

Radiology Services Billed by X-Ray Facilities

Radiology Services Billed by X-Ray Facilities.....	1
Billing Information	1
National Provider Identifier (NPI)	1
Paper Claims	1
Electronic Claims	2
General Prior Authorization Requirements	2
Procedure Codes Requiring Prior Authorization:	2
PAR Exceptions	5
PAR Revisions	6
PAR Denials.....	6
Paper PAR Instructional Reference	6
Prior Authorization Request Form.....	10
Electronic Prior Authorization Request Form	11
Special Benefits/Limitations/Exclusions	12
Covered Radiology Procedures	12
Covered procedures include but are not limited to:	12
Non-Covered Radiology Procedures	12
Cost of Radiology Procedures	12
Procedure/HCPSC Codes Overview.....	12
CO-1500 Paper Claim Reference Table	13
Radiology Claim Example	23
Late Bill Override Date	24

Radiology Services Billed by X-Ray Facilities

Providers must be enrolled as a Colorado Medical Assistance Program provider in order to:

- Treat a Colorado Medical Assistance Program client; and
- Submit claims for payment to the Colorado Medical Assistance Program.

Outpatient Radiology services are a benefit of the Colorado Medical Assistance Program for medical conditions requiring radiology services and supervised by a physician. Radiology services are a benefit under the following conditions:

1. The services have been authorized by a licensed physician.
2. The services are performed to diagnose conditions and illnesses with specific symptoms.
3. The services are performed to prevent or treat conditions that are benefits under the Medical Assistance Program.
4. The services are not routine diagnostic tests performed without apparent relationship to treatment or diagnosis for a specific illness, symptom, complaint or injury.
5. The radiology services are performed by a provider certified by the Colorado Department of Public Health and Environment (CDPHE) and enrolled as a Medicaid provider.



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

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

Billing Information

National Provider Identifier (NPI)

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

Paper Claims

Electronic claims format shall be required unless hard copy claims submittals are specifically prior authorized by the Department. Requests for paper claim submission 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 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 (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. Please refer to the [General Provider Information manual](#) for additional electronic billing information.

General Prior Authorization Requirements

The Colorado Medical Assistance Program requires all outpatient hospitals to obtain a prior authorization for non-emergent CT, non-emergent MRI and all PET scans. The PAR requirement is not enforced when Medicare or Medicare Advantage plans are primary, but is enforced when private insurance is primary.

Claims submitted with radiology procedure codes that require a PAR will be denied if the PAR does not list the correct Billing Provider ID number, the procedure codes do not match, or there is no record of a PAR. The Department allows retroactive authorizations when imaging services must be modified after a PAR has been obtained. If a radiology procedure is prior authorized but the desired test was changed just prior to the time of the service, the provider is responsible for submitting a PAR revision with adequate documentation within 48 hours in order for the PAR to be processed by the [ColoradoPAR Program](#). Prior Authorization Request revisions can only be submitted using the [CWQI](#). Please contact the ColoradoPAR Program at 1-888-454-7686 with questions regarding how to process PAR revisions.



Procedure Codes Requiring Prior Authorization:

PET SCANS & SPECTs			
Code	Description	Code	Description
78459	Myocardial Imaging, Positron Emission Tomography (PET) Metabolic Eval.	78811	Pet - Limited Area- Chest, Head, Neck
78491	Myocardial Imaging, Positron Emission Tomography (Pet), Perfusion; Single Study At Rest Or Stress	78812	Pet - Skull Base To Mid-Thigh
78492	Myocardial Imaging, Positron Emission Tomography (Pet), Perfusion; Multiple Studies At Rest Or Stress	78813	Pet -Whole Body
78607	Brain Imaging Complete Study Tomographic Spect	78814	PET W/CT - Chest, Head, Neck
78608	Brain Imaging, Positron Emission Tomography (PET) Metabolic Evaluation	78815	PET W/CT - Skull Base To Mid-Thigh

PET SCANS & SPECTs			
Code	Description	Code	Description
78609	Brain Imaging, Positron Emission Tomography (PET), Perfusion Evaluation	78816	PET W/CT - Whole Body

CT SCANS			
Code	Description	Code	Description
70450	CT Head/Brain W/O Contrast	70488	CT Maxllfcl W/O & W/ Contrast
70460	CT Head/Brain W/Contrast	70490	CT Soft Tissue Neck W/O Contrast
70470	CT Head/Brain W/O & W/ Contrast	70491	CT Soft Tissue Neck W/ Contrast
70480	CT Orbit W/O Contrast	70492	CT Soft Tissue Neck W/O & W/ Contrast
70481	CT Orbit W/ Contrast	71250	CT Thorax W/O Contrast
70482	CT Orbit W/O & W/ Contrast	71260	CT,Thorax; W/Contrast
70486	CT Maxllfcl W/O Contrast	71270	CT Thorax W/O & W/ Contrast
70487	CT Maxllfcl W/ Contrast	72125	CT C Spine W/O Contrast
72126	CT C Spine W/ Contrast	73200	CT Upper Extremity W/O Contrast
72127	CT C Spine W/O & W/ Contrast	73201	CT Upper Extremity W/ Contrast
72128	CT T Spine W/O Contrast	73202	CT Upper Extremity W/O & W/ Contrast
72129	CT T Spine W/ Contrast	73700	CT Lower Extremity W/O Contrast
72130	CT T Spine W/O & W/ Contrast	73701	CT Lower Extremity W/ Contrast
72131	CT L Spine W/O Contrast	73702	CT Lower Extremity W/O & W/ Contrast
72132	CT L Spine W/Contrast	74150	CT Abdomen W/O Contrast
72133	CT L Spine W/O & W/ Contrast	74160	CT Abdomen W/ Contrast
72192	CT Pelvis W/O Contrast	74170	CT Abdomen W/O & W/ Contrast
72193	CT Pelvis W/ Contrast	75571	CT Heart W/O Dye W/CA Test
72194	CT Pelvis W/O & W/ Contrast	75572	CT Heart W/ 3d Image
72292	Radiological Supervision And Interpretation, Percutaneous Vertebroplasty, Vertebral Augmentation, or Sacral Augmentation	75573	CT Heart W/3d Image Congen
		76380	CT Limited Or Localized Follow-Up Study
		77013	CT Guidance For And Monitoring of Tissue Ablation

CTA			
Code	Description	Code	Description
70496	CT Angiography, Head, With Contrast Material(S) Including Noncontrast Images, if performed	73706	CT Angiography Lower Extermity
70498	CT Angiography, Neck With Contrast Material(S) Including Non Contrast Images, if performed	74174	CT Tomographic Angiography, Abdomen, And Pelvis, With Contrast Material(S) Including Noncontrast Images if performed
71275	CT Angiography, Cnest(Nocoronary), With Contrast Material(S), Including Noncontrast Images, if performed	74175	CT Tomographic Angiography, Abdomen, With Contrast Material(S) Including Noncontrast Images, if performed
72191	CT Tomographic Angiography, Pelvis, With Contrast Material(S) Including Noncontrast Images, if performed	75574	CT Angiography Heart W/ 3D Image
73206	Ct Tomographic Angiography, Upper Extremity, With Contrast Material(s)		

MRA			
Code	Description	Code	Description
70544	MRA Head ;W/O Contrast Material(s)	71555	MRA, Chest (Excluding Myocardium), With Or Without Contrast Material(s)
70545	MRA Head; With Contrast Material(s)	72159	MRA, Spinal Canal And Contents With Or Without Contrast Material(s)
70546	MRA Head W/O Contrast Material(S),Followed By Contrast Material(s)	72198	MRA, Pelvis,W/& W/O Contrast Material(s)
70547	MRA,Neck;W/O Contrast Material(s)	73225	MRA,Upper Extremity W/ Or W/O Contrast
70548	MRA,Neck With Contrast Material(s)	73725	MRA,Lower Extremity,W/ Or W/O Contrast Material(s)
70549	MRA Neck,W/O Contrast Material(s) Followed By Contrast Material(s)	74185	MRA, Abdomen W/ Or W/O Contrast Material(s)

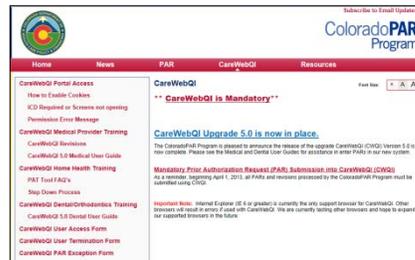
MRI			
Code	Description	Code	Description
70336	MRI TMJ	70543	MRI Face, Orbit, Neck W/ & W/O Contrast
70540	MRI Face, Orbit, Neck W/O Contrast	70551	MRI Head W/O Contrast
70542	MRI Face, Orbit, Neck W/Contrast	70552	MRI Head W/Contrast
70553	MRI Brain (Including Brain Stem) W/O Contrast Materials	73223	MRI Upper Extremity Joint W/ & W/O Contrast
71550	MRI Chest W/O Contrast	73718	MRI Lower Extremity W/O Contrast
71551	MRI Chest W/Contrast	73719	MRI Lower Extremity W/Contrast
71552	MRI Chest W/ & W/O Contrast	73720	MRI Lower Extremity W/ & W/O Contrast
72141	MRI Cervical Spine W/O Contrast	73721	MRI Lower Extremity Joint W/O Contrast
72142	MRI Cervical Spine W/Contrast	73722	MRI Lower Extremity Joint W/Contrast
72146	MRI Thoracic Spine W/O Contrast	73723	MRI Lower Extremity Joint W/ & W/O Contrast
72147	MRI Thoracic Spine W/Contrast	74181	MRI Abdomen W/O Contrast
72148	MRI Lumbar Spine W/O Contrast	74182	MRI Abdomen / Contrast
72149	MRI Lumbar Spine W/Contrast	74183	MRI Abdomen W/ & W/O Contrast
72156	MRI Spine W/ & W/O Contrast	75557	Cardiac MRI Morphology W/O Contrast
72157	MRI T Spine W/ & W/O Contrast	75559	Cardiac MRI Morphology W/Stress Imaging
72158	MRI Spine W/ & W/O Contrast	75561	Cardiac MRI Morphology W/O Contrast F/U Contrast & Sequences
72195	MRI Pelvis W/O Contrast	75563	Cardiac MRI For Morphology W/O Contrast F/U Contrast & Sequences W/ Stress Imaging
72196	MRI Pelvis W/Contrast	75565	Cardiac MRI Morphology W/Flow /Velocity Quantification & Stress
72197	MRI Pelvis W/ & W/O Contrast	76390	MRI Spectroscopy
73218	MRI Upper Extremity W/O Contrast	77021	MRI Guidance For Needle Placement
73219	MRI Upper Extremity W/ Contrast	77022	MRI Guidance For And Monitoring of Tissue Ablation
73220	MRI Upper Extremity Other Than Joint W/O Contrast Followed By Contrast	77058	MRI Breat Wi/And Or W/O Contrast
73221	MRI Upper Extremity Joint W/O Contrast	77059	MRI Breast Bilateral
73222	MRI Upper Extremity Joint W/Contrast	77084	MRI Bone Marrow Blodd Supply
0159T	Cad Breast MRI		

All PARs and revisions are processed by the ColoradoPAR Program and must be submitted using CareWebQI ([CWQI](#)). Prior Authorization Requests submitted via fax or mail **will not** be processed by the ColoradoPAR Program and subsequently not reviewed for medical necessity. These PARs will be returned to providers via mail. This requirement only impacts PARs submitted to the ColoradoPAR Program.

The electronic PAR format will be required unless an exception is granted by the ColoradoPAR Program. Exceptions may be granted for providers who submit five (5) or less PARs per month.

To request an exception, more information on electronic submission, or any other questions regarding PARs submitted to the ColoradoPAR Program, please contact the ColoradoPAR Program at

1-888-454-7686 or refer to the Department’s [ColoradoPAR Program](#) web page.



It is the provider’s responsibility to maintain clinical documentation to support services provided in the client’s file in the event of an audit or retroactive review. Submitted PARs without minimally required information or with missing or inadequate clinical information will result in a lack of information (LOI) denial



All accepted PARs are reviewed by the authorizing agency. The authorizing agency approves or denies, by individual line item, each requested service or supply listed on the PAR.

Paper PAR forms and completion instructions are located in the Provider Services [Forms](#) section of the Department’s website. They must be completed and signed by the client’s physician and submitted to the authorizing agency for approval.

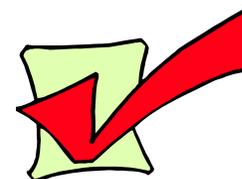
Do not render services or submit claims for services requiring prior authorization before the PAR is approved. When the authorizing agency has reviewed the service, the PAR status is transmitted to the fiscal agent’s prior approval system.

The status of the requested services is available through the [Web Portal](#). In addition, after a PAR has been reviewed, both the provider and the client receive a PAR response letter detailing the status of the requested services. Some services may be approved and others denied. **Check the PAR response carefully as some line items may be approved and others denied.**

Approval of a PAR does **not** guarantee Colorado Medical Assistance Program payment and does **not** serve as a timely filing waiver. Authorization only assures that the approved service is a medical necessity and is considered a benefit of the Colorado Medical Assistance Program.

All claims, including those for prior authorized services, must meet eligibility and claim submission requirements (e.g., timely filing, Primary Care Physician [PCP] information completed appropriately, third party resources payments pursued, required attachments included, etc.) before payment can be made.

Submitted claim data is checked against the PAR file, therefore, **do not** submit a copy of the PAR with the claim. The fiscal agent identifies the appropriate PAR data using patient identification information and the PAR number noted on the claim.



PAR Exceptions

Outpatient Radiology services that are indicated by checking the emergency indicator box are exempt from prior authorization requirements.

All PET and SPECT scan procedures always will require prior authorization regardless if emergency is indicated.

A PAR is not required when Medicare or Medicare Advantage plans or private insurance is primary.

The Department will allow retroactive authorizations when a client eligibility is determined after the date that the imaging service is delivered. When a client’s eligibility is determined after the date of service, the client is issued a Load Letter. The Load Letter must be submitted with the supporting clinical documentation for the PAR for a retroactive request to be processed by ColoradoPAR

PAR Revisions

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

PAR Denials

If the PAR is denied, direct inquiries to the authorizing agency listed in Appendix D of the Appendices in the Provider Services [Billing Manuals](#) section.

Paper PAR Instructional Reference

Field Label	Completion Format	Instructions
The upper margin of the PAR form must be left blank. This area is for authorizing agency’s use only.		
Invoice/Pat Account Number	Text	Optional Enter up to 12 characters, (numbers, letters, hyphens) which helps identify the claim or client.
1. Client Name	Text	Required Enter the client's last name, first name and middle initial. Example: Adams, Mary A.
2. Client Identification Number	7 characters, a letter prefix followed by six numbers	Required Enter the client's state identification number. This number consists of a letter prefix followed by six numbers. Example: A123456
3. Sex	Check box <input type="checkbox"/> M <input type="checkbox"/> F	Required Enter an "X" in the appropriate box.
4. Date of Birth	6 numbers (MMDDYY)	Required Enter the client's birth date using MMDDYY format. Example: January 1, 2010 = 010110.
5. Client Address	Characters: numbers and letters	Required Enter the client's full address: Street, city, state, and zip code.
6. Client Telephone Number	10 numbers ###-###-####	Optional Enter the client's telephone number.

Field Label	Completion Format	Instructions
7. Prior Authorization Number	None	System assigned Do not write in this area unless being revised. The authorizing agency reviews the PAR, and approves or denies the services. Enter the assigned PAR number in the appropriate field on the claim form when billing for prior authorized services.
8. Dates Covered by This Request	6 numbers for from date and 6 numbers for through date (MMDDYY)	Required Enter the date(s) within which service(s) will be provided. If left blank, dates are entered by the authorizing agency. Authorized services must be provided within these dates. If retroactive authorization is requested, enter the date(s) of service and provide justification in field 11 (Diagnosis).
9. Does Client Reside in a Nursing Facility?	Check box <input type="checkbox"/> Yes <input type="checkbox"/> No	Required Check the appropriate box.
10. Group Home Name - If Patient Resides in a Group Home	Text	Conditional Enter the name of the Group Home if the client lives in a group home.
11. Diagnosis	Text	Required Enter the diagnosis and sufficient relevant diagnostic information to justify the request and include the prognosis. Provide relevant clinical information, other drugs or alternative therapies tried in treating the condition, results of tests, etc., to justify a Colorado Medical Assistance Program determination of medical necessity. If diagnosis codes are used, the narrative is also required. Approval of the PAR is based on documented medical necessity. Attach documents as required.
12. Requesting Authorization for Repairs	None	Not required
13. Indicate Length of Necessity	None	Not required
14. Estimated Cost of Equipment	None	Not required

Field Label	Completion Format	Instructions
15. Services to be Authorized Line Number	None	Preprinted Do not alter preprinted line numbers. No more than five services or items can be requested on one form.
16. Describe Procedure, Supply, or Drug to be Provided	Text	Required Enter a description of the service(s) that will be provided.
17. Procedure, Supply or Drug Code	Revenue codes - 3 numbers HCPCS codes - 5 Characters	Required Enter the revenue and/or HCPCS code(s) for each service that will be billed on the claim form. The code(s) indicated on the PAR form must be used for billing.
18. Requested Number of Services	Numbers	Required Enter the number of visits, services, procedures requested. If this field is blank, the authorizing agency will complete it.
19. Authorized No. of Services	None	Leave Blank The authorizing agency indicates the number of services authorized. This number may or may not equal the number requested in field 18 (Number of Services).
20. Approved/Denied	None	Leave Blank Providers should check the PAR status online or refer to the PAR letter.
21. Primary Care Physician (PCP) Name Telephone Number	Text	Conditional If the client has a primary care physician, enter the name of the primary care physician in this field. Optional Enter the primary care physician's phone number.
22. Primary Care Physician Address	Text	Optional Enter the address of the primary care physician.
23. PCP Provider Number	8 numbers	Conditional If the client has a primary care physician, enter the primary care physician's provider number in this field.
24. Name and Address of Physician Requesting Prior Authorization	Text	Required Enter the complete name and address of the provider requesting the prior authorization.

Field Label	Completion Format	Instructions
25. Name and Address of Provider Who Will Render Service Telephone Number	Text 10 numbers ###-###-####	Required Enter the name of the rendering provider. Required Enter the telephone number of the rendering provider.
26. Requesting Physician Signature	Text	Required The requesting provider must sign the PAR. A rubber stamp facsimile signature is not acceptable on the PAR.
27. Date Signed	6 numbers (MM/DD/YY)	Required Enter the date the PAR form is signed by the requesting provider.
Telephone Number	10 numbers ###-###-####	Optional Enter the requesting provider's telephone number.
28. Requesting Physician Provider Number	8 numbers	Required Enter the eight-digit Colorado Medical Assistance Program provider number of the requesting provider.
Telephone Number	10 numbers ###-###-####	Optional Enter the telephone number of the rendering provider.
29. Service Provider Number	8 numbers	Required Enter the eight-digit Colorado Medical Assistance Program provider number of the billing provider. The rendering provider must be enrolled in the Colorado Medical Assistance Program.
30. Comments		Leave Blank This field is completed by the authorizing agency. Refer to the PAR response for comments submitted by the authorizing agency.
31. PA Number Being Revised		Leave Blank This field is completed by the authorizing agency.

Prior Authorization Request Form

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND FINANCING

INVOICE/PAT. ACCOUNT NUMBER

MEDICAID PRIOR AUTHORIZATION REQUEST (PAR)

To avoid delay, please answer all questions completely.

1. CLIENT NAME (Last, First, Middle Initial)		2. CLIENT IDENTIFICATION NUMBER		3. SEX <input type="checkbox"/> M <input type="checkbox"/> F		4. DATE OF BIRTH (MMDDYY)	
5. CLIENT ADDRESS (Street, City, State, ZIP Code)						6. CLIENT TELEPHONE NUMBER ()	
7. PRIOR AUTHORIZATION NUMBER * SYSTEM ASSIGNED		8. DATES COVERED BY THIS REQUEST FROM (MMDDYY) THROUGH (MMDDYY)		9. DOES CLIENT RESIDE IN A NURSING FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		10. GROUP HOME NAME - IF PATIENT RESIDES IN A GROUP HOME	
11. ICD-9-CM DIAGNOSIS CODE and DESCRIPTION (Must include Diagnosis Code and Description, Prognosis, Clinical Information and Other Medications presently prescribed)						12. REQUESTING AUTHORIZATION FOR REPAIRS EQUIPMENT MUST BE OWNED BY THE CLIENT - THE SERIAL NUMBER MUST BE ENTERED	
						13. INDICATE LENGTH OF NECESSITY (IN MONTHS AND YEARS) I.E., HOW LONG WILL THIS EQUIPMENT BE NEEDED?	
						14. ESTIMATED COST OF EQUIPMENT	

SERVICES TO BE AUTHORIZED

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

21. PRIMARY CARE PHYSICIAN (PCP) NAME		22. PRIMARY CARE PHYSICIAN ADDRESS (Street, City, State, ZIP code)			
TELEPHONE NUMBER ()		23. PCP PROVIDER NUMBER			
24. NAME AND ADDRESS OF PHYSICIAN REQUESTING PRIOR AUTHORIZATION			25. NAME AND ADDRESS OF PROVIDER WHO WILL RENDER SERVICE		
26. REQUESTING PHYSICIAN SIGNATURE		27. DATE SIGNED			
TELEPHONE NUMBER ()		28. REQUESTING PHYSICIAN PROVIDER NUMBER		29. SERVICE PROVIDER NUMBER	

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

30. COMMENTS **

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

SIGNATURE OF STATE AGENCY REPRESENTATIVE **		DATE **		31. PA NUMBER BEING REVISED **	
---	--	---------	--	--------------------------------	--

* THE ASSIGNED PAR NUMBER APPEARS ON THE PAR LETTER. ENTER THE PAR NUMBER FROM THE LETTER ON THE CLAIM WHEN BILLING FOR THE SERVICES. ** THESE FIELDS ARE COMPLETED BY THE AUTHORIZING AGENT

FORM NO. 10013 (REV. 12/98)
COL - 106

White - AUTHORIZING AGENT

Yellow - ORIGINATOR

Electronic Prior Authorization Request Form

Print Form

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

INVOICE/PAT. ACCOUNT NUMBER
[REDACTED]

DOES CLIENT HAVE PRIMARY INSURANCE?
 YES NO

MEDICAID PRIOR AUTHORIZATION REQUEST (PAR)

To avoid delay, please answer all questions completely.

1. CLIENT NAME (Last, First, Middle Initial)		2. CLIENT IDENTIFICATION NUMBER		3. SEX <input type="checkbox"/> M <input type="checkbox"/> F		4. DATE OF BIRTH (MMDDYYYY)	
5. CLIENT ADDRESS (Street, City, State, ZIP Code)						6. CLIENT TELEPHONE NUMBER	
7. PRIOR AUTHORIZATION NUMBER * SYSTEM ASSIGNED		8. DATES COVERED BY THIS REQUEST FROM (MMDDYYYY) THROUGH (MMDDYYYY)		9. DOES CLIENT RESIDE IN A NURSING FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		10. GROUP HOME NAME - IF PATIENT RESIDES IN A GROUP HOME	
11. ICD-9-CM DIAGNOSIS CODE and DESCRIPTION (Must include Diagnosis Code and Description, Prognosis, Clinical Information and Other Medications presently prescribed)						12. REQUESTING AUTHORIZATION FOR REPAIRS EQUIPMENT MUST BE OWNED BY THE CLIENT - THE SERIAL NUMBER MUST BE ENTERED	
						13. INDICATE LENGTH OF NECESSITY (IN MONTHS AND YEARS) I.E. HOW LONG WILL THIS EQUIPMENT BE NEEDED?	
						14. ESTIMATED COST OF EQUIPMENT	

SERVICES TO BE AUTHORIZED

15. LINE NO.	16. DESCRIBE THE PROCEDURE OR SUPPLY TO BE PROVIDED -- INCLUDE MODEL NUMBER FOR DME PURCHASE OR SERIAL NUMBER FOR REPAIR	17. PROCEDURE OR SUPPLY CODE	18. REQUESTED NUMBER OF SERVICES	19. AUTHORIZED NO. OF SERVICES ("LEAVE BLANK")	20. APPROVED/DENIED ("LEAVE BLANK")
01					
02					
03					
04					
05					

21. PRIMARY CARE PHYSICIAN (PCP) NAME		22. PRIMARY CARE PHYSICIAN ADDRESS (Street, City, State, ZIP code)	
TELEPHONE NUMBER	23. PCP PROVIDER NUMBER		
24. NAME AND ADDRESS OF PHYSICIAN REFERRING FOR PRIOR AUTHORIZATION		25. NAME AND ADDRESS OF PROVIDER WHO WILL BILL SERVICE	
26. REQUESTING PHYSICIAN SIGNATURE		27. DATE SIGNED	
TELEPHONE NUMBER	28. REQUESTING PHYSICIAN PROVIDER NUMBER	TELEPHONE NUMBER	29. BILLING PROVIDER NUMBER

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

30. COMMENTS

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

SIGNATURE OF STATE AGENCY REPRESENTATIVE **	DATE **	31. PA NUMBER BEING REVISED **
---	---------	--------------------------------

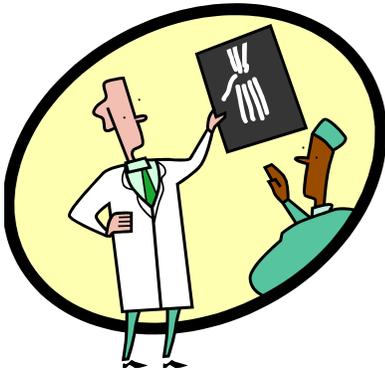
* THE ASSIGNED PAR NUMBER APPEARS ON THE PAR LETTER. ENTER THE PAR NUMBER FROM THE LETTER ON THE CLAIM WHEN BILLING FOR THE SERVICES. ** THESE FIELDS ARE COMPLETED BY THE AUTHORIZING AGENT

FORM NO. 10013 (REV. 0811) COL - 108

Special Benefits/Limitations/Exclusions

Covered Radiology Procedures

Covered procedures include but are not limited to:



- Angiograms
- Computed Tomography (CAT scans)
- Electrocardiograms (ECG)
- Magnetic Resonance Imaging (MRI scans)
- Mammograms
- Positron Emission Tomography (PET scans)
- Radiation treatment for tumors
- Ultrasounds
- X-rays

Non-Covered Radiology Procedures

Radiology procedures for cosmetic treatment or infertility treatment are not covered Medicaid benefits. Radiology procedures considered experimental or not approved by the Food and Drug Administration (FDA) are not covered Medicaid benefits.

Cost of Radiology Procedures

Clients are charged a \$1 co-payment for each day they receive a radiology procedure.

Procedure/HCPSC Codes 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.

The Department updates and revises HCPCS code listings through the billing manuals and bulletins. Providers should regularly consult the billing manuals and monthly bulletins in the Provider Services [Billing Manuals](#) and [Bulletins](#) section of the Department's website.

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 completing a publication preference form. Bulletins include updates on approved codes as well as the maximum allowable units billed per procedure.

All outpatient radiology procedures must be billed using HCPCS codes.

When submitting claims for radiology to the Colorado Medical Assistance Program, observe the following guidelines:

Always use the most current CPT revision. The Colorado Medical Assistance Program adds and deletes codes as they are published in annual revisions of the CPT.

Use CMS codes only when CPT codes are not available or are not as specific as the CMS codes.

Not all codes listed in the annual Colorado Medical Assistance Program HCPCS code publications are benefits of the Colorado Medical Assistance Program. Read the entire entry to determine the benefit status of the item.

The CPT can be purchased at local university bookstores and from the American Medical Association at the following address:



Book & Pamphlet Fulfillment: OP-341/9
 American Medical Association
 P.O. Box 10946
 Chicago, Illinois 60610

CO-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.

Field Label	Completion Format	Instructions
Invoice/Pat Acct Number	Up to 12 characters: letters, numbers or hyphens	Optional Enter information that identifies the patient or claim in the provider’s billing system. Submitted information appears on the Provider Claim Report.
Special Program Code	N/A	N/A
1. Client Name	Up to 25 characters: letters & spaces	Required Enter the client’s last name, first name, and middle initial.
2. Client Date of Birth	Date of Birth 8 digits MMDDCCYY	Required Enter the patient’s birth date using two digits for the month, two digits for the date, two digits for the century, and two digits for the year. Example: 07012010 for July 1, 2010

Field Label	Completion Format	Instructions
3. Medicaid ID Number (Client ID Number)	7 characters: a letter prefix followed by six numbers	Required Enter the client's Colorado Medical Assistance Program ID number. Each person has his/her own unique Colorado Medical Assistance Program ID number. Example: A123456
4. Client Address	Not required	Submitted information is not entered into the claim processing system.
5. Client Sex	Check box Male <input type="checkbox"/> Female <input type="checkbox"/>	Required
6. Medicare ID Number (HIC or SSN)	Up to 11 characters: numbers and letters	Conditional Complete if the client is eligible for Medicare benefits. Enter the individual's Medicare health insurance claim number. The term "Medicare-Medicaid enrollees" refers to a person who is eligible for both Colorado Medical Assistance Program and Medicare benefits.
7. Client Relationship to Insured	Check box Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	Conditional Complete if the client is covered by a commercial health care insurance policy. Enter a check mark or an "x" in the box that identifies the person's relationship to the policyholder.
8. Client Is Covered By Employer Health Plan	Text	Conditional Complete if the client is covered by an employer health plan as policyholder or as a dependent. Enter the employer name policyholder's name and group number. Also complete fields 9 and 9A.
9. Other Health Insurance Coverage	Text	Conditional Complete if the client has commercial health insurance coverage. Enter the name, address, policy number, and telephone numbers, if known, of the commercial health care insurer.
9A. Policyholder Name and Address	Text	Conditional Complete if the client has commercial health insurance coverage. Enter the name, address, and telephone number, if known, of the policyholder.

Field Label	Completion Format	Instructions
10. Was Condition Related To	Check box A. Client Employment Yes <input type="checkbox"/> B. Accident Auto <input type="checkbox"/> Other <input type="checkbox"/> C. Date of accident 6 digits: MMDDYY	Conditional Complete if the condition being treated is the result of employment, an automobile accident, or other accident. Enter a check mark or an "x" in the appropriate box. Enter the date of the accident in the marked boxes.
11. CHAMPUS Sponsors Service/SSN	Up to 10 characters	Conditional Complete if the client is covered under the Civilian Health And Medical Plan of the Uniformed Services (CHAMPUS). Enter the sponsor's service number or SSN.
Durable Medical Equipment Model/serial number (unlabeled field)	N/A	N/A
12. Pregnancy HMO NF	Check box <input type="checkbox"/>	Conditional Complete if the client is in the maternity cycle (i.e., pregnant or within 6 weeks postpartum). Conditional Complete if the client is enrolled in a Colorado Medical Assistance HMO. Conditional Complete if the client is a nursing facility resident.
13. Date of illness or injury or pregnancy	6 digits: MMDDYY	Optional Complete if information is known. Enter the following information as appropriate to the client's condition: Illness Date of first symptoms Injury Date of accident Pregnancy Date of Last Menstrual Period (LMP)
14. Medicare Denial	Check box <input type="checkbox"/> Benefits Exhausted <input type="checkbox"/> Non-covered services	Conditional Complete if the client has Medicare coverage and Medicare denied the benefits or does not cover the billed services.

Field Label	Completion Format	Instructions									
<p>18. ICD-9-CM</p> <p>Diagnosis or nature of illness or injury. In column F, relate diagnosis to procedure by Reference numbers 1, 2, 3, or 4</p>	<p>1 <input type="text"/> <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"/> <input type="text"/></p> <p>3 <input type="text"/> <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"/> <input type="text"/></p> <p>Codes: 3, 4, or 5 characters. 1st character may be a letter.</p> <p>Text</p>	<p>Required</p> <p>At least one diagnosis code must be entered.</p> <p>Enter up to four ICD-9-CM 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 4th or 5th digits)</p> <table border="0"> <tr> <td>ICD-9-CM</td> <td></td> <td>Claim</td> </tr> <tr> <td><u>description</u></td> <td><u>Code</u></td> <td><u>Entry</u></td> </tr> <tr> <td>Radiology Dx</td> <td>847.00</td> <td>847</td> </tr> </table> <p>Optional</p> <p>If entered, the written description must match the code(s).</p>	ICD-9-CM		Claim	<u>description</u>	<u>Code</u>	<u>Entry</u>	Radiology Dx	847.00	847
ICD-9-CM		Claim									
<u>description</u>	<u>Code</u>	<u>Entry</u>									
Radiology Dx	847.00	847									
<p>Transportation Certification attached</p>	<p>N/A</p>	<p>N/A</p>									
<p>Durable Medical Equipment</p> <p>Line #</p> <p>Make</p> <p>Model</p> <p>Serial Number</p>	<p>N/A</p>	<p>N/A</p>									
<p>Prior Authorization #:</p>	<p>N/A</p>	<p>N/A</p>									
<p>19A.Date of Service</p>	<p>From: 6 digits MMDDYY</p> <p>To: 6 digits MMDDYY</p>	<p>Required</p> <p>Enter 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> <p>06/06/2013</p> <p>Or</p> <p>From To</p> <p>06/06/2013 06/06/2013</p> <p>Span dates of service</p> <p>From To</p> <p>06/06/2013 06/20/2013</p> <p>Practitioner claims must be consecutive days.</p>									

Field Label	Completion Format	Instructions
19A.Date of Service (continued)	From: 6 digits MMDDYY To: 6 digits MMDDYY	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. Span billing: Span billing is permitted if the same service (same procedure code) is provided on consecutive dates.
19B.Place of Service	2 digits	Required Enter the Place Of Service (POS) code that describes the location where services were rendered. The Colorado Medical Assistance Program accepts the CMS place of service codes. Enter Place Of Service (POS) code 81.
19C. Procedure Code (HCPCS)	5 digits	Required Enter the radiology procedure code that specifically describes the radiology procedure for which payment is requested.
Mod(ifier)	2 characters -26 Professional component -TC Technical component -76 Repeat procedure, same physician -77 Repeat procedure, different physician -50 Bilateral procedure – Both sides of the body are imaged -LT/-RT Left side/Right side – Only one side was imaged -59 Indicates that two or more procedures are performed at different anatomic sites or different patient encounters. Only use if no other modifier more appropriately describes the relationships of the two or more procedure codes. -52 Reduced services – Under certain circumstances, a service or procedure is reduced or eliminated at the physician's discretion. -53 Discontinued services – Under certain circumstances, a physician may elect to terminate a diagnostic procedure -25 Separate procedure during an evaluation and management visit – If a radiologist performs office visits and/or consultations and performs procedures (not 7xxxx codes) that are separately identifiable on the same date of service	Conditional Complete if the procedure related modifier relates to the billed service.

Field Label	Completion Format	Instructions															
19D. Rendering Provider Number	N/A	N/A															
19E. Referring Provider Number	N/A	N/A															
19F. Diagnosis	<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px; text-align: center;">P</td> <td style="width: 20px; text-align: center;">S</td> <td style="width: 20px; text-align: center;">T</td> </tr> </table> <p style="text-align: center;">1 digit per column</p>	P	S	T	<p>Required</p> <p>From field 18 To field(s) 19F</p> <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>ertiary.</p> <p>Example: (May require 4th or 5th digits)</p> <p>1 7 8 5 5 9 ↓</p> <p>2 824X <table border="1" style="margin-left: 100px;"><tr><td>P</td><td>S</td><td>T</td></tr></table></p> <p>3 2765X Line 1 <table border="1" style="margin-left: 100px;"><tr><td>1</td><td>3</td><td>4</td></tr></table></p> <p>4 V22X Line 2 <table border="1" style="margin-left: 100px;"><tr><td>2</td><td></td><td></td></tr></table></p> <p style="margin-left: 100px;">Line 3 <table border="1"><tr><td>4</td><td>2</td><td></td></tr></table></p>	P	S	T	1	3	4	2			4	2	
P	S	T															
P	S	T															
1	3	4															
2																	
4	2																
19G. Charges	7 digits: Currency 99999.99	<p>Required</p> <p>Enter the usual and customary charge for the service represented by the procedure code on the detail line.</p> <p>Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one procedure from the same group is billed, special multiple pricing rules apply.</p> <p>The base procedure is the procedure with the highest allowable amount. The base code is used to determine the allowable amounts for additional CPT surgical procedures when more than one procedure from the same grouping is performed.</p> <p>Submitted charges cannot be more than charges made to non-Colorado Medical Assistance Program covered individuals for the same service.</p> <p>Do not deduct Colorado Medical Assistance Program co-payment or commercial insurance payments from usual and customary charges.</p>															
19H. Days or Units	4 digits	<p>Required</p> <p>Enter the number of services provided for each procedure code.</p> <p>Enter whole numbers only.</p> <p>Do not enter fractions or decimals.</p> <p>Do not enter a decimal point followed by a 0 for whole numbers.</p>															

Field Label	Completion Format	Instructions
19I.Co-pay	1 digit	Conditional Complete if co-payment is required of this client for this service. 1-Refused to pay co-payment 2-Paid co-payment 3-Co-payment not requested
19J.Emergency	1 character	Conditional Enter a check mark or an "x" in the column to indicate the service is rendered for a life-threatening condition or one that requires immediate medical intervention. If checked, the service on this detail line is exempt from co-payment and from PCP Program referral requirements.
19K.Family Planning	N/A	N/A
19L.EPSDT	1 character	Conditional Enter a check mark or an "x" in the column to indicate the service is provided as a follow-up to or referral from an EPSDT screening examination.
Medicare SPR Date (unlabeled field)	6 digits: MMDDYY	Conditional Complete for Medicare crossover claims. Enter the date of the Medicare Standard Paper Remit (SPR) or Electronic Remittance Advice (ERA). <ul style="list-style-type: none"> ▪ Do not complete this field if Medicare denied all benefits. ▪ Do not combine items from several SPRs/ERAs on a single claim form. ▪ Bill for as many crossover items as appear on a single SPR/ERA up to a maximum of 6 lines. Complete separate claim forms for additional lines on the SPR/ERA. ▪ Providers must submit a copy of the SPR/ERA with paper claims. Be sure to retain the original SPR/ERA for audit purposes.
20. Total Charges	7 digits: Currency 99999.99	Required Enter the sum of all charges listed in field 19G (Charges). Each claim form must be completed as a full document. Do not use the claim form as a continuation billing (e.g., Page 1 or 2, etc.).

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

Field Label	Completion Format	Instructions
<p>27. Signature (Subject to Certification on reverse) and Date</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>Unacceptable signature alternatives:</p> <p>Claim preparation personnel may not sign the enrolled provider’s name.</p> <p>Initials are not acceptable as a signature.</p> <p>Typed or computer printed names are not acceptable as a signature.</p> <p>“Signature on file” notation is not acceptable in place of an authorized signature.</p>
<p>28. Billing Provider Name</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>29. Billing Provider Number</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>30. Remarks</p>	<p>Text</p>	<p>Conditional</p> <p>Use to document the Late Bill Override Date for timely filing.</p> <p>Enter the word “CLIA” followed by the number in this field.</p>



Radiology Claim Example

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

INVOICE/PAY ACCT NUMBER
SPECIAL PROGRAM CODE

HEALTH INSURANCE CLAIM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL) Client, Ian	2. CLIENT DATE OF BIRTH 12/16/1940	3. MEDICAID ID NUMBER (CLIENT ID NUMBER) X222222
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. CLIENT SEX MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/>	6. MEDICARE ID NUMBER (HIC OR SSN)
TELEPHONE NUMBER	7. CLIENT RELATIONSHIP TO INSURED SELF <input 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 EMPLOYER NAME: _____
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 <input style="width: 50px;" type="text"/>	POLICYHOLDER NAME: _____ GROUP: _____ 11. CHAMPUS SPONSORS SERVICE/SSN
TELEPHONE NUMBER	12. PREGNANCY <input type="checkbox"/> HMO <input type="checkbox"/> NURSING FACILITY <input type="checkbox"/>	
10A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)		
TELEPHONE NUMBER		

PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF: <input type="checkbox"/> ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR FIRST PREGNANCY (LMP)	14. MEDICARE DENIAL (ATTACH THE MEDICARE STANDARD PAPER REMITTANCE (SPR) IF EITHER BOX IS CHECKED) <input type="checkbox"/> BENEFITS EXHAUSTED <input type="checkbox"/> NON-COVERED SERVICES	14A. OTHER COVERAGE DENIED <input type="checkbox"/> NO <input type="checkbox"/> YES PAY/DENY DATE: _____
15. NAME OF SUPERVISING PHYSICIAN	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 847	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. IN COLUMN F, RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE NUMBERS 1, 2, 3, OR 4
1.	
2.	
3.	
4.	

TRANSPORTATION CERTIFICATION ATTACHED <input type="checkbox"/> YES			
DURABLE MEDICAL EQUIPMENT Line #	Make	Model	Serial Number
PRIOR AUTHORIZATION #: 98765432			

19A. DATE OF SERVICE FROM TO	B. PLACE OF SERVICE	C. PROCEDURE CODE (HCPCS)	MODIFIERS	D. RENDERING PROVIDER NUMBER	E. REFERRING PROVIDER NUMBER	F. DIAGNOSIS P S T	G. CHARGES	H. DAYS OR UNITS	I. COPAY	J. EMERG ENCY	K. FAMILY PLANNING	L. EPSDT
01/02/2014 01/02/2014	11	70480	28	12345678	13579135	1	\$300.00	1		<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"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<p>THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE, AND COMPLETE. I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS.</p> <p>27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE <i>Authorized Signature 01/24/2014</i></p> <p>28. BILLING PROVIDER NAME The Imaging Center</p> <p>29. BILLING PROVIDER NUMBER 87654321</p> <p>COL-101 FORM NO. 94320 (REV. 02/99) ELECTRONIC APPLICATION</p>	<p>20. TOTAL CHARGES → \$300.00</p>	<p>LESS ↓</p> <p>21. MEDICARE PAID <input type="text"/></p> <p>22. THIRD PARTY PAID \$0.00</p> <p>23. NET CHARGE \$300.00</p>	<p>MEDICARE SPR DATE</p> <p>34. MEDICARE DEDUCTIBLE \$0.00</p> <p>25. MEDICARE COINSURANCE \$0.00</p> <p>36. MEDICARE DISALLOWED <input type="text"/></p>
---	--	---	---

COLORADO 1500

Late Bill Override Date

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

Valid Delay Reason Codes

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



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

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

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

Billing Instruction Detail	Instructions
<p>Delayed Notification of Eligibility</p>	<p>The provider was unable to determine that the patient had Colorado Medical Assistance Program coverage until after the timely filing period expired.</p> <p>File the claim within 60 days of the date of notification that the individual had Colorado Medical Assistance Program coverage.</p>
<p>Delayed Notification of Eligibility</p>	<p>Retain correspondence, phone logs, or a signed Delayed Eligibility Certification form (see Appendix H in the Appendices in the Provider Services Billing Manuals section of the Department’s Web site) 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/ERA date field documents crossover timely filing and completion of the LBOD is not required.)</p> <p>File the claim within 120 days of the Medicare processing/ payment date shown on the SPR/ERA. Maintain the original SPR/ERA on file.</p> <p>LBOD = the Medicare processing date shown on the SPR/ERA.</p>
<p>Medicare Denied Services</p>	<p>The claim is for Medicare denied services (Medicare non-benefit services, benefits exhausted services, or the client does not have Medicare coverage) being submitted within 60 days of the date of Medicare processing/denial.</p> <p><i>Note: This becomes a regular Colorado Medical Assistance Program claim, not a Medicare crossover claim.</i></p> <p>File the claim within 60 days of the Medicare processing date shown on the SPR/ERA. Maintain the original SPR/ERA on file.</p> <p>LBOD = the Medicare processing date shown on the SPR/ERA.</p>

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



Radiology Revisions Log

Revision Date	Additions/Changes	Pages	Made by
<i>11/25/2013</i>	<i>Created</i>	<i>All</i>	<i>ig</i>
<i>01/26/2014</i>	<i>Updated for Colorado 1500</i>	<i>Throughout</i>	<i>ig</i>

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.