

# Prenatal Plus Program

## Outpatient – Fee-For-Service

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# Prenatal Plus Program

The Prenatal Plus Program (PNP) is administered by the Colorado Department of Health Care Policy and Financing (the Department). This manual details information regarding the program's programmatic components and billing requirements. The Department periodically modifies the Prenatal Plus Program benefits and services therefore, the information in this manual is subject to change, and the manual is updated as new policies are implemented.

For general information about Colorado's Medical Assistance Program, please refer to the [General Provider Information Manual](#). The manual provides information about billing the Colorado Medical Assistance Program, reimbursement policies, provider participation, eligibility requirements and other useful information.

## Program Overview

The Prenatal Plus Program is a case management program for pregnant women who receive Medicaid benefits and who are at risk of negative maternal and infant health outcomes. The program gives women access to a care coordinator, a registered dietician, and a mental health professional who work together to help the woman reduce her risk of having a low birth weight baby. Prenatal Plus Program services are in addition to a woman's regular prenatal care services.



- To be eligible for the program, a woman must meet the following criteria:
- Be eligible for Medicaid;
- Be pregnant;
- Be at risk of negative maternal or infant health outcomes due to lifestyle, behavioral, and non-medical parts of the woman's life that could affect her pregnancy (see Eligibility Screening Form).

For more information about the Prenatal Plus Program, please visit the [Prenatal Plus Program's](#) web page.

## Reimbursable Services

Reimbursable services include nutrition and psychosocial counseling and support; general education and health promotion; and targeted case management services. With the exception of targeted case management, all services can be offered to clients in an individual or group setting.

- Nutrition counseling and support provided by the registered dietitian may include nutrition screening, education, and counseling. Counseling includes such activities as nutrition care-planning, goal-setting, monitoring, follow-up, and revision of the care plan.
- Psychosocial counseling and support provided by the mental health professional may include psychosocial health screening, assessment, and counseling. Counseling and support includes such activities as care-planning, goal-planning, monitoring, follow-up, and revision of the care plan.
- General client education, health promotion, and targeted case management are services offered by the care coordinator. Topics may include basic understanding of the prenatal period, concerns related to childbirth and breastfeeding, and the post partum period and healthy infancy. Targeted case management helps client gain access to needed medical, education, social, and other services.

## Rules and Regulations

The Prenatal Plus Program is administered by the Department. Rules governing the program are outlined in the Code of Colorado Regulations, 10 C.C.R. 2505 – 10 §8.748. Providers are required to comply with all of the rules and guidance provided by the Department and are encouraged to contact the Department's policy specialist with any questions.

## Required Documentation

Prenatal Plus Program sites utilize three specific forms to implement the program. All of these documents can be found on the [Prenatal Plus Program's](#) section of the Department's website at [colorado.gov/hcpf](http://colorado.gov/hcpf). They include:

- Prenatal Plus Eligibility Screening Form
- Initial Assessment Form
- Prenatal Weight Gain Chart

While these forms are required, the method and detail of documentation of clients' service plans is up to the discretion of the local Prenatal Plus Program staff. Every claim for reimbursement must be supported by clear evidence in the client's record/chart.

## Provider Enrollment and Participation

Providers must be enrolled as a Colorado Medical Assistance Program provider in order to treat a Colorado Medical Assistance Program client and to submit claims for payment to the Colorado Medical Assistance Program.

If interested in becoming a Colorado Medical Assistance Program provider, please refer to the [Provider Services Enrollment](#) section of the Department's website. Enrollment documents may be downloaded and mailed to the Department's fiscal agent at:

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

- Once enrolled in the Colorado Medical Assistance Program, providers who want to provide Prenatal Plus Program services must submit a [Prenatal Plus Program Provider Participation Form](#) as an addendum to the Colorado Medical Assistance Program Provider Participation Agreement.
- This form is housed on the Department's website in the Provider Services section, under [Other Forms](#) and at the Enrollment section, under [Standard Application](#). Please follow the instructions as written on the form.

Prenatal Plus Program providers must be enrolled in the Colorado Medical Assistance Program as one of the following Provider Types:

- Clinic
- Federally Qualified Health Center
- Rural Health Center
- Non-Physician Practitioner Group
- Physician
- Nurse Practitioner
- Certified Nurse-Midwife
- Physician's Assistant

## **Billing Information**

### **National Provider Identifier (NPI)**

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

### **Paper Claims**

Electronic claims format shall be required unless hard copy claims submittals are specifically 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/](http://wpc-edi.com/))
- Companion Guides for the 837P, 837I, or 837D in the Provider Services
- Web Portal User Guide (via within the Web Portal)

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

### **Procedure/Healthcare Common Procedural Coding System (HCPCS) 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 Current Procedural Terminology (CPT), 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.

**Prenatal Plus Program Procedure Codes and Modifiers**

The Prenatal Plus Program’s services are billed using one procedure code and a combination of modifiers. The code and modifiers are explained in the tables below.

Procedure Code	Description
H1005	Prenatal care, at-risk enhanced service package

Modifier(s)	Description
52	Reduced services
TF	Intermediate level of care
TG	Complex/high tech level of care
TH	Obstetrical treatment/services, prenatal or post partum

**Prenatal Plus Billing Packages**

The billing options for the Prenatal Plus Program are described in the table below.

Package Type	Procedure Code	Required Modifier(s)	Condition(s) Under Which Code Can Be Billed
Partial	H1005	TH and 52	Client enrolls at 28 or more weeks gestation and receives 1-4 contacts, at least one of which must be a face-to-face contact; <b>OR</b> Client enrolls in the first or second trimester (prior to 28 weeks) and receives 1-4 contacts, at least one of which must be a face-to-face contact, but withdraws from the program before delivery <b>OR</b> does not meet the criteria for the other package categories.

Package Type	Procedure Code	Required Modifier(s)	Condition(s) Under Which Code Can Be Billed
<b>Partial Plus</b>	H1005	TH and TF	Client enrolls at 28 or more weeks gestation and receives 5-9 contacts; <b>OR</b> Client enrolls in the first or second trimester (prior to 28 weeks) and receives 5-9 contacts, but withdraws from the program before delivery <b>OR</b> does not meet the criteria for the Full package categories. With appropriate documentation, one telephone call can be counted as a contact. Calls to reschedule an appointment or to make an appointment with a client cannot be considered a contact.
<b>Full</b>	H1005	TH	Client enrolls at 27 or fewer weeks gestation; A minimum of one case conference is held; <b>AND</b> Client receives a total of ten (10) contacts over the course of the pregnancy and through the end of the second month following the month in which the client delivered. With appropriate documentation, one telephone call can be counted as a contact. Calls to reschedule an appointment or to make an appointment with a client cannot be considered a contact.
<b>Full Plus</b>	H1005	TH and TG	Client enrolls at 27 or fewer weeks gestation; A minimum of one case conference is held; <b>AND</b> Client receives a minimum of eleven (11) contacts over the course of the pregnancy and through the end of the second month following the month in which the client delivered. With appropriate documentation, one telephone call can be counted as a contact. Calls to reschedule an appointment or to make an appointment with a client cannot be considered a contact.

**Claims Submission and Timely Filing**

Prenatal Plus Program claims must be submitted directly to the Colorado Medical Assistance Program for processing within 120 days after the last date of service. The last date of service is either the delivery date or the last date of contact for those who withdraw from the program. Providers should bill completed packages as soon as possible after the delivery date, even if the client may be seen for additional visits. Please see the Late Bill Override Date (LBOD) section of this manual for more information.

**Other Insurance Coverage**

Occasionally, Prenatal Plus Program clients have primary insurance coverage in addition to being eligible for Medicaid coverage. In these cases, claims for services must first be submitted to the primary insurance company. If the primary insurance company denies the claim, the claim can be submitted to the Colorado Medical Assistance Program for processing, along with a copy/date of the denial.

If the client is covered by one of the Colorado Medical Assistance Program’s managed care organizations, a denial is not necessary before billing for Prenatal Plus services covered by Medicaid.

Please refer to the [General Provider Information](#) manual for more information regarding payer of last resort.

### **Billing more than once in a nine-month period**

The Colorado Medicaid Management Information System (MMIS) allows for one billing per client in a nine-month period using Prenatal Plus billing codes. However, the following exceptions may be made:

- A client is seen for an initial pregnancy, subsequently has either a miscarriage or an abortion, and becomes pregnant again within a nine-month period. In this case, the provider may bill for the second pregnancy within the nine-month period.
- A client receives a Partial or Partial Plus package from one provider, then moves from the area and re-enrolls with a new provider. In this case, the first provider may bill a Partial or Partial Plus package, and the second provider may bill either a Partial, Partial Plus, Full or Full Plus package depending on the level of services provided (i.e., if all requirements for a Full package have been met, the provider can bill a Full package).

If a client leaves the program, and then re-enrolls with the same provider during the same pregnancy, the provider must request that the claim for the previously billed service package be voided out of the MMIS. Billing for the new service package can be done once criteria for the new package are met. An agency cannot bill the Colorado Medical Assistance Program for two separate packages for the same client during the same pregnancy.

### **Deactivate Participation in the Prenatal Plus Program**

Prenatal Plus Program sites can end participation in the program at any time. Instructions can be found on the [Prenatal Plus Program's](#) web page.

### **Other Covered Maternity Services Not Part of the Prenatal Plus Program**

The following services are available to pregnant women but must be billed in addition to Prenatal Plus Program claims:

- Clinical prenatal and postpartum care, labor, and delivery
- Depression screening for clients age 20 and under
- Non-emergent medical transportation (transportation to and from Medicaid services)
- Prenatal vitamins
- Substance use disorder counseling
- Tobacco cessation counseling and medications

### **Contact Information**

Please contact the Department's fiscal agent, Xerox State Healthcare, at 1-800-237- 0757 with billing inquiries.

The Department's Prenatal Plus Program policy specialist at 303-866-2844 can be contacted for all other inquiries.

### 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](http://wpc-edi.com)), 837P Companion Guide (in the Provider Services [Specifications](#) section of the Department’s website), and in the Web Portal User Guide (within the portal).

Field Label	Completion format	Instructions
<b>Invoice/Pat Acct Number</b>	Up to 12 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.
<b>Special Program Code</b>	2 digits	N/A
<b>1. Client Name</b>	Up to 25 characters: letters & spaces	Required Enter the client’s last name, first name, and middle initial.
<b>2. Client Date Of Birth</b>	Date of Birth 8 digits (MMDDCCYY)	Required Enter the client’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: 070110 for July 1, 2010
<b>3. Medicaid ID Number (Client ID Number)</b>	7 characters, a letter prefix followed by six numbers	Required Enter the client’s Colorado Medical Assistance Program ID number. Each person has his/her own unique Colorado Medical Assistance Program ID number. Example: A123456
<b>4. Client Address Telephone Number</b>	Not required	Submitted information is not entered into the claim processing system.
<b>5. Client Sex</b>	Check box Female <input type="checkbox"/>	Required Enter a check mark or an “x” in the box that indicates the client is female.
<b>6. Medicare ID Number (HIC or SSN)</b>	Up to 11 characters: numbers and letters	Conditional Complete if the client is eligible for Medicare benefits. Enter the individual’s Medicare health insurance claim number.  The term “dually eligible” refers to a person who is eligible for both Colorado Medical Assistance Program and Medicare benefits.

Field Label	Completion format	Instructions
<b>7. Client Relationship To Insured</b>	Check box Self    Spouse <input type="checkbox"/> <input type="checkbox"/> Child    Other <input type="checkbox"/> <input type="checkbox"/>	Conditional Complete if the client is covered by a commercial health care insurance policy. Enter a check mark or an “x” in the box that identifies the person’s relationship to the policyholder.
<b>8. Client Is Covered By Employer Health Plan</b>	Text	Conditional Complete if the client is covered by an employer health plan as policyholder or as a dependent. Enter the employer name policyholder’s name and group number. Also complete fields 9 and 9A.
<b>9. Other Health Insurance Coverage</b>	Text	Conditional Complete if the client has commercial health insurance coverage. Enter the name, address, policy number, and telephone numbers, if known, of the commercial health care insurer.
<b>9A. Policyholder Name and Address</b>	Text	Conditional Complete if the client has commercial health insurance coverage. Enter the name, address, and telephone number, if known, of the policyholder.
<b>10. Was Condition Related To</b>	Check box A. <input type="checkbox"/> Client employment Check box B. <input type="checkbox"/> 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.
<b>11. CHAMPUS Sponsors Service/SSN</b>	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.
<b>Durable Medical Equipment Model/serial number (unlabeled field)</b>	N/A	

Field Label	Completion format	Instructions
<b>12. Pregnancy</b> <b>HMO</b> <b>Nursing Facility</b>	Check box <input type="checkbox"/> Check box <input type="checkbox"/> Check box <input type="checkbox"/>	N/A
<b>13. Date Of Illness Or Injury Or Pregnancy</b>	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)
<b>14. Medicare Denial</b>	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.

Field Label	Completion format	Instructions
<p><b>14A. Other Coverage Denied</b></p>	<p>Check box                      No <input type="checkbox"/>                      Yes <input type="checkbox"/>                      Pay/Deny Date                      6 digits:                      MMDDYY</p>	<p>Conditional                      Complete if the client has commercial health care insurance coverage.                      Enter a check mark or an “x” in the “No” box if the other coverage has paid a portion of the billed charges.                      If the other coverage payment amount is the same or more than the Colorado Medical Assistance Program benefit, the Colorado Medical Assistance Program will not make additional payment.                      Enter a check mark or an “x” in the “Yes” box if the other coverage carrier has denied payment or has applied all of the allowed benefit to a deductible.                      Enter the date of the other coverage payment or denial.</p>
<p><b>15. Name Of Supervising Physician Provider Number</b></p>	<p>Text                      8 digits</p>	<p>Conditional                      Complete if the individual who performs the service (rendering provider) is a non-physician practitioner who requires on-premises supervision by a licensed physician (see Provider Participation).                      Enter the eight digit Colorado Medical Assistance Program provider number assigned to the on-premises supervising physician.</p>
<p><b>16. For Services Related To Hospitalization</b></p>	<p>N/A</p>	<p>N/A</p>
<p><b>17. Name And Address Of Facility Where Services Rendered  Provider Number</b></p>	<p>Text                      (address is optional)                       8 digits</p>	<p>Conditional                      Complete for services provided in a hospital or nursing facility. Enter the name of the hospital or nursing facility. This information is not edited.                      Complete for services provided in a hospital or nursing facility. Enter the Colorado Medical Assistance Program provider number of hospital or nursing facility, if known. This information is not edited.</p>

Field Label	Completion format	Instructions
<b>17A. Check Box If Laboratory Work Performed Outside Physician's Office</b>	Check box <input type="checkbox"/>	<p>Conditional</p> <p>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.</p> <p>Practitioners may not request payment for services performed by an independent or hospital laboratory.</p>
<b>18. ICD-9-CM</b>	<p>1 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>2 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>3 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>4 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>Codes: 3, 4, or 5 characters. 1<sup>st</sup> character may be a letter.</p>	<p>Required</p> <p>At least one diagnosis code must be entered. 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>Example (May require 4<sup>th</sup> or 5<sup>th</sup> digit):</p> <p><b>ICD description</b>                      <b>Code</b></p> <p>Supervision of high risk pregnancy                      V23 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>
<b>Diagnosis Or Nature Of Illness or Injury</b>	Text	<p>Optional</p> <p>Written description is not required. If entered, the written description must match the code(s).</p>
<b>Transportation Certification Attached</b>	Check box <input type="checkbox"/>	N/A
<b>Prior Authorization Number</b>	6 characters: Letter plus 5 digits	N/A



Field Label	Completion format	Instructions																		
<p><b>19A. Date Of Service</b></p>	<p>From: 6 digits MMDDYY To: 6 digits MMDDYY</p>	<p>Required</p> <p>The field accommodates the entry of two dates: a “beginning” or “from” date of service and an “ending” or “to” date of service.</p> <p>Single date of service</p> <p>From To</p> <table border="1" data-bbox="846 512 1219 564"> <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="846 663 1243 716"> <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="846 764 1243 816"> <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>	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															
<p><b>19B. Place Of Service</b></p>	<p>2 digits</p>	<p>Required</p> <p>Enter the Place Of Service (POS) code that describes the location where services were rendered. The Colorado Medical Assistance Program accepts the CMS place of service codes.</p> <ul style="list-style-type: none"> <li>04 Homeless Shelter</li> <li>11 Office</li> <li>12 Home</li> <li>15 Mobile Unit</li> <li>20 Urgent Care Facility</li> <li>21 Inpatient hospital</li> <li>22 Outpatient hospital</li> <li>23 Emergency room hospital</li> <li>25 Birthing Center</li> <li>26 Military Treatment Center</li> <li>31 Skilled Nursing Facility</li> <li>32 Nursing facility</li> </ul>																		

Field Label	Completion format	Instructions
<b>19B. Place Of Service</b> (continued)	2 digits	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
<b>19C. Procedure Code (HCPCS)</b>	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. <b>Prenatal Plus Program code:</b> H1005 for prenatal care, at-risk enhanced service package
<b>Modifiers</b>	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. <b>Prenatal Plus Program modifiers:</b> <ul style="list-style-type: none"> <li>• 52 – Reduced services</li> <li>• TF – Intermediate level of care</li> <li>• TG – Complex/high tech level of care</li> <li>• TH – Obstetrical treatment/services, prenatal or post partum</li> </ul> See the Prenatal Plus Billing Packages section for reference.

Field Label	Completion format	Instructions			
<b>19D. Rendering Provider Number</b>	8 digits	<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>			
<b>19E. Referring Provider Number</b>	8 digits	<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>			
<b>19F. Diagnosis</b>	<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="text-align: center;">P</td> <td style="text-align: center;">S</td> <td style="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	S	T			

Field Label	Completion format	Instructions																																																			
<b>19F. Diagnosis</b> (continued)	<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px; height: 20px; text-align: center;">P</td> <td style="width: 20px; height: 20px; text-align: center;">S</td> <td style="width: 20px; height: 20px; text-align: center;">T</td> </tr> </table> <p style="text-align: center;">1 digit per column</p>	P	S	T	<p>Example: (May require 4<sup>th</sup> or 5<sup>th</sup> digit)</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50px;">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: 20px; text-align: center;">↓</td> <td style="width: 20px;"></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></td> <td style="border: 1px solid black; padding: 2px; text-align: center;">P</td> <td style="border: 1px solid black; padding: 2px; text-align: center;">S</td> <td style="border: 1px solid black; padding: 2px; text-align: center;">T</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="text-align: right;">Line 1</td> <td style="border: 1px solid black; padding: 2px; text-align: center;">1</td> <td style="border: 1px solid black; padding: 2px; text-align: center;">2</td> <td style="border: 1px solid black; padding: 2px; text-align: center;">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="text-align: right;">Line 2</td> <td style="border: 1px solid black; padding: 2px; text-align: center;">2</td> <td style="border: 1px solid black; padding: 2px; text-align: center;"></td> <td style="border: 1px solid black; padding: 2px; text-align: center;"></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td style="text-align: right;">Line 3</td> <td style="border: 1px solid black; padding: 2px; text-align: center;">4</td> <td style="border: 1px solid black; padding: 2px; text-align: center;">2</td> <td style="border: 1px solid black; padding: 2px; text-align: center;"></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	↓		2	8	2	4	X			P	S	T	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																																																			
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3	2	7	6	5	X	Line 1	1	2	3																																												
4	V	2	2	X		Line 2	2																																														
						Line 3	4	2																																													
<b>19G. Charges</b>	Up to 7 digits: Currency 99999.99	Required Enter the usual and customary charge for the service represented by the procedure code on the detail line. Submitted charges cannot be more than charges made to non-Colorado Medical Assistance Program covered individuals for the same service. Do not deduct Colorado Medical Assistance Program co-payment or commercial insurance payments from usual and customary charges.																																																			
<b>19H. Days Or Units</b>	4 digits	Required Enter the number of services provided for each procedure code. Enter whole numbers only. Do not enter fractions or decimals.																																																			
<b>19I. Co-pay</b>	N/A	Prenatal Plus Program: Women in the maternity cycle (pregnancy through 60 days post partum) are exempt from co-payment.																																																			
<b>19J. Emergency</b>	N/A	N/A																																																			

Field Label	Completion format	Instructions
<b>19K. Family Planning</b>	Check box <input type="checkbox"/>	<p>Conditional</p> <p>Enter a check mark or an “x” in the column to indicate the service is rendered for family planning.</p> <p>If checked, the service on this detail line is exempt from co-payment and from PCP Program referral requirements.</p>
<b>19L. EPSDT</b>	Check box <input type="checkbox"/>	<p>Conditional</p> <p>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.</p>
<b>Medicare SPR Date (unlabeled field)</b>	6 digits: MMDDYY	<p>Conditional</p> <p>Complete for Medicare crossover claims. Enter the date of the Medicare Standard Paper Remit (SPR) or Electronic Remittance Advice (ERA).</p> <ul style="list-style-type: none"> <li>• Do not complete this field if Medicare denied all benefits.</li> <li>• Do not combine items from several SPRs/ERAs on a single claim form.</li> <li>• Bill for as many crossover items as appear on a single SPR/ERA up to a maximum of 6 lines. Complete separate claim forms for additional lines on the SPR/ERA.</li> <li>• Providers must submit a copy of the SPR/ERA with paper claims. Be sure to retain the original SPR/ERA for audit purposes.</li> </ul>
<b>20. Total Charges</b>	Up to 7 digits: Currency 99999.99	<p>Required</p> <p>Enter the sum of all charges listed in field 19G (Charges).</p> <p>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>
<b>21. Medicare Paid</b>	7 digits: Currency 99999.99	<p>Conditional</p> <p>Complete for Medicare crossover claims.</p> <p>Enter the Medicare payment amount shown on the Medicare payment voucher.</p>

Field Label	Completion format	Instructions
<p><b>22. Third Party Paid</b></p>	<p>7 digits: Currency 99999.99</p>	<p>Conditional</p> <p>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.</p> <p>Do <b>not</b> enter Colorado Medical Assistance Program co-payment in this field or anywhere else on the claim form.</p>
<p><b>23. Net Charge</b></p>	<p>7 digits: Currency 99999.99</p>	<p>Required</p> <p><b>Colorado Medical Assistance Program claims (Not Medicare Crossover)</b></p> <p>Claims without third party payment. Net charge equals the total charge (field 20).</p> <p>Claims with third party payment. Net charge equals the total charge (field 20) minus the third party payment (field 22) amount.</p> <p><b>Medicare Crossover claims</b></p> <p>Crossover claims without third party payment. Net charge equals the sum of the Medicare deductible amount (field 24) plus the Medicare coinsurance (field 25) amount.</p> <p>Crossover claims with third party payment. Net charge equals the sum of the Medicare deductible amount (field 24) plus the Medicare coinsurance (field 25) amount minus the third party payment (field 22) amount.</p>
<p><b>24. Medicare Deductible</b></p>	<p>7 digits: Currency 99999.99</p>	<p>Conditional</p> <p>Complete for Medicare crossover claims. Enter the Medicare deductible amount shown on the Medicare payment voucher.</p>
<p><b>25. Medicare Coinsurance</b></p>	<p>7 digits: Currency 99999.99</p>	<p>Conditional</p> <p>Complete for Medicare crossover claims. Enter the Medicare coinsurance amount shown on the Medicare payment voucher.</p>
<p><b>26. Medicare Disallowed</b></p>	<p>7 digits: Currency 99999.99</p>	<p>Conditional</p> <p>Complete for Medicare crossover claims. Enter the amount Medicare disallowed, if any, shown on the Medicare payment voucher.</p>

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



## Colorado 1500 Prenatal Plus Claim Example

**STATE OF COLORADO  
DEPARTMENT OF  
HEALTH CARE POLICY AND  
FINANCING**

INVOICE/PAT ACCT NUMBER
SPECIAL PROGRAM CODE

### HEALTH INSURANCE CLAIM

#### PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL) <b>Client Ima</b>	2. CLIENT DATE OF BIRTH <b>11/08/1992</b>	3. MEDICAID ID NUMBER (CLIENT ID NUMBER) <b>A333333</b>
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE) <b>123 Main Street Street Avenue Colorado CO</b>	5. CLIENT SEX MALE <input type="checkbox"/> FEMALE <input checked="" type="checkbox"/>	6. MEDICARE ID NUMBER (HIC OR SSN)
7. CLIENT RELATIONSHIP TO INSURED SELF <input checked="" type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. <input type="checkbox"/> CLIENT IS COVERED BY EMPLOYER HEALTH PLAN AS EMPLOYEE OR DEPENDENT	
9. OTHER HEALTH INSURANCE COVERAGE — (INSURANCE COMPANY NAME, ADDRESS, PLAN NAME, AND POLICY NUMBER(S))	10. WAS CONDITION RELATED TO: A. CLIENT EMPLOYMENT YES <input type="checkbox"/> B. ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/> C. DATE OF ACCIDENT	EMPLOYER NAME: _____ POLICYHOLDER NAME: _____ GROUP: _____ 11. CHAMPUS SPONSORS SERVICE/SSN
9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)	12. PREGNANCY <input checked="" type="checkbox"/> HMO <input type="checkbox"/> NURSING FACILITY <input type="checkbox"/>	

#### PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF: <span style="font-size: 2em;">←</span>	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	16. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES ADMITTED: _____ DISCHARGED: _____
17. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (IF OTHER THAN HOME OR OFFICE)		PROVIDER NUMBER	17A. CHECK BOX IF LABORATORY WORK WAS PERFORMED OUTSIDE THE PHYSICIANS OFFICE <input type="checkbox"/> YES

18. ICD-9-CM <b>V23</b>	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. IN COLUMN F, RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE NUMBERS 1, 2, 3, OR 4 <b>Supervision of High-Risk Pregnancy</b>
1. _____	TRANSPORTATION CERTIFICATION ATTACHED <input type="checkbox"/> YES
2. _____	DURABLE MEDICAL EQUIPMENT Line # Make Model Serial Number
3. _____	PRIOR AUTHORIZATION #:
4. _____	

19A. DATE OF SERVICE FROM TO		B. PLACE OF SERVICE	C. PROCEDURE CODE (HCPCS)	D. MODIFIERS	D. RENDERING PROVIDER NUMBER	E. REFERRING PROVIDER NUMBER	F. DIAGNOSIS	G. CHARGES	H. DAYS OR UNITS	I. COPAY	J. EMERG ENCY	K. FAMILY PLANNING	L. EPSDT
				TH TG			P I S T						
12/01/2012	12/01/2012	71	H1005		12345678		1	\$798.15	1		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
											<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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											<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
											<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
											<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.	20. TOTAL CHARGES → <b>\$798.15</b>	LESS ↓ 21. MEDICARE PAID 22. THIRD PARTY PAID NET CHARGE <b>\$798.15</b>	MEDICARE SPR DATE 24. MEDICARE DEDUCTIBLE <b>\$ .00</b> 25. MEDICARE COINSURANCE <b>\$ .00</b> 26. MEDICARE DISALLOWED
27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE <i>Authorized Signature</i> <b>12/7/2012</b>	30. REMARKS		
28. BILLING PROVIDER NAME <b>ABC Clinic</b>			
29. BILLING PROVIDER NUMBER <b>87654321</b>			

**COLORADO 1500**

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

### 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
<b>LBOD Completion Requirements</b>	<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>
<b>Adjusting Paid Claims</b>	<p>If the initial timely filing period has expired and a previously submitted claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was paid and now needs to be adjusted, resulting in additional payment to the provider.</p> <p><b>Adjust the claim within 60 days</b> of the claim payment. Retain all documents that prove compliance with timely filing requirements.</p> <p>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><b>LBOD</b> = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the payment.</p>

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

Billing Instruction Detail	Instructions
<p><b>Delayed Notification of Eligibility</b></p>	<p>The provider was unable to determine that the client had Colorado Medical Assistance Program coverage until after the timely filing period expired.</p> <p><b>File the claim within 60 days</b> of the date of notification that the individual had Colorado Medical Assistance Program coverage. Retain correspondence, phone logs, or a signed Delayed Eligibility Certification form (see Appendix H of the Appendices in the Provider Services <a href="#">Billing Manuals</a> section) that identifies the client, indicates the effort made to identify eligibility, and shows the date of eligibility notification.</p> <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><b>LBOD</b> = the date the provider was advised the individual had Colorado Medical Assistance Program benefits.</p>
<p><b>Electronic Medicare Crossover Claims</b></p>	<p>An electronic claim is being submitted for Medicare crossover benefits within 120 days of the date of Medicare processing/ payment. (Note: On the paper claim form (only), the Medicare SPR/ERA date field documents crossover timely filing and completion of the LBOD is not required.)</p> <p><b>File the claim within 120 days</b> of the Medicare processing/ payment date shown on the SPR/ERA. Maintain the original SPR/ERA on file.</p> <p><b>LBOD</b> = the Medicare processing date shown on the SPR/ERA.</p>
<p><b>Medicare Denied Services</b></p>	<p>The claim is for Medicare denied services (Medicare non-benefit services, benefits exhausted services, or the client does not have Medicare coverage) being submitted within 60 days of the date of Medicare processing/denial.</p> <p>Note: This becomes a regular Colorado Medical Assistance Program claim, not a Medicare crossover claim.</p> <p><b>File the claim within 60 days</b> of the Medicare processing date shown on the SPR/ERA. Attach a copy of the SPR/ERA if submitting a paper claim and maintain the original SPR/ERA on file.</p> <p><b>LBOD</b> = the Medicare processing date shown on the SPR/ERA.</p>

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



***Prenatal Plus Revisions Log***

Revision Date	Additions/Changes	Pages	Made by
12/03/2012	Manual Created	All	km,vcr, jg
04/26/2013	Formatted and updated TOC	All	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.