

# **Dialysis**

Dialysis ..... 2

Billing Information..... 2

Dialysis Benefits..... 2

Reimbursement ..... 4

UB-04 Paper Claim Reference Table..... 7

Institutional Provider Certification ..... 30

Timely Filing..... 31

Dialysis Revisions Log..... 32

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## **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.

Health First Colorado provides hemodialysis and peritoneal dialysis benefits to eligible members in outpatient, state-approved freestanding dialysis treatment centers and 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 of 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 Code of Colorado Regulations, [Program Rules](#) (10 C.C.R. 2505-10 8.310), 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**

Refer to the [General Provider Information manual](#) for general billing information.

## **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:**

#### **State-Approved Dialysis Treatment Center**

A dialysis treatment center is an independent, free-standing center or a department of a licensed hospital enrolled as a dialysis center that is planned, organized, operated, and maintained to provide outpatient hemodialysis treatment and/or training for home use of hemodialysis or peritoneal 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;
- The eligible member is not a proper candidate for self-treatment in a home environment;
- The home environment of the eligible member contraindicates self-treatment; or,
- The eligible member is awaiting a kidney transplant.

## Home Dialysis

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

The participating dialysis center shall be responsible for the provision and maintenance of all equipment and necessary fixtures required for home dialysis and the provision of all supplies.

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

Training must be provided by qualified personnel of a hospital with a separate dialysis center or by qualified personnel of an independent, free-standing dialysis treatment center.

The participating dialysis center must provide and install quality hemodialysis equipment or peritoneal 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.

Any facility providing regularly scheduled, outpatient dialysis treatments or billing for supplies necessary to perform the various types of home dialysis treatments shall apply for a separate Health First Colorado Provider ID. Such provider shall be designated solely for the purpose of claims submission for dialysis services.

## Emergency Medicaid & End-Stage Renal Disease

Effective February 1, 2019, Health First Colorado considers End-Stage Renal Disease (ESRD) to be an emergency medical condition.

Emergency Medical Condition is defined as "a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

- (A) Placing the patient's health in serious jeopardy,
- (B) Serious impairment to bodily function, or
- (C) Serious dysfunction of any bodily organ or party." 42 U.S.C. § 1396b(v)(3); Colorado Revised Statutes § 24-76.5-102(1).

Recipients of Emergency Medicaid Services can receive care and services related to the treatment of ESRD at independent, free-standing dialysis centers.

Dialysis is not a covered benefit in the outpatient hospital setting.

Home dialysis is not a covered benefit for recipients of Emergency Medicaid.

For emergency services billing guidance, please refer to the [General Provider Information Manual](#).

Additional information about this policy change is located on the [Department's Special Interest Meeting website](#).

## **Reimbursement**

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

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.

### **Routine v. Non-Routine Services**

Routine services performed with the dialysis treatment shall be considered part of the composite rate and billed on the UB-04 claim form or electronically on the 837I transaction.

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

Non-routine 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 applies to services provided in either an independent, free-standing dialysis center or a separate dialysis center in the 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

## **Laboratory Services**

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

## Routine Labs / Procedures

Hematocrit	Serum Bicarbonate
All Hematocrit and Clotting time tests	Serum Creatinine
Hemoglobin	Serum Calcium
White Blood Count	Serum Albumin
Red Blood Count	Serum Chloride
Reticulocyte	Serum Phosphorous
Platelet Count	Serum Potassium
CBC	Serum Aluminum
BUN	Serum Ferritin
CO2	Serum Sodium
Electrolyte panel	Magnesium
Metabolic panel	Vitamin D
Renal function panel	Iron
Hepatic function panel	Transferrin
Total Protein	Automated battery of tests (SMA-12)
Dialysate Protein	Saline Flush
Bicarbonate Dialysate	Specimen Collection
Alkaline Phosphatase	
Assay of Parathormone	
Lactate Dehydrogenase (LDH)	
Aspartate Aminotransferase (AST) or	
Serum Glutamic-Oxaloacetic	
Transaminase	

## Routine Drugs

Heparin  
 Hematinics  
 Darbepoetin alfa, Epoetin alfa, or  
 Epogen  
 Iron dextran, Iron sucrose, Sodium  
 ferric gluconate complex in sucrose  
 injection, or Ferumoxytol  
 Calcitriol  
 Doxercalciferol  
 Paricalcitol  
 Oxygen  
 Parsabiv (etelcalcetide)

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 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.

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
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<b>1. Billing Provider Name, Address, Telephone Number</b>	Text	<p>Required</p> <p>Enter the provider or agency name and complete mailing address of the provider who is billing for the services:</p> <p style="padding-left: 40px;">Street/Post Office box</p> <p style="padding-left: 40px;">City</p> <p style="padding-left: 40px;">State</p> <p style="padding-left: 40px;">Zip Code</p> <p>Abbreviate the state using standard post office abbreviations. Enter the telephone number.</p>
<b>2. Pay-to Name, Address, City, State</b>	Text	<p>Required only if different from FL 1.</p> <p>Enter the provider or agency name and complete mailing address of the provider who will receive payment for the services:</p> <p style="padding-left: 40px;">Street/Post Office box</p> <p style="padding-left: 40px;">City</p> <p style="padding-left: 40px;">State</p>



Form Locator and Label	Completion Format	Instructions
		Zip Code Abbreviate the state using standard post office abbreviations.
<b>3a. Patient Control Number</b>	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).
<b>3b. Medical Record Number</b>	17 digits	Optional Enter the number assigned to the member to assist in retrieval of medical records.
<b>4. Type of Bill</b>	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  <u>Digit 1</u> <u>Type of Facility</u> 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)
<b>4. Type of Bill (continued)</b>	3 digits	<u>Digit 2</u> <u>Bill Classification (Except clinics &amp; special facilities):</u> 1   Inpatient (Including Medicare Part A) 2   Inpatient (Medicare Part B only) 3   Outpatient

Form Locator and Label	Completion Format	Instructions
		<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 019X required with this bill type)</p> <p>8 Swing Beds</p> <p>9 Other</p> <p><u>Digit 2 Bill Classification (Clinics Only):</u></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 <u>C</u>omprehensive <u>O</u>utpatient <u>R</u>ehabilitation <u>F</u>acilities (CORFs)</p> <p>6 Community Mental Health Center</p> <p><u>Digit 2 Bill Classification (Special Facilities Only):</u></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>

<b>4. Type of Bill (continued)</b>	3 digits	<u>Digit 3</u> <u>Frequency:</u> 0    Non-Payment/Zero Claim 1    Admit through discharge claim 2    Interim - First claim 3    Interim - Continuous claim 4    Interim - Last claim 7    Replacement of prior claim 8    Void of prior claim
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<b>Form Locator and Label</b>	<b>Completion Format</b>	<b>Instructions</b>
<b>5. Federal Tax Number</b>	None	Submitted information is not entered into the claim processing system.
<b>6. Statement Covers Period – From/Through</b>	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.
<b>8a. Patient Identifier</b>		Submitted information is not entered into the claim processing system.
<b>8b. Patient Name</b>	Up to 25 characters: Letters & spaces	Required Enter the member's last name, first name and middle initial.
<b>9a. Patient Address – Street</b>	Characters Letters & numbers	Required Enter the member's street/post office as determined at the time of admission.
<b>9b. Patient Address – City</b>	Text	Required Enter the member's city as determined at the time of admission. Submitted information is not entered into the claim processing system.
<b>9c. Patient Address – State</b>	Text From: 6 digits MMDDYY Through: 6 digits MMDDYY	Required Enter the member's state as determined at the time of admission.
<b>9d. Patient Address – Zip</b>	Digits	Required Enter the member's zip code as determined at the time of admission.
<b>9e. Patient Address – Country Code</b>	Digits	Optional
<b>10. Birthdate</b>	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.
<b>11. Patient Sex</b>	1 letter	Required

Form Locator and Label	Completion Format	Instructions
		Enter an M (male) or F (female) to indicate the member's sex. Required
<b>12. Admission Date</b>		Not required
<b>13. Admission Hour</b>		Not required
<b>14. Admission Type</b>		Not required
<b>15. Source of Admission</b>		Required
<b>16. Discharge Hour</b>		Not Required
<b>17. Patient Discharge Status</b>	2 digits	Required Dialysis must use code 01.
<b>18-28. Condition Codes</b>	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
<b>29. Accident State</b>	1 letter	Optional
<b>31-34. Occurrence Code/Date</b>	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
		<ul style="list-style-type: none"> <li>1 Accident/Medical Coverage</li> <li>2 Auto Accident - No Fault Liability</li> <li>3 Accident/Tort Liability</li> <li>4 Accident/Employment Related</li> <li>5 Other Accident/No Medical Coverage or Liability Coverage</li> <li>6 Crime Victim</li> <li>20 Date Guarantee of Payment Began</li> <li>24* Date Insurance Denied</li> <li>25* Date Benefits Terminated by Primary Payer</li> <li>26 Date Skilled Nursing Facility Bed Available</li> <li>27 Date of Hospice Certification or Re-certification</li> <li>40 Scheduled Date of Admission (RTD)</li> <li>50 Medicare Pay Date</li> <li>51 Medicare Denial Date</li> <li>53 No longer used</li> <li>55 Insurance Pay Date</li> </ul>
<b>31-34. Occurrence Code/Date</b> (continued)	2 digits and 6 digits	<ul style="list-style-type: none"> <li>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</li> <li>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</li> <li>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</li> </ul> <p><i>*Other Payer occurrence codes 24 and 25 must be used when applicable. T Not Required Not required</i></p>

Form Locator and Label	Completion Format	Instructions
<b>35-36. Occurrence Span Code From/ Through</b>	None	Leave blank
<b>38. Responsible Party Name/ Address</b>	None	Leave blank
<b>39-41. Value Code and Amount</b>	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.</p> <p>Never enter negative amounts. Codes must be in ascending order.</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"> <li>01 Most common semiprivate rate (Accommodation Rate)</li> <li>06 Medicare blood deductible</li> <li>14 No fault including auto/other</li> <li>15 Worker's Compensation</li> <li>31 Member Liability Amount</li> <li>32 Multiple Member Ambulance Transport</li> </ul>

<b>39-41. Value Code and Amount</b> (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 <i>Enter the deductible amount applied by indicated payer:</i> A1 Deductible Payer A
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Form Locator and Label	Completion Format	Instructions
		<p>B1 Deductible Payer B                      C1 Deductible Payer C</p> <p><i>Enter the amount applied to member's co-insurance by indicated payer:</i></p> <p>A2 Coinsurance Payer A B2                      Coinsurance Payer B C2                      Coinsurance Payer C</p> <p><i>Enter the amount paid by indicated payer:</i></p> <p>A3 Estimated Responsibility Payer A B3                      Estimated Responsibility Payer B C3                      Estimated Responsibility Payer C</p>
<p><b>42. Revenue Code 35-36. Occurrence Span Code From/ Through 18-28. Condition Codes</b></p>	<p>4 digits</p>	<p>Required</p> <p>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 <a href="#">Billing Manuals</a> section at for valid dialysis revenue codes.</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. Leave blank</p> <p>Conditional</p> <p>Complete with as many codes necessary to identify conditions related to this bill.</p> <p><u>Condition Codes</u></p> <p>06 ESRD member – First 18 months entitlement</p> <p><u>Renal dialysis settings</u></p> <p>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</p>

Form Locator and Label	Completion Format	Instructions												
<p><b>43. Revenue Code Description</b></p>	<p>Text</p>	<p>Required</p> <p>Enter the revenue code description or abbreviated description.</p> <p>When reporting an NDC:</p> <ul style="list-style-type: none"> <li>▪ Enter NDC qualifier N4 in the first two positions on the left side of the field, immediately followed by the 11-digit NDC numeric code.</li> <li>▪ Enter one space for separation.</li> <li>▪ Enter the appropriate qualifier for the correct dispensing NDC unit of measure (UN – Units, ML – Milliliter, GR – Gram, or F2 – International Unit)</li> <li>▪ Enter one period for separation.</li> <li>▪ Enter the quantity (number of NDC units).</li> </ul> <p>Example:</p> <table border="1" data-bbox="834 915 1513 1066"> <thead> <tr> <th></th> <th>42 REV. CD.</th> <th>43 DESCRIPTION</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>0636</td> <td>N467066000501 ME.016</td> </tr> <tr> <td>2</td> <td></td> <td></td> </tr> <tr> <td>3</td> <td></td> <td></td> </tr> </tbody> </table>		42 REV. CD.	43 DESCRIPTION	1	0636	N467066000501 ME.016	2			3		
	42 REV. CD.	43 DESCRIPTION												
1	0636	N467066000501 ME.016												
2														
3														
<p><b>44. HCPCS/Rates/HIPPS Rate Codes</b></p>	<p>5 digits</p>	<p>Conditional</p>												

Form Locator and Label	Completion Format	Instructions
		<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><b>Services Requiring HCPCS</b></p> <p>Anatomical Laboratory: Bill with TC modifier Hospital Based Transportation</p> <p>Outpatient Laboratory: Use only HCPCS 80000s - 89000s.</p> <p>Outpatient Radiology Services</p> <p>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 <a href="#">Bulletins</a> section of the website.</p> <p>With the exception of outpatient lab and hospital-based transportation, outpatient radiology services can be billed with other outpatient services.</p> <p>HCPCS codes must be identified for the following revenue codes:</p> <p>030X Laboratory</p> <ul style="list-style-type: none"> <li>• 032X Radiology – Diagnostic</li> <li>• 033X Radiology – Therapeutic</li> <li>• 034X Nuclear Medicine</li> <li>• 035X CT Scan</li> <li>• 040X Other Imaging Services</li> <li>• 042X Physical Therapy</li> <li>• 043X Occupational Therapy</li> <li>• 054X Ambulance</li> <li>• 061X MRI and MRA</li> </ul> <p>HCPCS codes cannot be repeated for the same date of service. Combine the units in FL 46 (Units) to report multiple services.</p>

Form Locator and Label	Completion Format	Instructions
<b>45. Service Date</b>	6 digits	<p>Conditional</p> <p>For span bills only</p> <p>Enter the date of service using MMDDYY format for each detail line completed.</p> <p>Each date of service must fall within the date span entered in the "Statement Covers Period" (FL 6).</p>
<b>46. Service Units</b>	3 digits	<p>Required</p> <p>Enter a unit value on each line completed. Use whole numbers only. Do not enter fractions or decimals and do not show a decimal point followed by a 0 to designate whole numbers (e.g., Do not enter 1.0 to signify one unit)</p> <p>For span bills, the units of service reflect only those visits, miles or treatments provided on dates of service in FL 45.</p>
<b>47. Total Charges</b>	9 digits	<p>Required</p> <p>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.</p>
<b>48. Non-Covered Charges</b>	9 digits	<p>Required</p> <p>Enter incurred charges that are not payable by the Health First Colorado.</p> <p>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.</p> <p>Non-covered charges cannot be billed for outpatient hospital laboratory or hospital based transportation services.</p>
<b>50. Payer Name</b>	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 (1) line must indicate The Health First Colorado.</p> <p>Source Payment Codes</p>

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
<b>51. Health Plan ID</b>	10 digits	Required Enter the provider's Health Plan ID for each payer name. Enter the NPI number assigned to the <b>billing provider</b> . Payment is made to the enrolled provider or agency that is assigned this number.
<b>52. Release of Information</b>	None	Submitted information is not entered into the claim processing system.
<b>53. Assignment of Benefits</b>	None	Submitted information is not entered into the claim processing system.
<b>54. Prior Payments</b>	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
<b>55. Estimated Amount Due</b>	Up to 9 digits	<p>Conditional</p> <p>Complete when there are Medicare or third party payments.</p> <p>Enter the net amount due from The Health First Colorado after provider has received other third party, Medicare or member liability amount on the Health First Colorado line.</p> <p><b>Medicare Crossovers</b></p> <p>Enter the sum of the Medicare coinsurance plus Medicare deductible less third party payments and member liability amount.</p>
<b>56. National Provider Identifier (NPI)</b>	10 digits	<p>Required</p> <p>Enter the billing provider's 10-digit National Provider Identifier (NPI).</p>
<b>57. Other Provider ID</b>	10 digits	Submitted information is not entered into the claim processing system.

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

<b>62. Insurance Group Number</b>	17 digits	Conditional Complete when there is third party coverage.
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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.
<b>63. Treatment Authorization Code</b>	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.
<b>64. Document Control Number</b>		Conditional
<b>65. Employer Name</b>	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).
<b>66. Diagnosis Version Qualifier</b>		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)
<b>67. Principal Diagnosis Code</b>	Up to 6 digits	Not required
<b>67A- 67Q. Other Diagnosis</b>	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.
<b>69. Admitting Diagnosis Code</b>	6 digits	Not Required

Form Locator and Label	Completion Format	Instructions
<b>70. Patient Reason Diagnosis</b>		Not Required
<b>71. PPS Code</b>		Not Required
<b>72. External Cause of Injury Code (E-code)</b>	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".
<b>74. Principal Procedure Code/ Date</b>	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.
<b>74A. Other Procedure Code/Date</b>	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.
<b>76. Attending NPI – Required Attending- Last/ First Name</b>	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 <u>cannot</u> 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
		<p>ID form locator if the locum tenens physician is not enrolled in the Health First Colorado.</p> <p>Enter the attending physician's last and first name.</p> <p>This form locator must be completed for all services.</p>
<b>77. Operating-NPI/</b>		<p>Not required</p> <p>Submitted information is not entered into the claim processing system.</p>
<b>78-79. Other ID NPI – Conditional</b>	NPI - 10 digits	<p>Conditional –</p> <p>Complete when attending physician is not the PCP or to identify additional physicians.</p> <p>Ordering, Prescribing, or Referring NPI - when applicable</p> <p>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.</p> <p>The attending physician's last and first name are optional.</p>
<b>80. Remarks</b>	Text	<p>Enter specific additional information necessary to process the claim or fulfill reporting requirements.</p>
<b>81. Code-Code-QUAL/CODE/VALUE (a-d)</b>		<p>Submitted information is not entered into the claim processing system.</p>



# Dialysis UB-04 Crossover Claim Example

1 <b>Dialysis Center</b> 100 Saginaw Street Anytown, CO 80201 303-333-3333	2	3a PAT CONT # 3b MED REC #	4 TYPE OF BILL 721
5 FED TAX NO.	6 STATEMENT COVERED PERIOD FROM 10/01/2016	7 STATEMENT COVERED PERIOD THROUGH 10/31/2016	
8 PATIENT NAME Client, Ima D.	9 PATIENT ADDRESS 123 Main Street	10 CO	11 SSN 888-88
10 BIRTHDATE 02/13/1960	11 SEC F	12 DATE 2	13 ADMISSION 13 MTH 14 TYPE 15. SRC 16 DHS
17 STAT 01	18 19 20 21	22 CONDITION CODES	23 24 25 26 27 28 29 ACCT STATE 30
31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE
35 OCCURRENCE CODE	36 OCCURRENCE SPAN FROM THROUGH	37 OCCURRENCE SPAN FROM THROUGH	38 OCCURRENCE SPAN FROM THROUGH
39 CODE	40 VALUE CODES AMOUNT	41 VALUE CODES AMOUNT	42 VALUE CODES AMOUNT
43 REV CD	44 DESCRIPTION	45 HCPCS / RATE / HPPS CODE	46 SERV DATE
47 SERV UNITS	48 TOTAL CHARGES	49 NON-COVERED CHARGES	50
821	Hemo/Composite		10/01/16
821	Hemo/Composite		10/05/16
821	Hemo/Composite		10/09/16
PAGE 1 OF 1	CREATION DATE	TOTALS	700.00
50 PAYER NAME D-Medicatd C-Medicare	51 HEALTH PLAN ID 1234567890	52 REL INFO	53 AKA BEN
54 PRIOR PAYMENTS 472.00	55 EST AMOUNT DUE 228.00	56 NPI	57 OTHER PFTY ID
58 INSURED'S NAME Client, Ima D.	59 REL	60 INSURED'S UNIQUE ID A123456 111223333A	61 GROUP NAME
62 INSURANCE GROUP NO	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
66 N181	67 A	68 B	69 C
70 D	71 E	72 F	73 G
74 PRINCIPAL PROCEDURE CODE DATE	75 OTHER PROCEDURE CODE DATE	76 ATTENDING I-PT 1234567890	77 OPERATING I-PT
78 OTHER I-PT	79 OTHER I-PT	LAST Provider	FIRST Ima
80 REMARKS	81 HC	LAST	FIRST
	82	LAST	FIRST
	83	LAST	FIRST
	84	LAST	FIRST

UB-04 CMS-1450 © 2009 HUBC OMS APPROVAL PENDING NUBC® Billing Manual LIC8019307 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

## **Institutional Provider Certification**

The Institutional Provider Certification form can be found on the Department's [Provider Forms web page](#) under the Claim Forms and Attachments drop-down.

## **Timely Filing**

For more information on timely filing policy, including the resubmission rules for denied claims, please see the [General Provider Information manual](#).

## Dialysis Revisions Log

<b>Revision Date</b>	<b>Additions/Changes</b>	<b>Pages</b>	<b>Made by</b>
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
1/2/2018	Revenue Code Submission Update - instructions for reporting an NDC	15	DXC
6/25/2018	Updated billing and timely to point to general manual	2, 28	HCPF
6/28/2018	Minor formatting edit	10	HCPF
1/22/18	Many updates and clarifications were made throughout the billing manual. A section about "Emergency Medicaid & End-Stage Renal Disease" was added. The list of routine labs, procedures, and drugs was expanded.	Throughout	HCPF



**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.*