Dialysis

Dialysis

Providers must be enrolled as a Health First Colorado provider in order to:

- Treat a Health First Colorado member;
- Submit claims for payment to the Health First Colorado.

The Health First Colorado provides hemodialysis benefits to eligible Members in an outpatient, state-approved freestanding dialysis treatment center, and in the home setting. These services are billed on the UB-04 paper claim form or as an 837 Institutional (837I) electronic transaction.

State-approved non-routine services provided outside the routine dialysis treatment should be billed and reimbursed separately. The services must be billed on the CMS 1500 paper claim form or as an 837 Professional (837P) electronic transaction using the dialysis center NPI number. Providers should refer to the appropriate CMS 1500 billing manual for field completion format and instructions.

Providers should refer to the Code of Colorado Regulations, Program Rules (10 C.C.R. 2505-10), for specific information when providing dialysis services.

Dialysis may be provided as part of inpatient hospital treatment and included in the hospital inpatient claim (see the Dialysis Benefits chart below).

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. Certain Provider Types are not able to obtain an NPI. Those providers will be assigned a Health First Colorado provider number.

Paper Claims

Electronic claims format shall be required unless hard copy claims submittals are specifically prior authorized by the Department. Requests may be sent to DXC Technology (DXC), P.O. Box 30, Denver, CO 80201-0030. The following claims can be submitted on paper and processed for payment:

- Claims from providers who consistently submit five (5) claims or fewer per month (requires prior approval)
- Claims that, by policy, require attachments
    - Note: Attachments can be submitted electronically
- Reconsideration claims

Paper claims require an NPI for those provider types that can obtain one. Providers that cannot obtain an NPI are required to use an assigned Health First Colorado provider number on their claims. 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 EDI support section of the Department's website (edi-support)
- Online Portal User Guide (via within the Online Portal)

The Health First Colorado collects electronic claim information interactively through the Health First Colorado Secure Online Portal (Online Portal) or via batch submission through a host system. Please refer to the Colorado General Provider Information Manual for additional electronic information.

Interactive Claim Submission and Processing

Interactive claim submission through the Online Portal is a real-time exchange of information between the provider and the Health First Colorado. Health First Colorado providers may create and transmit HIPAA compliant 837P (Professional), 837I (Institutional), and 837D (Dental) claims electronically one at a time. These claims are transmitted through the Health First Colorado Online Portal (OP).

The Online Portal contains training, user guides and help that describe claim completion requirements, edits that verify the format and validity of the entered information, and edits that assure that required fields are completed.

The Health First Colorado OP reviews the claim information for compliance with Health First Colorado billing policy and passes the claim to the Colorado interChange system for adjudication and reporting on the Health First Colorado Provider Remittance Advice (RA).

The OP immediately returns a response to the provider about that single transaction indicating whether the claim will be rejected, suspended or paid.

- If the claim is rejected, the OP sends a rejection response that identifies the rejection reason. The rejected claim can immediately be resubmitted.
- If the claim is suspended then it needs additional manual review by the Fiscal Agent.
- If the claim is accepted, the provider receives a message indicating that the claim is will be paid.

The Online Portal provides immediate feedback directly to the submitter. All claims are processed to provide a weekly Health Care Claim Payment/Advice (Accredited Standards Committee [ASC] X12N 835) transaction and/or Remittance Advice to providers. The Online Portal also provides access to reports and transactions generated from claims submitted via paper and through electronic data submission methods other than the Online Portal. The reports and transactions include:

Accept/Reject Report

Remittance Advice

Health Care Claim Payment/Advice (ASC X12N 835)

Managed Care Reports such as Primary Care Physician Rosters

Eligibility Inquiry (interactive and batch)

Claim Status Inquiry

Claims may be adjusted, edited and resubmitted, and voided in real time through the Online Portal. Access the Online Portal through Secured Site at colorado.gov/hcpf. For help with claim submission via the Online Portal, please choose the *User Guide* option available for each Online Portal transaction.

For additional electronic billing information, please refer to the appropriate Companion Guide located in the Provider Services Specifications section of the Department's website.

Batch Electronic Claims Submission

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

All batch claim submission software must be tested and approved by the Health First Colorado fiscal agent.

For additional electronic billing information, please refer to the appropriate Companion Guide located in the Provider Services Specifications section of the Department's website.

Dialysis Benefits

Inpatient Hospital:

Inpatient hemodialysis is a benefit when:

- Hospitalization is required for an acute medical condition requiring hemodialysis treatment.
- Hospitalization is required for a covered medical condition and the member receives regular maintenance outpatient hemodialysis treatment.
- Hospitalization is required for placement or repair of the hemodialysis route (shunt or cannula).
- Inpatient hemodialysis payment is included as part of the Diagnosis Related Group (DRG).
- Hospital admissions solely for hemodialysis are not a Health First Colorado benefit.

Outpatient Hospital:

State-Approved Dialysis Treatment Center

A dialysis treatment center is a health institution or a department of a licensed hospital that is planned, organized, operated and maintained to provide outpatient hemodialysis treatment and/or training for home use of hemodialysis equipment. Other conditions for participation are those specifically entered into the agreement with the Department.

Continued outpatient hemodialysis is a benefit when:

- Training of the eligible recipient to perform self-treatment in the home environment is contraindicated; or
- The eligible member is not a proper candidate for self-treatment in a home environment; or
- The home environment of the eligible member contraindicates self-treatment; or
- The eligible member is awaiting a kidney transplant.

Home

The high costs of dialysis treatments and the budgetary limitations of the Health First Colorado (Colorado's Medicaid Program) program require that all Health First Colorado members be considered for the most cost efficient method of dialysis based upon their individual medical diagnosis and condition. Such treatments include home dialysis and peritoneal methods of dialysis.

The participating separate dialysis unit within a hospital or the free-standing dialysis treatment center shall be responsible for the provision and maintenance of all equipment and necessary fixtures required for home dialysis and provision of all supplies.

All eligible Members approved for self-treatment must be trained in the use of hemodialysis equipment while undergoing outpatient hemodialysis treatments.

Training must be provided by qualified personnel of a hospital with a separate dialysis unit or by qualified personnel of a freestanding dialysis treatment center.

The participating hospital or dialysis treatment center must provide and install quality hemodialysis equipment to be used by the member at home and must provide routine medical surveillance of the member's adaptation and adjustment to the self-treatment at home.

Any facility providing regularly scheduled outpatient or chronic dialysis treatments at a free-standing facility or billing for supplies necessary to perform the various types of home dialysis treatments shall apply for a separate Health First Colorado enrollment from the fiscal agent. Such provider shall be designated solely for the purpose of claims submission for dialysis services.

Reimbursement

The amount of payment for regularly scheduled routine outpatient dialysis or necessary supplies to perform home dialysis treatments, when provided by a separate unit within a hospital or a free standing dialysis treatment center approved for participation by the Department, shall be the lesser of the unit's charges or the currently posted Health First Colorado rate.

The amount of payment for non-routine outpatient dialysis treatments, when provided by a separate unit within a hospital or free standing dialysis treatment center, shall be based upon the Health First Colorado fee schedule.

Ancillary services performed in addition to the routine dialysis treatment shall be considered as part of the composite rate and billed on the UB-04 claim form or electronically on the 837I transaction.

Non-routine ancillary services performed in addition to the dialysis treatment shall be reimbursed separately and billed on the CMS 1500 claim form or electronically as an 837P transaction. This requires the provider use the appropriate Healthcare Common Procedure Coding System (HCPCS) codes designated for the service provided.

The following dialysis services are reimbursed at the lower of the composite Medicare rate ceiling or the individual center's Medicare facility rate:

- Outpatient hemodialysis
- Outpatient peritoneal dialysis
- Continuous Ambulatory Peritoneal Dialysis (CAPD)
- Continuous Cycling Peritoneal Dialysis (CCPD)

There is no reimbursement for home dialysis, only for necessary home dialysis equipment and supplies.

The following applies to services provided in either a free-standing dialysis center or outpatient hospital setting:

- Charges by a dialysis facility for routine drugs, electrocardiograms (EKGs) and X-rays are considered part of the dialysis treatment. Non-routine drugs must be billed on the CMS 1500 paper claim form or as an 837 Professional (837P) electronic transaction using the dialysis center NPI number.
- Drugs not dispensed by the dialysis provider are billed by and reimbursed to the dispensing pharmacy. Physician's charges for EKG or X-ray services must be billed by the physician.
- A physician must supervise the process when blood is furnished and may bill for any professionally rendered covered service using his/her NPI number

- Routine laboratory services are included as part of the dialysis service reimbursement.

Non-routine laboratory services are reimbursed as laboratory services separate from the dialysis treatment.

- Hospitals having separate dialysis units must submit services according to outpatient hospital laboratory regulations and UB-04 billing instructions.
- A free-standing dialysis center that performs its own laboratory tests must be licensed as an independent clinical laboratory and enrolled in the Health First Colorado as an independent laboratory. The non-routine laboratory services must be billed under the independent laboratory's NPI number on the CMS 1500 claim form or electronically as an 837P transaction.
- If an outside laboratory provides the service, that laboratory must bill for the service.

All routine laboratory services performed by a dialysis treatment facility, with the designation as a certified clinical laboratory, or as a certified independent laboratory are included as part of the dialysis treatment reimbursement. All routine tests must be performed by the facility, with designation as a certified clinical laboratory, and reimbursed as part of the composite rate or performed by a certified independent outside laboratory and billed to the facility performing the dialysis treatment.

The following required procedures constitute routine laboratory services that are considered medically necessary. These laboratory tests are included as part of the dialysis service reimbursement.

Per Treatment

Hematocrit		

Weekly

Prothrombin time for members on anti-coagulant therapy	Serum Creatinine	BUN

Monthly

HCT	Hgb	Dialysate Protein
Alkaline Phosphatase Magnesium	CBC Sodium	LDH
Potassium	Serum Albumin	CO 2
Serum Calcium	Serum Chloride	Specimen Collection
Serum Phosphorous	Serum Potassium	SGOT
Total Protein	All Hematocrit and Clotting time tests	Serum Bicarbonate

Drugs considered part of the routine dialysis treatment:

Heparin	Protamine	Mannitol
Glucose	Saline	Dextrose
Pressor Drugs	Antihistamines	Antiarrhythmics
Antihypertensives		

Drugs considered non-routine:

Antibiotics	Anabolics	Hematinics
Sedatives	Analgesics	Tranquilizers
Muscle Relaxants		

Nonparenteral items may not be billed separately by the dialysis center, but may be billed directly to Health First Colorado by the supplier. Nonparenteral items administered during the dialysis treatment are reimbursed as part of the composite rate.

UB-04 Paper Claim Reference Table

Dialysis treatment center claims that are submitted on paper 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 paper claim form are based on the current *National Uniform Billing Committee (NUBC) UB-04 Reference Manual.* Unless otherwise noted, all data form locators on the UB-04 have the same attributes (specifications) for the Health First Colorado as those indicated in the *NUBCUB-04 Reference Manual*.

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

The UB-04 Certification document (located in the Provider Services Forms section of the Department's website) must be completed and attached to all claims submitted on the UB-04 paper claim form.

Completed UB-04 paper claims for Health First Colorado services, including hardcopy Medicare claims, should be mailed to the correct fiscal agent address located in Appendix A in the Appendices of the Provider Services Billing Manuals section of the Department's website.

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

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 Health First Colorado for dialysis services.

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

Form Locator and Label	Completion Format	Instructions
		Zip Code Abbreviate the state using standard post office abbreviations.
3a. Patient Control Number	Up to 20 characters: Letters, numbers or hyphens	Optional Enter information that identifies the member or claim in the provider's billing system. Submitted information appears on the Remittance Advice (RA).
3b. Medical Record Number	17 digits	Optional Enter the number assigned to the member to assist in retrieval of medical records.
4. Type of Bill	3 digits	Required Enter the three-digit number indicating the specific type of bill. The three-digit code requires one digit each in the following sequences (Type of facility, Bill classification, and Frequency): For Dialysis, use TOB 72X Digit 1 — Type of Facility 1 Hospital 2 Skilled Nursing 3 Home Health Services 4 Religious Non-Medical Health Care Institution 6 Intermediate Care 7 Clinic (Rural Health/FQHC/Dialysis Center) 8 Special Facility (Hospice, RTCs)
4. Type of Bill (continued)	3 digits	Digit 2 — Bill Classification (Except clinics & special facilities): 1 Inpatient (Including Medicare Part A) 2 Inpatient (Medicare Part B only) 3 Outpatient

Form Locator and Label	Completion Format	Instructions
		4 Other (for hospital referenced diagnostic services or home health not under a plan of treatment) 5 Intermediate Care Level I 6 Intermediate Care Level II 7 Sub-Acute Inpatient (revenue code 019X required with this bill type) 8 Swing Beds 9 Other Digit 2 Bill Classification (Clinics Only): 1 Rural Health/FQHC 2 Hospital Based or Independent Renal Dialysis Center 3 Freestanding 4 Outpatient Rehabilitation Facility (ORF) 5 Comprehensive Outpatient Rehabilitation Facilities (CORFs) 6 Community Mental Health Center Digit 2 Bill Classification (Special Facilities Only): 1 Hospice (Non-Hospital Based) 2 Hospice (Hospital Based) 3 Ambulatory Surgery Center 4 Freestanding Birthing Center 5 Critical Access Hospital 6 Residential Facility
4. Type of Bill (continued)	3 digits	Digit 3 Frequency: 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

Form Locator and Label	Completion Format	Instructions
5. Federal Tax Number	None	Submitted information is not entered into the claim processing system.
6. Statement Covers Period – From/Through	From: 6 digits MMDDYY Through: 6 digits MMDDYY	Required This form locator must reflect the beginning and ending dates of service. When span billing for multiple dates of service and multiple procedures, complete FL 45 (Service Date). Providers not wishing to span bill following these guidelines, must submit one claim per date of service. "From" and "Through" dates must be the same. All line item entries must represent the same date of service.
8a. Patient Identifier		Submitted information is not entered into the claim processing system.
8b. Patient Name	Up to 25 characters: Letters & spaces	Required Enter the member's last name, first name and middle initial.
9a. Patient Address – Street	Characters Letters & numbers	Required Enter the member's street/post office as determined at the time of admission.
9b. Patient Address – City	TextNone	Required Enter the member's city as determined at the time of admission. Submitted information is not entered into the claim processing system.
9c. Patient Address – State	TextFrom: 6 digits MMDDYY Through: 6 digits MMDDYY	Required Enter the member's state as determined at the time of admission.
9d. Patient Address – Zip	Digits	Required Enter the member'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 member's birthdate using two digits for the month, two digits for the date, and four digits for the year (MMDDCCYY format). Example: 01012010 for January 1, 2010.
11. Patient Sex	1 letter	Required

Form Locator and Label	Completion Format	Instructions
		Enter an M (male) or F (female) to indicate the member's sex. Required
12. Admission Date		Not required
13. Admission Hour		Not required
14. Admission Type		Not required
15. Source of Admission		Required
16. Discharge Hour		Not Required
17. Patient Discharge Status	2 digits	Required Dialysis must use code 01.
18-28. Condition Codes	2 Digits	Conditional Complete with as many codes necessary to identify conditions related to this bill. <u>Condition Codes</u> 06 ESRD member – First 18 months entitlement <u>Renal dialysis settings</u> 71 Full care unit 72 Self care unit 73 Self care training 74 Home care 75 Home care – 100 percent reimbursement 76 Back-up facility
29. Accident State	1 letter	Optional
31-34. Occurrence Code/Date	2 digits and 6 digits	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. <u>Occurrence Codes</u>:

Form Locator and Label	Completion Format	Instructions
		1 Accident/Medical Coverage 2 Auto Accident - No Fault Liability 3 Accident/Tort Liability 4 Accident/Employment Related 5 Other Accident/No Medical Coverage or Liability Coverage 6 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 No longer used 55 Insurance Pay Date
31-34. Occurrence Code/Date (continued)	2 digits and 6 digits	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 **Other Payer occurrence codes 24 and 25 must be used when applicable.* *T* Not Required Not required

Form Locator and Label	Completion Format	Instructions
35-36. Occurrence Span Code From/ Through	None	Leave blank
38. Responsible Party Name/ Address	None	Leave blank
39-41. Value Code and Amount	2 characters and 9 digits	Conditional 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. Codes must be in ascending order. If a value code is entered, a dollar amount or numeric value related to the code must always be entered. 01 Most common semiprivate rate (Accommodation Rate) 06 Medicare blood deductible 14 No fault including auto/other 15 Worker's Compensation 31 Member Liability Amount 32 Multiple Member Ambulance Transport
39-41. Value Code and Amount (continued)	2 characters and 9 digits	37 Pints of Blood Furnished 38 Blood Deductible Pints 40 New Coverage Not Implemented by HMO 45 Accident Hour Enter the hour when the accident occurred that necessitated medical treatment. Use the same coding used in FL 18 (Admission Hour). 49 Hematocrit Reading - EPO Related 58 Arterial Blood Gas (PO2/PA2) 68 EPO-Drug 80 Covered Days 81 Non-covered Days *Enter the deductible amount applied by indicated payer:* A1 Deductible Payer A

Form Locator and Label	Completion Format	Instructions
		B1 Deductible Payer B C1 Deductible Payer C *Enter the amount applied to member's co-insurance by indicated payer:* A2 Coinsurance Payer A B2 Coinsurance Payer B C2 Coinsurance Payer C *Enter the amount paid by indicated payer:* A3 Estimated Responsibility Payer A B3 Estimated Responsibility Payer B C3 Estimated Responsibility Payer C
42. Revenue Code 35-36. Occurrence Span Code From/ Through18-28. Condition Codes	4 digits	Required Enter the revenue code which identifies the specific service provided. List revenue codes in ascending order. Please refer to Appendix Q of the Appendices in the Provider Services Billing Manuals section at for valid dialysis revenue codes. A revenue code must appear only once per date of service. * If more than one of the same service is provided on the same day, combine the units and charges on one line accordingly. Leave blank Conditional Complete with as many codes necessary to identify conditions related to this bill. Condition Codes 06 ESRD member – First 18 months entitlement Renal dialysis settings 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
43. Revenue Code Description	Text	Required Enter the revenue code description or abbreviated description.
44. HCPCS/Rates/ HIPPS Rate Codes	5 digits	Conditional

Form Locator and Label	Completion Format	Instructions
		Enter only the HCPCS code for each detail line. Use approved modifiers listed in this section for hospital based transportation services. Complete for laboratory, radiology, physical therapy, occupational therapy, and hospital based transportation. When billing HCPCS codes, the appropriate revenue code must also be billed. **Services Requiring HCPCS** Anatomical Laboratory: Bill with TC modifier Hospital Based Transportation Outpatient Laboratory: Use only HCPCS 80000s - 89000s. Outpatient Radiology Services Enter HCPCS and revenue codes for each radiology line. The only valid modifier for OP radiology is TC. Refer to the annual HCPCS bulletin for instructions in the Provider Services Bulletins section of the website. With the exception of outpatient lab and hospital-based transportation, outpatient radiology services can be billed with other outpatient services. HCPCS codes must be identified for the following revenue codes: 030X Laboratory • 032X Radiology – Diagnostic • 033X Radiology – Therapeutic • 034X Nuclear Medicine • 035X CT Scan • 040X Other Imaging Services • 042X Physical Therapy • 043X Occupational Therapy • 054X Ambulance • 061X MRI and MRA HCPCS codes cannot be repeated for the same date of service. Combine the units in FL 46 (Units) to report multiple services.

Form Locator and Label	Completion Format	Instructions
45. Service Date	6 digits	Conditional 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).
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) For span bills, the units of service reflect only those visits, miles or treatments provided on dates of service in FL 45.
47. Total Charges	9 digits	Required Enter the total charge for each line item. Calculate the total charge as the number of units multiplied by the unit charge. Do not subtract Medicare or third party payments from line charge entries. Do not enter negative amounts. A grand total in line 23 is required for all charges.
48. Non-Covered Charges	9 digits	Required Enter incurred charges that are not payable by the Health First Colorado. Non-covered charges must be entered in both FL 47 (Total Charges) and FL 48 (Non-Covered Charges.) Each column requires a grand total on line 23. Non-covered charges cannot be billed for outpatient hospital laboratory or hospital based transportation services.
50. Payer Name	1 letter and text	Required Enter the payment source code followed by name of each payer organization from which the provider might expect payment. At least one (1) line must indicate The Health First Colorado. Source Payment Codes

Form Locator and Label	Completion Format	Instructions
		B Workmen's Compensation C Medicare D Health First Colorado E Other Federal Program F Insurance Company G Blue Cross, including Federal Employee Program H Other - Inpatient (Part B Only) I Other Line A Primary Payer Line B Secondary Payer Line C Tertiary Payer
51. Health Plan ID	10 digits	Required Enter the provider's Health Plan ID for each payer name. Enter the NPI number assigned to the **billing provider**. Payment is made to the enrolled provider or agency that is assigned this number.
52. Release of Information	None	Submitted information is not entered into the claim processing system.
53. Assignment of Benefits	None	Submitted information is not entered into the claim processing system.
54. Prior Payments	Up to 9 digits	Conditional Complete when there are Medicare or third party payments. Enter third party and/or Medicare payments.

Form Locator and Label	Completion Format	Instructions
55. Estimated Amount Due	Up to 9 digits	Conditional Complete when there are Medicare or third party payments. Enter the net amount due from The Health First Colorado after provider has received other third party, Medicare or member liability amount on the Health First Colorado line. **Medicare Crossovers** Enter the sum of the Medicare coinsurance plus Medicare deductible less third party payments and member liability amount.
56. National Provider Identifier (NPI)	10 digits	Required Enter the billing provider's 10-digit National Provider Identifier (NPI).
57. Other Provider ID	10 digits	Submitted information is not entered into the claim processing system.

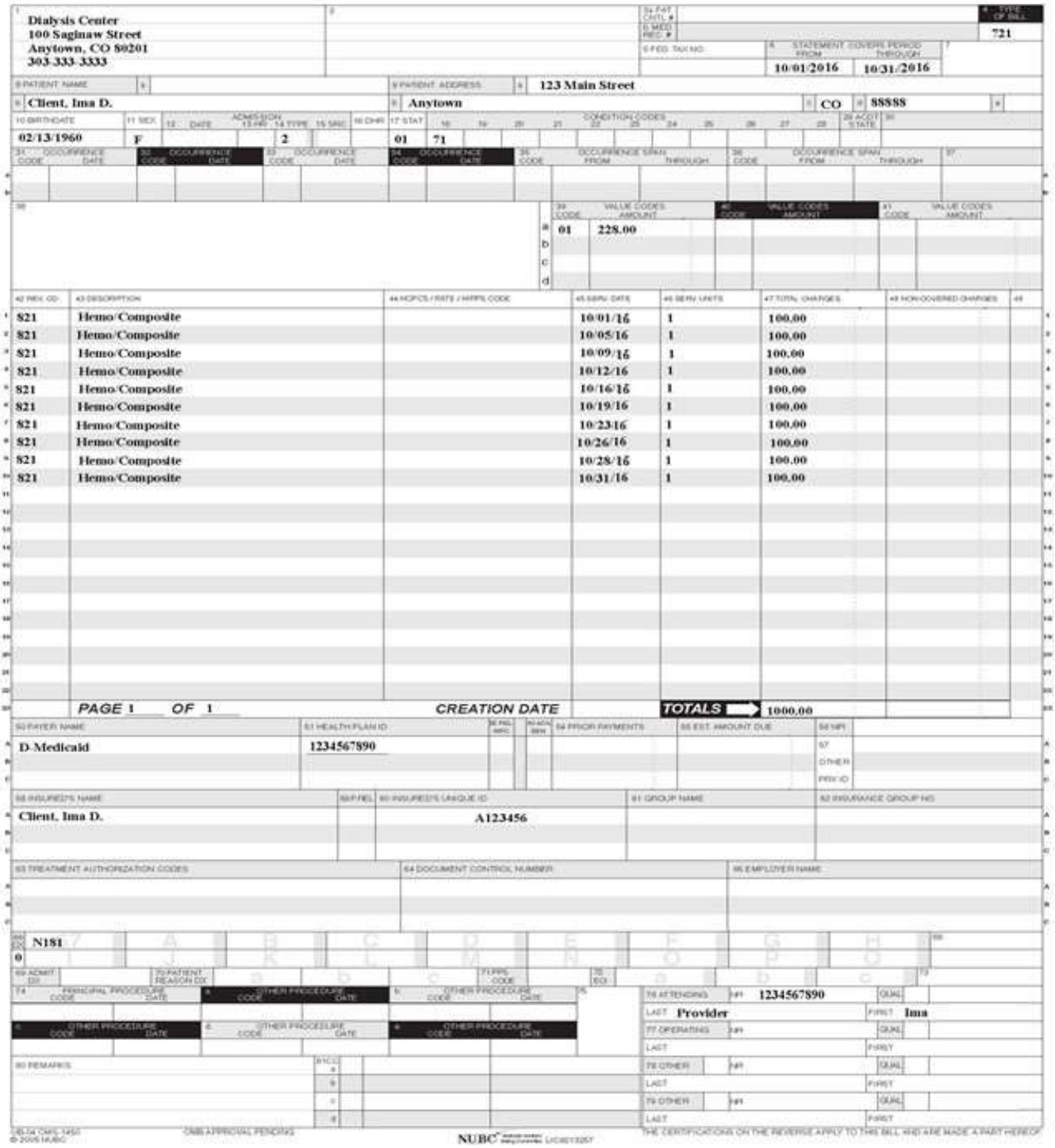
Form Locator and Label	Completion Format	Instructions
58. Insured's Name	Up to 30 characters	Required Enter the member's name on the Health First Colorado line. **Other Insurance/Medicare** Complete additional lines when there is third party coverage. Enter the policyholder's last name, first name, and middle initial.
60. Insured's Unique ID	Up to 20 characters	Required Enter the insured's unique identification number assigned by the payer organization. Include letter prefixes or suffixes.
61. Insurance Group Name	14 letters	Conditional Complete when there is third party coverage. Enter the name of the group or plan providing the insurance to the insured.
62. Insurance Group Number	17 digits	Conditional Complete when there is third party coverage.

Form Locator and Label	Completion Format	Instructions
		Enter the identification number, control number, or code assigned by the carrier or fund administrator identifying the group under which the individual is carried.
63. Treatment Authorization Code	Up to 18 characters	Conditional Complete when the service requires a PAR. Enter the PAR/authorization number in this FL, if a PAR is required and has been approved for services.
64. Document Control Number		Conditional
65. Employer Name	Text	Conditional Complete when there is third party coverage. Enter the name of the employer that provides health care coverage for the individual identified in FL 58 (Insured Name).
66. Diagnosis Version Qualifier		Submitted information is not entered into the claim processing system. Enter applicable ICD indicator to identify which version of ICD codes is being reported. 0 ICD-10-CM (DOS 10/1/15 and after) 9 ICD-10-CM (DOS 9/30/15 and before)
67. Principal Diagnosis Code	Up to 6 digits	Not required
67A- 67Q. Other Diagnosis	6 digits	Optional 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	6 digits	Not Required

Form Locator and Label	Completion Format	Instructions
70. Patient Reason Diagnosis		Not Required
71. PPS Code		Not Required
72. External Cause of Injury Code (E-code)	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".
74. Principal Procedure Code/ Date	7 characters and 6 digits	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.
74A. Other Procedure Code/Date	7 characters and 6 digits	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.
76. Attending NPI – Required **Attending- Last/ First Name**	NPI - 10 digits Text	Health First Colorado ID Required NPI - Enter the 10-digit NPI number assigned to the physician having primary responsibility for the member's medical care and treatment. This number is obtained from the physician, and cannot be a clinic or group number. (If the attending physician is not enrolled in the Health First Colorado or if the member leaves the ER before being seen by a physician, the hospital may enter their individual numbers.) Hospitals may enter the member's regular physician's 10-digit NPI in the Attending Physician

Form Locator and Label	Completion Format	Instructions
		ID form locator if the locum tenens physician is not enrolled in the Health First Colorado. Enter the attending physician's last and first name. This form locator must be completed for all services.
77. Operating-NPI/		Not required Submitted information is not entered into the claim processing system.
78-79. Other ID **NPI – Conditional**	NPI - 10 digits	Conditional – Complete when attending physician is not the PCP or to identify additional physicians. Ordering, Prescribing, or Referring NPI - when applicable NPI - Enter up to two 10-digit NPI 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 NPI number as the referring physician. The name of the Health First Colorado member's PCP appears on the eligibility verification. Review either for eligibility and PCP. The Health First Colorado 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	Enter specific additional information necessary to process the claim or fulfill reporting requirements.
81. Code-Code-QUAL/CODE/VALUE (a-d)		Submitted information is not entered into the claim processing system.

Dialysis UB-04 Claim Example



Dialysis Center
100 Saginaw Street
Anytown, CO 80201
303-333-3333

TYPE OF BILL: 721

STATEMENT COVERS PERIOD: FROM 10/01/2016 THROUGH 10/31/2016

9 PATIENT NAME: Client, Ima D.

9 PATIENT ADDRESS: 123 Main Street
Anytown CO 88888

10 BIRTHDATE: 02/13/1960
11 SEX: F
ADMISSION 13 HR 14 TYPE 15 SRC: 2
17 STAT: 01
CONDITION CODES: 71

39 VALUE CODES AMOUNT: a 01 228.00

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
821	Hemo/Composite		10/01/16	1	100.00	
821	Hemo/Composite		10/05/16	1	100.00	
821	Hemo/Composite		10/09/16	1	100.00	
821	Hemo/Composite		10/12/16	1	100.00	
821	Hemo/Composite		10/16/16	1	100.00	
821	Hemo/Composite		10/19/16	1	100.00	
821	Hemo/Composite		10/23/16	1	100.00	
821	Hemo/Composite		10/26/16	1	100.00	
821	Hemo/Composite		10/28/16	1	100.00	
821	Hemo/Composite		10/31/16	1	100.00	
	PAGE 1 OF 1		CREATION DATE	TOTALS	1000.00	

50 PAYER NAME: D-Medicaid
51 HEALTH PLAN ID: 1234567890
54 PRIOR PAYMENTS:
55 EST. AMOUNT DUE:

58 INSURED'S NAME: Client, Ima D.
60 INSURED'S UNIQUE ID: A123456
61 GROUP NAME:
62 INSURANCE GROUP NO:

63 TREATMENT AUTHORIZATION CODES:
64 DOCUMENT CONTROL NUMBER:
66 EMPLOYER NAME:

42 N181
0

76 ATTENDING NPI: 1234567890
LAST: Provider
FIRST: Ima

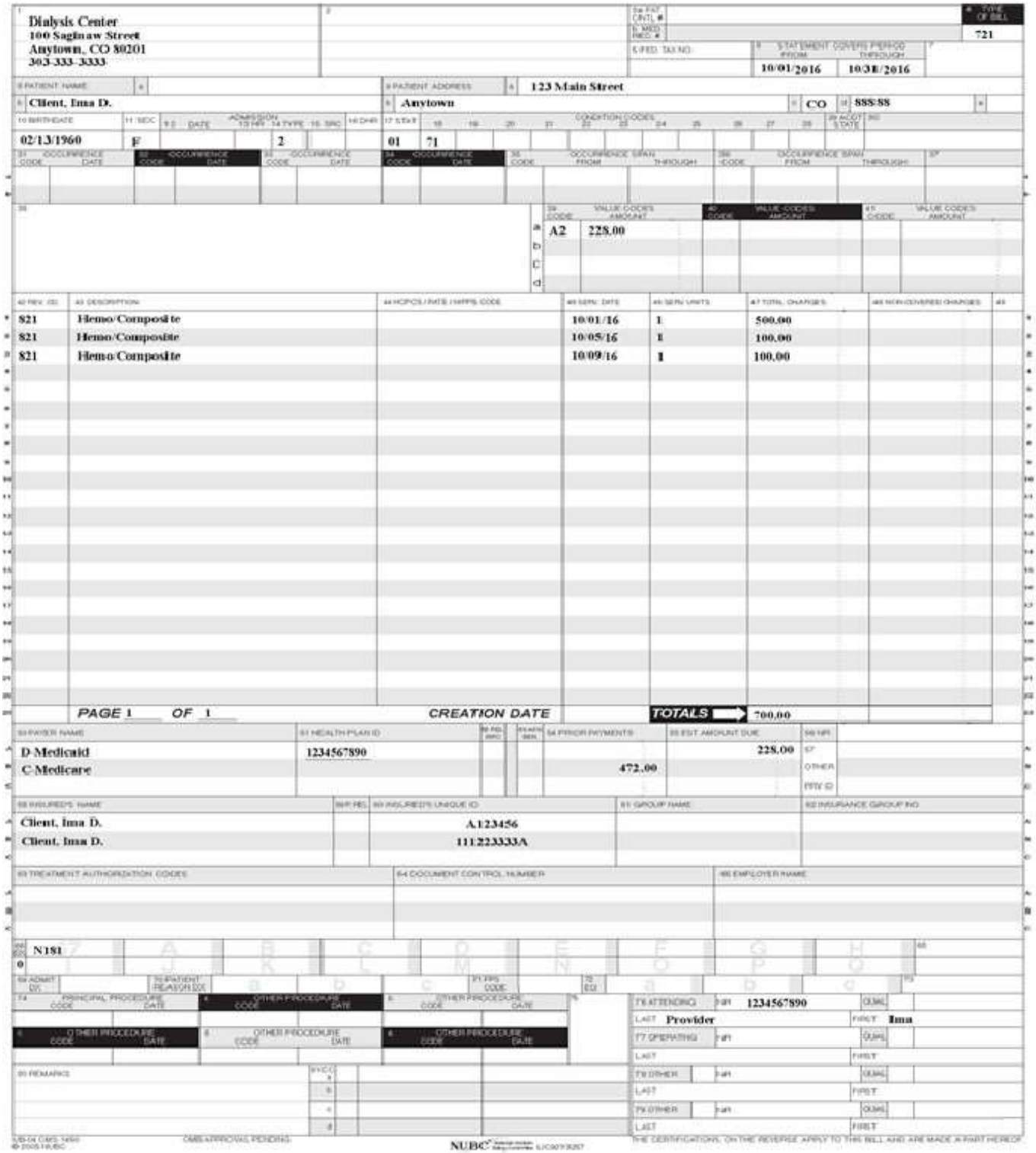
77 OPERATING
78 OTHER
79 OTHER

80 REMARKS:

NUBC

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

Dialysis UB-04 Crossover Claim Example



Dialysis Center
100 Saginaw Street
Anytown, CO 80201
303-333-3333

TYPE OF BILL: 721

STATEMENT COVERS PERIOD: FROM 10/01/2016 THROUGH 10/31/2016

PATIENT NAME: Client, Ima D.

PATIENT ADDRESS: 123 Main Street; Anytown; CO; 88888

BIRTHDATE: 02/13/1960 | SEX: F | ADMISSION DATE: | HR: | TYPE: 2 | SRC: | DHR: | STAT: 01 | CONDITION CODES: 71

VALUE CODES: A2 228.00

REV. CD.	DESCRIPTION	HCPCS/RATE/HIPPS CODE	SERV. DATE	SERV. UNITS	TOTAL CHARGES	NON-COVERED CHARGES
821	Hemo/Composite		10/01/16	1	500.00	
821	Hemo/Composite		10/05/16	1	100.00	
821	Hemo/Composite		10/09/16	1	100.00	
	PAGE 1 OF 1	CREATION DATE		TOTALS	700.00	

PAYER NAME	HEALTH PLAN ID	PRIOR PAYMENTS	EST. AMOUNT DUE
D-Medicaid	1234567890		228.00
C-Medicare		472.00	

INSURED'S NAME	INSURED'S UNIQUE ID	GROUP NAME	INSURANCE GROUP NO.
Client, Ima D.	A123456		
Client, Ima D.	111223333A		

N181

ATTENDING: NPI 1234567890 LAST Provider FIRST Ima

OPERATING: NPI QUAL LAST FIRST

OTHER: NPI QUAL LAST FIRST

OTHER: NPI QUAL LAST FIRST

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

NUBC

COLORADO
Department of Health Care Policy & Financing

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.

Timely Filing

The Health First Colorado allows providers to document compliance with timely filing requirements when the initial timely filing period has expired. Health First Colorado providers have 120 days from the date of service to submit their claim. For information on the 60-day resubmission rule for denied/rejected claims, please see the General Provider Information manual in the Provider Services Billing Manuals section.

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

Dialysis Revisions Log

Revision Date	Additions/Changes	Pages	Made by
12/01/2016	*Manual revised for interChange implementation. For manual revisions prior to 12/01/2016, please refer to Archive.*	*All*	*HPE (now DXC)*
12/27/2016	*Updates based on Colorado iC Stage II Provider Billing Manual Comment Log v0_2.xlsx*	*Multiple*	*HPE (now DXC)*
1/10/2017	*Updates based on Colorado iC Stage Provider Billing Manual Comment Log v0_3.xlsx*	*Multiple*	*HPE (now DXC)*
1/19/2017	*Updates based on Colorado iC Stage Provider Billing Manual Comment Log v0_4.xlsx*	*Multiple*	*HPE (now DXC)*
1/26/2017	*Updates based on Department 1/20/2017 approval email*	*Accepted tracked changes throughout*	*HPE (now DXC)*
3/13/2017	*Updated the Type of Bill section in the Paper Claims Table to reflect the NUBC manual*	*8*	*RC*
5/26/2017	*Updates based on Fiscal Agent name change from HPE to DXC*	*1*	*DXC*

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.*