

Speech Therapy

Outpatient – Fee-For-Service

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Provider Qualifications

Eligible Providers

Eligible providers may be individual practitioners or may be employed by home care agencies, children's developmental service agencies, health departments, Federally Qualified Health Centers (FQHC), clinics, or hospital outpatient facilities. The provider agency or the individual provider must verify that rendering providers meet the following qualifications:

Speech-Language Pathologists (SLPs) must have a current certification by the Colorado Department of Regulatory Agencies (DORA) pursuant to the [Speech-language Pathology Practice Act](#).

Speech-Language Pathology Assistants are support personnel who, following academic and/or on-the-job training, perform tasks prescribed, directed, and supervised by DORA-certified speech-language pathologists. Speech-language pathologists must follow the ASHA guidelines on the training, use, and supervision of assistants. (Assistants cannot render services under the Home Health benefit of the Medical Assistance Program.) **Speech-language pathology assistants** must practice under the general supervision of a Colorado registered speech-language pathologist.

Clinical Fellows, practicing under the general supervision of a DORA-certified speech-language pathologist may provide speech therapy services.

Provider Participation

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

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

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

Speech-language pathologists/SLPs not employed by an agency, clinic, hospital, or physician may bill the Colorado Medical Assistance Program directly. Providers should refer to the Code of Colorado Regulations, [Qualified Non-Physician Practitioners Eligible to Provide Physician's Services](#) (10 CCR 2505-10, Section 8.2003.C), for specific information when providing speech therapy.

All speech services must be medically necessary and prescribed by an M.D. or D.O., nurse practitioner or physician's assistant.

Educational, personal need, and comfort therapies are not covered speech therapy benefits for any client regardless of age.

For detailed coverage and service limitations, please refer to the [Speech-language and Hearing Services Benefit Coverage Standard](#) on the Department's website.

Habilitative Speech Therapy

Habilitative therapy is a covered benefit for Medicaid expansion clients ages 19 through 64 receiving benefits through the Alternative Benefits Plan (ABP). Eligible clients may receive outpatient speech therapy (ST) benefits for the purposes of Habilitation in addition to Rehabilitation.

Definition

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

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

Benefit Limitations

Eligible clients may not receive both Rehabilitative and Habilitative speech therapy services on the same date of service (DOS). All Habilitative speech therapy services require a prior authorization request (PAR). Rehabilitative and Habilitative ST is limited to five (5) units per DOS. Rehabilitative speech therapy services, available to all clients, does not need a PAR. Instructions for submitting a PAR are below.

Additional Limitations and Notes

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

Daily Unit Limits

Rehabilitative or Habilitative ST is limited to five units per DOS. Some specific daily limits per procedure code do apply. Please see the table below.

While a maximum of five units of service is allowed per date of service, providers are required to consult the American Medical Association's (AMA) Current Procedural Terminology (CPT) manual for each coded service. Some codes represent a treatment session without regard to its length of time (1 unit maximum) while other codes may be billed incrementally as "timed" units.

Clients determined to need a speech generating device (HCPCS codes E2500, E2502, E2504, E2510, E2211, E2512 and E2599) should be referred to a Medicaid participating medical supplier to be prior authorized.

All claims must meet eligibility and claim submission requirements (e.g. timely filing, third party resources payment pursued, required attachments included, etc.) before payment can be made.

Procedure Code Table			
Description*	Procedure Code* + Modifier 'GN' must be placed on all speech therapy claims		Unit Limits Max # units per client, per provider, per DOS
Evaluation of speech fluency (e.g. stuttering, cluttering)	92521	Rehabilitative: GN Habilitative GN+HB	1

Procedure Code Table			
Description*	Procedure Code* + Modifier ‘GN’ must be placed on all speech therapy claims		Unit Limits Max # units per client, per provider, per DOS
Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)	92522	Rehabilitative: GN Habilitative GN+HB	1
Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)	92523	Rehabilitative: GN Habilitative GN+HB	1
Behavioral and qualitative analysis of voice and resonance	92524	Rehabilitative: GN Habilitative GN+HB	1
Treatment of speech, language, voice, communication and/or auditory disorder; individual.	92507	Rehabilitative: GN Habilitative GN+HB	1
Speech/hearing treatment, group, 2 or more individuals	92508	Rehabilitative: GN Habilitative GN+HB	1
Laryngeal function studies	92520	Rehabilitative: GN Habilitative GN+HB	1
Treatment of swallowing dysfunction or oral.	92526	Rehabilitative: GN Habilitative GN+HB	1
Oral speech device evaluation	92597	Rehabilitative: GN Habilitative GN+HB	1
Evaluate for device	92605	Rehabilitative: GN Habilitative GN+HB	1
Non-speech device service	92606	Rehabilitative: GN Habilitative GN+HB	1

Procedure Code Table			
Description*	Procedure Code* + Modifier 'GN' must be placed on all speech therapy claims		Unit Limits Max # units per client, per provider, per DOS
Evaluation for speech generating device, first hour	92607	Rehabilitative: GN Habilitative GN+HB	1
Additional 30 minutes of evaluation for 92607	92608	Rehabilitative: GN Habilitative GN+HB	1
Use of speech device service	92609	Rehabilitative: GN Habilitative GN+HB	1
Evaluation of oral and pharyngeal swallowing function	92610	Rehabilitative: GN Habilitative GN+HB	1
Motion fluoroscopic evaluation of swallowing function	92611	Rehabilitative: GN Habilitative GN+HB	1
Flexible fiber optic endoscopic evaluation by cine or video recording	92612	Rehabilitative: GN Habilitative GN+HB	1
Flexible fiber optic endoscopic laryngeal sensory testing by cine or video recording	92614	Rehabilitative: GN Habilitative GN+HB	1
Evaluation of auditory rehab status; first hour	92626	Rehabilitative: GN Habilitative GN+HB	1
Each additional 15 minutes of 92626	92627	Rehabilitative: GN Habilitative GN+HB	4
Assessment of aphasia, per hour	96105	Rehabilitative: GN Habilitative GN+HB	2

Procedure Code Table			
Description*	Procedure Code* + Modifier 'GN' must be placed on all speech therapy claims		Unit Limits Max # units per client, per provider, per DOS
Developmental testing; extended with interpretation and report, per hour	96111	Rehabilitative: GN Habilitative GN+HB	1
Development of cognitive skills, per 15 minutes	97532	Rehabilitative: GN Habilitative GN+HB	3
Telehealth, originating site facility fee	Q3014	Rehabilitative: GN Habilitative GN+HB	1

National Correct Coding Initiative (NCCI)

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

Prior Authorization Requests (PARs) – Habilitative Speech Therapy Only

Independent speech therapists and outpatient hospital based therapy clinics providing Habilitative speech therapy must submit, and have approved, PARs for medically necessary services prior to rendering the services.

Prior Authorization Requests are approved for up to a twelve (12) month period (depending on medical necessity determined by the authorizing agency).

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

Submit PARs for the number of units for each specific procedure code requested, not for the number of services. Modifiers must be included on both the PAR and claim submission. When submitting a PAR for either rehabilitative or habilitative services, the procedure codes must include the GN or GN + HB modifiers (e.g. 92507+GN+HB).

PAR requests must include:

- Legibly written and signed ordering practitioner prescription, to include diagnosis (preferably with ICD-9 code) and reason for therapy, the number of requested therapy sessions per week and total duration of therapy.
- The client’s Physical or Occupational treatment history, including current assessment and treatment. Include duration of previous treatment and treating diagnosis.
- Documentation indicating if the client has received PT or OT under the Home Health Program or inpatient hospital treatment.

- Current treatment diagnosis.
- Course of treatment, measurable goals and reasonable expectation of completed treatment.
- Documentation supporting medical (physical NOT developmental) necessity for the course and duration of treatment being requested.
- Assessment or progress notes submitted for documentation, must not be more than sixty (60) days prior to submission of PAR request.
- If the PAR is submitted for services delivered by an independent therapist, the name and address of the individual therapist providing the treatment must be present in field #24 of the PAR.
- The billing provider name and address needs to be present in field #25 on the PAR.
- The Colorado Medical Assistance Program provider number of the independent therapist must be present in PAR field #28.
- The billing provider’s Colorado Medical Assistance Program number must be present in field #29 of the PAR.

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

The claim must contain the PAR number for payment.

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

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

[ColoradoPAR Program](#)

Provider Prior Authorization (PAR) Vendor for the Colorado Medical Assistance Program
 Provider PAR Request Line: 1-888-454-7686
 PAR Fax Line: 1-866-492-3176

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

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

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

PAR Revisions

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

Paper PAR Instructional Reference

Field Label	Completion Format	Instructions
		The upper margin of the PAR form must be left blank. This area is for authorizing agency use only.

Field Label	Completion Format	Instructions
Invoice/Pat Account Number	Text	Optional Enter up to 12 characters (numbers, letters, hyphens) that help identify the claim or client.
Does Client Have Primary Insurance?	Check box <input type="checkbox"/> Y <input type="checkbox"/> N	Optional Enter an "X" in the appropriate box.
1. Client Name	Text	Required Enter the client's last name, first name, and middle initial.
2. Client Identification Number	1 letter followed by 6 numbers	Required Enter the client's state identification number. This number consists of a letter prefix followed by six numbers. Example: A123456.
3. Sex	Check box <input type="checkbox"/> Y <input type="checkbox"/> N	Required Enter an "X" in the appropriate box.
4. Date of Birth	6 digits (MMDDYY)	Required Enter the client's birth date using MMDDYY format. Example: January 1, 2009 = 010109.
5. Client Address	Characters: numbers and letters	Required Enter the client's full address: Street, City, State, and Zip code.
6. Client Telephone Number	Text	Optional Enter the client's telephone number.
7. Prior Authorization Number		System assigned Leave blank
8. Dates Covered by this Request	6 digits for From date and 6 digits for Through date (MMDDYY)	Optional Enter the date(s) within which service(s) will be provided. If left blank, dates are entered by the authorizing agency. Authorized services must be provided within these dates.
9. Does Client Reside in a Nursing Facility?	Check box <input type="checkbox"/> Y <input type="checkbox"/> N	Required Check the appropriate box.
10. Group Home Name if Patient Resides in a Group Home	Text	Not applicable.

Field Label	Completion Format	Instructions
11. Diagnosis	Text	Required Enter the medical/physiological diagnosis code and sufficient relevant diagnostic information to justify the request. Include the prognosis. Provide relevant clinical information, other drugs or alternative therapies tried to treating the condition, results of tests, etc. to justify a Colorado Medical Assistance Program determination of medical necessity. Approval of necessity. Attach documents as required.
12. Requesting Authorization for Repairs	Text	Not applicable
13. Indicate Length of Necessity	Text	Not applicable
14. Estimated Cost of Equipment	Digits	Not applicable
15. Services to be Authorized	None	Preprinted Do not alter preprinted lines. No more than five items can be requested on one form.
16. Describe Procedure, Supply, or Drug to be Provided	Text	Required Enter the description of the service/procedure to be provided.
17. Procedure, Supply or Drug Code Required	HCPCS code	Enter the procedural code for each item that will be billed on the claim form. The authorized agency may change any code. The approved code(s) on the PAR form must be used on the claim form.
18. Requested Number of Services	Digits	Required Enter the number of units for supplies, services or equipment requested. If this field is blank, the authorizing agency will complete with one unit.
19. Authorized No. of Services	None	Leave blank The authorizing agency indicates the number of services authorized which may be more not equal number of requested in Field 18 (Number of Services).
20. A = Approved D = Denied	None	Leave blank Check the PAR on-line or refer to the PAR letter.

Field Label	Completion Format	Instructions
21. Primary Care Physician (PCP) Name	Text	Conditional Complete if client has a PCP.
Telephone Number	Text	Optional Enter the PCP's telephone number.
22. Primary Care Physician Address	Text	Conditional Complete if client has a PCP. Enter the PCP's complete address.
23. PCP Provider Number	8 Digits	Conditional Complete if client has a PCP. Enter the PCP's eight-digit Colorado Medical Assistance provider number. This number must be obtained by contacting the PCP for the necessary authorization.
24. Name and Address of Physician Referring for Prior Authorization	Text	Required Enter the complete name and address of the physician requesting prior authorization (the physician ordering/writing the prescription).
25. Name and Address of Provider Who will Bill Service	Text	Required Enter the name and telephone number of the provider who will be billing for the service.
26. Requesting Physician Signature	Text	Required The requesting provider must sign the PAR and must be the physician ordering the service. Under unusual circumstances, when the prescribing physician is not available, a legible copy of a signed prescription may be attached in place of the signature of the requesting provider. The written diagnosis must be entered in Field 11 (Diagnosis), even if a prescription form is attached. Do not send the original prescription; send a photocopy on an 8 ½ x 11 sheet. A rubber stamp facsimile signature is not acceptable on the PAR.
27. Date Signed	6 Digits	Required Enter the date the PAR form is signed by the requesting provider.
Telephone Number	Text	Required Enter the telephone number of the requesting provider.

Field Label	Completion Format	Instructions
28. Requesting Physician Provider Number	8 Digits	Required Enter the eight-digit Colorado Medical Assistance Program provider number of the requesting provider.
29. Billing Provider Number	8 Digits	Required Enter the eight-digit Colorado Medical Assistance Program provider number of the billing provider. All rendering and billing providers must be Colorado Medical Assistance program providers.
30. Comments	Text	Leave Blank This field is completed by the authorizing agency. Refer to the PAR response for comments submitted by the authorizing agent.
31. PA Number Being Revised	Text	Leave Blank This field is completed by the authorizing agency.

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.

Procedure/HCPCS Code Overview

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

The Healthcare Common Procedural Coding System (HCPCS) is divided into two principal subsystems, referred to as level I and level II of the HCPCS.

Level I of the HCPCS is comprised of CPT, a numeric coding system maintained by the AMA.

The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter followed by 4 numeric digits, while CPT codes are identified using 5 numeric digits.

HIPAA requires providers to comply with the coding guidelines of the AMA CPT Procedure Codes and the International Classification of Disease, Clinical Modification Diagnosis Codes. If there is no time designated in the official descriptor, the code represents one unit or session. Providers should regularly consult monthly bulletins located in the Provider Services [Bulletins](#) section. To receive electronic provider bulletin notifications, an email address can be entered into the Web Portal in the *(MMIS) Provider Data Maintenance* area or by filling out a publication preference form. Bulletins include updates on approved procedure codes as well as the maximum allowable units billed per procedure.

Colorado 1500 Paper Claim Reference Table

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

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

Field Label	Completion format	Instructions
Invoice/Pat Acct Number	Up to 12 characters: letters, numbers or hyphens	Optional Enter information that identifies the patient or claim in the provider's billing system. Submitted information appears on the Provider Claim Report.
Special Program Code	2 digits	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. <i>Example: 070110 = July 1, 2010</i>
3. Medicaid ID Number (Client ID Number)	7 characters, a letter prefix followed by six numbers	Required Enter the client's Colorado Medical Assistance Program ID number. Each person has his/her own unique Colorado Medical Assistance Program ID number. Example: A123456
4. Client Address Telephone Number	Characters: numbers and letters	Not required Submitted information is not entered into the claim processing system.
5. Client Sex	Check box Male <input type="checkbox"/> Female <input type="checkbox"/>	Required Enter a check mark or an "x" in the correct box to indicate the client's sex.
6. Medicare ID Number (HIC or SSN)	Up to 11 characters: numbers and letters	Conditional Complete if the client is eligible for Medicare benefits. Enter the individual's Medicare health insurance claim number. The term "dually eligible" refers to a person who is eligible for both Colorado Medical Assistance Program and Medicare benefits.
7. Client relationship to Insured	Check box Self Spouse <input type="checkbox"/> <input type="checkbox"/> Child Other <input type="checkbox"/> <input type="checkbox"/>	Conditional Complete if the client is covered by a commercial health care insurance policy. Enter a check mark or an "x" in the box that identifies the person's relationship to the policyholder.

Field Label	Completion format	Instructions
8. Client is covered by Employer Health Plan	Text	Conditional Complete if the client is covered by an employer health plan as policyholder or as a dependent. Enter the employer name policyholder's name and group number. Also complete fields 9 and 9A.
9. Other Health Insurance Coverage	Text	Conditional Complete if the client has commercial health insurance coverage. Enter the name, address, policy number, and telephone numbers, if known, of the commercial health care insurer.
9A. Policyholder Name and Address	Text	Conditional Complete if the client has commercial health insurance coverage. Enter the name, address, and telephone number, if known, of the policyholder.
10. Was condition related to	Check box A. <input type="checkbox"/> Client employment Check box B. <input type="checkbox"/> Accident 6 digits: MMDDYY C. Date of accident 6 digits: MMDDYY	Conditional Complete if the condition being treated is the result of employment, an automobile accident, or other accident. Enter a check mark or an "x" in the appropriate box. Enter the date of the accident in the marked boxes.
11. CHAMPUS Sponsors Service/SSN	10 digits	Conditional Complete if the client is covered under the Civilian Health And Medical Plan of the Uniformed Services (CHAMPUS). Enter the sponsor's service number or SSN.
Durable Medical Equipment Model/serial number (unlabeled field)	N/A	
12. Pregnancy HMO Nursing Facility	Check box <input type="checkbox"/> Check box <input type="checkbox"/> Check box <input type="checkbox"/>	N/A

Field Label	Completion format	Instructions
<p>13. Date of illness or injury or pregnancy</p>	<p>6 digits: MMDDYY</p>	<p>Complete if information is known. Enter the following information as appropriate to the client's condition:</p> <p>Illness Date of first symptoms Injury Date of accident Pregnancy Date of Last Menstrual Period (LMP)</p>
<p>14. Medicare Denial</p>	<p>Check box</p> <p><input type="checkbox"/> Benefits Exhausted</p> <p><input type="checkbox"/> Non-covered services</p>	<p>Conditional</p> <p>Complete if the client has Medicare coverage and Medicare denied benefits or does not cover the billed services.</p> <p>Enter a check mark or an "x" in the Benefits Exhausted box if a Medicare payment voucher shows that Medicare has denied payment because a limited benefit is exhausted. A copy of the Medicare denial notice must be provided upon request.</p> <p>Enter a check mark or an "x" in the Non-covered Services box if a Medicare publication or denial notice shows the billed service(s) is/are not a Medicare covered benefit. A copy of the Medicare denial or Medicare publication showing that the service is not covered must be provided upon request.</p> <p>Bill claims for Medicare denied services and Medicare crossover claims separately.</p>
<p>14A. Other Coverage Denied</p>	<p>Check box</p> <p>No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/></p> <p>Pay/Deny Date 6 digits: MMDDYY</p>	<p>Conditional</p> <p>Complete if the client has commercial health care insurance coverage.</p> <p>Enter a check mark or an "x" in the "No" box if the other coverage has paid a portion of the billed charges.</p> <p>If the other coverage payment amount is the same or more than the Colorado Medical Assistance Program benefit, the Colorado Medical Assistance Program will not make additional payment.</p> <p>Enter a check mark or an "x" in the "Yes" box if the other coverage carrier has denied payment or has applied all of the allowed benefit to a deductible.</p> <p>Enter the date of the other coverage payment or denial.</p>

Field Label	Completion format	Instructions
<p>15. Name of supervising physician Provider Number</p>	<p>Text 8 digits</p>	<p>Conditional Complete if the individual who performs the service (rendering provider) is a non-physician practitioner who requires on-premises supervision by a licensed physician (see Provider Participation). Enter the eight digit Colorado Medical Assistance Program provider number assigned to the on-premises supervising physician.</p>
<p>16. For services related to hospitalization</p>	<p>6 digits: MMDDYY</p>	<p>Admitted <input type="text"/> MM <input type="text"/> DD <input type="text"/> YY Discharged <input type="text"/> MM <input type="text"/> DD <input type="text"/> YY Conditional Complete for services provided in an inpatient hospital setting. Enter the date of hospital admission and the date of discharge, if known. If the client is still hospitalized, the discharge date may be omitted. This information is not edited.</p>
<p>17. Name and address of facility where services rendered Provider Number</p>	<p>Text (address is optional) 8 digits</p>	<p>Conditional Complete for services provided in a hospital or nursing facility. Enter the name of the hospital or nursing facility. This information is not edited. Complete for services provided in a hospital or nursing facility. Enter the Colorado Medical Assistance Program provider number of hospital or nursing facility, if known. This information is not edited.</p>
<p>17A. Check box if laboratory work performed outside physician's office</p>	<p>Check box <input type="checkbox"/></p>	<p>Conditional Complete if <u>all</u> laboratory work was referred to and performed by an outside laboratory. If this box is checked, no payment will be made to the physician for lab services. Do not complete this field if <u>any</u> laboratory work was performed in the office. Practitioners may not request payment for services performed by an independent or hospital laboratory.</p>

Field Label	Completion format	Instructions
18. ICD-9-CM	1 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 2 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 3 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 4 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Codes: 3, 4, or 5 characters. 1 st character may be a letter.	Required At least one diagnosis code must be entered. Enter up to four diagnosis codes starting at the far left side of the coding area. Do not enter the decimal point. Do not enter zeros to fill the spaces when the diagnosis code is fewer than 5 digits. Example (May require 4 th or 5 th digit): ICD-9-CM Code description Cerebral Palsy 434.9 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Diagnosis or nature of illness or injury	Text	Optional Written description is not required. If entered, the written description must match the code(s).
Transportation Certification attached	Check box <input type="checkbox"/>	N/A
Prior Authorization No.	6 characters: Letter plus 5 digits	Conditional If the procedure requires prior authorization, enter the prior authorization from the approved Prior Authorization Request (PAR). Do not combine services from more than one approved PAR on a single claim form. Do not attach a copy of the approved PAR unless advised to do so by the authorizing agency or the fiscal agent.
19A. Date of Service	From: 6 digits MMDDYY To: 6 digits MMDDYY	Required The field accommodates the entry of two dates: a “beginning” or “from” date of service and an “ending” or “to” date of service. Single date of service From To <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Or From To <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Span dates of service <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 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.

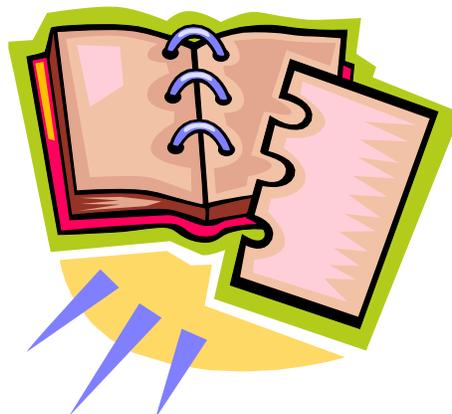
Field Label	Completion format	Instructions
19A. Date of Service (continued)	From: 6 digits MMDDYY To: 6 digits MMDDYY	Span billing: Span billing is permissible if the same service (same procedure code) is provided on consecutive dates.
19B. Place of Service	2 digits	Required Enter the Place Of Service (POS) code that describes the location where services were rendered. The Colorado Medical Assistance Program accepts the CMS place of service codes. 04 Homeless Shelter 11 Office 12 Home 15 Mobile Unit 20 Urgent Care Facility 21 Inpatient hospital 22 Outpatient hospital 23 Emergency room hospital 25 Birthing Center 26 Military Treatment Center 31 Skilled Nursing Facility 32 Nursing facility 33 Custodial Care Facility 34 Hospice 41 Transportation Land 51 Inpatient Psychiatric Facility 52 Psychiatric Facility Partial Hospitalization 53 Community mental health center 54 Intermediate Care Facility - MR 60 Mass Immunization Center 61 Comprehensive IP Rehab Facility 62 Comprehensive OP Rehab Facility 65 End Stage Renal Dialysis Trtmt Facility 71 State-Local Public Hlth Clinic 99 Other Unlisted

Field Label	Completion format	Instructions
19C. Procedure Code (HCPCS)	5 characters: 5 digits or 1 letter plus 4 digits or 2 letters plus 3 digits	<p>Required</p> <p>Enter the HCPCS procedure code that specifically describes the service for which payment is requested.</p> <p>All procedures must be identified with codes in the current edition of the AMA CPT. CPT is updated annually.</p> <p>HCPCS Level II Codes</p> <p>The current Medicare coding publication (for Medicare crossover claims only).</p> <p>Only approved codes from the current CPT or HCPCS publications will be accepted.</p>
Modifiers	2 characters: Letters or digits May enter up to two 2 character modifiers	<p>Enter the appropriate procedure-related modifier that applies to the billed service.</p> <p>Enter two (2) characters in each field.</p> <p>Modifier for Speech = GN</p>
19D. Rendering Provider No.	8 digits	<p>Required</p> <p>Enter the eight-digit Colorado Medical Assistance Program provider number assigned to the <u>individual</u> who actually performed or rendered the billed service. This number cannot be assigned to a group or clinic.</p>
19E. Referring Provider No.	8 digits	<p>Conditional</p> <p>Complete for clients enrolled in the Primary Care Physician (PCP) program if:</p> <p>The rendering or billing provider is not the primary care provider and</p> <p>The billed service requires PCP referral.</p> <p>Enter the PCP's eight-digit Colorado Medical Assistance Program provider number. Entry of the PCP's provider number represents the provider's declaration that he/she has a referral from the PCP.</p>



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

Field Label	Completion format	Instructions
19G. Charges	Up to 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>



Field Label	Completion format	Instructions
19I. COPAY	1 digit	Conditional Complete if co-payment is required of this client for this service. Enter one of the following codes: 1-Refused to pay co-payment 2-Paid co-payment 3-Co-payment not requested
19J. Emergency	Check box <input type="checkbox"/>	Conditional Enter a check mark or an "x" in the column to indicate the service is rendered for a life-threatening condition or one that requires immediate medical intervention. If checked, the service on this detail line is exempt from co-payment and from PCP Program referral requirements.
19K. Family Planning	Check box <input type="checkbox"/>	Conditional Enter a check mark or an "x" in the column to indicate the service is rendered for family planning. If checked, the service on this detail line is exempt from co-payment and from PCP Program referral requirements.
19L. EPSDT	Check box <input type="checkbox"/>	Conditional Enter a check mark or an "x" in the column to indicate the service is provided as a follow-up to or referral from an EPSDT screening examination.
Medicare SPR Date (unlabeled field)	6 digits: MMDDYY	Conditional Complete for Medicare crossover claims. Enter the date of the Medicare Standard Paper Remit (SPR) or Electronic Remittance Advice (ERA). <ul style="list-style-type: none"> ▪ Do not complete this field if Medicare denied all benefits. ▪ Do not combine items from several SPRs/ERAs on a single claim form. ▪ Bill for as many crossover items as appear on a single SPR/ERA up to a maximum of 6 lines. Complete separate claim forms for additional lines on the SPR/ERA. ▪ Providers must submit a copy of the SPR/ERA with paper claims. Be sure to retain the original SPR/ERA for audit purposes.

Field Label	Completion format	Instructions
<p>20. Total Charges</p>	<p>Up to 7 digits: Currency 99999.99</p>	<p>Required Enter the sum of all charges listed in field 19G (Charges). Each claim form must be completed as a full document. Do not use the claim form as a continuation billing (e.g., Page 1 of 2, etc.).</p>
<p>21. Medicare Paid</p>	<p>7 digits: Currency 99999.99</p>	<p>Conditional Complete for Medicare crossover claims. Enter the Medicare payment amount shown on the Medicare payment voucher.</p>
<p>22. Third Party Paid</p>	<p>7 digits: Currency 99999.99</p>	<p>Conditional Complete if the client has commercial health insurance and the third party resource has made payment on the billed services. Enter the amount of the third party payment shown on the third party payment voucher. Do not enter Colorado Medical Assistance Program co-payment in this field or anywhere else on the claim form.</p>
<p>23. Net Charge</p>	<p>7 digits: Currency 99999.99</p>	<p>Required Colorado Medical Assistance Program claims (Not Medicare Crossover) Claims without third party payment. Net charge equals the total charge (field 20). Claims with third party payment. Net charge equals the total charge (field 20) minus the third party payment (field 22) amount. Medicare Crossover claims Crossover claims without third party payment. Net charge equals the sum of the Medicare deductible amount (field 24) plus the Medicare coinsurance (field 25) amount. Crossover claims with third party payment. Net charge equals the sum of the Medicare deductible amount (field 24) plus the Medicare coinsurance (field 25) amount minus the third party payment (field 22) amount.</p>
<p>24. Medicare Deductible</p>	<p>7 digits: Currency 99999.99</p>	<p>Conditional Complete for Medicare crossover claims. Enter the Medicare deductible amount shown on the Medicare payment voucher.</p>

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

UB-04 Paper Claim Reference Table

Speech therapy outpatient hospital paper claims must be submitted on the UB-04 claim form.

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

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

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

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

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

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

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
<p>2. Pay-to Name, Address, City, State</p>	<p>Text</p>	<p>Required if different from FL 1. Enter the provider or agency name and complete mailing address of the provider who will receive payment for the services: Street/Post Office box City State Zip Code Abbreviate the state using standard post office abbreviations. Enter the telephone number.</p>
<p>3a. Patient Control Number</p>	<p>Up to 20 characters: Letters, numbers or hyphens</p>	<p>Optional Enter information that identifies the client or claim in the provider's billing system. Submitted information appears on the Provider Claim Report.</p>
<p>3b. Medical Record Number</p>	<p>17 digits</p>	<p>Optional Enter the number assigned to the patient to assist in retrieval of medical records.</p>
<p>4. Type of Bill</p>	<p>3 digits</p>	<p>Required Enter the three digit number indicating the specific type of bill. The three digit code requires one digit each in the following sequences (Type of facility, Bill classification, and Frequency): Digit 1 Type of Facility 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)</p>

Form Locator and Label	Completion Format	Instructions
<p>4. Type of Bill (continued)</p>	<p>3 digits</p>	<p>Required</p> <p>Enter the three digit number indicating the specific type of bill. The three digit code requires one digit each in the following sequences (Type of facility, Bill classification, and Frequency):</p> <p>Digit 2 Bill Classification (Except clinics & special facilities):</p> <p>1 Inpatient (Including Medicare Part A)</p> <p>2 Inpatient (Medicare Part B only)</p> <p>3 Outpatient</p> <p>4 Other (for hospital referenced diagnostic services or home health not under a plan of treatment)</p> <p>5 Intermediate Care Level I</p> <p>6 Intermediate Care Level II</p> <p>7 Sub-Acute Inpatient (revenue code 19X required with this bill type)</p> <p>8 Swing Beds</p> <p>9 Other</p> <p>Digit 2 Bill Classification (Clinics Only):</p> <p>1 Rural Health/FQHC</p> <p>2 Hospital Based or Independent Renal Dialysis Center</p> <p>3 Freestanding</p> <p>4 Outpatient Rehabilitation Facility (ORF)</p> <p>5 Comprehensive Outpatient Rehabilitation Facilities (CORFs)</p> <p>6 Community Mental Health Center</p> <p>Digit 2 Bill Classification (Special Facilities Only):</p> <p>1 Hospice (Non-Hospital Based)</p> <p>2 Hospice (Hospital Based)</p> <p>3 Ambulatory Surgery Center</p> <p>4 Freestanding Birthing Center</p> <p>5 Critical Access Hospital</p> <p>6 Residential Facility</p>

Form Locator and Label	Completion Format	Instructions
<p>4. Type of Bill (continued)</p>	<p>3 digits</p>	<p>Required</p> <p>Enter the three digit number indicating the specific type of bill. The three digit code requires one digit each in the following sequences (Type of facility, Bill classification, and Frequency):</p> <p>Digit 3 Frequency:</p> <p>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</p>
<p>5. Federal Tax Number</p>	<p>None</p>	<p>Not required</p> <p>Submitted information is not entered into the claim processing system.</p>
<p>6. Statement Covers Period – From/Through</p>	<p>From: 6 digits MMDDYY</p> <p>Through: 6 digits MMDDYY</p>	<p>Required</p> <p>(Note: OP claims cannot span over a month's end)</p> <p>Enter the From (beginning) date and Through (ending) date of service covered by this bill. <i>Example:</i> 01012011 = January 1, 2014</p> <p>This form locator must reflect the beginning and ending dates of service. When span billing for multiple dates of service and multiple procedures, complete FL 45 (Service Date). Providers not wishing to span bill following these guidelines, must submit one claim per date of service. "From" and "Through" dates must be the same. All line item entries must represent the same date of service.</p>
<p>8a. Patient Identifier</p>		<p>Not required</p> <p>Submitted information is not entered into the claim processing system.</p>
<p>8b. Patient Name</p>	<p>Up to 25 characters: Letters & spaces</p>	<p>Required</p> <p>Enter the client's last name, first name and middle initial.</p>
<p>9a. Patient Address – Street</p>	<p>Characters Letters & numbers</p>	<p>Required</p> <p>Enter the client's street/post office box as determined at the time of admission.</p>

Form Locator and Label	Completion Format	Instructions
9b. Patient Address – City	Text	Required Enter the client's city as determined at the time of admission.
9c. Patient Address – State	Text	Required Enter the client's state as determined at the time of admission.
9d. Patient Address – Zip	Digits	Required Enter the client's zip code as determined at the time of admission.
9e. Patient Address – Country Code	Digits	Optional
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. <i>Example:</i> 01012010 = January 1, 2010
11. Patient Sex	1 letter	Required Enter an M (male) or F (female) to indicate the client's sex.
12. Admission Date	6 digits	Conditional Required for observation holding beds only
13. Admission Hour	6 digits	Conditional Required for observation holding beds only



Form Locator and Label	Completion Format	Instructions
<p>14. Admission Type</p>	<p>1 digit</p>	<p>Required Enter the following to identify the admission priority:</p> <p>1 – Emergency Client requires immediate intervention as a result of severe, life threatening or potentially disabling conditions. Exempts inpatient hospital & clinic claims from co-payment and PCP referral. Exempts outpatient hospital claims from co-payment and PCP only if revenue code 450 or 459 is present. This is the only benefit service for an undocumented alien. If span billing, emergency services cannot be included in the span bill and must be billed separately from other outpatient services.</p> <p>2 - Urgent The client requires immediate attention for the care and treatment of a physical or mental disorder.</p> <p>3 - Elective The client’s condition permits adequate time to schedule the availability of accommodations.</p> <p>4 - Newborn Required for inpatient and outpatient hospital.</p> <p>5 - Trauma Center Visit to a trauma center/hospital as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons <u>and</u> involving trauma activation.</p> <p>Clinics Required only for emergency visit.</p>

Form Locator and Label	Completion Format	Instructions
<p>15. Source of Admission</p>	<p>1 digit</p>	<p>Required</p> <p>Enter the appropriate code for co-payment exceptions on claims submitted for outpatient services. (To be used in conjunction with FL 14, Type of Admission).</p> <ul style="list-style-type: none"> 1 Physician referral 2 Clinic referral 4 Transfer from a hospital 5 Transfer from a skilled nursing facility (SNF) 6 Transfer from another health care facility 8 Court/Law Enforcement 9 Information not available E Transfer from an Ambulatory Surgery Center F Transfer from a Hospice Agency <p>Newborns</p> <ul style="list-style-type: none"> 5 Baby born inside this hospital 6 Baby born outside this hospital
<p>16. Discharge Hour</p>	<p>2 digits</p>	<p>Not Required</p>
<p>17. Patient Discharge Status</p>	<p>2 digits</p>	<p>Conditional</p> <p>Enter patient status as of discharge date.</p> <ul style="list-style-type: none"> 01 Discharged to Home or Self Care (Dialysis is limited to code 01) 02 Discharged/transferred to another short term hospital 03 Discharged/transferred to a Skilled Nursing Facility (SNF) 04 Discharged/transferred to an Intermediate Care Facility (ICF) 05 Discharged/transferred to another type institution 06 Discharged/transferred to home under care of organized Home and Community Based Services Program (HCBS) 07 Left against medical advice or discontinued care 08 Discharged/transferred to home under care of a Home Health provider 09 Admitted as an inpatient to this hospital 20 Expired 30** Still a patient or expected to return for outpatient services

Form Locator and Label	Completion Format	Instructions
<p>17. Patient Discharge Status (continued)</p>	<p>2 digits</p>	<p>31** Still a patient - Awaiting transfer to long term psychiatric hospital 32** Still a Patient - Awaiting placement by Colorado Medical Assistance Program 50 Hospice – Home 51 Hospice - Medical Facility 61 Discharged/transferred within this institution to hospital based Medicare approved swing bed 62 Discharged/transferred to an inpatient rehabilitation hospital. 63 Discharged/transferred to a Medicare certified long term care hospital. 65 Discharge/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital 66 Transferred/Discharged to Critical Access Hospital CAH 70 Discharged/Transferred to Other HC Institution 71 Discharged/transferred/referred to another institution for outpatient services 72 Discharged/transferred/referred to this institution for outpatient services</p> <p>Use code <u>02</u> for a PPS hospital transferring a patient to another PPS hospital. Code <u>05</u>, Discharged to Another Type Institution, is the most appropriate code to use for a PPS hospital transferring a patient to an exempt hospital. **A PPS hospital cannot use Patient Status codes 30, 31 or 32 on any claim submitted for DRG reimbursement. The code(s) are valid for use on exempt hospital claims only. Interim bills may be submitted for Prospective Payment System (PPS) -DRG claims, but must meet specific billing requirements. For exempt hospitals use the appropriate code from the codes listed. Note: Refer to the “Interim” billing instruction in this section of the manual.</p>

Form Locator and Label	Completion Format	Instructions
<p>18-28. Condition Codes</p>	<p>2 Digits</p>	<p>Conditional Complete with as many codes necessary to identify conditions related to this bill that may affect payer processing.</p> <p>Condition Codes</p> <ul style="list-style-type: none"> 01 Military service related 02 Employment related 04 HMO enrollee 05 Lien has been filed 06 ESRD patient - First 18 months entitlement 07 Treatment of non-terminal condition/hospice patient 17 Patient is homeless 25 Patient is a non-US resident 39 Private room medically necessary 42 Outpatient Continued Care not related to Inpatient 44 Inpatient CHANGED TO Outpatient 51 Outpatient Non-diagnostic Service unrelated to Inpatient admit 60 DRG (Day outlier) <p>Renal dialysis settings</p> <ul style="list-style-type: none"> 71 Full care unit 72 Self care unit 73 Self care training 74 Home care 75 Home care - 100 percent reimbursement 76 Back-up facility

Form Locator and Label	Completion Format	Instructions
<p>18-28. Condition Codes (continued)</p>	<p>2 Digits</p>	<p>Special Program Indicator Codes</p> <ul style="list-style-type: none"> A1 EPSDT/CHAP A2 Physically Handicapped Children's Program A4 Family Planning A6 PPV/Medicare A9 Second Opinion Surgery AA Abortion Due to Rape AB Abortion Done Due to Incest AD Abortion Due to Life Endangerment AI Sterilization B3 Pregnancy Indicator B4 Admission Unrelated to Discharge <p>PRO Approval Codes</p> <ul style="list-style-type: none"> C1 Approved as billed C2 Automatic approval as billed - Based on focused review C3 Partial approval C4 Admission/Services denied C5 Post payment review applicable C6 Admission preauthorization C7 Extended authorization
<p>29. Accident State</p>		<p>Optional</p>

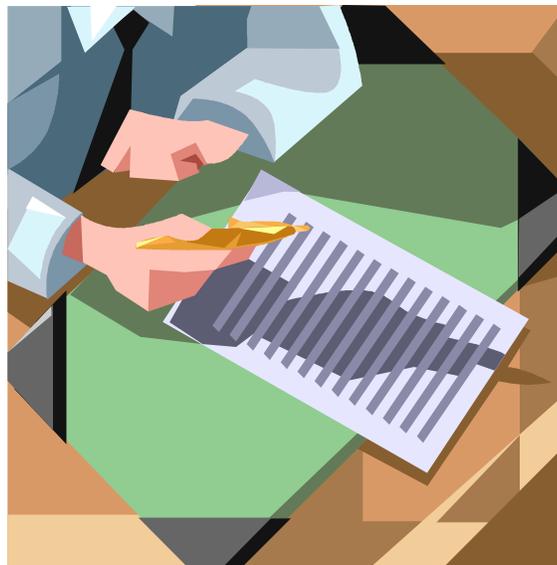


Form Locator and Label	Completion Format	Instructions
<p>31-34. Occurrence Code/Date</p>	<p>2 digits and 6 digits</p>	<p>Conditional Complete both the code and date of occurrence. Enter the appropriate code and the date on which it occurred. Enter the date using MMDDYY format.</p> <p>Occurrence Codes: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

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

Form Locator and Label	Completion Format	Instructions
<p>39-41. Value Code-Code Value Code-Amount (continued)</p>	<p>2 characters and 9 digits</p>	<p>Enter the deductible amount applied by indicated payer: A1 Deductible Payer A B1 Deductible Payer B C1 Deductible Payer C</p> <p>Enter the amount applied to client's co-insurance by indicated payer: A2 Coinsurance Payer A B2 Coinsurance Payer B C2 Coinsurance Payer C</p> <p>Enter the amount paid by indicated payer: A3 Estimated Responsibility Payer A B3 Estimated Responsibility Payer B C3 Estimated Responsibility Payer C</p> <p>Enter the amount paid by client FC Patient Paid Amount</p> <p>For Rancho Coma Score bill with appropriate diagnosis for head injury. Medicare & TPL - See A1-A3, B1-B3, & C1-C3 above</p>
<p>42. Revenue Code</p>	<p>3 digits</p>	<p>Required</p> <p>Enter the revenue code which identifies the specific accommodation or ancillary service provided. List revenue codes in ascending order.</p> <p>A <u>revenue code</u> must appear only <u>once</u> per date of <u>service</u>. If more than one of the same service is provided on the same day, combine the <u>units</u> and charges on one line accordingly.</p> <p>When billing outpatient hospital radiology, the radiology revenue code may be repeated, but the corresponding HCPCS code cannot be repeated for the same date of service. Refer to instructions under FL 44 (HCPCS/Rates).</p> <p>Psychiatric step down</p> <p>Use the following revenue codes: 114 Psychiatric Step Down 1 124 Psychiatric Step Down 2</p>

Form Locator and Label	Completion Format	Instructions
<p>43. Revenue Code Description</p>	<p>Text</p>	<p>Required Enter the revenue code description or abbreviated description. When reporting an NDC Enter the NDC qualifier of "N4" in the first two positions on the left side of the field. Enter the 11-digit NDC numeric code Enter the NDC unit of measure qualifier (examples include): F2 – International Unit GR – Gram ML – Milliliter UN – Units Enter the NDC unit of measure quantity</p>



Form Locator and Label	Completion Format	Instructions
<p>44. HCPCS/Rates /HIPPS Rate Codes</p>	<p>5 digits</p>	<p>Conditional</p> <p>Enter only the HCPCS code for each detail line. Use approved modifiers listed in this section for hospital based transportation services.</p> <p>Complete for laboratory, radiology, physical therapy, occupational therapy, and hospital based transportation. When billing HCPCS codes, the appropriate revenue code must also be billed.</p> <p>HCPCS codes must be identified for the following revenue codes:</p> <ul style="list-style-type: none"> ▪ 30X LABORATORY ▪ 32X RADIOLOGY – DIAGNOSTIC ▪ 33X RADIOLOGY – THERAPEUTIC ▪ 34X NUCLEAR MEDICINE ▪ 35X CT SCAN ▪ 40X OTHER IMAGING SERVICES ▪ 42X PHYSICAL THERAPY ▪ 43X OCCUPATIONAL THERAPY ▪ 44X SPEECH THERAPY ▪ 54X AMBULANCE ▪ 61X MRI <p>HCPCS codes cannot be repeated for the same date of service. Combine the units in FL 46 (Service Units) to report multiple services.</p> <p>The following revenue codes always require a HCPCS code. Please reference the Provider Services Bulletins section of the Department’s Web site for a list of physician-administered drugs that also require an NDC code.</p> <p>When a HCPCS code is repeated more than once per day and billed on separate lines, use modifier 76 to indicate this is a repeat procedure and not a duplicate.</p> <ul style="list-style-type: none"> 0252 Non-Generic Drugs 0253 Take Home Drugs 0255 Drugs Incident to Radiology 0257 Non-Prescription 0258 IV Solutions 0259 Other Pharmacy 0260 IV Therapy General Classification 0261 Infusion Pump 0262 IV Therapy/Pharmacy Services 0263 IV Therapy/Drug/Supply Delivery 0264 IV Therapy/Supplies

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

Form Locator and Label	Completion Format	Instructions
50. Payer Name	1 letter and text	<p>Required</p> <p>Enter the payment source code followed by name of each payer organization from which the provider might expect payment.</p> <p>At least one line must indicate The Colorado Medical Assistance Program.</p> <p>Source Payment Codes</p> <ul style="list-style-type: none"> B Workmen's Compensation C Medicare D Colorado Medical Assistance Program E Other Federal Program F Insurance Company G Blue Cross, including Federal Employee Program H Other - Inpatient (Part B Only) I Other <p>Line A Primary Payer Line B Secondary Payer Line C Tertiary Payer</p>
51. Health Plan ID	8 digits	<p>Required</p> <p>Enter the provider's Health Plan ID for each payer name. Enter the eight digit Colorado Medical Assistance Program provider number assigned to the billing provider. Payment is made to the enrolled provider or agency that is assigned this number.</p>
52. Release of Information		<p>Not required</p> <p>Submitted information is not entered into the claim processing system.</p>
53. Assignment of Benefits		<p>Not required</p> <p>Submitted information is not entered into the claim processing system.</p>
54. Prior Payments	Up to 9 digits	<p>Conditional</p> <p>Complete when there are Medicare or third party payments.</p> <p>Enter third party and/or Medicare payments.</p>

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

Form Locator and Label	Completion Format	Instructions
63. Treatment Authorization Code	Up to 18 characters	Conditional Complete when the service requires a PAR. Enter the authorization number in this FL if a PAR is required and has been approved for services.
64. Document Control Number		Not required Submitted information is not entered into the claim processing system.
65. Employer Name	Text	Conditional Complete when there is third party coverage. Enter the name of the employer that provides health care coverage for the individual identified in FL 58 (Insured Name).
66. Diagnosis Version Qualifier		Not required Submitted information is not entered into the claim processing system.
67. Principal Diagnosis Code	Up to 6 digits	Required Enter the exact diagnosis code describing the principal diagnosis that exists at the time of admission or develops subsequently and affects the length of stay. Do not add extra zeros to the diagnosis code.
67A- 67Q. Other Diagnosis	Up to 6 digits	Conditional Enter the exact diagnosis code corresponding to additional conditions that co-exist at the time of admission or develop subsequently and which effect the treatment received or the length of stay. Do not add extra zeros to the diagnosis code.
69. Admitting Diagnosis Code	Up to 6 digits	Optional Enter the diagnosis code as stated by the physician at the time of admission.
70. Patient Reason Diagnosis		Not required Submitted information is not entered into the claim processing system.
71. PPS Code		Not required Submitted information is not entered into the claim processing system.
72. External Cause of Injury Code (E-code)	Up to 6 digits	Optional Enter the diagnosis code for the external cause of an injury, poisoning, or adverse effect. This code must begin with an "E".

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

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



Institutional Provider Certification

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

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

Signature: _____

Date: _____

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

Colorado 1500 Speech Therapy 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, Ima	2. CLIENT DATE OF BIRTH 01/04/2006	3. MEDICAID ID NUMBER (CLIENT ID NUMBER) Y123456
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. CLIENT SEX MALE <input type="checkbox"/> FEMALE <input checked="" type="checkbox"/>	6. MEDICARE ID NUMBER (HIC OR SSN)
TELEPHONE NUMBER	7. CLIENT RELATIONSHIP TO INSURED SELF <input checked="" type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. <input type="checkbox"/> CLIENT IS COVERED BY EMPLOYER HEALTH PLAN AS EMPLOYEE OR DEPENDENT 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"/>	

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 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. IN COLUMN F, RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE NUMBERS 1, 2, 3, OR 4 1. 31531 Developmental speech-language delay 2. 78460 Organic speech-language disorder		TRANSPORTATION CERTIFICATION ATTACHED <input type="checkbox"/> YES DURABLE MEDICAL EQUIPMENT Line # Make Model Serial Number PRIOR AUTHORIZATION #:

19A. DATE OF SERVICE FROM TO	B. PLACE OF SERVICE	C. PROCEDURE CODE (HCPCS)	D. MODIFIERS	E. RENDERING PROVIDER NUMBER	F. REFERRING PROVIDER NUMBER	G. DIAGNOSIS P S T	H. CHARGES	I. DAYS OR UNITS	J. CO-PAY	K. EMERGENCY	L. FAMILY PLANNING	M. EPSDT
02/01/2014 02/02/2014	11	92524	GN	12345678	98765432	1	\$31.60	1		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
02/02/2014 02/02/2014	11	92507	GN	12345678	98765432	2	\$58.00	1		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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"/>

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.

27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE <i>Authorized Signature February 7, 2014</i>	20. TOTAL CHARGES → \$89.60	LESS ↓ 21. MEDICARE PAID 22. THIRD PARTY PAID NET CHARGE \$89.60
28. BILLING PROVIDER NAME ABC Clinic	30. REMARKS	24. MEDICARE DEDUCTIBLE \$0.00
29. BILLING PROVIDER NUMBER 00112233		25. MEDICARE COINSURANCE \$0.00
COL-101 FORM NO. 94320 (REV. 02/99) ELECTRONIC APPLICATION		26. MEDICARE DISALLOWED

COLORADO 1500

UB-04 Outpatient Speech Therapy Claim Example

1 City Hospital 100 Saginaw St. Anytown, CO 80000 333-333-3333		2		3a PAT. CNTL. # b. MED. REC. #		4 TYPE OF BILL 131																																							
8 PATIENT NAME a Client, Ima				9 PATIENT ADDRESS a 123 Main Street b Anytown c CO d 80000																																									
10 BIRTHDATE 01/04/2006		11 SEX F	12 DATE 3 3		13 HR 3		14 TYPE 3		15 SRC 3		16 DHR		17 STAT		18		19		20		21		22		23		24		25		26		27		28		29 ACDT STATE		30						
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE		35 OCCURRENCE DATE		36 OCCURRENCE SPAN FROM THROUGH		37 OCCURRENCE SPAN FROM THROUGH		38		39 VALUE CODES CODE AMOUNT		40 VALUE CODES CODE AMOUNT		41 VALUE CODES CODE AMOUNT		42 REV. CD.		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49									
1		2		3		4		5		6		7		8		9		10		11		12		13		14		15		16		17		18		19		20		21		22		23	
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Late Bill Override Date

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

Valid Delay Reason Codes

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

▼

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

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

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

Billing Instruction Detail	Instructions
Denied Paper Claims	<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>
Returned Paper Claims	<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>
Rejected Electronic Claims	<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>
Denied/Rejected Due to Client Eligibility	<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>
Retroactive Client Eligibility	<p>The claim is for services provided to an individual whose Colorado Medical Assistance Program eligibility was backdated or made retroactive.</p> <p>File the claim within 120 days of the date that the individual’s eligibility information appeared on state eligibility files. Obtain and maintain a letter or form from the county departments of social services that:</p> <ul style="list-style-type: none"> Identifies the patient by name States that eligibility was backdated or retroactive Identifies the date that eligibility was added to the state eligibility system. <p>LBOD = the date shown on the county letter that eligibility was added to or first appeared on the state eligibility system.</p>

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

Billing Instruction Detail	Instructions
Commercial Insurance Processing	<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>
Correspondence LBOD Authorization	<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>
Client Changes Providers during Obstetrical Care	<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>



Speech Therapy Revisions Log

Revision Date	Additions/Changes	Pages	Made by
10/01/2012	<i>Stand-alone Speech Therapy Billing Manual created(separated from Physical/Occupational Therapy Manual</i>	<i>All</i>	<i>mjb</i>
10/01/2012	<i>Updated Global information such as Electronic Claim Submission and LBOD</i>	<i>3 54</i>	<i>vr</i>
10/05/2012	<i>Formatted document. Added TOC Added CO-1500 and UB-04 claim examples.</i>	<i>All 1 42-43</i>	<i>cc</i>
10/05/2012	<i>Reformatted manual Added claim examples Added TOC</i>	<i>All 41 & 42 i</i>	<i>jg</i>
1/23/2014	<i>Significant changes throughout. Added content on Habilitative speech therapy.</i>	<i>All</i>	<i>as</i>
02/07/2014	<i>Paper claim reference table updates: 17- Added discharge status of 65, 66, 70 18-28- Added condition codes 42, 44, 51; Added special program indicator AA, AB, AD, AI Removed A7 and A8 35-63- Removed IP/OP- Leave blank Added 74 and 75 39-41- Added value code/amount 30 Added FC to enter amount paid by client 42- Removed 0134 from psychiatric step down 44- Added zero to HCPCS</i>	<i>31 33-34 37-43 36-37 37 39-40</i>	<i>cc</i>
02/07/2014	<i>Updated Billing Information Formatted Updated Claim examples Updated TOC</i>	<i>11 Throughout 47 & 48 i</i>	<i>jg</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.