departments of social services that:</p> <ul style="list-style-type: none"> <li>• Identifies the patient by name</li> <li>• States that eligibility was backdated or retroactive</li> <li>• Identifies the date that eligibility was added to the state eligibility system.</li> </ul> <p><b>LBOD</b> = the date shown on the county letter that eligibility was added to or first appeared on the state eligibility system.</p>

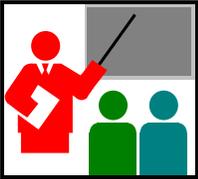
Billing Instruction Detail	Instructions
<p><b>Delayed Notification of Eligibility</b></p>	<p>The provider was unable to determine that the patient had Colorado Medical Assistance Program coverage until after the timely filing period expired.</p> <p><b>File the claim within 60 days</b> of the date of notification that the individual had Colorado Medical Assistance Program coverage.</p>
<p><b>Delayed Notification of Eligibility</b></p>	<p>Retain correspondence, phone logs, or a signed Delayed Eligibility Certification form (in the Provider Services <a href="#">Forms</a> section of the Department’s website) 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. Maintain the original SPR/ERA on file.</p> <p><b>LBOD</b> = the Medicare processing date shown on the SPR/ERA.</p>

Billing Instruction Detail	Instructions
<p><b>Commercial Insurance Processing</b></p>	<p>The claim has been paid or denied by commercial insurance.  <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.                      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.  <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.  <b>File the claim within 60 days</b> of the date on the authorization letter. Retain the authorization letter.  <b>LBOD</b> = the date on the authorization letter.</p>
<p><b>Client Changes Providers during Obstetrical Care</b></p>	<p>The claim is for obstetrical care where the patient transferred to another provider for continuation of OB care. The prenatal visits must be billed using individual visit codes but the service dates are outside the initial timely filing period.  <b>File the claim within 60 days</b> of the last OB visit. Maintain information in the medical record showing the date of the last prenatal visit and a notation that the patient transferred to another provider for continuation of OB care.  <b>LBOD</b> = the last date of OB care by the billing provider.</p>

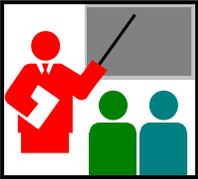


## Sterilizations, Hysterectomies, and Abortions

Billing Instruction Detail	Instructions
<p style="text-align: center;"><b>Sterilizations, Hysterectomies, and Abortions</b></p> 	<p><b>Voluntary sterilizations</b></p> <p>Sterilization for the purpose of family planning is a benefit of the Colorado Medical Assistance Program in accordance with the following procedures:</p> <p><b>General requirements</b></p> <p>The following requirements must be followed precisely or payment will be denied. These claims <b>must</b> be filed on paper. A copy of the sterilization consent form (MED-178) must be attached to each related claim for service including the hospital, anesthesiologist, surgeon, and assistant surgeon.</p> <ul style="list-style-type: none"> <li>▪ The individual must be at least 21 years of age at the time the consent is obtained.</li> <li>▪ The individual must be mentally competent. An individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose cannot consent to sterilization. The individual can consent if she has been declared competent for purposes that include the ability to consent to sterilization.</li> <li>▪ The individual must voluntarily give "informed" consent as documented on the MED-178 consent form (see illustration) and specified in the "Informed Consent Requirements" described in these instructions.</li> <li>▪ At least 30 days but not more than 180 days must pass between the date of informed consent and the date of sterilization with the following exceptions:</li> </ul> <p><b>Emergency Abdominal Surgery:</b> An individual may consent to sterilization at the time of emergency abdominal surgery if at least 72 hours have passed since he/she gave informed consent for the sterilization.</p> <p><b>Premature Delivery:</b> A woman may consent to sterilization at the time of a premature delivery if at least 72 hours have passed since she gave informed consent for the sterilization and the consent was obtained at least 30 days prior to the expected date of delivery.</p>

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<p><b>Sterilizations, Hysterectomies, and Abortions</b></p> 	<p>The person may not be an "institutionalized individual".</p> <p>Institutionalized includes:</p> <ul style="list-style-type: none"> <li>▪ Involuntarily confinement or detention, under a civil or criminal statute, in a correctional or rehabilitative facility including a mental hospital or other facility for the care and treatment of mental illness.</li> <li>▪ Confinement under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.</li> </ul> <p><b>If any of the above requirements are not met, the claim will be denied.</b></p> <p>Unpaid or denied charges resulting from clerical errors such as the provider's failure to follow the required procedures in obtaining informed consent or failure to submit required documentation with the claim may not be billed to the client.</p> <p><b>Informed consent requirements</b></p> <p>The person obtaining informed consent must be a professional staff member who is qualified to address all the consenting individual's questions concerning medical, surgical, and anesthesia issues.</p> <p>Informed consent is considered to have been given when the person who obtained consent for the sterilization procedure meets <b>all</b> of the following criteria:</p> <ul style="list-style-type: none"> <li>▪ Has offered to answer any questions that the individual who is to be sterilized may have concerning the procedure</li> <li>▪ Has provided a copy of the consent form to the individual</li> <li>▪ Has verbally provided all of the following information or advice to the individual who is to be sterilized: <ul style="list-style-type: none"> <li>➤ Advice that the individual is free to withhold or withdraw consent at any time before the sterilization is done without affecting the right to any future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled</li> <li>➤ A description of available alternative methods of family planning and birth control</li> <li>➤ Advice that the sterilization procedure is considered to be irreversible</li> <li>➤ A thorough explanation of the specific sterilization procedure to be performed</li> <li>➤ A full description of the discomforts and risks that may accompany or follow the performing of the procedure including an explanation of the type and possible effects of any anesthetic to be used.</li> </ul> </li> </ul>

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<p><b>Sterilizations, Hysterectomies, and Abortions</b></p> 	<p><b>Completion of the MED-178 consent form</b></p> <p>Please refer to the MED-178 Instructions on the Department’s website (<a href="http://colorado.gov/hcpf">colorado.gov/hcpf</a>)→Provider Services→<a href="#">Forms</a>→Sterilization Consent Forms. Information entered on the consent form must correspond directly to the information on the submitted Colorado Medical Assistance Program claim form.</p> <p>Federal regulations require strict compliance with the requirements for completion of the MED-178 consent form or claim payment is denied. Claims that are denied because of errors, omissions, or inconsistencies on the MED-178 may be resubmitted if corrections to the consent form can be made in a legally acceptable manner.</p> <p>Any corrections to the patient's portion of the sterilization consent must be approved and initialed by the patient.</p> <p><b>Hysterectomies</b></p> <p>Hysterectomy is a benefit of the Colorado Medical Assistance Program when performed solely for medical reasons. Hysterectomy is <u>not</u> a benefit of the Colorado Medical Assistance Program if the procedure is performed solely for the purpose of sterilization, or if there was more than one purpose for the procedure and it would not have been performed but for the purpose of sterilization.</p> <p><b>The following conditions must be met for payment of hysterectomy claims under the Colorado Medical Assistance Program.</b> These claims must be filed on paper.</p> <ul style="list-style-type: none"> <li>• Prior to the surgery, the person who secures the consent to perform the hysterectomy must inform the patient and her representative, if any, verbally and in writing that the hysterectomy will render the patient permanently incapable of bearing children.</li> <li>• The patient and her representative, if any, must sign a written acknowledgment that she has been informed that the hysterectomy will render her permanently incapable of reproducing. The written acknowledgment may be any form created by the provider that states specifically that, “I acknowledge that prior to surgery, I was advised that a hysterectomy is a procedure that will render me permanently incapable of having children.” The acknowledgment must be signed and dated by the patient.</li> </ul> <p>A written acknowledgment from the patient is not required if:</p> <ul style="list-style-type: none"> <li>• The patient is already sterile at the time of the hysterectomy, or</li> <li>• The hysterectomy is performed because of a life-threatening emergency in which the practitioner determines that prior acknowledgment is not possible.</li> </ul>

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<p><b>Sterilizations, Hysterectomies, and Abortions</b> (continued)</p> 	<p>If the patient’s acknowledgment is not required because of the one of the above noted exceptions, the practitioner who performs the hysterectomy <b>must certify in writing</b>, as applicable, one of the following:</p> <ul style="list-style-type: none"> <li>• A signed and dated statement certifying that the patient was already sterile at the time of hysterectomy and stating the cause of sterility;</li> <li>• A signed and dated statement certifying that the patient required hysterectomy under a life-threatening, emergency situation in which the practitioner determined that prior acknowledgment by the patient was not possible. The statement must describe the nature of the emergency.</li> </ul> <p>A copy of the patient’s written acknowledgment or the practitioner’s certification as described above must be attached to all claims submitted for hysterectomy services. A suggested form on which to report the required information is located in <b>Claim Forms and Attachments</b> in the Provider Services <a href="#">Forms</a> section of the Department’s website. Providers may copy this form, as needed, for attachment to claim(s). Providers may substitute any form that includes the required information. The submitted form or case summary documentation must be signed and dated by the practitioner performing the hysterectomy.</p> <p>The surgeon is responsible for providing copies of the appropriate acknowledgment or certification to the hospital, anesthesiologist, and assistant surgeon for billing purposes. <b>Claims will be denied if a copy of the written acknowledgment or practitioner’s statement is not attached.</b></p> <p><b>Abortions</b></p> <p><b>Induced abortions</b></p> <p>Therapeutic legally induced abortions are a benefit of the Colorado Medical Assistance Program when performed to save the life of the mother. The Colorado Medical Assistance Program also reimburses legally induced abortions for pregnancies that are the result of sexual assault (rape) or incest.</p> <p>A copy of the appropriate certification statement must be attached to all claims for legally induced abortions performed for the above reasons. Because of the attachment requirement, claims for legally induced abortions must be submitted on paper and must <b>not</b> be electronically transmitted. Claims for spontaneous abortions (miscarriages), ectopic, or molar pregnancies are not affected by these regulations.</p> <p>The following procedure codes are appropriate for identifying induced abortions:</p> <ul style="list-style-type: none"> <li>• 59840      • 59841      • 59850      • 59851</li> <li>• 59852      • 59855      • 59856      • 59857</li> </ul>

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<p><b>Sterilizations, Hysterectomies, and Abortions</b> (continued)</p> 	<p>Diagnosis code ranges: (decimal not required when billing)</p> <p>635.00-635.92</p> <p>637.00-637.92</p> <p>Surgical diagnosis codes:</p> <ul style="list-style-type: none"> <li>• 69.01      • 69.51      • 69.93      • 74.91      • 75.0</li> </ul> <p><b>Providers billing on the Colorado 1500 claim form</b></p> <p>Use the appropriate procedure/diagnosis code from the list above <b>and</b> the most appropriate modifier from the list below:</p> <ul style="list-style-type: none"> <li>• G7 - Termination of pregnancy resulting from rape, incest, or certified by physician as life threatening.</li> </ul> <p>In addition to the required coding, all claims must be submitted with the required documentation. Claims submitted for induced abortion-related services submitted without the required documentation will be denied.</p> <p><b>Providers billing on the UB-04 claim form</b></p> <p>Use the appropriate procedure/diagnosis code from those listed previously <b>and</b> the most appropriate condition code from the list below:</p> <ul style="list-style-type: none"> <li>• AA Abortion Due to Rape</li> <li>• AB Abortion Done Due to Incest</li> <li>• AD Abortion Due to Life Endangerment</li> </ul> <p>In addition to the required coding, all claims must be submitted with the required documentation. Claims submitted for induced abortion-related services submitted without the required documentation will be denied.</p> <p><b>Induced abortions to save the life of the mother</b></p> <p>Every reasonable effort to preserve the lives of the mother and unborn child must be made before performing an induced abortion. The services must be performed in a licensed health care facility by a licensed practitioner, unless, in the judgment of the attending practitioner, a transfer to a licensed health care facility endangers the life of the pregnant woman and there is no licensed health care facility within a 30 mile radius of the place where the medical services are performed.</p> <p><b>“To save the life of the mother”</b> means:</p> <p>The presence of a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, as determined by the attending practitioner, which represents a serious and substantial threat to the life of the pregnant woman if the pregnancy is allowed to continue to term.</p>

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<p style="text-align: center;"><b>Sterilizations, Hysterectomies, and Abortions</b> (continued)</p> 	<p>The presence of a psychiatric condition which represents a serious and substantial threat to the life of the pregnant woman if the pregnancy continues to term.</p> <p>All claims for services related to induced abortions to save the life of the mother must be submitted with the following documentation:</p> <ul style="list-style-type: none"> <li>▪ Name, address, and age of the pregnant woman</li> <li>▪ Gestational age of the unborn child</li> <li>▪ Description of the medical condition which necessitated the performance of the abortion</li> <li>▪ Description of services performed</li> <li>▪ Name of the facility in which services were performed</li> <li>▪ Date services were rendered</li> </ul> <p>And, at least one of the following forms with additional supporting documentation that confirms life-endangering circumstances:</p> <ul style="list-style-type: none"> <li>▪ Hospital admission summary</li> <li>▪ Hospital discharge summary</li> <li>▪ Consultant findings and reports</li> <li>▪ Laboratory results and findings</li> <li>▪ Office visit notes</li> <li>▪ Hospital progress notes</li> </ul> <p><b>A suggested form on which to report the required information is in Claim Forms and Attachments</b> in the Provider Services <a href="#">Forms</a> section of the Department’s website. Providers may copy this form, as needed, for attachment to claim(s). Providers may substitute any form that includes the required information. The submitted form or case summary documentation must be signed and dated by the practitioner performing the abortion service.</p> <p>For psychiatric conditions lethal to the mother if the pregnancy is carried to term, the attending practitioner must:</p> <ul style="list-style-type: none"> <li>▪ Obtain consultation with a physician specializing in psychiatry.</li> <li>▪ Submit a report of the findings of the consultation unless the pregnant woman has been receiving prolonged psychiatric care.</li> </ul>

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<p style="text-align: center;"><b>Sterilizations, Hysterectomies, and Abortions</b> (continued)</p> 	<p><b>Spontaneous abortion (Miscarriage)</b> <b>Ectopic and molar pregnancies</b></p> <p>Surgical and/or medical treatment of pregnancies that have terminated spontaneously (miscarriages) and treatment of ectopic and molar pregnancies are routine benefits of the Colorado Medical Assistance Program. Claims for treatment of these conditions do not require additional documentation. The claim must indicate a diagnosis code that specifically demonstrates that the termination of the pregnancy was not performed as a therapeutic legally induced abortion.</p> <p>The following diagnosis codes are appropriate for identifying conditions that may properly be billed for Colorado Medical Assistance Program reimbursement.</p> <p>630            Hydatidiform Mole 631            Other Abnormal Products of Conception 632            Missed Abortion 633-633.91    Ectopic Pregnancy 634-639.9    Spontaneous Abortion 656.4          Intrauterine Death</p> <p>The following HCPCS (CPT) procedure codes may be submitted for covered abortion and abortion related services.</p> <p>58120            D &amp; C For Hydatidiform Mole 59100            Hysterectomy For Removal of Hydatidiform Mole 59812-59830    Medical and Surgical Treatment of Abortion</p> <p>Fetal anomalies incompatible with life outside the womb</p> <p>Therapeutic abortions performed due to fetal anomalies incompatible with life outside the womb are not a Colorado Medical Assistance Program benefit.</p>

***Obstetrical Care Revisions Log***

<b>Revision Date</b>	<b>Additions/Changes</b>	<b>Pages</b>	<b>Made by</b>
<i>01/20/2014</i>	<i>Created</i>	<i>All</i>	<i>ig</i>
<i>01/14/2014</i>	<i>Edited</i>	<i>Throughout</i>	<i>km</i>
<i>01/23/2014</i>	<i>Edited</i>	<i>Throughout</i>	<i>cc</i>
<i>01/23/2014</i>	<i>Formatted and updated TOC</i>	<i>Throughout</i>	<i>ig</i>
<i>01/30/2014</i>	<i>Removed condition codes A7 &amp; A8. Added condition codes AA, AB, &amp; AD</i>	<i>34</i>	<i>cc</i>