

Psychiatric Residential Treatment Facilities (PRTFs)

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

Psychiatric Residential Treatment Facilities (PRTFs) provide services to mentally ill children and adolescents by treating mental disabilities and restoring the client to his or her best possible functional level. PRTF services are provided under the direction of a physician. The client must be:

- Colorado Medical Assistance eligible
- Determined to need PRTF care by a licensed professional
- PRTFs complete a Level of Care Review and submit it to the referring agency for prior authorization
- Determined in need of mental health services by the referring agency



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

Billing Information

National Provider Identifier (NPI)

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

Paper Claims



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

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

Paper claims do not require an NPI, but do require the Colorado Medical Assistance Program provider number. In addition, the UB-04 Certification document must be completed and attached to all claims submitted on the paper UB-04. Electronically mandated claims submitted on paper are processed, denied, and marked with the message “Electronic Filing Required”.

Electronic Claims

Instructions for completing and submitting electronic claims are available through the following:

- X12N Technical Report 3 (TR3) for the 837P, 837I, or 837D (<http://www.wpc-edi.com/>)
- Companion Guides for the 837P, 837I, or 837D (in the Provider Services [Specifications](#) section of the Department's Web site).
- Web Portal User Guide (via within the portal)

The Colorado Medical Assistance Program collects electronic claim information interactively through the Colorado Medical Assistance Program Secure Web Portal (Web Portal) or via batch submission through a host system.

Interactive Claim Submission and Processing

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



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

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



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

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

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

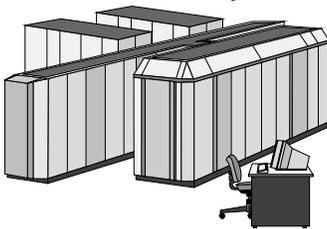
Claims may be adjusted, edited and resubmitted, and voided in real time through the Web Portal. Access the Web Portal through Secured Site at colorado.gov/hcpf. For help with claim submission via the Web Portal, please choose the *User Guide* option available for each Web Portal transaction. For additional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

Batch Electronic Claims Submission

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

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

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



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

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

Testing and Vendor Certification

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

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



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



Prior Authorization Requirements

PRTF services must be provided and billed only by a licensed and certified PRTF provider. PRTFs complete a Level of Care Review and submit it to the referring agency for prior authorization. PRTFs are not required to submit any prior authorization documents to the fiscal agent (ACS).

Paper Claim Reference Table

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

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

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

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

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

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

Form Locator and Label	Completion Format	Instructions																		
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.																		
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	Required Enter the three-digit number indicating the specific type of bill followi. For PRTF, use TOB 89X <table border="0"> <thead> <tr> <th style="text-align: left;"><u>Digit 1</u></th> <th style="text-align: left;"><u>Type of Facility</u></th> </tr> </thead> <tbody> <tr> <td>1</td> <td>Hospital</td> </tr> <tr> <td>2</td> <td>Skilled Nursing Facility</td> </tr> <tr> <td>3</td> <td>Home Health</td> </tr> <tr> <td>4</td> <td>Religious Non-Medical Health Care Institution Hospital Inpatient</td> </tr> <tr> <td>5</td> <td>Religious Non-Medical Health Care Institution Post-Hospital Extended Care Services</td> </tr> <tr> <td>6</td> <td>Intermediate Care</td> </tr> <tr> <td>7</td> <td>Clinic (Rural Health/FQHC/Dialysis Center)</td> </tr> <tr> <td>8</td> <td>Special Facility (Hospice, RTCs)</td> </tr> </tbody> </table>	<u>Digit 1</u>	<u>Type of Facility</u>	1	Hospital	2	Skilled Nursing Facility	3	Home Health	4	Religious Non-Medical Health Care Institution Hospital Inpatient	5	Religious Non-Medical Health Care Institution Post-Hospital Extended Care Services	6	Intermediate Care	7	Clinic (Rural Health/FQHC/Dialysis Center)	8	Special Facility (Hospice, RTCs)
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Form Locator and Label	Completion Format	Instructions
<p>4. Type of Bill (continued)</p>	<p>3 digits</p>	<p><u>Digit 2</u> <u>Bill Classification (Except clinics & special facilities):</u></p> <ul style="list-style-type: none"> 1 Inpatient (Including Medicare Part A) 2 Inpatient (Medicare Part B only) 3 Outpatient 4 Other (for hospital referenced diagnostic services or home health not under a plan of treatment) 5 Intermediate Care Level I 6 Intermediate Care Level II 7 Sub-Acute Inpatient (revenue code 19X required with this bill type) 8 Swing Beds 9 Other <p><u>Digit 2</u> <u>Bill Classification (Clinics Only):</u></p> <ul style="list-style-type: none"> 1 Rural Health/FQHC 2 Hospital Based or Independent Renal Dialysis Center 3 Freestanding 4 Outpatient Rehabilitation Facility (ORF) 5 Comprehensive Outpatient Rehabilitation Facilities (COFRs) 6 Community Mental Health Center <p><u>Digit 2</u> <u>Bill Classification (Special Facilities Only):</u></p> <ul style="list-style-type: none"> 1 Hospice (Non-Hospital Based) 2 Hospice (Hospital Based) 3 Ambulatory Surgery Center 4 Freestanding Birthing Center 5 Critical Access Hospital 6 Residential Facility

Form Locator and Label	Completion Format	Instructions
4. Type of Bill (continued)	3 digits	<u>Digit 3</u> <u>Frequency:</u> 0 Non-Payment/Zero Claim 1 Admit through discharge claim 2 Interim - First claim 3 Interim - Continuous claim 4 Interim - Last claim 7 Replacement of prior claim 8 Void of prior claim
5. Federal Tax Number	None	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 Each date of service must be billed on a separate line (see FL 45). On paper split an entire month into 2 claims. This form locator must reflect the beginning and ending dates of service. "From" date is the actual start date of services. "From" date cannot be prior to the start date reported on the initial prior authorization, if applicable, or is the first date of an interim bill. "Through" date is the actual discharge date, or final date of an interim bill. "From" and "Through" dates cannot exceed a calendar month (e.g., bill 01/15/09 thru 01/30/09 and 02/01/09 thru 02/15/09, not 01/15/09 thru 02/15/09). Match dates to the prior authorization if applicable. If patient is admitted and discharged on the same date, the same date must appear in this FL. Detail dates of service must be within the "Statement Covers Period" dates.
8a. Patient Identifier		Submitted information is not entered into the claim processing system.
8b. Patient Name	Up to 25 characters: Letters & spaces	Required Enter the client's last name, first name and middle initial.
9a. Patient Address – Street	Characters Letters & numbers	Required Enter the client's street/post office box exactly as it appears on the eligibility verification or as determined at the time of admission.

Form Locator and Label	Completion Format	Instructions
9b. Patient Address – City	Text	Required Enter the client's city exactly as it appears on the eligibility verification or as determined at the time of admission.
9c. Patient Address – State	Text	Required Enter the client's state exactly as it appears on the eligibility verification or as determined at the time of admission.
9d. Patient Address – Zip	Digits	Required Enter the client's zip code exactly as it appears on the eligibility verification or as determined at the time of admission.
9e. Patient Address – Country Code	Digits	Optional
10. Birthdate	8 digits (MMDDCCYY)	Required Enter the client's birthdate using two digits for the month, two digits for the date, and four digits for the year (MMDDCCYY format). Example: 07012007 for July 1, 2007. Use the birthdate that appears on the eligibility verification.
11. Patient Sex	1 letter	Required Enter an M (male) or F (female) to indicate the client's sex.
12. Admission Date	6 digits	Required Enter the date admitted to the PRTF
13. Admission Hour	6 digits	Not Required
14. Admission Type	1 digit	Required Enter the following to identify the admission priority: 3 - Elective The client's condition permits adequate time to schedule the availability of accommodations.
15. Source of Admission	1 digit	Required Enter the appropriate code. (To be used in conjunction with FL 19, Type of Admission). 8 Court/Law Enforcement 9 Information not available
16. Discharge Hour	2 digits	Not Required

Form Locator and Label	Completion Format	Instructions
17. Patient Discharge Status	2 digits	<p>Required</p> <p>Valid Status Codes for PRTFs include</p> <p>01 Discharged to Home or Self Care</p> <p>05 Discharged to Another Type of Institution</p> <p>06 Discharged to Home under Organized Home Health Care Program (HCBS)</p> <p>07 Left Against Medical Advice</p> <p>09 Admitted as an Inpatient to Hospital</p> <p>20 Expired</p> <p>30 Still Patient</p> <p>31 Still Patient- Waiting Transfer to Long Term Psychiatric Hospital</p> <p>32 Still Patient- Waiting Placement by Department of Social Services</p> <p>Claims with Patient Status of 30, 31 or 32 will pay for each day billed on the detail lines, including the through date of service shown at the header.</p> <p>Claims with any other patient status will not pay for the through date of service if it is billed on a detail line. When a client is discharged, the date of discharge is not covered.</p>
18-28. Condition Codes	2 Digits	Not required
29. Accident State		Not required
31-34. Occurrence Code/Date	2 digits and 6 digits	Not Required
35-36. Occurrence Span Code From/ Through	2 digits and 6 digits	Not Required
38. Responsible Party Name/ Address	None	Leave blank

Form Locator and Label	Completion Format	Instructions
<p>39-41. Value Code and Amount</p>	<p>2 characters and 9 digits</p>	<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.</p> <p>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 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 13 (Admission Hour). 49 Hematocrit Reading - EPO Related 58 Arterial Blood Gas (PO2/PA2) 68 EPO-Drug 80 Covered Days 81 Non-Covered Days <p><i>Enter the deductible amount applied by indicated payer:</i></p> <ul style="list-style-type: none"> A1 Deductible Payer A B1 Deductible Payer B C1 Deductible Payer C

Form Locator and Label	Completion Format	Instructions
39-41. Value Code and Amount (continued)	2 characters and 9 digits	<p><i>Enter the amount applied to client's co-insurance by indicated payer:</i></p> <p>A2 Coinsurance Payer A B2 Coinsurance Payer B C2 Coinsurance Payer C</p> <p><i>Enter the amount paid by indicated payer:</i></p> <p>A3 Estimated Responsibility Payer A B3 Estimated Responsibility Payer B C3 Estimated Responsibility Payer C</p> <p>For Rancho Coma Score bill with appropriate diagnosis for head injury. Medicare & TPL - See A1-A3, B1-B3, & C1-C3 above.</p>
42. Revenue Code	3 digits	<p>Required</p> <p>Enter the revenue code 911.</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>
43. Revenue Code Description	Text	<p>Required</p> <p>Enter the revenue code description or abbreviated description.</p>
44. HCPCS/Rates/HIPPS Rate Codes	5 digits	Not required
45. Service Date	6 digits	<p>For span bills only</p> <p>Enter the date of service using MMDDYY format for each detail line completed.</p> <p>Each date of service must fall within the date span entered in the "Statement Covers Period" field (FL 6).</p>
46. Service Units	3 digits	<p>Required</p> <p>Enter a unit value on each line completed. Use whole numbers only. Do not enter fractions or decimals and do not show a decimal point followed by a 0 to designate whole numbers (e.g., Do not enter 1.0 to signify one unit)</p>

Form Locator and Label	Completion Format	Instructions
46. Service Units (continued)	3 digits	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	Required 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.
50. Payer Name	Text	Required Enter the name of each payer organization from which the provider might expect payment. At least one line must be the Colorado Medical Assistance Program.
51. Health Plain ID	8 digits	Required Enter the provider's Health Plan ID for each payer name. Enter the eight digit Colorado Medical Assistance Program provider number assigned to the billing provider . Payment is made to the enrolled provider or agency that is assigned this number.
52. Release of Information	None	Submitted information is not entered into the claim processing system.
53. Assignment of Benefits	None	Submitted information is not entered into the claim processing system.
54. Prior Payments	Up to 9 digits	Inpatient - Conditional Complete when there are Medicare or third party payments. Enter third party and/or Medicare payments.

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

Form Locator and Label	Completion Format	Instructions
62. Insurance Group Number	17 digits	Conditional Complete when there is third party coverage. Enter the identification number, control number, or code assigned by the carrier or fund administrator identifying the group under which the individual is carried.
63. Treatment Authorization Code	Up to 18 characters	Conditional Complete when the service requires a PAR. Enter the PAR/authorization number in this field, if a PAR is required and has been approved for services.
64. Document Control Number		Submitted information is not entered into the claim processing system.
65. Employer Name	Text	Conditional Complete when there is third party coverage. Enter the name of the employer that provides health care coverage for the individual identified in FL 58 (Insured Name).
66. Diagnosis Version Qualifier		Submitted information is not entered into the claim processing system.
67. Principal Diagnosis Code	Up to 6 digits	Required Enter the exact ICD-9-CM diagnosis code describing the principal diagnosis that exists at the time of admission or develops subsequently and affects the length of stay. Do not add extra zeros to the diagnosis code.
67A- 67Q. Other Diagnosis	6 digits	Optional Enter the exact ICD-9-CM diagnosis code corresponding to additional conditions that co-exist at the time of admission or develop subsequently and which effect the treatment received or the length of stay. Do not add extra zeros to the diagnosis code.
69. Admitting Diagnosis Code	6 digits	Required Enter the ICD-9-CM diagnosis code as stated by the physician at the time of admission. RTCs Do not use DSM-III diagnosis codes.

Form Locator and Label	Completion Format	Instructions
70. Patient Reason Diagnosis		Submitted information is not entered into the claim processing system.
71. PPS Code		
72. External Cause of Injury Code (E-code)	6 digits	Optional Enter the ICD-9-CM diagnosis code for the external cause of an injury, poisoning, or adverse effect. This code must begin with an "E".
74. Principal Procedure Code/ Date	7 characters and 6 digits	Conditional Enter the ICD-9-CM 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.
74A. Other Procedure Code/Date	7 characters and 6 digits	Conditional Complete when there are additional significant procedure codes. Enter the ICD-9-CM procedure codes identifying all significant procedures other than the principle procedure and the dates on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principle diagnosis. Enter the date using MMDDYY format.
76. Attending NPI – Conditional QUAL - Conditional ID - (Colorado Medical Assistance Provider #) – Required	NPI - 10 digits QUAL – Text Medicaid ID - 8 digits	NPI - Enter the 10-digit NPI assigned to the physician having primary responsibility for the patient's medical care and treatment. QUAL – Enter "1D" for Medicaid followed by the provider's eight-digit Colorado Medical Assistance Program provider ID. Medicaid ID - Enter the eight-digit Colorado Medical Assistance Program provider number assigned to the physician having primary responsibility for the patient's medical care and treatment. Numbers are obtained from the physician, and <u>cannot</u> be a clinic or group number.

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



Late Bill Override Date

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

Valid Delay Reason Codes

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

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

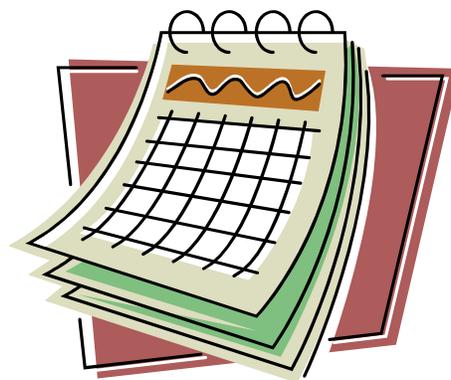
Making false statements about timely filing compliance is a misrepresentation and falsification that, upon conviction, makes the individual who prepares the claim and the enrolled provider subject to a fine and imprisonment under state and/or federal law.

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

Billing Instruction Detail	Instructions
<p>Denied 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> <ul style="list-style-type: none"> • Claims must be filed within 365 days of the date of service. No exceptions are allowed. • This extension is available only if the provider had no way of knowing that the individual had Colorado Medical Assistance Program coverage. • Providers who render services in a hospital or nursing facility are expected to get benefit coverage information from the institution. • The extension does not give additional time to obtain Colorado Medical Assistance Program billing information. • If the provider has previously submitted claims for the client, it is improper to claim that eligibility notification was delayed. <p>LBOD = the date the provider was advised the individual had Colorado Medical Assistance Program benefits.</p>
<p>Electronic Medicare Crossover Claims</p>	<p>An electronic claim is being submitted for Medicare crossover benefits within 120 days of the date of Medicare processing/ payment. (Note: On the paper claim form (only), the Medicare SPR date field documents crossover timely filing and completion of the LBOD is not required.)</p> <p>File the claim within 120 days of the Medicare processing/ payment date shown on the Standard Paper Remit (SPR) or Provider Claim Report. Maintain a copy of the SPR or Provider Claim Report on file.</p> <p>LBOD = the Medicare processing date shown on the SPR or Provider Claim Report.</p>
<p>Medicare Denied Services</p>	<p>The claim is for Medicare denied services (Medicare non-benefit services, benefits exhausted services, or the client does not have Medicare coverage) being submitted within 60 days of the date of Medicare processing/denial.</p> <p><i>Note: This becomes a regular Colorado Medical Assistance Program claim, not a Medicare crossover claim.</i></p> <p>File the claim within 60 days of the Medicare processing date shown on the Standard Paper Remit (SPR) or Provider Claim Report. Maintain a copy of the SPR or Provider Claim Report on file.</p> <p>LBOD = the Medicare processing date shown on the SPR or Provider Claim Report.</p>

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





Colorado Medical Assistance Program

Institutional Provider Certification

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

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

Signature: _____ *Date:* _____

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

PRTF Claim Example

1 PRTF 100 Saginaw Street Anytown, CO 80201 303-333-3333		2		3a PAT. CNTL. # b. MED. REC. # 1111110060		4 TYPE OF BILL 892	
8 PATIENT NAME a Client, Ima D.				9 PATIENT ADDRESS a 123 Main Street c CO d 88888			
10 BIRTHDATE 02/13/1998		11 SEX F	12 DATE 01/01/08		13 HR 03	14 TYPE 8	15 SRC 30
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PRTF Revisions Log

Revision Date	Additions/Changes	Pages	Made by
02/13/2008	<i>Electronic Claims – Updated first two paragraphs with bullets</i>	1	<i>pr-z</i>
11/05/2008	<i>Updated web addresses</i>	<i>Throughout</i>	<i>jg</i>
03/29/2009	<i>General updates</i>	<i>Throughout</i>	<i>jg</i>
01/19/2010	<i>Updated Web site links</i>	<i>Throughout</i>	<i>jg</i>
02/17/2010	<i>Replaced EOMB with SPR</i>	19	<i>jf</i>
03/04/2010	<i>Added link to Program Rules</i>	1	<i>Jg</i>
12/06/2011	<i>Replaced 997 with 999</i>	3	ss
	<i>Replaced www.wpc-edi.com/hipaa with www.wpc-edi.com/</i>	2	
	<i>Replaced Implementation Guide with Technical Report 3 (TR3)</i>	2	

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.*