

Physical and Occupational Therapy Outpatient – Fee-For-Service

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Physical and Occupational Therapy Outpatient – Fee-For-Service

Provider Qualifications

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

Licensed physical therapists (PT) and registered occupational therapists (OT) who meet the qualifications prescribed by federal regulations for participation at 42 CFR 484.4 and who meet all the requirements under state law are eligible to become Colorado Medical Assistance providers.

Physical therapists must be licensed by the Colorado Department of Regulatory Agencies ([DORA](#)) pursuant to Title 12 Article 41.106 and may supervise up to four individuals at one time who are not physical therapists, including certified nurse aides, to assist in the therapist's clinical practice (§12-41-113(1) C.R.S.).



Physical therapist assistants (PTA) must be certified by DORA pursuant to Title 12 Article 41.204 and must work under the supervision of a licensed physical therapist as defined in the Colorado Physical Therapy Practice Act (§12-41-203(2) C.R.S.) and accompanying rules as promulgated by the State Board of Physical Therapy.

Occupational therapists must be registered by DORA pursuant to Title 12 Article 40.5.

Occupational therapy assistants (OTA) must practice under the general supervision of a Colorado registered occupational therapist.

All physical and occupational therapists must submit a completed provider enrollment packet to become a Colorado Medical Assistance Program eligible provider. Providers will find enrollment information in the [Provider Services Enrollment](#) section of the Department's website (colorado.gov/hcpt). Enrollment documents may be downloaded and mailed to:

Xerox State Healthcare
Colorado Medical Assistance Program Provider Enrollment
PO Box 1100
Denver, CO 80201-1100

As of July 1, 2002, physical and occupational therapists not employed by an agency, clinic, hospital, or physician may bill the Colorado Medical Assistance Program directly. Providers should refer to the Code of Colorado Regulations, [Qualified Non-Physician Practitioners Eligible to Provide Physician's Services](#) (10 CCR 2505-10, Section 8.200.2.C), for specific information when providing physical and occupational therapy.

All PT/OT services must be prescribed by an M.D. or D.O., nurse practitioner or physician's assistant. Educational, personal need, and comfort therapies are not covered benefits of fee-for-service for any client regardless of age. Medically necessary as defined under 8.200.1, physician services, means a covered service that will, or is reasonably expected to prevent, diagnose, cure, correct, reduce or ameliorate the pain and suffering, or the physical, mental, cognitive or developmental effects of an illness, injury or disability; and for which there is no other equally effective or substantially less costly course of treatment suitable for the client's needs.



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.

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

Paper Claims

Electronic claims format shall be required unless hard copy claims submittals are specifically authorized by the Department. Requests may be sent to the Department's fiscal agent, Xerox State Healthcare, P.O. Box 90, Denver, CO 80201-0090. The following claims can be submitted on paper and processed for payment:



- Claims from providers who consistently submit 5 claims or fewer per month (requires approval)
- Claims that, by policy, require attachments
- 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/)
- Companion Guides for the 837P, 837I, or 837D in the Provider Services [Specifications](#) section of the Department's Web site.
- Web Portal User Guide (via within the 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.

Interactive Claim Submission and Processing

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



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

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

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

Because a claim submitter connects to the Web Portal through the Internet, there is no delay for “dialing up” when submitting claims. The Web Portal provides immediate feedback directly to the submitter. All claims are processed to provide a weekly Health Care Claim Payment/Advice (Accredited Standards Committee [ASC] X12N 835) transaction and/or a PCR containing information related to submitted claims. The Web Portal provides access to the following reports through the File and Report Service (FRS):

- Accept/Reject Report
- Provider Claim Report
- Health Care Claim Payment/Advice (ASC X12N 835)
- Managed Care Reports such as Primary Care Physician Rosters
- Prior Authorization Letters

Users may also inquire about information generated from claims submitted via paper and through electronic data submission methods other than the Web Portal. Other inquiry options include:

- Eligibility Inquiry (interactive and batch)
- Claim Status Inquiry
- PAR Status Inquiry

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

Batch Electronic Claim Submission

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



All batch claim submission software must be tested and approved by the Department's fiscal agent.

Any entity sending electronic transactions through the fiscal agent's Electronic Data Interchange (EDI) Gateway for processing where reports and responses will be delivered must complete an EDI enrollment package. This provides EDI Gateway the information necessary to assign a Logon Name, Logon ID, and Trading Partner ID, which are required to submit electronic transactions, including claims.

An enrollment package may be obtained by contacting the Department's fiscal agent or by downloading it from the Provider Services [EDI Support](#) section.

The X12N 837 Professional (837P), Institutional (837I), or Dental (837D) transaction data will be submitted to the EDI Gateway, which validates submission of American National Standards Institute (ANSI) X12N format(s).

The TA1 Interchange Acknowledgement reports the syntactical analysis of the interchange header and trailer. If the data is corrupt or the trading partner relationship does not exist within the MMIS, the interchange will reject and a TA1 along with the data will be forwarded to the State Healthcare Clearinghouse (SHCH) Technical Support for review and follow-up with the sender. An X12N 999 Functional Acknowledgement is generated when a file that has passed the header and trailer check passes through the SHCH.

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

Testing and Vendor Certification

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



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

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

Procedure/HCPCS Code Overview

The codes used for submitting claims for services provided to Colorado Medical Assistance Program clients represent services that are approved by the Centers for Medicare and Medicaid Services (CMS) and services that may be provided by an enrolled Colorado Medical Assistance Program provider.

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

HIPAA requires providers to comply with the coding guidelines of the AMA CPT Procedure Codes and the International Classification of Disease, Clinical Modification Diagnosis Codes. If there is no time designated in the official descriptor, the code represents one unit or session. Providers should regularly consult monthly bulletins located in the Provider Services [Bulletins](#) section.

To receive electronic provider bulletin notifications, an email address can be entered into the Web Portal in the *(MMIS) Provider Data Maintenance* area or by filling out a publication preference form. Bulletins include updates on approved procedure codes as well as the maximum allowable units billed per procedure.

National Correct Coding Initiative (NCCI)

National Correct Coding Initiative Procedure-To-Procedure (PTP) and Medically Unlikely Edits (MUE) edits apply to certain combinations of PT and OT procedure codes. Please refer to the Medicaid.gov website for NCCI edits, here a complete list of impacted codes, guidance on bypass modifier use, and general information.

Physical Therapy (PT) and Occupational Therapy (OT) Codes

Habilitative therapy is now a covered benefit for Medicaid expansion clients ages 19 through 64 receiving benefits through the Alternative Benefits Plan (ABP). Eligible clients may receive outpatient PT, OT benefits for the purposes of habilitation **in addition** to rehabilitation.

Definition of Habilitative Therapy

The Colorado Division of Insurance has defined Habilitative services to be:

Services that help a person retain, learn, or improve skills and functioning for daily living that are offered in parity with, and in addition to, any rehabilitative services offered in Colorado's Essential Health Benefits (EHB) benchmark plan. Parity in this context means of like type and substantially equivalent in scope, amount, and duration.

Benefit Limits for Habilitative and Rehabilitative Physical and Occupational Therapy

Clients may receive up to 24 units of Rehabilitative PT and up to 24 units of Rehabilitative OT per 12 month period before a Prior Authorization Request (PAR) is required, **and** up to 24 units of Habilitative PT and up to 24 units of Habilitative OT per 12 month period with a PAR submitted in advance of the services. Units of service exceeding the initial 24 units for each therapy type will not be reimbursed without an approved PAR. Please refer to the below table.

Benefit	Rehabilitative	Habilitative
Physical Therapy	24 units of PT and 24 units of OT per 12 months.	24 units of PT and 24 units of OT per 12 months.
Occupational Therapy	5 units of either PT <i>or</i> OT per date of service.	5 units of either PT <i>or</i> OT per date of service.
PAR Requirement	Required for PT and OT.	Required for PT, OT, and ST.

Additional Notes

- Habilitative therapies are not an Inpatient or Home Health benefit.
- Habilitative therapies are not a benefit if provided in nursing facilities; Rehabilitative PT, OT, ST remain so.
- Habilitative therapies are not to be confused with Habilitation services found within Home and Community Based Services (HCBS) waivers.

A client is eligible for another 24 units of service without a PAR when the client has not received any PT or OT services within a 366 consecutive day period. The 24 units accumulate from paid units for a specific client, regardless of provider, for each treatment modality. A unit equals 1) a timed increment or 2) one treatment session as described in the specific CPT procedure codes.

PT and OT must be deemed medically necessary, and the client’s physician, nurse practitioner or physician assistant must provide a written prescription for service to be reimbursed.

In addition to procedure codes, PT and OT providers are able to bill for the following orthotics:

L3730, L3763, L3764, L3808, L3900, L3906, L3908, L3911, L3912, L3919, L3929, L3933, L3982

For further billing information on the above codes, please refer to the Durable Medical Equipment (DME) and Supplies Provider Reference Manual which can be found in the Provider Services [Billing Manuals](#) section. DME products **cannot** be requested on the same PAR as therapy services.

Service Limitations and Prior Authorization Requests (PARs)

Daily Unit Limits

A daily limit of five units of therapy services allowed for PT/OT, whether it is Rehabilitative or Habilitative. Clients cannot receive both Rehabilitative and Habilitative therapy on the same date of service (DOS). Some specific daily limits per procedure code do apply, please refer to the below table.

Procedure Code	Daily Limit	Procedure Code	Daily Limit
97012	1	97150	1
97014	1	97530	3
97016	1	97532	3
97024	1	97533	4
97026	1	97535	4
97028	1	97537	4
97039	1	97542	4
97110	4	97760	4
97113	2	97761	4
97116	3	97762	4
97139	3	97799	1
97140	2		

Prior Authorization Requests (PARs)

Independent Physical and Occupational Therapists and hospital based therapy clinics providing PT and OT outpatient therapy services must submit PARs for medically necessary services when:

- The client has exceeded 24 units of service provided by a PT, or
- The client has exceeded 24 units of service provided by an OT.
- When Habilitative PT/OT is being sought a PAR must always be submitted.

PARs are approved for up to a twelve (12) month period (depending on medical necessity determined by the reviewer).

- Retroactive PAR request forms will not be accepted.
- Overlapping PAR request dates for same provider types will not be accepted.
- Incomplete, incorrect or insufficient client information on a PAR request form will not be accepted.

Submit PARs for the number of units for each specific procedure code requested, not for the number of services. Modifier codes must be included.

- When submitting Rehabilitative PARs, CPT codes for PT service providers, must use the GP modifier (e.g. 97001+GP).
- When submitting Habilitative PARs, CPT codes for PT service providers, must use the GP modifier and HB modifier (e.g. 97001+GP+HB).
- When submitting Rehabilitative PARs, CPT codes for OT service providers, must use the GO modifier (e.g. 97003+GO).
- When submitting Habilitative PARs, CPT codes for OT service providers, must use the GO modifier and HB modifier (e.g. 97003+GO+HB).

PAR/Claim Modifier	Rehabilitative	Habilitative
Physical Therapy	GP	GP + HB
Occupational Therapy	GO	GO + HB

Additional Limitations:

- A client may receive PT and OT services during the same time period and service dates. However, duplicative therapies (the same therapy performed by both an OT and PT) may not be performed on the same DOS.
- A client may not receive both Rehabilitative and Habilitative therapies of the same type (e.g. Rehabilitative PT and Habilitative PT) on the same DOS.
- The same modifiers used for the PAR must be used when submitting claims.
- A client may have one active PAR for each type of therapy (Rehabilitative PT, Rehabilitative OT, Habilitative PT, Habilitative OT) with independent time spans.

PAR Requirements:

- Legibly written and signed ordering practitioner prescription, to include diagnosis (preferably with ICD-9 code) and reason for therapy, the number of requested therapy sessions per week and total duration of therapy.
- The client’s Physical or Occupational treatment history, including current assessment and treatment. Include duration of previous treatment and treating diagnosis.
- Documentation indicating if the client has received PT or OT under the Home Health Program or inpatient hospital treatment.
- Current treatment diagnosis.
- Course of treatment, measurable goals and reasonable expectation of completed treatment.
- Documentation supporting medical (physical NOT developmental) necessity for the course and duration of treatment being requested.
- Assessment or progress notes submitted for documentation, must not be more than sixty (60) days prior to submission of PAR request.
- If the PAR is submitted for services delivered by an independent therapist, the name and address of the individual therapist providing the treatment must be present in field #24 of the PAR.
- The billing provider name and address needs to be present in field #25 on the PAR.
- The Colorado Medical Assistance Program provider number of the independent therapist must be present in PAR field #28.
- The billing provider’s Colorado Medical Assistance Program number must be present in field #29 of the PAR.

The authorizing agency reviews all completed PARs and approves or denies, by individual line item, each requested service or supply listed on the PAR. PAR status inquiries can be made through the Web Portal and results are included in PAR letters sent to both the provider and the client. **Read the results carefully as some line items may be approved and others denied. Do not render or bill for services until the PAR has been processed.**

The claim must contain the PAR number for payment.

Approval of a PAR does not guarantee Colorado Medical Assistance Program payment and does not serve as a timely filing waiver. Prior authorization only assures that the service is considered a benefit of the Colorado Medical Assistance Program. All claims, including those for prior authorized services, must meet eligibility and claim submission requirements (e.g. timely filing, third party resources payment pursued, required attachments included, etc.) before payment can be made.

If the PAR is denied, providers should direct inquiries to the authorizing agency:

[ColoradoPAR Program](#)

Provider Prior Authorization (PAR) Vendor for the Colorado Medical Assistance Program

Provider PAR Request Line: 1-888-454-7686

PAR Fax Line: 1-866-492-3176

The Colorado Medical Assistance Program PAR forms are available in the Provider Services [Forms](#) section or by contacting the ColoradoPAR Program at 1-888-454-7686 (toll free).

Providers can fax documents to the ColoradoPAR Program at 1-866-492-3176. Documents that may be compromised by faxing can be mailed to:

APS Healthcare
 55 N. Robinson Ave., Suite 600
 Oklahoma City, OK 73102

PAR Revisions

Please print "REVISION" in bold letters at the top and enter the PAR number being revised in box #7. Do not enter the PAR number being revised anywhere else on the PAR.

Paper PAR Instructional Reference

Field Label	Completion Format	Instructions
The upper margin of the PAR form must be left blank. This area is for authorizing agency use only.		
Invoice/Pat Account Number	Text	Optional Enter up to 12 characters (numbers, letters, hyphens) that help identify the claim or client.
Does Client Have Primary Insurance?	Check box <input type="checkbox"/> Y <input type="checkbox"/> N	Optional Enter an "X" in the appropriate box.
1. Client Name	Text	Required Enter the client's last name, first name, and middle initial.
2. Client Identification Number	1 letter followed by 6 numbers	Required Enter the client's state identification number. This number consists of a letter prefix followed by six numbers. Example: A123456.
3. Sex	Check box <input type="checkbox"/> Y <input type="checkbox"/> N	Required Enter an "X" in the appropriate box.

Field Label	Completion Format	Instructions
4. Date of Birth	6 digits (MMDDYY)	Required Enter the client's birth date using MMDDYY format. Example: January 1, 2009 = 010109.
5. Client Address	Characters: numbers and letters	Required Enter the client's full address: Street, City, State, and Zip code.
6. Client Telephone Number	Text	Optional Enter the client's telephone number.
7. Prior Authorization Number		System assigned Leave blank
8. Dates Covered by this Request	6 digits for From date and 6 digits for Through date (MMDDYY)	Optional Enter the date(s) within which service(s) will be provided. If left blank, dates are entered by the authorizing agency. Authorized services must be provided within these dates.
9. Does Client Reside in a Nursing Facility?	Check box <input type="checkbox"/> Y <input type="checkbox"/> N	Required Check the appropriate box.
10. Group Home Name if Patient Resides in a Group Home	Text	Not applicable.
11. Diagnosis	Text	Required Enter the medical/physiological diagnosis code and sufficient relevant diagnostic information to justify the request. Include the prognosis. Provide relevant clinical information, other drugs or alternative therapies tried to treating the condition, results of tests, etc. to justify a Colorado Medical Assistance Program determination of medical necessity. Approval of necessity. Attach documents as required.
12. Requesting Authorization for Repairs	Text	Not applicable
13. Indicate Length of Necessity	Text	Not applicable
14. Estimated Cost of Equipment	Digits	Not applicable
15. Services to be Authorized	None	Preprinted Do not alter preprinted lines. No more than five items can be requested on one form.

Field Label	Completion Format	Instructions
16. Describe Procedure, Supply, or Drug to be Provided	Text	Required Enter the description of the service/procedure to be provided.
17. Procedure, Supply or Drug Code Required	HCPCS code	Enter the procedural code for each item that will be billed on the claim form. The authorized agency may change any code. The approved code(s) on the PAR form must be used on the claim form.
18. Requested Number of Services	Digits	Required Enter the number of units for supplies, services or equipment requested. If this field is blank, the authorizing agency will complete with one unit.
19. Authorized No. of Services	None	Leave blank The authorizing agency indicates the number of services authorized which may be more not equal number of requested in Field 18 (Number of Services).
20. A = Approved D = Denied	None	Leave blank Check the PAR on-line or refer to the PAR letter.
21. Primary Care Physician (PCP) Name	Text	Conditional Complete if client has a PCP.
Telephone Number	Text	Optional Enter the PCP's telephone number.
22. Primary Care Physician Address	Text	Conditional Complete if client has a PCP. Enter the PCP's complete address.
23. PCP Provider Number	8 Digits	Conditional Complete if client has a PCP. Enter the PCP's eight-digit Colorado Medical Assistance provider number. This number must be obtained by contacting the PCP for the necessary authorization.
24. Name and Address of Physician Referring for Prior Authorization	Text	Required Enter the complete name and address of the physician requesting prior authorization (the physician ordering/writing the prescription).
25. Name and Address of Provider Who will Bill Service	Text	Required Enter the name and telephone number of the provider who will be billing for the service.

Field Label	Completion Format	Instructions
26. Requesting Physician Signature	Text	<p>Required</p> <p>The requesting provider must sign the PAR and must be the physician ordering the service. Under unusual circumstances, when the prescribing physician is not available, a legible copy of a signed prescription may be attached in place of the signature of the requesting provider. The written diagnosis must be entered in Field 11 (Diagnosis), even if a prescription form is attached. Do not send the original prescription; send a photocopy on an 8 ½ x 11 sheet.</p> <p>A rubber stamp facsimile signature is not acceptable on the PAR.</p>
27. Date Signed	6 Digits	<p>Required</p> <p>Enter the date the PAR form is signed by the requesting provider.</p>
Telephone Number	Text	<p>Required</p> <p>Enter the telephone number of the requesting provider.</p>
28. Requesting Physician Provider Number	8 Digits	<p>Required</p> <p>Enter the eight-digit Colorado Medical Assistance Program provider number of the requesting provider.</p>
29. Billing Provider Number	8 Digits	<p>Required</p> <p>Enter the eight-digit Colorado Medical Assistance Program provider number of the billing provider.</p> <p>All rendering and billing providers must be Colorado Medical Assistance program providers.</p>
30. Comments	Text	<p>Leave Blank</p> <p>This field is completed by the authorizing agency.</p> <p>Refer to the PAR response for comments submitted by the authorizing agent.</p>
31. PA Number Being Revised	Text	<p>Leave Blank</p> <p>This field is completed by the authorizing agency.</p>

Physical Therapy PAR Form Example

*** Required Field**

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND FINANCING

MEDICAID PRIOR AUTHORIZATION REQUEST (PAR)

INVOICE/PAT. ACCOUNT NUMBER

DOES CLIENT HAVE PRIMARY INSURANCE?

YES NO

To avoid delay, please answer all questions completely.

1. CLIENT NAME (Last, First, Middle Initial) *Doe, Jane A		2. CLIENT IDENTIFICATION NUMBER * Y123456	3. SEX * <input type="checkbox"/> M <input checked="" type="checkbox"/> F	4. DATE OF BIRTH (MMDDYYYY) * 01/04/2006
5. CLIENT ADDRESS (Street, City, State, ZIP Code) * 1234 Any St. Denver, CO 88888			6. CLIENT TELEPHONE NUMBER * (123) 456-7890	
7. PRIOR AUTHORIZATION NUMBER * SYSTEM ASSIGNED * 	8. DATES COVERED BY THIS REQUEST FROM (MMDDYYYY) * 02/06/2013	THROUGH (MMDDYYYY) * 02/06/2014	9. DOES CLIENT RESIDE IN A NURSING FACILITY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10. GROUP HOME NAME - IF PATIENT RESIDES IN A GROUP HOME Leave blank - Not applicable				
11. ICD-9-CM DIAGNOSIS CODE and DESCRIPTION (Must include Diagnosis Code and Description, Prognosis, Clinical Information and Other Medications presently prescribed) * 3 4 3 9 Cerebral Palsy			12. REQUESTING AUTHORIZATION FOR REPAIRS EQUIPMENT MUST BE OWNED BY THE CLIENT - THE SERIAL NUMBER MUST BE ENTERED Leave blank - Not applicable	
			13. INDICATE LENGTH OF NECESSITY (IN MONTHS AND YEARS) I.E., HOW LONG WILL THIS EQUIPMENT BE NEEDED? Leave blank - Not applicable	
			14. ESTIMATED COST OF EQUIPMENT Leave blank - Not applicable	

SERVICES TO BE AUTHORIZED

15. LINE NO.	16. * DESCRIBE THE PROCEDURE OR SUPPLY TO BE PROVIDED — INCLUDE MODEL NUMBER FOR DME PURCHASE OR SERIAL NUMBER FOR REPAIR	17. * PROCEDURE OR SUPPLY CODE	18. * REQUESTED NUMBER OF SERVICES	19. * AUTHORIZED NO. OF SERVICES (* LEAVE BLANK *)	20. * APPROVED/DENIED (* LEAVE BLANK *)
01	PT Evaluation	97001-GT	1		
02	PT Treatment	97032-GT	90		
03					
04					
05					

21. PRIMARY CARE PHYSICIAN (PCP) NAME * Enter the PCP's name		22. PRIMARY CARE PHYSICIAN ADDRESS (Street, City, State, ZIP code) Enter the PCP's address	
TELEPHONE NUMBER	23. PCP PROVIDER NUMBER		
24. NAME AND ADDRESS OF PHYSICIAN REFERRING FOR PRIOR AUTHORIZATION * Enter the Requesting Physician's name & address		25. NAME AND ADDRESS OF PROVIDER WHO WILL BILL SERVICE	
26. REQUESTING PHYSICIAN SIGNATURE * Enter the Requesting Physician's Signature		27. DATE SIGNED	
TELEPHONE NUMBER *	28. REQUESTING PHYSICIAN PROVIDER NUMBER * Enter the Requesting Physician's Provider Number	TELEPHONE NUMBER *	29. BILLING PROVIDER NUMBER *

If services are provided according to the manner prescribed by State of Colorado Laws and Regulations, reimbursement will be provided for authorized services following submission of an appropriately completed Medicaid claim.

30. COMMENTS

ATTACH COPY OF THIS PAR TO CLAIM(S) **

SIGNATURE OF STATE AGENCY REPRESENTATIVE **	DATE **	31. PA NUMBER BEING REVISED **
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* THE ASSIGNED PAR NUMBER APPEARS ON THE PAR LETTER. ENTER THE PAR NUMBER FROM THE LETTER ON THE CLAIM WHEN BILLING FOR THE SERVICES. ** THESE FIELDS ARE COMPLETED BY THE AUTHORIZING AGENT

Occupational Therapy PAR Form Example

*** Required Field**

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND FINANCING

MEDICAID PRIOR AUTHORIZATION REQUEST (PAR)

INVOICE/PAT. ACCOUNT NUMBER

DOES CLIENT HAVE PRIMARY INSURANCE?

YES NO

To avoid delay, please answer all questions completely.

1. CLIENT NAME (Last, First, Middle Initial) * Doe, Jane A		2. CLIENT IDENTIFICATION NUMBER * Y123456		3. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	4. DATE OF BIRTH (MMDDYYYY) * 01/04/2006
5. CLIENT ADDRESS (Street, City, State, ZIP Code) * 1234 Any St. Denver, CO 88888				6. CLIENT TELEPHONE NUMBER * (123) 456-7890	
7. PRIOR AUTHORIZATION NUMBER * SYSTEM ASSIGNED	8. DATES COVERED BY THIS REQUEST FROM (MMDDYYYY) * 02/06/2013	* THROUGH (MMDDYYYY) 02/06/2014	9. DOES CLIENT RESIDE IN A NURSING FACILITY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10. GROUP HOME NAME - IF PATIENT RESIDES IN A GROUP HOME Leave blank – Not applicable
11. ICD-9-CM DIAGNOSIS CODE and DESCRIPTION (Must include Diagnosis Code and Description, Prognosis, Clinical Information and Other Medications presently prescribed) * 3 4 3 9 Cerebral Palsy					12. REQUESTING AUTHORIZATION FOR REPAIRS EQUIPMENT MUST BE OWNED BY THE CLIENT - THE SERIAL NUMBER MUST BE ENTERED Leave blank – Not applicable
					13. INDICATE LENGTH OF NECESSITY (IN MONTHS AND YEARS) I.E., HOW LONG WILL THIS EQUIPMENT BE NEEDED? Leave blank – Not applicable
					14. ESTIMATED COST OF EQUIPMENT Leave blank – Not applicable

SERVICES TO BE AUTHORIZED

15. LINE NO.	16. * DESCRIBE THE PROCEDURE OR SUPPLY TO BE PROVIDED — INCLUDE MODEL NUMBER FOR ONE PURCHASE OR SERIAL NUMBER FOR REPAIR	17. * PROCEDURE OR SUPPLY CODE	18. * REQUESTED NUMBER OF SERVICES	19. * AUTHORIZED NO. OF SERVICES (* LEAVE BLANK *)	20. * APPROVED/DENIED (* LEAVE BLANK *)
01	OT Evaluation	97003-GO	1		
02	OT Treatment	97033-GO	140		
03					
04					
05					

21. PRIMARY CARE PHYSICIAN (PCP) NAME Enter the PCP's name		22. PRIMARY CARE PHYSICIAN ADDRESS (Street, City, State, ZIP code) Enter the PCP's address	
TELEPHONE NUMBER	23. PCP PROVIDER NUMBER		
24. NAME AND ADDRESS OF PHYSICIAN REFERRING FOR PRIOR AUTHORIZATION * Enter the Requesting Physician's name & address		25. NAME AND ADDRESS OF PROVIDER WHO WILL BILL SERVICE *	
26. REQUESTING PHYSICIAN SIGNATURE * Enter the Requesting Physician's Signature		27. DATE SIGNED	
TELEPHONE NUMBER	28. REQUESTING PHYSICIAN PROVIDER NUMBER * Enter the Requesting Physician's Provider Number	TELEPHONE NUMBER	29. BILLING PROVIDER NUMBER *

If services are provided according to the manner prescribed by State of Colorado Laws and Regulations, reimbursement will be provided for authorized services following submission of an appropriately completed Medicaid claim.

30. COMMENTS

ATTACH COPY OF THIS PAR TO CLAIM(S) **

SIGNATURE OF STATE AGENCY REPRESENTATIVE **	DATE **	31. PA NUMBER BEING REVISED **
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* THE ASSIGNED PAR NUMBER APPEARS ON THE PAR LETTER. ENTER THE PAR NUMBER FROM THE LETTER ON THE CLAIM WHEN BILLING FOR THE SERVICES. ** THESE FIELDS ARE COMPLETED BY THE AUTHORIZING AGENT

FORM NO. 10013
(REV. 0811)
COL — 106

Colorado 1500 Paper Claim Reference Table

The following paper form reference table shows required, optional, and conditional fields and detailed field completion instructions for the Colorado 1500 claim form.

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

Field Label	Completion format	Instructions
Invoice/Pat Acct Number	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.
Special Program Code	2 digits	Not required
1. Client Name	Up to 25 characters: letters & spaces	Required Enter the client’s last name, first name, and middle initial.
2. Client Date of Birth	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. Example: 07012010 for July 1, 2010.
3. Medicaid ID Number (Client ID Number)	7 characters, a letter prefix followed by six numbers	Required Enter the client’s Colorado Medical Assistance Program ID number. Each person has his/her own unique Colorado Medical Assistance Program ID number. Example: A123456
4. Client Address Telephone Number	Characters: numbers and letters	Not required Submitted information is not entered into the claim processing system.
5. Client Sex	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.
6. Medicare ID Number (HIC or SSN)	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	Instructions
7. Client relationship to Insured	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.
8. Client is covered by Employer Health Plan	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.
9. Other Health Insurance Coverage	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.
9A. Policyholder Name and Address	Text	Conditional Complete if the client has commercial health insurance coverage. Enter the name, address, and telephone number, if known, of the policyholder.
10. Was condition related to	Check box <input type="checkbox"/> A. Client Employment Check box <input type="checkbox"/> B. Accident 6 digits: MMDDYY 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.
11. CHAMPUS Sponsors Service/SSN	10 digits	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.
Durable Medical Equipment Model/serial number (unlabeled field)	Not required	Leave Blank
12. Pregnancy HMO Nursing Facility	Check box <input type="checkbox"/> Check box <input type="checkbox"/> Check box <input type="checkbox"/>	Not required

Field Label	Completion format	Instructions
13. Date of illness or injury or pregnancy	6 digits: MMDDYY	Complete if information is known. Enter the following information as appropriate to the client's condition: Illness Date of first symptoms Injury Date of accident Pregnancy Date of Last Menstrual Period (LMP)
14. Medicare Denial	Check box <input type="checkbox"/> Benefits Exhausted <input type="checkbox"/> Non-covered services	Conditional Complete if the client has Medicare coverage and Medicare denied benefits or does not cover the billed services. 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. 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. Bill claims for Medicare denied services and Medicare crossover claims separately.
14A. Other Coverage Denied	Check box No <input type="checkbox"/> Yes <input type="checkbox"/> Pay/Deny Date 6 digits: MMDDYY	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.
15. Name of supervising physician Provider Number	Text 8 digits	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.

Field Label	Completion format	Instructions																												
16. For services related to hospitalization	6 digits: MMDDYY	Admitted <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>MM</td><td>DD</td><td>YY</td></tr></table> Discharged <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>MM</td><td>DD</td><td>YY</td></tr></table> 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.	MM	DD	YY	MM	DD	YY																						
MM	DD	YY																												
MM	DD	YY																												
17. Name and address of facility where services rendered Provider Number	Text (address is optional) 8 digits	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.																												
17A. Check box if laboratory work performed outside physician's office	Check box <input type="checkbox"/>	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.																												
18. ICD-9-CM	1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table> 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table> 3 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table> 4 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table> Codes: 3, 4, or 5 characters. 1 st 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 th or 5 th digit): ICD-9-CM description Code Claim Entry Cerebral Palsy 434.9 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>4</td><td>3</td><td>4</td><td>9</td></tr></table>	4	3	4	9
4	3	4	9																											
Diagnosis or nature of illness or injury	Text	Optional Written description is not required. If entered, the written description must match the code(s).																												
Transportation Certification attached	Check box <input type="checkbox"/>	N																												

Field Label	Completion format	Instructions																		
Prior Authorization No.	6 characters: Letter plus 5 digits	<p>Conditional</p> <p>If the procedure requires prior authorization, enter the prior authorization 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 agency or the fiscal agent.</p>																		
19A. Date of Service	From: 6 digits MMDDYY To: 6 digits MMDDYY	<p>Required</p> <p>The field accommodates the entry of two dates: a “beginning” or “from” date of service and an “ending” or “to” date of service.</p> <p>Single date of service</p> <p>From To</p> <table border="1" data-bbox="716 772 1068 827"> <tr> <td>01</td> <td>01</td> <td>2012</td> <td></td> <td></td> <td></td> </tr> </table> <p>Or</p> <p>From To</p> <table border="1" data-bbox="716 926 1084 980"> <tr> <td>01</td> <td>01</td> <td>2012</td> <td>01</td> <td>01</td> <td>2012</td> </tr> </table> <p>Span dates of service</p> <table border="1" data-bbox="716 1024 1084 1079"> <tr> <td>01</td> <td>01</td> <td>2012</td> <td>01</td> <td>31</td> <td>2012</td> </tr> </table> <p>Single Date of Service: Enter the six digit date of service in the “From” field. Completion of the “To” field is not required. Do not spread the date entry across the two fields.</p> <p>Span billing: Span billing is permissible if the same service (same procedure code) is provided on consecutive dates.</p>	01	01	2012				01	01	2012	01	01	2012	01	01	2012	01	31	2012
01	01	2012																		
01	01	2012	01	01	2012															
01	01	2012	01	31	2012															
19B. Place of Service	2 digits	<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"> 04 Homeless Shelter 11 Office 12 Home 15 Mobile Unit 20 Urgent Care Facility 21 Inpatient hospital 22 Outpatient hospital 23 Emergency room hospital 25 Birthing Center 																		

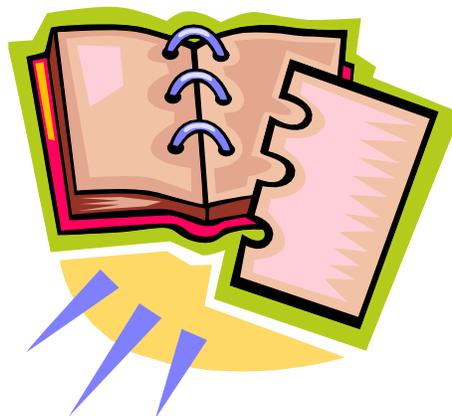
Field Label	Completion format	Instructions
19B. Place of Service (continued)	2 digits	26 Military Treatment Center 31 Skilled Nursing Facility 32 Nursing facility 33 Custodial Care Facility 34 Hospice 41 Transportation Land 51 Inpatient Psychiatric Facility 52 Psychiatric Facility Partial Hospitalization 53 Community mental health center 54 Intermediate Care Facility - MR 60 Mass Immunization Center 61 Comprehensive IP Rehab Facility 62 Comprehensive OP Rehab Facility 65 End Stage Renal Dialysis Trtmt Facility 71 State-Local Public Hlth Clinic 99 Other Unlisted
19C. Procedure Code (HCPCS)	5 characters: 5 digits or 1 letter plus 4 digits or 2 letters plus 3 digits	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.
Modifiers	2 characters: Letters or digits May enter up to two 2 character modifiers	Enter the appropriate procedure-related modifier that applies to the billed service. Enter two (2) characters in each field. Modifiers GO – Occupational Therapy GT – Physical Therapy

Field Label	Completion format	Instructions
<p>19D. Rendering Provider No.</p>	<p>8 digits</p>	<p>Required</p> <p>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>19E. Referring Provider No.</p>	<p>8 digits</p>	<p>Conditional</p> <p>Complete for clients enrolled in the Primary Care Physician (PCP) program if:</p> <p>The rendering or billing provider is not the primary care provider and</p> <p>The billed service requires PCP referral.</p> <p>Enter the PCP's eight-digit Colorado Medical Assistance Program provider number. Entry of the PCP's provider number represents the provider's declaration that he/she has a referral from the PCP.</p>



Field Label	Completion format	Instructions																																																					
<p>19F. Diagnosis</p>	<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px; text-align: center;">P</td> <td style="width: 20px; text-align: center;">S</td> <td style="width: 20px; text-align: center;">T</td> </tr> </table> <p>1 digit per column</p>	P	S	T	<p>Required</p> <p>Each billed line must have at least one primary diagnosis referenced. At least one diagnosis code must be entered.</p> <p>Enter up to four diagnosis codes starting at the far left side of the coding area.</p> <p>Do not enter the decimal point. Do not enter zeros to fill the spaces when the diagnosis code is fewer than 5 digits.</p> <p>From field 18 To field(s) 19F</p> <p>Example: (May require 4th or 5th digit)</p> <table style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px;">1</td> <td style="border: 1px solid black; padding: 2px;">7</td> <td style="border: 1px solid black; padding: 2px;">8</td> <td style="border: 1px solid black; padding: 2px;">5</td> <td style="border: 1px solid black; padding: 2px;">5</td> <td style="border: 1px solid black; padding: 2px;">9</td> <td style="width: 50px;"></td> <td style="border: 1px solid black; padding: 2px;">P</td> <td style="border: 1px solid black; padding: 2px;">S</td> <td style="border: 1px solid black; padding: 2px;">T</td> </tr> <tr> <td>2</td> <td style="border: 1px solid black; padding: 2px;">8</td> <td style="border: 1px solid black; padding: 2px;">2</td> <td style="border: 1px solid black; padding: 2px;">4</td> <td style="border: 1px solid black; padding: 2px;">X</td> <td style="border: 1px solid black; padding: 2px;"></td> <td style="width: 50px;"></td> <td></td> <td></td> <td></td> </tr> <tr> <td>3</td> <td style="border: 1px solid black; padding: 2px;">2</td> <td style="border: 1px solid black; padding: 2px;">7</td> <td style="border: 1px solid black; padding: 2px;">6</td> <td style="border: 1px solid black; padding: 2px;">5</td> <td style="border: 1px solid black; padding: 2px;">X</td> <td style="width: 20px;">Line 1</td> <td style="border: 1px solid black; padding: 2px;">1</td> <td style="border: 1px solid black; padding: 2px;">2</td> <td style="border: 1px solid black; padding: 2px;">3</td> </tr> <tr> <td>4</td> <td style="border: 1px solid black; padding: 2px;">V</td> <td style="border: 1px solid black; padding: 2px;">2</td> <td style="border: 1px solid black; padding: 2px;">2</td> <td style="border: 1px solid black; padding: 2px;">X</td> <td style="border: 1px solid black; padding: 2px;"></td> <td style="width: 20px;">Line 2</td> <td style="border: 1px solid black; padding: 2px;">2</td> <td style="border: 1px solid black; padding: 2px;"></td> <td style="border: 1px solid black; padding: 2px;"></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td style="width: 20px;">Line 3</td> <td style="border: 1px solid black; padding: 2px;">4</td> <td style="border: 1px solid black; padding: 2px;">2</td> <td style="border: 1px solid black; padding: 2px;"></td> </tr> </table> <p>For each billed service, indicate which of the diagnoses in field 18 are <u>P</u> Primary, <u>S</u> Secondary, or <u>T</u> Tertiary.</p> <p>In the example above, for services reported on line 1, the primary reason for the service (diagnosis) was diagnosis 785.59, the secondary reason was 276.5, and the tertiary reason was V22. For the services reported on line 2, the primary (and only reason) was 824. On line 3, there were two reasons for the services, V22. primary and 824 secondary.</p>	1	7	8	5	5	9		P	S	T	2	8	2	4	X						3	2	7	6	5	X	Line 1	1	2	3	4	V	2	2	X		Line 2	2									Line 3	4	2	
P	S	T																																																					
1	7	8	5	5	9		P	S	T																																														
2	8	2	4	X																																																			
3	2	7	6	5	X	Line 1	1	2	3																																														
4	V	2	2	X		Line 2	2																																																
						Line 3	4	2																																															

Field Label	Completion format	Instructions
<p>19G. Charges</p>	<p>Up to 7 digits: Currency 99999.99</p>	<p>Required</p> <p>Enter the usual and customary charge for the service represented by the procedure code on the detail line.</p> <p>Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one procedure from the same group is billed, special multiple pricing rules apply.</p> <p>The base procedure is the procedure with the highest allowable amount. The base code is used to determine the allowable amounts for additional CPT surgical procedures when more than one procedure from the same grouping is performed.</p> <p>Submitted charges cannot be more than charges made to non-Colorado Medical Assistance Program covered individuals for the same service.</p> <p>Do not deduct Colorado Medical Assistance Program co-payment or commercial insurance payments from usual and customary charges.</p>
<p>19H. Days or Units</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>



Field Label	Completion format	Instructions
19I. COPAY	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
19J. Emergency	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.
19K. Family Planning	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.
19L. EPSDT	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.
Medicare SPR Date (unlabeled field)	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"> ▪ Do not complete this field if Medicare denied all benefits. ▪ Do not combine items from several SPRs/ERAs on a single claim form. ▪ 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. ▪ Providers must submit a copy of the SPR/ERA with paper claims. Be sure to retain the original SPR/ERA for audit purposes.

Field Label	Completion format	Instructions
<p>20. Total Charges</p>	<p>Up to 7 digits: Currency 99999.99</p>	<p>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.).</p>
<p>21. Medicare Paid</p>	<p>7 digits: Currency 99999.99</p>	<p>Conditional Complete for Medicare crossover claims. Enter the Medicare payment amount shown on the Medicare payment voucher.</p>
<p>22. Third Party Paid</p>	<p>7 digits: Currency 99999.99</p>	<p>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 not enter Colorado Medical Assistance Program co-payment in this field or anywhere else on the claim form.</p>
<p>23. Net Charge</p>	<p>7 digits: Currency 99999.99</p>	<p>Required Colorado Medical Assistance Program claims (Not Medicare Crossover) 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. Medicare Crossover claims 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>24. Medicare Deductible</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>

Field Label	Completion format	Instructions
25. Medicare Coinsurance	7 digits: Currency 99999.99	Conditional Complete for Medicare crossover claims. Enter the Medicare coinsurance amount shown on the Medicare payment voucher.
26. Medicare Disallowed	7 digits: Currency 99999.99	Conditional Complete for Medicare crossover claims. Enter the amount Medicare disallowed, if any, shown on the Medicare payment voucher.
27. Signature (Subject to Certification on Reverse) and Date	Text	<p>Required</p> <p>Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent.</p> <p>A holographic signature stamp may be used <u>if</u> authorization for the stamp is on file with the fiscal agent.</p> <p>An authorized agent or representative may sign the claim for the enrolled provider <u>if</u> the name and signature of the agent is on file with the fiscal agent</p> <p>Unacceptable signature alternatives:</p> <p>Claim preparation personnel may not sign the enrolled provider's name.</p> <p>Initials are not acceptable as a signature.</p> <p>Typed or computer printed names are not acceptable as a signature.</p> <p>"Signature on file" notation is not acceptable in place of an authorized signature.</p>
28. Billing Provider Name	Text	<p>Required</p> <p>Enter the name of the individual or organization that will receive payment for the billed services.</p>
29. Billing Provider Number	8 digits	<p>Required</p> <p>Enter the eight-digit Colorado Medical Assistance Program provider number assigned to the individual or organization that will receive payment for the billed services.</p>
30. Remarks	Text	<p>Conditional</p> <p>Use to document the Late Bill Override Date for timely filing.</p> <p>When applicable, enter the word "CLIA" followed by the number.</p>

UB-04 Paper Claim Reference Table

PT and OT outpatient hospital paper claims must be submitted on the UB-04 claim form.

The information in the following Paper Claim Reference Table lists the required, optional and/or conditional form locators for submitting the UB-04 paper claim form to the Colorado Medical Assistance Program for PT and OT services. It also provides instructions for completing Form Locators (FL) as they appear on the paper UB-04 claim form. Instructions for completing the UB-04 claim form are based on the current *National Uniform Billing Committee (NUBC) UB-04 Reference Manual*. Unless otherwise noted, all data FLs on the UB-04 have the same attributes (specifications) for the Colorado Medical Assistance Program as those indicated in the *NUBC UB-04 Reference Manual*.

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

The UB-04 certification must be completed and attached to all claims submitted on the UB-04 paper claim form. A copy of the certification form is included with this manual. Completed UB-04 paper Colorado Medical Assistance Program claims, including hardcopy Medicare claims, should be mailed to the correct fiscal agent address located in Appendix A of the Appendices section in [Provider Services Billing Manuals](#).

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

Form Locator and Label	Completion Format	Instructions
1. Billing Provider Name, Address, Telephone Number	Text	Required Enter the provider or agency name and complete mailing address of the provider who is billing for the services: Street/Post Office box City State Zip Code Abbreviate the state using standard post office abbreviations. Enter the telephone number.
2. Pay-to Name, Address, City, State	Text	Required if different from FL 1. Enter the provider or agency name and complete mailing address of the provider who will receive payment for the services: Street/Post Office box City State Zip Code Abbreviate the state using standard post office abbreviations. Enter the telephone number.

Form Locator and Label	Completion Format	Instructions
3a. Patient Control Number	Up to 20 characters: Letters, numbers or hyphens	Optional Enter information that identifies the client or claim in the provider's billing system. Submitted information appears on the Provider Claim Report.
3b. Medical Record Number	17 digits	Optional Enter the number assigned to the patient to assist in retrieval of medical records.
4. Type of Bill	3 digits	<p>Required</p> <p>Enter the three-digit number indicating the specific type of bill. The three-digit code requires one digit each in the following sequences (Type of facility, Bill classification, and Frequency):</p> <p><u>Digit 1</u> <u>Type of Facility</u></p> <p>1 Hospital</p> <p>2 Skilled Nursing Facility</p> <p>3 Home Health</p> <p>4 Religious Non-Medical Health Care Institution Hospital Inpatient</p> <p>5 Religious Non-Medical Health Care Institution Post-Hospital Extended Care Services</p> <p>6 Intermediate Care</p> <p>7 Clinic (Rural Health/FQHC/Dialysis Center)</p> <p>8 Special Facility (Hospice, RTCs)</p> <p><u>Digit 2</u> <u>Bill Classification (Except clinics & special facilities):</u></p> <p>1 Inpatient (Including Medicare Part A)</p> <p>2 Inpatient (Medicare Part B only)</p> <p>3 Outpatient</p> <p>4 Other (for hospital referenced diagnostic services or home health not under a plan of treatment)</p> <p>5 Intermediate Care Level I</p> <p>6 Intermediate Care Level II</p> <p>7 Sub-Acute Inpatient (revenue code 19X required with this bill type)</p>

Form Locator and Label	Completion Format	Instructions
<p>4. Type of Bill (continued)</p>	<p>3 digits</p>	<p>Required</p> <p>Enter the three-digit number indicating the specific type of bill. The three-digit code requires one digit each in the following sequences (Type of facility, Bill classification, and Frequency):</p> <p><u>Digit 2 Bill Classification (Except clinics & special facilities):</u></p> <p>8 Swing Beds</p> <p>9 Other</p> <p><u>Digit 2 Bill Classification (Clinics Only):</u></p> <p>1 Rural Health/FQHC</p> <p>2 Hospital Based or Independent Renal Dialysis Center</p> <p>3 Freestanding</p> <p>4 Outpatient Rehabilitation Facility (ORF)</p> <p>5 Comprehensive Outpatient Rehabilitation Facilities (CORFs)</p> <p>6 Community Mental Health Center</p> <p><u>Digit 2 Bill Classification (Special Facilities Only):</u></p> <p>1 Hospice (Non-Hospital Based)</p> <p>2 Hospice (Hospital Based)</p> <p>3 Ambulatory Surgery Center</p> <p>4 Freestanding Birthing Center</p> <p>5 Critical Access Hospital</p> <p>6 Residential Facility</p> <p><u>Digit 3 Frequency:</u></p> <p>0 Non-Payment/Zero Claim</p> <p>1 Admit through discharge claim</p> <p>2 Interim - First claim</p> <p>3 Interim - Continuous claim</p> <p>4 Interim - Last claim</p> <p>7 Replacement of prior claim</p> <p>8 Void of prior claim</p>

Form Locator and Label	Completion Format	Instructions
5. Federal Tax Number	None	Not required Submitted information is not entered into the claim processing system.
6. Statement Covers Period – From/Through	From: 6 digits MMDDYY Through: 6 digits MMDDYY	Required (Note: OP claims cannot span over a month’s end) Enter the From (beginning) date and Through (ending) date of service covered by this bill using MMDDYY format. <i>For Example:</i> January 1, 2011 = 0101011 This form locator must reflect the beginning and ending dates of service. When span billing for multiple dates of service and multiple procedures, complete FL 45 (Service Date). Providers not wishing to span bill following these guidelines, must submit one claim per date of service. "From" and "Through" dates must be the same. All line item entries must represent the same date of service.
8a. Patient Identifier		Not required Submitted information is not entered into the claim processing system.
8b. Patient Name	Up to 25 characters: Letters & spaces	Required Enter the client’s last name, first name and middle initial.
9a. Patient Address – Street	Characters Letters & numbers	Required Enter the client's street/post office box as determined at the time of admission.
9b. Patient Address – City	Text	Required Enter the client's city as determined at the time of admission.
9c. Patient Address – State	Text	Required Enter the client's state as determined at the time of admission.
9d. Patient Address – Zip	Digits	Required Enter the client's zip code as determined at the time of admission.
9e. Patient Address – Country Code	Digits	Optional

Form Locator and Label	Completion Format	Instructions
10. Birthdate	8 digits (MMDDCCYY)	Required Enter the client's birthdate using two digits for the month, two digits for the date, and four digits for the year (MMDDCCYY format). Example: 01012010 for January 1, 2010.
11. Patient Sex	1 letter	Required Enter an M (male) or F (female) to indicate the client's sex.
12. Admission Date	6 digits	Conditional Required for observation holding beds only
13. Admission Hour	6 digits	Conditional Required for observation holding beds only
14. Admission Type	1 digit	<p>Required</p> <p>Enter the following to identify the admission priority:</p> <p><u>1 – Emergency</u> Client requires immediate intervention as a result of severe, life threatening or potentially disabling conditions. Exempts inpatient hospital & clinic claims from co-payment and PCP referral. Exempts outpatient hospital claims from co-payment and PCP only if revenue code 450 or 459 is present. This is the only benefit service for an undocumented alien. If span billing, emergency services cannot be included in the span bill and must be billed separately from other outpatient services.</p> <p><u>2 - Urgent</u> The client requires immediate attention for the care and treatment of a physical or mental disorder.</p> <p><u>3 - Elective</u> The client's condition permits adequate time to schedule the availability of accommodations.</p> <p><u>4 - Newborn</u> Required for inpatient and outpatient hospital.</p> <p><u>5 - Trauma Center</u> Visit to a trauma center/hospital as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons <u>and</u> involving trauma activation.</p> <p>Clinics Required only for emergency visit.</p>

Form Locator and Label	Completion Format	Instructions
<p>15. Source of Admission</p>	<p>1 digit</p>	<p>Required</p> <p>Enter the appropriate code for co-payment exceptions on claims submitted for outpatient services. (To be used in conjunction with FL 14, Type of Admission).</p> <ul style="list-style-type: none"> 1 Physician referral 2 Clinic referral 3 Referred from HMO 4 Transfer from a hospital 5 Transfer from a skilled nursing facility (SNF) 6 Transfer from another health care facility 7 Emergency Room 8 Court/Law Enforcement 9 Information not available A Transfer from a Critical Access Hospital B Transfer from another Home Health Agency C Readmission to Same Home Health Agency <p>Newborns</p> <ul style="list-style-type: none"> 1 Normal Delivery 2 Premature Delivery 3 Sick Baby 4 Extramural Birth (Birth in a non-sterile environment)
<p>16. Discharge Hour</p>	<p>2 digits</p>	<p>Not Required</p> <p>Enter the hour the client was discharged from inpatient hospital care. Use the same coding used in FL 13 (Admission Hr.)</p>
<p>17. Patient Discharge Status</p>	<p>2 digits</p>	<p>Conditional</p> <p>Enter patient status as of discharge date.</p> <ul style="list-style-type: none"> 01 Discharged to Home or Self Care (Dialysis is limited to code 01) 02 Discharged/transferred to another short term hospital

Form Locator and Label	Completion Format	Instructions
<p>17. Patient Discharge Status (continued)</p>	<p>2 digits</p>	<p>70 Discharged/Transferred to Other HC Institution</p> <p>71 Discharged/transferred/referred to another institution for outpatient services</p> <p>72 Discharged/transferred/referred to this institution for outpatient services</p> <p>Use code <u>02</u> for a PPS hospital transferring a patient to another PPS hospital.</p> <p>Code <u>05</u>, Discharged to Another Type Institution, is the most appropriate code to use for a PPS hospital transferring a patient to an exempt hospital.</p> <p>**A PPS hospital cannot use Patient Status codes 30, 31 or 32 on any claim submitted for DRG reimbursement. The code(s) are valid for use on exempt hospital claims only.</p> <p>Interim bills may be submitted for Prospective Payment System (PPS)-DRG claims, but must meet specific billing requirements.</p> <p>For exempt hospitals use the appropriate code from the codes listed. Note: Refer to the "Interim" billing instruction in this section of the manual.</p>
<p>18-28. Condition Codes</p>	<p>2 Digits</p>	<p>Conditional</p> <p>Complete with as many codes necessary to identify conditions related to this bill that may affect payer processing.</p> <p><u>Condition Codes</u></p> <p>01 Military service related</p> <p>02 Employment related</p> <p>04 HMO enrollee</p> <p>05 Lien has been filed</p> <p>06 ESRD patient - First 18 months entitlement</p> <p>07 Treatment of non-terminal condition/hospice patient</p> <p>17 Patient is homeless</p> <p>25 Patient is a non-US resident</p> <p>39 Private room medically necessary</p> <p>42 Outpatient Continued Care not related to Inpatient</p>

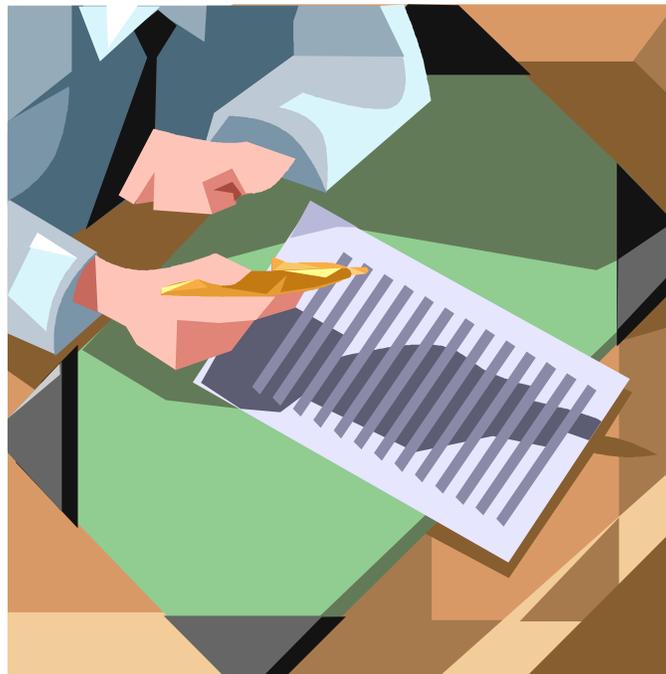
Form Locator and Label	Completion Format	Instructions
<p>18-28. Condition Codes (continued)</p>	<p>2 Digits</p>	<p>44 Inpatient CHANGED TO Outpatient 51 Outpatient Non-diagnostic Service unrelated to Inpatient admit 60 DRG (Day outlier) <u>Renal dialysis settings</u> 71 Full care unit 72 Self care unit 73 Self care training 74 Home care 75 Home care - 100 percent reimbursement 76 Back-up facility <u>Special Program Indicator Codes</u> A1 EPSDT/CHAP A2 Physically Handicapped Children's Program A4 Family Planning A6 PPV/Medicare A9 Second Opinion Surgery AA Abortion Due to Rape AB Abortion Done Due to Incest AD Abortion Due to Life Endangerment AI Sterilization B3 Pregnancy Indicator B4 Admission Unrelated to Discharge <u>PRO Approval Codes</u> C1 Approved as billed C2 Automatic approval as billed - Based on focused review C3 Partial approval C4 Admission/Services denied C5 Post payment review applicable C6 Admission preauthorization C7 Extended authorization</p>
<p>29. Accident State</p>		<p>Optional</p>

Form Locator and Label	Completion Format	Instructions
<p>31-34. Occurrence Code/Date</p>	<p>2 digits and 6 digits</p>	<p>Conditional Complete both the code and date of occurrence. Enter the appropriate code and the date on which it occurred. Enter the date using MMDDYY format.</p> <p>Occurrence Codes:</p> <ul style="list-style-type: none"> 01 Accident/Medical Coverage 02 Auto Accident - No Fault Liability 03 Accident/Tort Liability 04 Accident/Employment Related 05 Other Accident/No Medical Coverage or Liability Coverage 06 Crime Victim 20 Date Guarantee of Payment Began 24* Date Insurance Denied 25* Date Benefits Terminated by Primary Payer 26 Date Skilled Nursing Facility Bed Available 27 Date of Hospice Certification or Re-certification 40 Scheduled Date of Admission (RTD) 50 Medicare Pay Date 51 Medicare Denial Date 53 Late Bill Override Date 55 Insurance Pay Date A3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer A indicated in FL 50 B3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer B indicated in FL 50 C3 Benefits Exhausted - Indicate the last date of service that benefits are available and after which payment can be made by payer C indicated in FL 50 <p>*Other Payer occurrence codes 24 and 25 must be used when applicable. The claim must be submitted with the third party information</p>

Form Locator and Label	Completion Format	Instructions
35-36. Occurrence Span Code From/ Through	2 digits and 6 digits	Leave blank
38. Responsible Party Name/ Address	None	Not required Submitted information is not entered into the claim processing system.
39-41. Value Code- Code Value Code- Amount	2 characters and 9 digits	<p>Conditional</p> <p>Enter appropriate codes and related dollar amounts to identify monetary data or number of days using whole numbers, necessary for the processing of this claim. Never enter negative amounts.</p> <p>If a value code is entered, a dollar amount or numeric value related to the code <u>must</u> always be entered.</p> <ul style="list-style-type: none"> 01 Most common semiprivate rate (Accommodation Rate) 06 Medicare blood deductible 14 No fault including auto/other 15 Worker's Compensation 30 Preadmission testing 31 Patient Liability Amount 32 Multiple Patient Ambulance Transport 37 Pints of Blood Furnished 38 Blood Deductible Pints 40 New Coverage Not Implemented by HMO 45 Accident Hour Enter the hour when the accident occurred that necessitated medical treatment. Use the same coding used in FL 18 (Admission Hour). 49 Hematocrit Reading - EPO Related 58 Arterial Blood Gas (PO2/PA2) 68 EPO-Drug 80 Covered Days 81 Non-Covered Days

Form Locator and Label	Completion Format	Instructions
<p>39-41. Value Code-Code Value Code-Amount (continued)</p>	<p>2 characters and 9 digits</p>	<p>Enter the deductible amount applied by indicated payer:</p> <p>A1 Deductible Payer A B1 Deductible Payer B C1 Deductible Payer C</p> <p>Enter the amount applied to client’s co-insurance by indicated payer:</p> <p>A2 Coinsurance Payer A B2 Coinsurance Payer B C2 Coinsurance Payer C</p> <p>Enter the amount paid by indicated payer:</p> <p>A3 Estimated Responsibility Payer A B3 Estimated Responsibility Payer B C3 Estimated Responsibility Payer C</p> <p>Enter the amount paid by client:</p> <p>FC Patient Paid Amount</p> <p>For Rancho Coma Score bill with appropriate diagnosis for head injury. Medicare & TPL - See A1-A3, B1-B3, & C1-C3 above</p>
<p>42. Revenue Code</p>	<p>3 digits</p>	<p>Required</p> <p>Enter the revenue code which identifies the specific accommodation or ancillary service provided. List revenue codes in ascending order.</p> <p>A <u>revenue code</u> must appear only <u>once</u> per date of <u>service</u>. If more than one of the same service is provided on the same day, combine the <u>units</u> and charges on one line accordingly.</p> <p>When billing outpatient hospital radiology, the radiology revenue code may be repeated, but the corresponding HCPCS code cannot be repeated for the same date of service. Refer to instructions under FL 44 (HCPCS/Rates).</p> <p>Psychiatric step down</p> <p>Use the following revenue codes:</p> <p>0114 Psychiatric Step Down 1 0124 Psychiatric Step Down 2</p>

Form Locator and Label	Completion Format	Instructions
<p>43. Revenue Code Description</p>	<p>Text</p>	<p>Required Enter the revenue code description or abbreviated description.</p> <p>When reporting an NDC</p> <ul style="list-style-type: none"> ▪ Enter the NDC qualifier of “N4” in the first two positions on the left side of the field. ▪ Enter the 11-digit NDC numeric code ▪ Enter the NDC unit of measure qualifier (examples include): <ul style="list-style-type: none"> ✓ F2 – International Unit ✓ GR – Gram ✓ ML – Milliliter ✓ UN – Units ▪ Enter the NDC unit of measure quantity



Form Locator and Label	Completion Format	Instructions
<p>44. HCPCS/Rates/ HIPPS Rate Codes</p>	<p>5 digits</p>	<p>Conditional</p> <p>Enter only the HCPCS code for each detail line. Use approved modifiers listed in this section for hospital based transportation services.</p> <p>Complete for laboratory, radiology, physical therapy, occupational therapy, and hospital based transportation. When billing HCPCS codes, the appropriate revenue code must also be billed.</p> <p>HCPCS codes must be identified for the following revenue codes:</p> <ul style="list-style-type: none"> ▪ 030X Laboratory ▪ 032X Radiology – Diagnostic ▪ 033X Radiology – Therapeutic ▪ 034X Nuclear Medicine ▪ 035X CT Scan ▪ 040X Other Imaging Services ▪ 042X Physical Therapy ▪ 043X Occupational Therapy ▪ 054X Ambulance ▪ 061X MRI <p>HCPCS codes cannot be repeated for the same date of service. Combine the units in FL 46 (Service Units) to report multiple services.</p> <p>The following revenue codes always require a HCPCS code. Please reference the Provider Services Bulletins section of the Department’s Web site for a list of physician-administered drugs that also require an NDC code.</p> <p>When a HCPCS code is repeated more than once per day and billed on separate lines, use modifier 76 to indicate this is a repeat procedure and not a duplicate.</p> <ul style="list-style-type: none"> 0252 Non-Generic Drugs 0253 Take Home Drugs 0255 Drugs Incident to Radiology 0257 Non-Prescription 0258 IV Solutions 0259 Other Pharmacy 0260 IV Therapy General Classification 0261 Infusion Pump 0262 IV Therapy/Pharmacy Services 0263 IV Therapy/Drug/Supply Delivery

Form Locator and Label	Completion Format	Instructions
44. HCPCS/Rates/ HIPPS Rate Codes (continued)	5 digits	0264 IV Therapy/Supplies 0269 Other IV Therapy 0631 Single Source Drug 0632 Multiple Source Drug 0633 Restrictive Prescription 0634 Erythropoietin (EPO) <10,000 0635 Erythropoietin (EPO) >10,000 0636 Drugs Requiring Detailed Coding
45. Service Date	6 digits	Required For span bills only Enter the date of service using MMDDYY format for each detail line completed. Each date of service must fall within the date span entered in the "Statement Covers Period" (FL 6). Not required for single date of service claims.
46. Service Units	3 digits	Required Enter a unit value on each line completed. Use whole numbers only. Do not enter fractions or decimals and do not show a decimal point followed by a 0 to designate whole numbers (e.g., Do not enter 1.0 to signify one unit) The grand total line (Line 23) does not require a unit value. For span bills, the units of service reflect only those visits, miles or treatments provided on dates of service in FL 45.
47. Total Charges	9 digits	Required Enter the total charge for each line item. Calculate the total charge as the number of units multiplied by the unit charge. Do not subtract Medicare or third party payments from line charge entries. Do not enter negative amounts. A grand total in line 23 is required for all charges.
48. Non-Covered Charges	9 digits	Conditional Enter incurred charges that are not payable by the Colorado Medical Assistance Program. Non-covered charges must be entered in both FL 47 (Total Charges) and FL 48 (Non-Covered Charges). Each column requires a grand total. Non-covered charges cannot be billed for outpatient hospital laboratory or hospital based transportation services.

Form Locator and Label	Completion Format	Instructions
<p>50. Payer Name</p>	<p>1 letter and text</p>	<p>Required</p> <p>Enter the payment source code followed by name of each payer organization from which the provider might expect payment.</p> <p>At least one line must indicate The Colorado Medical Assistance Program.</p> <p><u>Source Payment Codes</u></p> <p>B Workmen's Compensation</p> <p>C Medicare</p> <p>D Colorado Medical Assistance Program</p> <p>E Other Federal Program</p> <p>F Insurance Company</p> <p>G Blue Cross, including Federal Employee Program</p> <p>H Other - Inpatient (Part B Only)</p> <p>I Other</p> <p>Line A Primary Payer</p> <p>Line B Secondary Payer</p> <p>Line C Tertiary Payer</p>
<p>51. Health Plan ID</p>	<p>8 digits</p>	<p>Required</p> <p>Enter the provider's Health Plan ID for each payer name. Enter the eight digit Colorado Medical Assistance Program provider number assigned to the billing provider. Payment is made to the enrolled provider or agency that is assigned this number.</p>
<p>52. Release of Information</p>		<p>Not required</p> <p>Submitted information is not entered into the claim processing system.</p>
<p>53. Assignment of Benefits</p>		<p>Not required</p> <p>Submitted information is not entered into the claim processing system.</p>
<p>54. Prior Payments</p>	<p>Up to 9 digits</p>	<p>Conditional</p> <p>Complete when there are Medicare or third party payments.</p> <p>Enter third party and/or Medicare payments.</p>

Form Locator and Label	Completion Format	Instructions
<p>55. Estimated Amount Due</p>	<p>Up to 9 digits</p>	<p>Conditional Complete when there are Medicare or third party payments. Enter the net amount due from The Colorado Medical Assistance Program after provider has received other third party, Medicare or patient liability amount. Medicare Crossovers Enter the sum of the Medicare coinsurance plus Medicare deductible less third party payments and patient payments.</p>
<p>56. National Provider Identifier (NPI)</p>	<p>10 digits</p>	<p>Optional Enter the billing provider's 10-digit National Provider Identifier (NPI).</p>
<p>57. Other Provider ID</p>		<p>Not required Submitted information is not entered into the claim processing system.</p>
<p>58. Insured's Name</p>	<p>Up to 30 characters</p>	<p>Required Enter the client's name on the Colorado Medical Assistance Program line. Other Insurance/Medicare Complete additional lines when there is third party coverage. Enter the policyholder's last name, first name, and middle initial.</p>
<p>60. Insured's Unique ID</p>	<p>Up to 20 characters</p>	<p>Required Enter the insured's unique identification number assigned by the payer organization exactly as it appears on the health insurance card. Include letter prefixes or suffixes shown on the card.</p>
<p>61. Insurance Group Name</p>	<p>14 letters</p>	<p>Conditional Complete when there is third party coverage. Enter the name of the group or plan providing the insurance to the insured exactly as it appears on the health insurance card.</p>
<p>62. Insurance Group Number</p>	<p>17 digits</p>	<p>Conditional Complete when there is third party coverage. Enter the identification number, control number, or code assigned by the carrier or fund administrator identifying the group under which the individual is carried.</p>
<p>63. Treatment Authorization Code</p>	<p>Up to 18 characters</p>	<p>Conditional Complete when the service requires a PAR. Enter the authorization number in this FL if a PAR is required and has been approved for services.</p>

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

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

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





Institutional Provider Certification

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

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

Signature: _____

Date: _____

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

Colorado 1500 OT/PT 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) Client, Ima	2. CLIENT DATE OF BIRTH 01/04/2007	3. MEDICAID ID NUMBER (CLIENT ID NUMBER) D333333
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE) 1234 Anywhere Street Anytown, CO 88888	5. CLIENT SEX MALE <input type="checkbox"/> FEMALE <input checked="" type="checkbox"/>	6. MEDICARE ID NUMBER (HIC OR SSN)
TELEPHONE NUMBER	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	EMPLOYER NAME: POLICYHOLDER NAME: GROUP:
11. CHAMPUS SPONSORS SERVICE/SSN	12. PREGNANCY <input type="checkbox"/> HMO <input type="checkbox"/> NURSING FACILITY <input type="checkbox"/>	

PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF:	ILLNESS (FIRST SYMPTON) 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		PROVIDER NUMBER	15. 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)		PROVIDER NUMBER	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	TRANSPORTATION CERTIFICATION ATTACHED <input type="checkbox"/> YES
1. 3439	Cerebral Palsy	DURABLE MEDICAL EQUIPMENT Line # Make Model Serial Number
2. 8233	Tibia/Fibula Fracture	
3. 7845	Speech Disorder	
PRIOR AUTHORIZATION #:		

15A	DATE OF SERVICE FROM TO	B. PLACE OF SERVICE	C. PROCEDURE CODE (HCPCS)	D. MODIFIERS	E. RENDERING PROVIDER NUMBER	F. REFERRING PROVIDER NUMBER	G. DIAGNOSIS P S T	H. CHARGES	I. DAYS OR UNITS	J. COPAY	K. EMERG ENCY	L. FAMILY PLANNING	M. EP/SDT
	02/05/2014 02/05/2014	12	97003	GO	12345678	76543210	1	\$20.00	1		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	02/05/2014 02/05/2014	12	97033	GO	12345678	76543210	1	\$10.00	2		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	02/05/2014 02/05/2014	12	97001	GP	87654321	76543210	2 1	\$20.00	1		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	02/05/2014 02/05/2014	12	97032	GP	87654321	76543210	2 1	\$10.00	2		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	02/05/2014 02/05/2014	12	92506		01234567	76543210	3	\$20.00	1		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<p style="font-size: 8px;">THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE, AND COMPLETE. I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS.</p>	20. TOTAL CHARGES → \$80.00	LESS ↓	21. MEDICARE PAID 22. THIRD PARTY PAID 23. NET CHARGE \$80.00
27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE <i>Authorized Signature February 28, 2014</i>	30. REMARKS	24. MEDICARE DEDUCTIBLE \$0.00	25. MEDICARE COINSURANCE \$0.00
28. BILLING PROVIDER NAME ABC Clinic		26. MEDICARE DISALLOWED	
29. BILLING PROVIDER NUMBER 11223344		COLORADO 1500	

COL-101
FORM NO. 54320 (REV. 02/99)
ELECTRONIC APPLICATION

UB-04 Outpatient PT Claim Example

1 City Hospital 100 Saginaw St. Anytown, CO 80000 333-333-3333		2		3a PAT. CNTL. # b. MED. REC. #		4 TYPE OF BILL 131	
8 PATIENT NAME a Client, Ima				9 PATIENT ADDRESS a 123 Main Street b Anytown c CO d 80000			
10 BIRTHDATE 01/04/2006		11 SEX F		12 DATE		13 HR	
14 TYPE 3		15 SRC 3		16 DHR		17 STAT	
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
35 CODE		36 CODE		37 CODE		38	
39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT		42	
43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE		46 SERV. UNITS	
47 TOTAL CHARGES		48 NON-COVERED CHARGES		49		50	
440 Speech therapy		92502		02/06/14		1	
440 Speech Therapy		92507		02/06/14		1	
21 21 64		21 64					
PAGE 1 OF 1		CREATION DATE		TOTALS		43 28	
50 PAYER NAME D - Medicaid		51 HEALTH PLAN ID 12345678		52 P.F. INFO		53 ASG. BEN.	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI		57 OTHER PRV ID	
58 INSURED'S NAME Client, Ima		59 P.F. INFO		60 INSURED'S UNIQUE ID Y123456		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66 DX 434.91		67		68		69	
70 PATIENT REASON DX		71 PPS CODE		72 EQ		73	
74 PRINCIPAL PROCEDURE CODE DATE		75 OTHER PROCEDURE CODE DATE		76 OTHER PROCEDURE CODE DATE		77 ATTENDING NPI	
78 QUAL		79 QUAL		80 QUAL		81 QUAL	
77 OPERATING NPI		78 OTHER NPI		79 OTHER NPI		80 OTHER NPI	
81 QUAL		82 QUAL		83 QUAL		84 QUAL	
80 REMARKS		81		82		83	
84		85		86		87	

Late Bill Override Date

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

Valid Delay Reason Codes

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

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

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

Billing Instruction Detail	Instructions
LBOD Completion Requirements	<p>Electronic claim formats provide specific fields for documenting the LBOD. Supporting documentation must be kept on file for 6 years.</p> <p>For paper claims, follow the instructions appropriate for the claim form you are using.</p> <p><i>UB-04:</i> Occurrence code 53 and the date are required in FL 31-34.</p> <p><i>Colorado 1500:</i> Indicate “LBOD” and the date in box 30 - Remarks.</p> <p><i>2006 ADA Dental:</i> Indicate “LBOD” and the date in box 35 - Remarks</p>
Adjusting Paid Claims	<p>If the initial timely filing period has expired and a previously submitted claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was paid and now needs to be adjusted, resulting in additional payment to the provider.</p> <p>Adjust the claim within 60 days of the claim payment. Retain all documents that prove compliance with timely filing requirements.</p> <p>Note: There is no time limit for providers to adjust paid claims that would result in repayment to the Colorado Medical Assistance Program.</p> <p>LBOD = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the payment.</p>

Billing Instruction Detail	Instructions
<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>
<p>Denied/Rejected Due to Client 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 client and date of eligibility rejection.</p> <p>LBOD = the date shown on the eligibility rejection report.</p>
<p>Retroactive Client 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>

Billing Instruction Detail	Instructions
<p>Delayed Notification of Eligibility</p>	<p>The provider was unable to determine that the patient had Colorado Medical Assistance Program coverage until after the timely filing period expired.</p> <p>File the claim within 60 days of the date of notification that the individual had Colorado Medical Assistance Program coverage. Retain correspondence, phone logs, or a signed Delayed Eligibility Certification form (see Appendix H of the Appendices in the Provider Services Billing Manuals section) that identifies the client, indicates the effort made to identify eligibility, and shows the date of eligibility notification.</p> <p>Claims must be filed within 365 days of the date of service. No exceptions are allowed.</p> <p>This extension is available only if the provider had no way of knowing that the individual had Colorado Medical Assistance Program coverage.</p> <p>Providers who render services in a hospital or nursing facility are expected to get benefit coverage information from the institution.</p> <p>The extension does not give additional time to obtain Colorado Medical Assistance Program billing information.</p> <p>If the provider has previously submitted claims for the client, it is improper to claim that eligibility notification was delayed.</p> <p>LBOD = the date the provider was advised the individual had Colorado Medical Assistance Program benefits.</p>
<p>Electronic Medicare Crossover Claims</p>	<p>An electronic claim is being submitted for Medicare crossover benefits within 120 days of the date of Medicare processing/ payment. (Note: On the paper claim form (only), the Medicare SPR/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 client does not have Medicare coverage) being submitted within 60 days of the date of Medicare processing/denial.</p> <p>Note: This becomes a regular Colorado Medical Assistance Program claim, not a Medicare crossover claim.</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>

Billing Instruction Detail	Instructions
<p>Commercial Insurance Processing</p>	<p>The claim has been paid or denied by commercial insurance.</p> <p>File the claim within 60 days of the insurance payment or denial. Retain the commercial insurance payment or denial notice that identifies the patient, rendered services, and shows the payment or denial date.</p> <p>Claims must be filed within 365 days of the date of service. No exceptions are allowed. If the claim is nearing the 365-day limit and the commercial insurance company has not completed processing, file the claim, receive a denial or rejection, and continue filing in compliance with the 60-day rule until insurance processing information is available.</p> <p>LBOD = the date commercial insurance paid or denied.</p>
<p>Correspondence LBOD Authorization</p>	<p>The claim is being submitted in accordance with instructions (authorization) from the Colorado Medical Assistance Program for a 60 day filing extension for a specific client, claim, services, or circumstances.</p> <p>File the claim within 60 days of the date on the authorization letter. Retain the authorization letter.</p> <p>LBOD = the date on the authorization letter.</p>
<p>Client Changes Providers during Obstetrical Care</p>	<p>The claim is for obstetrical care where the patient transferred to another provider for continuation of OB care. The prenatal visits must be billed using individual visit codes but the service dates are outside the initial timely filing period.</p> <p>File the claim within 60 days of the last OB visit. Maintain information in the medical record showing the date of the last prenatal visit and a notation that the patient transferred to another provider for continuation of OB care.</p> <p>LBOD = the last date of OB care by the billing provider.</p>



PT and OT Therapy Revisions Log

Revision Date	Additions/Changes	Pages	Made by
04/22/2009	<i>Drafted Manual</i>	<i>All</i>	<i>jg</i>
09/14/2009	<i>Updates and formatting</i>	<i>Throughout</i>	<i>jg</i>
10/19/2009	<i>LBOD</i>	<i>44</i>	<i>jg</i>
01/12/2010	<i>Updated Web site links</i>	<i>Throughout</i>	<i>jg</i>
02/10/2010	<i>Changed EOMB to SPR</i>	<i>23 & 46</i>	<i>jg</i>
03/04/2010	<i>Added link to Program Rules</i>	<i>2</i>	<i>jg</i>
07/14/2010	<i>Updated date examples for field 19A Updated Colorado 1500 claim example UB-04 claim example</i>	<i>19 49 & 50</i>	<i>jg</i>
07/15/2010	<i>Added Electronic Remittance Advice (ERA) to Special Instructions for Medicare SPR Date field, to Electronic Medicare Crossover Claims and to Medicare Denied Services in Late Bill Override Date section</i>	<i>23 46</i>	<i>jg</i>
08/30/2011	<i>Deleted CFMC information and added ColoradoPAR fax number and address</i>	<i>8</i>	<i>crc</i>
09/13/2011	<i>Updated Par Reference Table to reflect changes to PAR form</i>		<i>vr</i>
09/15/2011	<i>Updated PAR Form Examples</i>		<i>jg</i>
12/06/2011	<i>Replaced 997 and 999 Replaced wpc-edi.com/hipaa with wpc-edi.com/Replaced Implementation Guide with Technical Report 3 (TR3)</i>	<i>5 3 3</i>	<i>ss</i>
05/18/2012	<i>Redrafted Manual Removed all Speech Therapy references Added in contact information, etc for ColoradoPAR</i>	<i>Throughout</i>	<i>akb</i>
10/01/2012	<i>Updated Global information such as Electronic Claim Submission and LBOD</i>	<i>3 54</i>	<i>vr</i>
10/01/2012	<i>Reformatted Updated TOC</i>	<i>All i</i>	<i>jg</i>
10/03/2012	<i>Reformatted Updated TOC</i>	<i>All i</i>	<i>jg</i>
02/7/2014	<i>Significant changes through. Added Habilitation Therapy content.</i>	<i>All</i>	<i>as</i>

Revision Date	Additions/Changes	Pages	Made by
02/27/2014	<i>UB-04 Paper Claim Reference Table Update:</i> 17- Added discharge status of 65, 66, 70 18-28- Added condition codes 42, 44, 51; Added special program indicator AA, AB, AD, AI Removed A7 and A8 35-63- Added 74 and 75 39-41- Added value code/amount 30 Added FC to enter amount paid by client 42- Removed 0134 from psychiatric step down 44- Added zero to HCPCS	34-35 36 37 37 39 40 40 40 42-43	cc
02/07/2014	Updated TOC Formatted Updated PAR Examples Updated Claim Examples	i Throughout 12 & 13 46 & 47	jg

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