

Pediatric Personal Care Benefit Billing Manual

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Pediatric Personal Care Benefit Billing Manual

The purpose of this billing manual is to provide policy and billing guidance to providers to obtain reimbursement for personal care services. This manual is updated periodically to reflect changes in policy and regulations. It applies only to the Colorado Medicaid Pediatric Personal Care benefit and does not address services available through other Colorado Medicaid benefits or any services available through Home and Community-Based Services (HCBS) waiver programs.

Personal Care Benefit Overview

The Pediatric Personal Care benefit is available to Colorado Medicaid members 20 years old and younger who require personal care (PC) services.

Personal Care services are medically necessary services that do not require a provider to have a medical certification or a professional license to safely provide services. Under this benefit, a PC provider assists the Medicaid member with PC tasks in order to meet his or her physical, maintenance, and supportive needs. This assistance may take the form of hands-on assistance (actually performing a task for the person), supervision (ensuring a task is performed safely, including active intervention), or prompting or cuing the member to complete the task.

If a member requires support of a medically skilled caregiver to complete a task, such as bathing or hygiene, the associated task shall be considered skilled in nature and covered under other Medicaid state plan benefits and/or Colorado HCBS waiver programs.

Additional information about this benefit, including eligibility rules for providers, details about what tasks are covered, and interaction with other Colorado Medicaid programs, can be found in the Personal Care Benefit Coverage Standard.

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 that 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. Class A and Class B Home Care Agencies must have a NPI in order to bill for services rendered.

Eligible Providers

Prescribing/Ordering Providers

- Physician, either a Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO)
- Advanced Practice Nurse (APN)

Note: Under the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation, all 485 Plans of Care – or other form with identical content – must be signed by an MD, DO, or APN.

Rendering and Billing Provider Numbers

Personal Care services must be billed using the 837 Professional (837P) transaction or CMS 1500 form, which requires using rendering provider identification numbers.

Class B agencies billing for PC services through Web Portal must enter their billing number in the Rendering Provider ID field on the Detail Line Items tab or in line 24J of the CMS 1500 Professional claim form.

Each agency's specific billing number will be used to reimburse the claim.

Prior Authorization Requests (PARs)

The ColoradoPAR Program is Colorado Medicaid's Utilization Management (UM) Program. A third-party vendor reviews Prior Authorization Requests (PARs) to ensure services requested meet medical necessity guidelines and are within Colorado Medicaid's policies.

The ColoradoPAR Program's third-party vendor processes electronic PARs through an online PAR portal. The online PAR portal is a web-based HIPAA-compliant PAR system that offers providers 24/7 access to the information and functions providers need. Clinical documentation will be accepted in the following formats: doc, docx, xls, xlsx, ppt, pdf, jpg, gif, bmp, tiff, tif, and jpeg.

See ColordaoPAR.com for information and instructions on how to submit PARs electronically through the online PAR portal. For additional assistance or support, contact

the ColoradoPAR provider helpline at 888-801-9355. PAR status may be verified in the online PAR portal or by contacting the ColoradoPAR provider helpline. The approved PAR identification number must be submitted with the claim to receive payment.

Claims for prior authorized services must be submitted within 120 days of the date of service. Services rendered prior to the authorized date will be denied reimbursement.

Approval of the PAR does not guarantee payment by Medicaid. The member and the PC provider shall meet all applicable eligibility requirements at the time services are rendered and services shall be delivered in accordance with all applicable service limitations. Medicaid is the payer of last resort and the presence of an approved or partially approved PAR does not release the agency from the requirement to bill Medicare or other third party insurance prior to billing Medicaid.

PAR Requirements

Any provider submitting a PAR must be enrolled in the Colorado Medicaid Program for. Providers must also verify eligibility at the time service is rendered and include the necessary information with the PAR.

- All PC services require prior authorization by Colorado Medicaid's third-party vendor using the approved prior authorization request online portal.
- The PAR is comprised of a completed Personal Care Assessment Tool (PCAT), the physician's orders, and the Plan of Care:
 - The PCAT can be completed by a Class A or B agency
 - PC services must be ordered in writing by the member's prescribing provider as part of a written Plan of Care
 - The prescribing provider's order and signed Plan of Care must be submitted with the PCAT as part of the PAR
- It is the agency's responsibility to provide sufficient documentation to support the medical necessity for the requested services.
- PC services PARs may be submitted for up to a full year of anticipated services unless:

- The member is not expected to need a full year of services
- The member's eligibility is not expected to span the entire year or,
- As otherwise specified by Colorado Medicaid
- PARs must be submitted to Colorado Medicaid's third-party vendor in accordance with 10 CCR 2505-10 § 8.058.
- A PAR will be pended by Colorado Medicaid's third-party vendor if all of the required information is not provided in the PAR, or additional information is required by the third-party vendor to complete the review. If the third-party vendor does not receive the required documentation within four (4) business days, the PAR will be denied for lack of information.
- When a PAR includes a request for reimbursement for two (2) staff members at the same time (excluding supervisory visits) to perform two-person transfers or another PC task, documentation supporting the need for two (2) people and the reason adaptive equipment cannot be used must be included.
- All other information determined necessary by Colorado Medicaid's third-party vendor to make a decision on the medical necessity and appropriateness of the proposed treatment plan must be included.
- The agency is required to submit a PAR revision, which must include revisions to all documentation, including the Plan of Care, if/when the member experiences a change in condition necessitating a change in the amount, duration, or frequency of a member's PC services.
- When a member receiving PC services through Colorado Medicaid receives additional PC services through a Home and Community-Based Services (HCBS) waiver, the HCBS waiver program is considered the payer of last resort.
- The PAR will be reviewed by medical experts in children's health who work for the Colorado Medicaid program's third-party vendor. Nurses and doctors will decide if the request for personal care meets the rules for medical necessity and for the Personal Care Benefit.
- An approved PAR is valid for up to one (1) year. After one (1) year, a personal care provider must submit a new PAR for another year of PC services.

Peer-to-Peer and Reconsideration Process

Prior to denying or partially denying a PAR, the MD, DO, or APN who requested the PAR will be contacted to discuss the PAR over the phone in a process called a Peer-To-Peer review. If the Peer-To-Peer review still results in a denied or partially denied PAR, the personal care provider can work with the MD, DO, or APN on these two (2) options:

- PAR Reconsideration: A PAR Reconsideration is similar to a second opinion and must be requested by the personal care provider. A MD, DO, or APN who is different from the one who made the initial PAR denial will re-review the PAR along with the new information and make a final PAR decision. Additional documents not submitted with the original request may be submitted during the Reconsideration process.
- PAR Resubmission: Submit a new PAR that includes additional medical information needed for the PAR review.

The provider will be notified of the final PAR determination via the online PAR portal. The provider and member will receive the final PAR determination letter from the Department's fiscal agent. If the PAR is

denied, the provider will also receive a detailed explanation of why the PAR was denied. A member who receives a denial notification letter has the option to submit a written request for an appeal to the Office of Administrative Courts.

Claim Submission

Paper Claims

Personal Care claims are submitted on the CMS 1500 claim form. Electronic claims format shall be required unless hard copy claims submittals are specifically authorized by the Department. Requests may be sent to the Department's fiscal agent, Xerox State Healthcare, P.O. Box 30, Denver, CO 80201-0090.

The following claims can be submitted on paper and processed for payment:

- Claims from providers who consistently submit five (5) claims or fewer per month (requires approval)
- Claims that, by policy, require attachments
- Reconsideration claims

Paper claims do not require an NPI, but do require the Colorado Medical Assistance Program provider number. Electronically mandated claims submitted on paper are processed, denied, and marked with the message "Electronic Filing Required."

For more detailed CMS 1500 billing instructions, refer to the CMS 1500 General Billing Information manual in the Provider Services [Billing Manuals](#) section.

Electronic Claims

Instructions for completing and submitting electronic claims are available through the 837 Professional (837P) Web Portal User guide via the Web Portal and also on the [Department's Colorado Medical Assistance Program Web Portal](#) page.

Electronically mandated claims submitted on paper are processed, denied, and marked with the message "Electronic Filing Required."

The Colorado Medical Assistance Program collects claim information interactively through the Colorado Medical Assistance Program Secure Web Portal ([Web Portal](#)) or via batch submission through a host system. Refer to the [CMS 1500 General Billing Information Manual](#) (for additional electronic billing information).

The Special Program Indicator (SPI) must be completed on claims submitted electronically. Claims submitted electronically and on paper are identified by using the specific national modifiers along with the procedure code. The appropriate procedure codes and modifiers for each HCBS waiver are noted throughout this manual. When the services are approved, the claim may be submitted to the Department's fiscal agent. For more detailed billing instructions, refer to the CMS 1500 General Billing Information in the Provider Services [Billing Manuals](#) section.

Procedure/HCPSC Codes Overview

The Department develops procedure codes that are approved by the Centers for Medicare & Medicaid Services (CMS). The codes are used to submit claims for services provided to Colorado Medical Assistance Program members. The procedure codes represent services that may be provided by enrolled certified Colorado Medical Assistance Program providers.

The Healthcare Common Procedural Coding System (HCPCS) is divided into two principal subsystems, referred to as level I and level II of the HCPCS. Level I of the HCPCS is comprised of CPT (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA).

The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes.

These include ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DME/Supplies) when used outside a physician's office. Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter followed by four (4) numeric digits. CPT codes are identified using five (5) numeric digits.

Pediatric Personal Care Benefit Procedure Code Table

Providers may bill the following procedure codes for Pediatric Personal Care services:

Pediatric Personal Care Benefit Procedure Code Table		
Description	Procedure Code	Units
Personal care services, per 15 minutes, not for an inpatient or resident of a hospital nursing facility, icf/mr or imd, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant).	T1019	1 unit = 15 minutes

Paper Claim Reference Table

The following paper form reference table gives required and/or conditional fields for the paper CMS 1500 claim form for Pediatric Personal Care claims:

CMS Field #	Field Label	Field is?	Instructions
1	Insurance Type	Required	Place an "X" in the box marked as Medicaid.
1a	Insured's ID Number	Required	Enter the member's Colorado Medical Assistance Program seven-digit Medicaid ID number as it appears on the Medicaid Identification card. Example: A123456.
2	Patient's Name	Required	Enter the member's last name, first name, and middle initial.
3	Patient's Date of Birth / Sex	Required	Enter the member's birth date using two digits for the month, two digits for the date, and two digits for the year. Example: 070115 for July 1, 2015. Place an "X" in the appropriate box to indicate the sex of the member.
4	Insured's Name	Not Required	
5	Patient's Address	Not Required	
6	Patient's Relationship to Insured	Conditional	Complete if the member is covered by a commercial health insurance policy. Place an "X" in the box that identifies the member's relationship to the policyholder.
7	Insured's Address	Not Required	
8	Reserved for NUCC Use		
9	Other Insured's Name	Conditional	If field 11d is marked "YES," enter the insured's last name, first name and middle initial.

CMS Field #	Field Label	Field is?	Instructions
9a	Other Insured's Policy or Group Number	Conditional	If field 11d is marked "YES," enter the policy or group number.
9b	Reserved for NUCC Use		
9c	Reserved for NUCC Use		
9d	Insurance Plan or Program Name	Conditional	If field 11d is marked "YES," enter the insurance plan or program name.
10a-c	Is Patient's Condition Related to?	Not Required	
10d	Reserved for Local Use		
11	Insured's Policy, Group or FECA Number	Not Required	
11a	Insured's Date of Birth, Sex	Not Required	
11b	Other Claim ID	Not Required	
11c	Insurance Plan Name or Program Name	Not Required	
11d	Is there another Health Benefit Plan?	Conditional	When appropriate, place an "X" in the correct box. If marked "YES," complete 9, 9a, and 9d.
12	Patient's or Authorized Person's signature	Required	Enter "Signature on File," "SOF," or legal signature. If there is no signature on file, leave blank or enter "No Signature on File." Enter the date the claim form was signed.

CMS Field #	Field Label	Field is?	Instructions
13	Insured's or Authorized Person's Signature	Not Required	
14	Date of Current Illness Injury or Pregnancy	Not Required	
15	Other Date	Not Required	
16	Date Patient Unable to Work in Current Occupation	Not Required	
17	Name of Referring Physician	Not Required	
18	Hospitalization Dates Related to Current Service	Conditional	Complete for services provided in an inpatient hospital setting. Enter the date of hospital admission and the date of discharge using two digits for the month, two digits for the date and two digits for the year. Example: 070115 for July 1, 2015. If the member is still hospitalized, the discharge date may be omitted. This information is not edited.
19	Additional Claim Information	Conditional	LBOD Use to document the Late Bill Override Date for timely filing.
20	Outside Lab? \$ Charges	Conditional	Complete if <u>all</u> laboratory work was referred to and performed by an outside laboratory. If this box is checked, no payment will be made to the physician for lab services. Do not complete this field if <u>any</u> laboratory work was performed in the office. Practitioners may not request payment for services performed by an independent or hospital laboratory.
21	Diagnosis or Nature of Illness or Injury	Required	Enter at least one but no more than twelve diagnosis codes based on the member's diagnosis/condition. Enter applicable ICD indicator to identify which version of ICD codes is being reported.

CMS Field #	Field Label	Field is?	Instructions												
			0 ICD-10-CM												
22	Medicaid Resubmission Code	Conditional	List the original reference number for adjusted claims. When resubmitting a claim as a replacement or a void, enter the appropriate bill frequency code in the left-hand side of the field. 7 Replacement of prior claim 8 Void/Cancel of prior claim This field is not intended for use for original claim submissions.												
23	Prior Authorization	Not Required													
24	Claim Line Detail	Information	The paper claim form allows entry of up to six detailed billing lines. Fields 24A through 24J apply to each billed line. Do not enter more than six lines of information on the paper claim. If more than six lines of information are entered, the additional lines will not be entered for processing. Each claim form must be fully completed (totaled). Do not file continuation claims (e.g., Page 1 of 2).												
24A	Dates of Service	Required	The field accommodates the entry of two dates: a "From" date of services and a "To" date of service. Enter the date of service using two digits for the month, two digits for the date and two digits for the year. Example: 010115 for January 1, 2015 <div style="text-align: center;"> From To <table border="1" style="margin: auto;"> <tr> <td style="width: 20px;">01</td> <td style="width: 20px;">01</td> <td style="width: 20px;">15</td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> </tr> </table> Or <table border="1" style="margin: auto;"> <tr> <td style="width: 20px;">01</td> <td style="width: 20px;">01</td> <td style="width: 20px;">15</td> <td style="width: 20px;">01</td> <td style="width: 20px;">01</td> <td style="width: 20px;">15</td> </tr> </table> </div>	01	01	15				01	01	15	01	01	15
01	01	15													
01	01	15	01	01	15										

CMS Field #	Field Label	Field is?	Instructions						
			Span dates of service From To <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="padding: 2px;">01</td> <td style="padding: 2px;">01</td> <td style="padding: 2px;">15</td> <td style="padding: 2px;">01</td> <td style="padding: 2px;">31</td> <td style="padding: 2px;">15</td> </tr> </table> <p>EPSDT All dates of service must by the same date as screening.</p>	01	01	15	01	31	15
01	01	15	01	31	15				
24B	Place of Service	Required	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. 12 Home						
24C	EMG	Conditional	Enter a "Y" for YES or leave blank for NO in the bottom, unshaded area of the field to indicate the service is rendered for a life-threatening condition or one that requires immediate medical intervention. If a "Y" for YES is entered, the service on this detail line is exempt from co-payment requirements.						
24D	Procedures, Services, or Supplies	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.						
24E	Diagnosis Pointer	Required	Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis. At least one diagnosis code reference letter must be entered. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow.						

CMS Field #	Field Label	Field is?	Instructions
			This field allows for the entry of 4 characters in the unshaded area.
24F	\$ Charges	Required	<p>Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number. Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one procedure from the same group is billed, special multiple pricing rules apply.</p> <p>The base procedure is the procedure with the highest allowable amount. The base code is used to determine the allowable amounts for additional CPT surgical procedures when more than one procedure from the same grouping is performed.</p> <p>Submitted charges cannot be more than charges made to non-Colorado Medical Assistance Program covered individuals for the same service.</p> <p>Do not deduct Colorado Medical Assistance Program co-payment or commercial insurance payments from the usual and customary charges.</p>
24G	Days or Units	Required	<p>Enter the number of services provided for each procedure code.</p> <p>Enter whole numbers only - do not enter fractions or decimals.</p>
24H	EPSDT/Family Plan	Conditional	<p>EPSDT (shaded area) For Early & Periodic Screening, Diagnosis, and Treatment related services, enter the response in the shaded portion of the field as follows:</p> <ul style="list-style-type: none"> AV Available- Not Used S2 Under Treatment ST New Service Requested NU Not Used <p>Family Planning (unshaded area) Not Required</p>

CMS Field #	Field Label	Field is?	Instructions
24I	ID Qualifier	Not Required	
24J	Rendering Provider ID #	Required	<p>In the unshaded portion of the field, enter the eight-digit Colorado Medicaid 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. Class B agencies providing services should use their billing provider ID in this line.</p> <p>NOTE: When billing a paper claim form, do not use the individual's NPI.</p>
25	Federal Tax ID Number	Not Required	
26	Patient's Account Number	Optional	<p>Enter information that identifies the patient or claim in the provider's billing system. Submitted information appears on the Provider Claim Report (PCR).</p>
27	Accept Assignment?	Required	<p>The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.</p>
28	Total Charge	Required	<p>Enter the sum of all charges listed in field 24F. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.</p>
29	Amount Paid	Conditional	<p>Enter the total amount paid by Medicare or any other commercial health insurance that has made payment on the billed services. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.</p>
30	Rsvd for NUCC Use		
31	Signature of Physician or Supplier Including Degrees or Credentials	Required	<p>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.</p>

CMS Field #	Field Label	Field is?	Instructions
			<p>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.</p> <p>Each claim must have the date the enrolled provider or registered authorized agent signed the claim form. Enter the date the claim was signed using two digits for the month, two digits for the date and two digits for the year. Example: 070115 for July 1, 2015.</p> <p>Unacceptable signature alternatives: 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>
32	<p>32- Service Facility Location Information 32a- NPI Number 32b- Other ID #</p>	Not Required	
33	<p>33- Billing Provider Info & Ph. # 33a- NPI Number 33b- Other ID #</p>	Required	<p>Enter the name of the individual or organization that will receive payment for the billed services in the following format:</p> <p>1st Line Name 2nd Line Address 3rd Line City, State and ZIP Code</p> <p>33a- NPI Number Enter the NPI of the billing provider</p> <p>33b- Other ID # Enter the eight-digit Colorado Medical Assistance Program provider number of the individual or organization.</p>

Pediatric Personal Care Claim Example



HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> PICA <input type="checkbox"/> PICA													
1. MEDICARE <input type="checkbox"/> (Medicare #) <input checked="" type="checkbox"/> MEDICAID <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> TRICARE <input type="checkbox"/> (ID#/DoD#) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (ID#) <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> (ID#) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID#)					1a. INSURED'S I.D. NUMBER (For Program in Item 1) D444444								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Client, Ima A					3. PATIENT'S BIRTH DATE MM DD YY 10 16 45		SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
5. PATIENT'S ADDRESS (No., Street) _____ CITY _____ STATE _____					6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) _____ CITY _____ STATE _____						
ZIP CODE _____ TELEPHONE (Include Area Code) _____ ()		8. RESERVED FOR NUCC USE			ZIP CODE _____ TELEPHONE (Include Area Code) _____ ()		11. INSURED'S POLICY GROUP OR FECA NUMBER						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:			a. INSURED'S DATE OF BIRTH MM DD YY M F					
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>			b. AUTO ACCIDENT? PLACE (State) _____ YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		b. OTHER CLAIM ID (Designated by NUCC)						
b. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>			c. INSURANCE PLAN NAME OR PROGRAM NAME			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>If yes, complete Items 9, 9a and 9d.</i>					
c. RESERVED FOR NUCC USE		10d. RESERVED FOR LOCAL USE			13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____ DATE 1/1/15								
d. INSURANCE PLAN NAME OR PROGRAM NAME					14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL _____								
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____					15. OTHER DATE MM DD YY QUAL _____		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE _____					17a. NPI _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____		22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind: 0					23. PRIOR AUTHORIZATION NUMBER								
A. F84.0		B. _____		C. _____		D. _____		E. _____		F. _____			
E. F90.9		F. _____		G. _____		H. _____		I. _____		J. _____			
I. _____		J. _____		K. _____		L. _____		M. _____		N. _____			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) MODIFIER				E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. (SPIC) Family Plan	I. ID QUAL	J. RENDERING PROVIDER ID. #
01 01 15 01 01 15 12		_____	_____	T1019				_____	142 50	30	_____	NPI 311Z00000X	
25. FEDERAL TAX I.D. NUMBER _____ SSN EIN _____		26. PATIENT'S ACCOUNT NO. Optional		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ 142 50		29. AMOUNT PAID \$ _____		30. Rsvd for NUCC Use			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Signature DATE 1/1/15				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH# () Personal Care Provider 100 Any Street Any City					

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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, see the General Provider Information manual in the Provider Services [Billing Manuals](#) section.

Making false statements about timely filing compliance is a misrepresentation and falsification that, upon conviction, makes the individual who prepares the claim and the enrolled provider subject to fine and imprisonment under state and/or federal law.

Billing Instruction Detail	Instructions
<p>LBOD Completion Requirements</p>	<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>CMS 1500</i>: Indicate "LBOD" and the date in box 19 – Additional Information. ➤ <i>2006 ADA Dental</i>: Indicate "LBOD" and the date in box 35 - Remarks

Billing Instruction Detail	Instructions
<p>Adjusting Paid Claims</p>	<p>If the initial timely filing period has expired and a previously submitted claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was paid and now needs to be adjusted, resulting in additional payment to the provider.</p> <p>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>
<p>Denied Paper Claims</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>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>
<p>Returned Paper Claims</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>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>
<p>Rejected Electronic Claims</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>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>

Billing Instruction Detail	Instructions
<p>Denied/Rejected Due to Member Eligibility</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>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 member and date of eligibility rejection.</p> <p>LBOD = the date shown on the eligibility rejection report.</p>
<p>Retroactive Member Eligibility</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"> • 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>
<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 member, 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 member, 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>

Billing Instruction Detail	Instructions
<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/ERA 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 SPR/ERA. Maintain the original SPR/ERA on file.</p> <p>LBOD = the Medicare processing date shown on the SPR/ERA.</p>
<p>Medicare Denied Services</p>	<p>The claim is for Medicare denied services (Medicare non-benefit services, benefits exhausted services, or the member 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 SPR/ERA. Attach a copy of the SPR/ERA if submitting a paper claim and maintain the original SPR/ERA on file.</p> <p>LBOD = the Medicare processing date shown on the SPR/ERA.</p>
<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 member, 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>Member 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>

Pediatric Personal Care Specialty Manual Revisions Log

<i>Revision Date</i>	<i>Additions/Changes</i>	<i>Pages</i>	<i>Made by</i>
<i>9/22/15</i>	<i>Reviewed and made for changes addressed for Josh. Changed font, changed client to members, made formatting changes, made changes requested in comment review of document.</i>	<i>Throughout</i>	<i>JH</i>