Nursing Facility

Nursing Facility

The Department periodically modifies billing information therefore, the information in this manual is subject to change, and the manual is updated as new billing information is implemented. The following information is effective March 1, 2017. Refer to the archives for previous billing manual.

How to Use the Manual

This manual should be used in conjunction with the General Provider Information manual.

- The General Provider Information manual contains Health First Colorado information common to all provider types, including eligibility, covered services, and provider enrollment and participation guidelines.
- The Nursing Facility Billing manual is a UB-04 Specialty manual and contains provider specific benefit, procedural, and billing information for providers.

Updated Health First Colorado information is published in the Health First Colorado Bulletins.

Nursing Facility Overview

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 Nursing Facility program provides skilled and maintenance services to members meeting long-term care guidelines. Long-term guidelines are based on a member's functional needs assessment in several areas.

Providers should refer to the Code of Colorado Regulations, Program Rules (10 C.C.R. 2505-10), for specific information when providing nursing facility care. See Section 8.

Provider Participation

Revalidation Information

Federal regulations established by the Centers for Medicare and Medicaid (CMS) require enhanced screening and revalidation for all existing (and newly enrolling) providers. These regulations are designed to increase compliance and quality of care, and to reduce fraud.

Failure to respond to a revalidation request or requirement may result in provider suspension or termination.

This means that every Medicaid provider must be validated and/or re-validated by the Department before the provider can receive payment from the Department.

In 2016/2017, the initial revalidation process was completed by the Department.

Enrollment Information Accuracy

Providers are responsible for: 1) Furnishing accurate enrollment information; 2) Confirming the accuracy of the fiscal agent's enrollment information; 3) Maintaining up-to-date enrollment

information via the Provider Web Portal; and 4) Responding to requests from the fiscal agent for updated enrollment information.

Providers who are also enrolled in the Medicare Program should update their enrollment information online immediately when Medicare billing information is changed.

All enrollment changes must be made online through the Provider Web Portal. Telephoned requests cannot be accepted.

Refer to the General Provider Information manual for further information on provider re-certification, termination of enrollment and inactive enrollment.

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.

The NPI must be used to submit claims and to communicate with the Health First Colorado.

Change of Ownership (CHOW) or Change in Tax Identification Number

A change of ownership or a change of tax ID number terminates the Medical Assistance Program Provider Participation Agreement. A copy of the current Provider Participation Agreement can be found on the Department's Provider Enrollment web page.

A change of ownership requires the new owner(s) to submit an application, complete a new Medical Assistance Program Provider Participation Agreement, and be fully approved in order to participate in Health First Colorado.

Providers with a change in tax ID number must re-apply, complete a new Medical Assistance Program Provider Participation Agreement, and be fully approved in order to participate in the Health First Colorado.

Refer to Department rule 10 C.C.R. 2505-10, section 8.443 for further CHOW requirements.

- Notice must be given to the Department's Nursing Facility Operations Specialist at least 45 days before the change is to occur.
- The NPI should not be transferred between providers when a change of ownership (CHOW) takes place.
- New owner must have their own Medicaid billing number before they can bill Medicaid.

Provider Web Portal Registration Information

New providers must register in the fiscal agent's Online Portal before they can access provider information and claim information. Refer to the Provider Enrollment Web page on the Department's website.

General Claim Information

(Also refer to the General Information Manual)

Claim Formats

Electronic claims format shall be required unless hard copy claims submittals are specifically prior authorized by the Department. Requests may be sent to the fiscal agent, DXC Technology (DXC), P.O. Box 30, Denver, Colorado 80201-0030.

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 (www.wpc-edi.com/)
- Companion Guides for the 837P, 837I or 837D EDI support section of the Department's website (edi-support)
- Provider Web 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. See the General Provider Information manual for additional electronic information.

Paper Claims

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
    - Note: Attachments may be sent electronically
- Reconsideration claims

Paper claims require an NPI. 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."

In addition, the UB-04 Certification document must be completed and attached to all claims submitted on the paper UB-04. Refer to the General Provider Information manual for a copy of the UB-04 Certification document.

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 compliance 837P (Professional), 837I (Institutional), and 837D (Dental) claims electronically one at a time. These claims are transmitted through the Health First Colorado Online Portal (Online Portal).

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

The Online Portal 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 Online Portal 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 the claim 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:

- X12N 999 Functional Acknowledgement
- 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 Claim 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 member 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 Department's fiscal agent. Any entity sending electronic transactions through the Health First Colorado file delivery and retrieval system secure website (SFTP) - for processing or the Provider Web Portal - where reports and responses will be delivered must complete an EDI Trading Partner enrollment. This provides EDI the information necessary to assign a Logon Name, Logon ID, and Trading Partner ID, which are required to submit electronic transactions, including claims.

The X12N 837P, 837I, or 837D transaction data may be submitted via SFTP or Provider Web Portal, each which validates submission of American National Standards Institute (ANSI) X12N format(s). The TA1 Interchange Acknowledgement reports the syntactical analysis of the interchange header and trailer. If the data is corrupt or the trading partner relationship does not exist within the interChange System, the interchange will reject and a TA1 will be made available for research and correction. An X12N 999 Functional Acknowledgement is generated when a file that has passed the header and trailer check passes through X12 validation.

If the file contains syntactical error(s), the segment(s) and element(s) where the error(s) occurred will be reported.

Testing and Vendor Certification

Completion of the testing process must occur prior to submission of electronic batch claims to Production interChange. The EDI testing packet and Companion Guides may be downloaded from EDI Support.

Assistance from the EDI helpdesk is available throughout this process. Each test transmission is inspected thoroughly to ensure no formatting errors are present. Testing is conducted to verify the integrity of the format, not the integrity of the data; however, in order to simulate a production environment, EDI requests that providers send real transmission data.

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

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 provider 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 refer to the General Provider Information manual.

Refer to the General Provider Information manual in the Provider Services Billing Manuals section for more details.

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.

Health First Colorado claims must be filed in a timely manner. A claim is considered to be filed when the fiscal agent documents **receipt** of the claim.

With few exceptions, electronic claims can be submitted twenty-four hours a day, seven days a week. Electronic claim receipt is documented by the assignment of an Internal Control Number (ICN). Electronic acceptance and rejection messages include the transaction date.
Paper claim receipt is documented by the fiscal agent's date stamp or the imprinted ICN.

Holidays, weekends, and dates of business closure do not extend the timely filing period.

Dated claim signatures, computerized or clerically prepared claim listings, and/or postmarks and certified mail receipts do not constitute proof of receipt for timely filing purposes.

The provider is responsible for assuring that each claim is received within the timely filing period. With the exceptions of paper claims that are returned to the provider because of missing information and rejected electronic claims, all claims filed with the fiscal agent appear on the RA as paid, denied, or "in process" within 30 days of receipt. If claim information does not appear on the RA within 30 days of an electronic transmission or paper claim mailing, the provider is responsible for contacting the fiscal agent to determine the status of the claim and **resubmitting the claim if necessary.**

Agent or software failure to transmit accurate and acceptable claims or failure to identify transmission errors in a timely manner needs to be resolved between the provider and the agent or software vendor. Failure to comply with filing requirements -including timely filing - because of software product failure or the action (or inaction) of a billing agent are not recognized as extenuating circumstances beyond the provider's control.

Original Timely Filing

Timely filing for Health First Colorado claim submission is **120 days from the date of service**.

Type of Service	Timely Filing Calculation
Nursing Facility; Home Health, Inpatient, Outpatient; all services filed on the UB-04	From the "through" date of service
Dental; EPSDT; Supply; Pharmacy; All services filed on the CMS 1500	From the date of each service (line item)
Home & Community Based Services	From the "through" date of service
Obstetrical services professional fees Global procedure codes: The service date must be the delivery date.	From the delivery date
Services billed separately; additional services	From date of service
Equipment rental - The service date must be the last day of the rental period	From the date of service

Crossover Claims

Nursing facility care is a Health First Colorado benefit only after the member's eligibility requirements have been satisfied. Refer to the General Eligibility Member Requirements section below.

Refer to the General Provider Information manual for more detailed information on Crossover Benefits.

Medicare Crossover Claims

When the member is dually eligible (both Medicare/ Health First Colorado eligible), most claims for nursing facility services are automatically electronically transferred from Medicare to the Health First Colorado. This is known as a "crossover."

If a crossover claim does not appear on the Medical Assistance Program Remittance Advice (RA) within 30 days after the Medicare processing date, a provider must submit the crossover either electronically through the Provider Web Portal or on paper.

Nursing facility services are a Medicare Part A benefit if the member is discharged after a hospital stay of at least three days, and qualifies for skilled nursing care as defined by Medicare. Some services for nursing facility residents may qualify for Medicare Part B coverage.

Medicare Part A Crossover Claims

Medicare Part A reimburses the first through the 20th day of the Nursing Facility stay at 100% of the Medicare allowed rate. The 21st through the 100th day are subject to a coinsurance amount per day.

The Health First Colorado uses the "lower of" pricing formula to process the coinsurance amount.

Please note the proper completion of the following UB-04 form locators (FL) when submitting a Medicare Part A paper-based crossover claim:

Form Locator	Instructions
39-41	Value Codes/Amount – Enter the appropriate value code and related dollar amount that identifies Medicare Coinsurance and Medicare payment amount. A2 is the amount billed to Medicare Coinsurance; A3 is the amount Medicare paid
42	Revenue Code – Enter appropriate revenue code.
44	Rates – Enter Nursing Facility's Medicaid per diem rate.
50	Payer Name – Enter Health First Colorado on the appropriate payer line.
51	Health Plan ID – Enter the Nursing Facility's NPI number
60	Insured's Unique ID – Enter the Member's Medicaid State ID number

Medicare Part B Crossover Claims

Some dually eligible members do not qualify for comprehensive skilled nursing care as defined by Medicare, but do quality for certain nursing facility ancillary services (e.g., physical therapy). Medicare Part B processes benefit ancillary services. Part B services are subject to the Medicare annual deductible and reimbursed at 80% by Medicare.

Please note the proper completion of the following UB-04 form locators (FL) when submitting a Medicare Part B paper-based crossover claim:

Form Locator	Instructions
39-41	Value Codes/Amount – Enter the appropriate value code and related dollar amount that identifies Medicare Deductible, Medicare Coinsurance and Medicare payment amount. A1 is the deductible; A2 is the amount billed to Medicare Coinsurance; A3 is the amount Medicare paid
42	Revenue Code – Enter appropriate revenue code.
50	Payer Name – Enter Health First Colorado on the appropriate payer line.
51	Health Plan ID – Enter the Nursing Facility's NPI number
60	Insured's Unique ID – Enter the Member's Medicaid State ID number

Fraud, Waste and Abuse

Overpayments

The Health First Colorado is the payer of last resort. Regardless of the payment source, when providers receive payment from a third party for services that have previously been paid by the Health First Colorado, the Health First Colorado payment must be refunded immediately.

Providers must report all overpayments to the fiscal agent immediately. Overpayments are adjusted and recovered upon discovery even if the timely filing period has expired.

Refer to the General Provider Information manual for instructions on how to return overpayments or contact the Department's fiscal agent for instructions on specific circumstances.

Audits/Reviews

Providers must maintain records that support the accuracy of submitted claim information for a period of six years. Providers should document, date and sign notes about reported member discussions regarding nursing facility billing and personal needs account activities. Upon request, records must be submitted to the authorized requester for Health First Colorado audits and reviews. Failure to provide requested audit materials may result in sanctions and recovery of Health First Colorado payments.

General Member Eligibility Requirements

ULTC 100.2 and 5615 Forms

The Uniform Long-term Care (ULTC) 100.2 form must include medical information from the medical provider. Forms are filed by the SEP via the "Bridge" which directly interfaces with the Colorado interChange System. Access to the Bridge is accomplished via the Medicaid Enterprise User Provisioning System (MEUPS) which can be found at https://home.co-meups.xco.dcs-usps.com/home/.

The nursing facility (or hospital) completes only the Initial Screening and Intake and Professional Medical Information portions and submits these two portions of the form to the Single Entry Point (SEP). When the SEP completes the ULTC 100.2 and approves the care, a confirmation number is assigned and the approval is faxed to the nursing facility.

Approval of a ULTC 100.2 does not guarantee Health First Colorado payment and does not serve as a timely filing waiver. Authorization only assures that the approved service is a medical necessity and is considered a benefit of the Health First Colorado.

The County Income Maintenance Technician reviews and determines the financial eligibility of the member. The county updates CBMS with the member's financial information and sends the completed 5615 form to the nursing facility. The facility verifies member eligibility using the Online Portal and bills for dates of service.

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

Prior to March 1, 2017, a Nursing Facility Prior Authorization was created by the ULTC 100.2 and the 5615 form. After March 1, 2017, this prior authorization was discontinued as the ULTC 100.2 and 5615 form information is systematically matched. Additionally, the member's program aid code is "MJ", indicating the applicable level of care.

Member Liability Amount

The Member Liability Amount is payment made by the member for nursing facility care, after the personal needs allowance and other approved expenses are deducted from the member's income.

The County Income Maintenance Technicians determine the member liability amount by identifying the personal needs allowance amount and other approved deductions. The 5615 form is used to communicate the calculated amount to the facility.

Refer to program rules for more details on the 5615 form, facility responsibilities and county responsibilities. Section 8.400-8.499.

When reporting the member liability amount for the entire month, the full member liability amount must be applied to the member's care at the beginning of each month as Medicaid is the payer of last resort.

How to calculate member liability amount for a partial month

- Calculate the Health First Colorado amount by multiplying the number of days in the facility (excluding the date of discharge) times the per diem rate.
- If the Health First Colorado amount exceeds the member liability amount, the partial month's member liability amount remains the same as the regular member liability amount.
- If the member liability amount is more than the Health First Colorado amount, the partial month's member liability amount is considered the same as the Health First Colorado amount. The excess of the member liability amount over the partial month's member liability amount belongs to the member and, if it has already been paid to the facility, shall be refunded to the member.

Medical and Non-Medical Leave Days

Medical Leave Days

Medical leave days are days that the member is absent from the nursing facility due to an inpatient hospital stay or admittance to another institution (e.g. skilled bed payable by Medicare). Medical leave days must be ordered by a physician and documented in the member's medical record. Medical leave days must be tracked on the facility's daily census report.

Nursing facility medical leave days are not a Health First Colorado benefit.

Non-Medical Leave Days

Non-medical leave days are leave days from the nursing facility for non-medical reasons (e.g., visits to the homes of family or friends or absences for therapeutic and/or rehabilitative reasons.) The attending physician must approve the leave and certify that the leave is not contrary to the member's plan of care. Approval must be documented in the member's medical record. Non-medical leave days must be tracked on the facility's daily census report.

Excessive Non-Medical Leave Days

The Health First Colorado pays for a total of 42 non-medical leave days per calendar year. With physician approval, members may pay for room reservations in excess of the combined total of 42 non-medical leave days per calendar year. Approval must be documented in the member's medical record. Non-medical leave days must be tracked on the facility's daily census report.

Revenue Coding

The following tables identify the only valid revenue codes for billing nursing facility services to the Health First Colorado. Claims submitted with revenue codes that are not listed below are denied.

Nursing Facility Revenue Codes

Revenue Code	Description
0119	Private Room *
0129	Semi-Private Room
0182	Non-Medical Leave Days (member convenience/ therapeutic)
0185	Medical Leave Days (Hospitalization)
042X	Physical Therapy
043X	Occupational Therapy
044X	Speech Therapy

*Health First Colorado reimburses the facility for a member in a private room at the semi-private per diem rate. There is no additional reimbursement for a member in a private room.

Post Eligibility Treatment of Income/Incurred Medical Expenses (PETI/IME)

In addition to the above codes, seven State-specific revenue codes for PETI/IME can be billed on nursing facility claims. PETI/IME services include services that are medically necessary but

are not covered by the Health First Colorado (e.g., hearing aids, eye glasses). PETI/IME services are paid via the member's member liability amount.

PETI/IME services can only be billed on claims that have an accommodation line item revenue code and a member liability amount greater than zero.

As of March 1, 2017, all PETI/IME services must be prior authorized (PA) by the Department. All PETI/IME services must be submitted through the Online Portal for Department review and determination. A PA confirmation number is provided for tracking the status of the request. Once PA is approved by the Department, the provider can bill the PETI/IME service on the next claim containing a member liability amount greater than zero.

See the Prior Authorization PETI/IME Section below for further information.

PETI/IME Revenue Codes

Revenue Code	Description
0259	Non-covered Prescription Drugs
0479	Hearing and Ear Care
0949	Acupuncture
0962	Vision and Eye Care
0969	Dental Services *
0982	Other Outpatient Services
0999	Health Insurance Premiums and Other Approved Services

*Dental Services only applicable after the $1,000 State Benefit has been exhausted or Medicaid has denied the service.

UB-04 Paper Claim Reference Table

The information in the following table provides instructions for completing form locators (FL) as they appear on the paper UB-04 claim form. Instructions for completing the UB-04 claim form are based on the current *National Uniform Billing Committee (NUBC) UB-04 Reference Manual.* Unless otherwise noted, all data form locators on the UB-04 have the same attributes (specifications) for the 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 must be completed and attached to all claims submitted on the paper UB-04. Completed UB-04 paper Health First Colorado claims, including hardcopy Medicare claims, should be mailed to the correct fiscal agent address located in Appendix A of the Appendices in the Provider Services Billing Manuals section.

Do not submit "continuation" claims. Each claim form has a set number of billing lines available for completion. Do not crowd more lines on the form.

Billing lines in excess of the designated number are not processed or acknowledged. Claims with more than one page may be submitted through the Provider Web Portal.

You can bill with a date span (From and To dates of service) only if the service was provided every consecutive day within the span. The From and To dates must be in the same month.

The Paper Claim Reference Table below lists the required, optional and/or conditional form locators for submitting the paper UB-04 claim form to the Health First Colorado for nursing facility services.

Form Locator/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/PO Box, City, State, Zip Code.
2 – Pay-to Name, Address	Text	Required if different from FL 1. Enter service provider if different from billing provider.
3a – Patient Control Number	Up to 20 characters	Optional Enter information that identifies the member or claim in the provider's billing system. Submitted information appears on the Provider Claim Report.
3b – Medical Record Number	17 digits	Optional Enter the number assigned to the member to assist in retrieval of medical records.
4 – Type of Bill	3 digits	Required First two digits, use 21 for SNF Inpatient (IP) includes Medicare A 22 for SNF Inpatient (OP) Medicare B only 23 for SNF Outpatient (OP) 65 for ICF Level I (IP) 66 for ICF Level II (IP) Third digit must be one of the following: Frequency 1 – Admit thru Discharge Claim 2 – Interim – First Claim 3 – Interim – Continuing Claim 4 – Interim – Last Claim

Form Locator/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 Enter the From (beginning) date and the Through (ending) date of service covered by this bill using MM/DD/YY format. "From" date is the actual start date of services, and cannot be prior to the eligibility start date or is the first date of an interim bill. "From" date cannot be prior to the "admission date" reported in FL 12 "Through" date is the actual discharge date; or is the final date of an interim bill "From" and "Through" dates cannot exceed a calendar month (e.g., bill 01/15/17 thru 01/31/17 and 02/01/17 thru 02/15/17 rather than 01/15/17 thru 02/15/17. The end date of one eligibility period and the begin date of the following eligibility period cannot be billed on the same claim. If the member is admitted and discharged on the same date, that date appears in both form locators.
8a – Patient Identifier	Text	Required Enter the Medicaid ID number for the member.
8b – Patient Name	Up to 25 characters	Required Enter the member's last name, first name and middle initial.
9a – Patient Address – Street	Text	Required Enter the member's street/post office box exactly as it appears on the eligibility verification or as determined at the time of admission.

Form Locator/Label	Completion Format	Instructions
9b – Patient Address – City	Text	Required Enter the member's city exactly as it appears on the eligibility verification or as determined at the time of admission.
9c – Patient Address – State	Text	Required Enter the member's state exactly as it appears on the eligibility verification or as determined at the time of admission.
9d – Patient Address – Zip	Digits	Required Enter the member's zip code exactly as it appears on the eligibility verification or as determined at the time of admission.
9e – Patient Address – County 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. Use the birthdate that appears on the eligibility verification.
11 – Patient Sex	1 letter	Required Enter an M (male) or F (female) to indicate the member's sex.
12 – Admission Date	6 digits	Required Enter the date the member was admitted to the nursing facility using MM/DD/YY format.

Form Locator/Label	Completion Format	Instructions
13 – Admission Hour	6 digits	Optional Code — Time 00 — 12:00-12:59 am 01 — 1:00-1:59 am 02 — 2:00-2:59 am 03 — 3:00-3:59 am 04 — 4:00-4:59 am 05 — 5:00-5:59 am 06 — 6:00-6:59 am 07 — 7:00-7:59 am 08 — 8:00-8:59 am 09 — 9:00-9:59 am 10 — 10:00-10:59 am 11 — 11:00-11:59 am 12 — 12:00-12:59 pm 13 — 1:00-1:59 pm 14 — 2:00-2:59 pm 15 — 3:00-3:59 pm 16 — 4:00-4:59 pm 17 — 5:00-5:59 pm 18 — 6:00-6:59 pm 19 — 7:00-7:59 pm 20 — 8:00-8:59 pm 21 — 9:00-9:59 pm 22 — 10:00-10:59 pm 23 — 11:00-11:59 pm 99 — Unknown
14 – Admission Type	1 digit	Required 1 – Emergency 2 – Urgent 3 – Elective 9 – Information Not Available
15 – Source of Admission	1 digit	Required Complete if the member has been admitted or readmitted during the billing period. Use one of the following codes: 1 – Non-Health Care Facility Point of Origin 2 – Clinic or Physician Office 4 – Transfer from a Hospital/Different Facility 5* – Transfer from a SNF/ICF or ACF

Form Locator/Label	Completion Format	Instructions
		6 – Transfer from another Health Care Facility 8 – Court/Law Enforcement 9 – Information Not Available F – Transfer from Hospice or enrolled in Hospice *Use code 5 if the member is a nursing facility resident transfer or is changing from private pay to Health First Colorado pay.
16 – Discharge Hour	2 digits	Optional See FL 13 for valid codes.
17 – Patient Discharge Status	2 digits	Required Enter the appropriate member status code as of the discharge date or billing period "through" date. Use one of the following codes: 01 – Discharged to Home (Routine) 02 – Discharged to Hospital 03 – Discharged/Transferred to SNF 04 – Discharged/Transferred to Another Type of Institution 06 – Discharged/Transferred to organized Home and Community Based Services Program (HCBS) 07 – Left Against Medical Advice 20 – Deceased\Expired 30 – Still a Patient 50 – Discharged to Hospice – Home 64 – Discharged/Transferred to a nursing facility certified under the Health First Colorado but not certified under Medicare.

Form Locator/Label	Completion Format	Instructions
18-28 Condition Codes	2 digits	Conditional Enter the code that corresponds to the member's other resources for reimbursement. Use the following codes: 01 – Military Service Related 02 – Employment Related 03 – Other Insurance 05 – Lien Has Been Filed 06 – ESRD Member – 30 Months of Entitlement
29 Accident State		Optional
31-34 Occurrence Code / Date	Digits	Conditional Enter the appropriate code (2 digits) and the date of occurrence (MMDDYY) on which it occurred. 01 – Accident/Medical Coverage 02 – Auto Accident – No Fault Liability 03 – Accident/Tort Liability 04 – Accident/Employment Related 05 – Accident/No Medical 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 Recertification 40 – Scheduled Date of Admission (RTD) 42 – Date of Discharge 55 – Date of Death A3 – Benefits Exhausted – Indicate the last date of service that benefits are available and after which payment can be made by payer indicated in FL 50, line A. B3 – Benefits Exhausted – Indicate the last date of service that benefits are available and after which payment can be made by payer indicated in FL 50, line B.

Form Locator/Label	Completion Format	Instructions
		C3 – Benefits Exhausted – Indicate the last date of service that benefits are available and after which payment can be made by payer indicated in FL 50, line C. *Other payer occurrence codes 24 and 25 must be used when applicable. The claim must be submitted with appropriate third party information.
35-36 Occurrence Span Code From / Through	Digits	Conditional Complete if nursing facility bills PETI service code(s) on the claim. Enter occurrence span code 76. Enter the "From" and "Through" dates for the PETI services in MM/DD/YY format
38 Responsible Party Name / Address	None	Leave Blank
39-41 Value Codes and Amount	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 the 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. Most Common Codes 01 – Semi-Private Room Rate 31* – Member Liability Amount 80 – Covered Days 81 – Non-Covered Days 06 – Medicare Blood Deductible 14 – No Fault including Auto/Other 15 – Worker's Compensation

Form Locator/Label	Completion Format	Instructions
		32 – Multiple Member Ambulance Transport 37 – Pints of Blood Furnished 38 – Blood Deductible Units 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 Enter the deductible amount applied by indicated payer: A1 – Deductible Payer A 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 Medicare and TPL see A1-A3, B1-B3 and C1-C3 above. *Member Liability Amount is payment made by the member for care. This amount is determined by the County Income Maintenance Technicians. This member liability amount must be applied to the member's care at the beginning of each month using code 31. When reporting the member liability amount for the entire month, regardless of the number of days in that month, apply the total member liability amount. When reporting member liability amount for less than one full month of care, use the per diem calculation to calculate the correct amount.

Form Locator/Label	Completion Format	Instructions
		The per diem calculation is the number of days in the facility, excluding the date of discharge, times the facility's per diem rate. When member has Medicare "Part B only" coverage, and the provider is billing for the Health First Colorado Accommodation Per Diem and the payer source code is H, enter the "Part B only" ancillary services payment in this form locator on the Medicare line.
42 – Revenue Code	4 digits	Required Enter the revenue code that identifies the specific accommodation or ancillary service provided. List revenue codes in ascending order. 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. Nursing Facility Claims: 0119 – Private 0129 – Semi-Private 0182 – Non-Medical Leave 0185 – Medical Leave Medicare Part B Crossover Claims: 042X – Physical Therapy 043X – Occupational Therapy 044X – Speech Therapy PETI/IME Claims: 0259 – Non-Covered Prescription Drugs 0479 – Hearing and Ear Care 0949 - Acupuncture 0962 – Vision and Eye Care 0969 – Dental Services 0982 – Outpatient Services 0999 – Health Insurance Premiums and Other Approved Services

Form Locator/Label	Completion Format	Instructions
43 – Revenue Code Description	Text	Required Enter the revenue code description or abbreviated description
44 – HCPCS / Rates / HIPPS Rate Codes	Digits	Required Enter the rates (dollar amounts) for the per diem or the PETI/IME.
45 – Service Date	Digits	Conditional Enter the first date of service for PETI/IME service code(s).
46 – Service Units	Digits	Required Enter the number of covered days. Do not enter fractions or decimals and do not show a decimal point followed by a 0 to designate whole numbers. Enter the number of Non-Medical Leave days. Do not enter fractions or decimals.
47 – Total Charges	Digits	Required Enter the total charge for each revenue code. For Medicare Part B claims, enter the total ancillary charges billed to Medicare. A grand total on line 23 is required for all charges.
48 – Non-Covered Charges	None	Leave Blank
50 – Payer Name	Text	Required Enter the payment source code followed by name of each payer organization from which the provider might expect payment. At least one line must indicate the Health First Colorado.

Form Locator/Label	Completion Format	Instructions
		Source Payment Codes: 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	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	Digits	Conditional Complete when there are Medicare or third party payments made prior to submission to the Health First Colorado. **Enter Medicare and/or third party payments.**
55 – Estimated Amount Due	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

Form Locator/Label	Completion Format	Instructions
		party, Medicare or member liability amounts 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 amounts.
56 – National Provider Identifier (NPI)	Digits	Required Enter the billing provider's 10 digit National Provider Identifier (NPI).
57 – Other Provider ID	Digits	Optional Enter the eight digit Health First Colorado provider number assigned to the billing provider. Submitted information is not entered into the claim processing system.
58 – Insured's Name	Text	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 exactly as it appears on the eligibility verification or on the health insurance card.
60 – Insured's Unique ID	Text	Required Enter the insured's unique identification number assigned by the payer organization exactly as it appears on the eligibility verification or on the health insurance card. Include letter prefixes or suffixes.
61 – Insurance Group Name	Text	Conditional Complete when there is third party coverage.

Form Locator/Label	Completion Format	Instructions
		Enter the name of the group or plan providing the insurance to the insured exactly as it appears on the health insurance card.
62 – Insurance Group Number	Digits	Conditional Complete when there is third party coverage. Enter the identification number, control number or code assigned by the carrier or fund administrator identifying the group under which the individual is carried.
63 – Treatment Authorization Code	Text	Conditional Complete when the service requires a PAR. Enter the PAR/authorization number in this form locator, if a PAR is required and has been approved for services. As of March 1, 2017, PETI/IMEs require a PAR.
64 – Document Control Number	None	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	None	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)

Form Locator/Label	Completion Format	Instructions
67 – Principal Diagnosis Code	Digits	Required Enter the exact ICD-10-CM diagnosis code describing the principal diagnosis that exists at the time of admission or develops subsequently and affects the length of stay. Do not add extra zeros to the diagnosis code.
67A-67Q – Other Diagnosis	Digits	Optional Complete when there are additional conditions that affect treatment.
69 – Admitting Diagnosis Code	Digits	Required Enter the ICD-10-CM diagnosis code as stated by the physician at the time of admission.
70 – Patient Reason Diagnosis	None	Submitted information is not entered into the claim processing system.
71 – PPS Code	None	Submitted information is not entered into the claim processing system.
72 – External Cause of Injury Code (E-Code)	Digits	Optional Enter the ICD-10-CM diagnosis code for the external cause of injury, poisoning or adverse effect. This code must begin with an "E."
74 – Principal Procedure Code / Date	Digits	Not Required
74A – Other Procedure Code / Date	Digits	Not Required
76 – Attending NPI – Required Attending – Last / First Name	Digits	Health First Colorado ID Required NPI - Enter the 10-digit NPI 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.

Form Locator/Label	Completion Format	Instructions
		(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 ID form locator if the locum tenens physician is not enrolled in the Health First Colorado. QUAL – Enter "1D" for Medicaid Enter the attending physician's last and first name. This form locator must be completed for all services.
77 – Operating NPI	None	Submitted information is not entered into the claim processing system.
78-79 – Other ID NPI – Required	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.

Form Locator/Label	Completion Format	Instructions
81 – Code-Code QUAL / Code / Value (a-d)	None	Submitted information is not entered into the claim processing system.

Nursing Facility Claim Examples

General Nursing Facility Claim Example

1 Nursing Care Facility
100 Saginaw Street
Anytown, CO 80201
303-333-3333

3a PAT CNTL # SM000123
4 TYPE OF BILL 213
5 FED TAX NO
6 STATEMENT COVERS PERIOD FROM 10/1/2016 THROUGH 10/31/2016

8 PATIENT NAME: Client, Ima D.
9 PATIENT ADDRESS: 123 Main Street
Anytown CO 88888

10 BIRTHDATE 02/13/1950
11 SEX F
12 DATE 10/06/16

39 VALUE CODES
a 80 31.00
b 31 53.00

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
129	Semi-Private	90.05		31	2791.55	

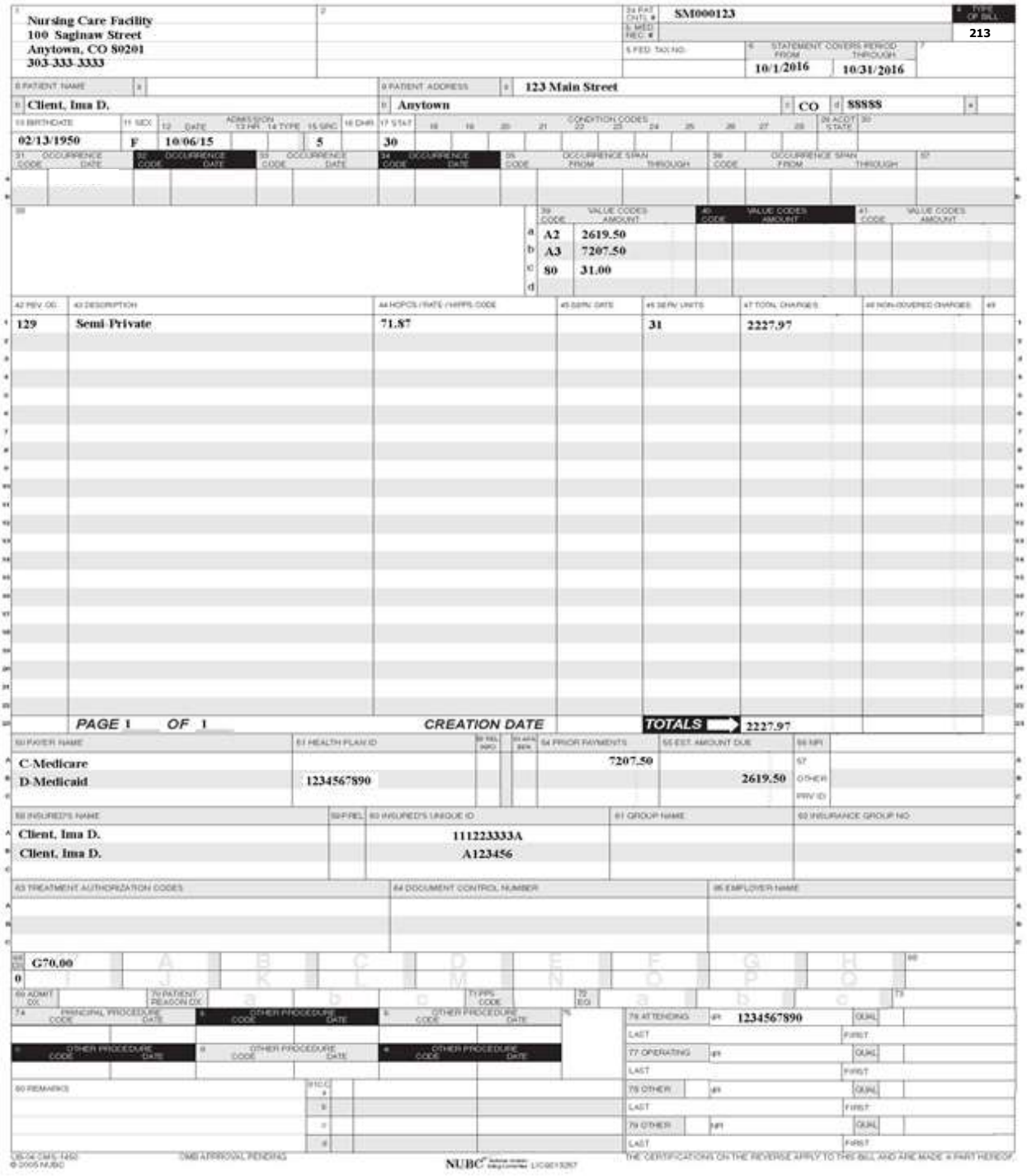
PAGE 1 OF 1 CREATION DATE TOTALS 2791.55

50 PAYER NAME: D-Medicaid
51 HEALTH PLAN ID: 1234567890
58 INSURED'S NAME: Client, Ima D.
60 INSURED'S UNIQUE ID: A123456

76 ATTENDING NPI 1234567890

NUBC

Nursing Facility – Medicare Part A Crossover Claim Example



Nursing Care Facility
100 Saginaw Street
Anytown, CO 80201
303-333-3333

SM1000123

213

10/1/2016 10/31/2016

Client, Ima D. | 123 Main Street | Anytown | CO | $$$$$

02/13/1950 | F | 10/06/15 | 5 | 30

a	A2	2619.50			
b	A3	7207.50			
c	80	31.00			
d					

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
129	Semi-Private	71.87		31	2227.97		
	PAGE 1 OF 1	CREATION DATE		TOTALS	2227.97		

50 PAYER NAME	51 HEALTH PLAN ID	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
C-Medicare		7207.50	
D-Medicaid	1234567890		2619.50

58 INSURED'S NAME	60 INSURED'S UNIQUE ID	61 GROUP NAME
Client, Ima D.	111223333A	
Client, Ima D.	A123456	

66 DX	
0	G70.00

76 ATTENDING 1234567890

Nursing Facility - Medicare Part B Crossover Claim Example

Nursing Care Facility
100 Saginaw Street
Anytown, CO 80201
303-333-3333

SM000123
223
10/1/2016 10/31/2016

Client, Ima D. | 123 Main Street | Anytown | CO | 88888

02/13/1950 | F | 10/06/15 | 12 | 2 | 04 | 17 | 30

	CODE	AMOUNT
a	A1	120.00
b	A2	130.00
c	A3	550.00
d		

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
440	Speech Therapy		01/01/08	2	$00.00	

PAGE 1 OF 1 CREATION DATE TOTALS $00.00

50 PAYER NAME	51 HEALTH PLAN ID	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
C-Medicare		550.50	
D-Medicaid	1234567890		250.00

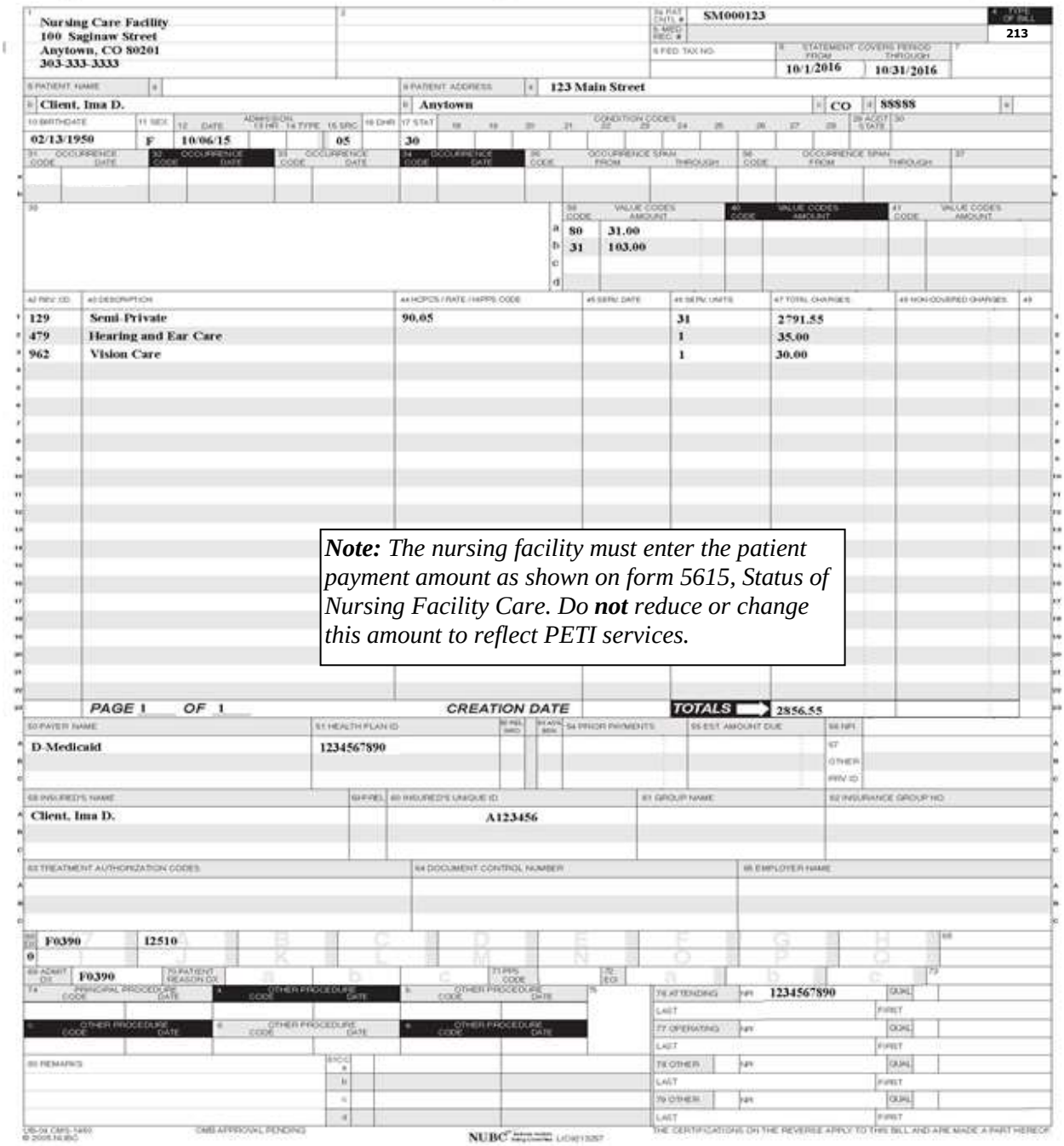
58 INSURED'S NAME	60 INSURED'S UNIQUE ID	61 GROUP NAME
Client, Ima D.	111223333A	
Client, Ima D.	A123456	

21	22	64 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI
R13.10		R13.10			
0					

76 ATTENDING NPI 1234567890 QUAL
LAST FIRST
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

OMB APPROVAL PENDING
NUBC
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Nursing Facility with PETI Codes and Member Liability Amount Claim Example



Nursing Care Facility
100 Saginaw Street
Anytown, CO 80201
303-333-3333

SM000123

213

10/1/2016 10/31/2016

Client, Ima D. | Anytown | CO | 88888 | 123 Main Street

02/13/1950 | F | 10/06/15 | 05 | 30

129	Semi-Private	90.05		31	2791.55	
479	Hearing and Ear Care			1	35.00	
962	Vision Care			1	30.00	

PAGE 1 OF 1 CREATION DATE TOTALS 2856.55

D-Medicaid | 1234567890

Client, Ima D. | A123456

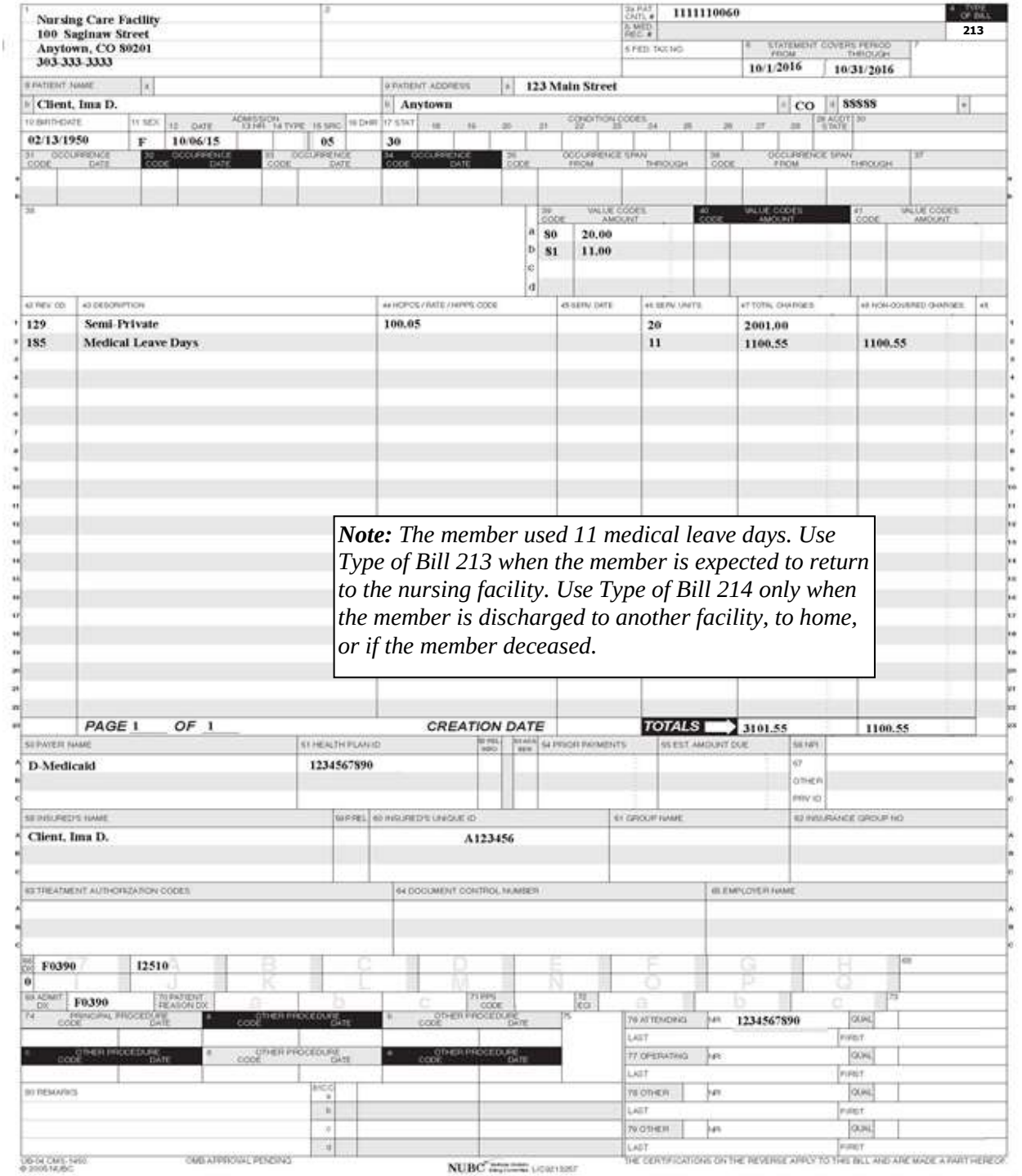
F0390 | I2510

F0390

1234567890

Note: *The nursing facility must enter the patient payment amount as shown on form 5615, Status of Nursing Facility Care. Do* ***not*** *reduce or change this amount to reflect PETI services.*

Nursing Facility with Medical Leave Days Claim Example



Nursing Care Facility
100 Saginaw Street
Anytown, CO 80201
303-333-3333

1a PAT CNTL # 1111110060
4 TYPE OF BILL 213
6 STATEMENT COVERS PERIOD FROM 10/1/2016 THROUGH 10/31/2016

9 PATIENT NAME: Client, Ima D.
9 PATIENT ADDRESS: 123 Main Street
Anytown CO 88888

12 BIRTHDATE 02/13/1950 | 11 SEX F | 13 ADMISSION DATE 10/06/15 | 15 SRC 05 | 17 STAT 30

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
129	Semi-Private	100.05		20	2001.00	
185	Medical Leave Days			11	1100.55	1100.55
	PAGE 1 OF 1	CREATION DATE		TOTALS	3101.55	1100.55

39 VALUE CODES: a 80 20.00; b 81 11.00

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

66 DX: 0 F0390 I2510

69 ADMIT DX: F0390

76 ATTENDING NPI 1234567890 LAST FIRST QUAL
77 OPERATING NPI LAST FIRST QUAL
78 OTHER NPI LAST FIRST QUAL
79 OTHER NPI LAST FIRST QUAL

80 REMARKS

OMB APPROVAL PENDING
NUBC
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Note: *The member used 11 medical leave days. Use Type of Bill 213 when the member is expected to return to the nursing facility. Use Type of Bill 214 only when the member is discharged to another facility, to home, or if the member deceased.*

Prior Authorization - PETI/IME

Implemented March 1, 2017

Overview

Post Eligibility Treatment of Income (PETI) is the amount of an individual's income that must be paid to the nursing facility for the cost of care provided to the individual after certain deductions have been applied.

It is federally mandated that this income may be used for an incurred medical expense not covered by Medicaid or by any other third party insurance.

Types of Incurred Medical Expenses (IME) include health insurance premiums, hearing aids, dental and eye glasses. Check with the Department's Long-Term Services and Supports, Nursing Facility Operations Specialist to verify if a service or item is covered by PETI/IME.

Eligibility Criteria

The member must meet the following criteria to receive PETI/IME approval.

- Active Medicaid member
- Nursing facility resident
- Monthly member payment greater than zero
- Documented medical necessity
- Other potential payer sources exhausted

Reasonable Limits

The State Plan Amendment Supplement 3 to Attachment 2.6-A imposes the following reasonable limits:

- Prior authorization for all expenses ~~exceeding $400 per calendar year~~. (New MMIS requires all PETI/IMEs to be submitted electronically.)
- Verification of medical necessity required by physician.
- Validation expense is not a benefit of Health First Colorado.
- Allowable cost does not exceed the basic Medicaid rate.
- Cost will not be allowed for items for cosmetic reasons only.
- Expenses are not a duplication of expenses previously authorized.

Prior Authorization

Prior authorization by the Department is required for all PETI/IME requests, starting March 1, 2017. The Provider Web Portal is utilized to submit the NF PETI Prior Authorization request.

See the Create Authorization in the Provider Web Portal section below for further details.

Adult Medicaid Dental Benefit

Historically, Medicaid has not covered dental services for adults and PETI/IME had been utilized by many members in nursing facilities in order to obtain oral health services. Lack of preventive dental coverage can contribute to a range of serious health complications and drives Medicaid costs for both emergency services and medical services.

In 2013, the state legislature passed Senate Bill 242. This authorized the Department to create a new limited dental benefit for adults in Medicaid. It's provided to all Medicaid enrolled adults age 21 years and over, including members using the PETI/IME program. There is an annual dental benefit up to $1,000 in dental services per member per state fiscal year which runs from July 1 to June 30.

As of July 1, 2014, the following is covered.
The following dental benefits are covered by the State Plan $1,000 annual dental benefit.

- Basic dental preventive
- Diagnostic and minor restorative dental services (such as x-rays and minor fillings)
- Root canals
- Crowns
- Partial dentures
- Complete dentures
- Periodontal scaling
- Root planning

Requirements for Adult Dental Benefit

- The dental provider must be enrolled in Medicaid. This enables the dental provider to bill directly to Medicaid for reimbursement of services.
- Once the member's $1,000 benefit has been exhausted, then for those PETI/IME eligible members a PETI/IME request can be submitted to the Department for additional services.
- The $1,000 benefit for each member will also be tracked by the Department's Administrative Service Organization (ASO). The ASO duties will include outreach, recruitment and assisting residents in finding a Medicaid provider.

Search for PETI/IME documents and resources on the Department's website under Providers for the PETI/IME Fee Schedule and the PETI/IME Forms.
Look on the Department's website under Stakeholder for the Rules, 10 CCR 2505-10, Section 8.482.33.

Facility Requirements

Basics

- If the member does not have a monthly member payment that is greater than zero, then no PETI/IME will be approved.
- NF PETI/IME requests are for incurred medical expenses that are not a benefit of Health First Colorado.

Required Documents

Hearing	Vision	Health Insurance	Dental
Signed medical necessity form	Signed medical necessity form	Signed medical necessity form	Signed medical necessity form
Itemized invoice	Itemized invoice	Verification of premium amount	Itemized invoice
Audiogram		Insurance card – front and back	Denial from Medicaid – if applicable
			Explanation of benefits – if applicable
		A new request is required each calendar year	Documentation if 2nd request

Activity Log

The nursing facility will document all the member's use of the PETI/IME funds on an annual basis. The log should include the following information as it may be asked for during an audit or review performed by the Department or designee to validate all steps of the PETI/IME process were performed. Log should include the $1,000 Dental benefit and PETI/IMEs.

- Member number and name receiving the service
- Type of service requested
- Date service was requested by the member
- Date PAR was added to Provider Web Portal
- Date PAR was approved by the Department
- Date facility received payment for Medicaid for service
- Date service provider was paid by the facility
- Date service was rendered to the member
- Was the member's personal needs account funds used?
- Was the member's personal needs account reimbursed?
- Was the member still at the facility when the service was rendered?

10 CCR 2505-10, Section 8.482.33 states:

- All allowable costs must be documented in the resident's record with date of purchase and receipt of payment, whether or not these costs meet the requirements for prior authorization. Lack of documentation shall cause the cost to be disallowed, causing the nursing facility to be overpaid by the Medicaid program.

Create Prior Authorization in the Provider Web Portal

As of March 1, 2017, all PETI/IME requests must be submitted to the Department via the Provider Web Portal. Once submitted the Nursing Facility Operations Specialist or designee will approve, approve – with revisions or deny the request. The facility can look up the status of any PETI/IME request on the Provider Web Portal.

Prior Authorization Required Steps

Note: This prior authorization form is used by all HCPF divisions so it is generic in nature and requirements to complete this form are built into the new MMIS system. The various codes used are based on the NUBC (national) codes. Follow the instructions below to navigate through the various sections of the form.

The form must be completed all at once. There is no saving partial information.

The Prior Authorization form must be approved by the Department before the PETI/IME can be submitted on a claim for payment.

The following steps walk the processor through the Provider Web Portal NF PETI Authorization Form. Please follow these instructions in order and make the keystrokes indicated. Caution should be used when working through this form, so slow is better than fast.

If an expected step result does not appear or a section of the form isn't working correctly, sign out of the portal and sign back in.

STEPS

Log into the Provider Web Portal using your assigned User ID and password.

Your home page will appear. On the blue menu bar, select Care Management.
Three options will appear: Create Authorization, View Status of Authorizations, and Maintain Favorite Provider List.

Click on the Create Authorization option

In the Create Authorization box: (required)

- Use the drop down arrow to select the Authorization Type **PETI NURSING FACILITY**

In the Member Information box: (required)

- Type in the Member ID **MEDICAID ID** with a capital letter (example: X123456).
- Hit the **TAB key**
- Member name and birthdate will display.

In the Service Provider Information box: (required)

- Select the Check Box, if you are the requesting provider.
- Or use the drop down box to Select From Favorites
- Or if a new requesting provider, use the Magnifier Search Icon to locate the provider.

Note: when provider is selected, make sure the taxonomy box populates. If not, try selecting the provider again.

- Use the drop down box to select the Location.
  - **Skilled Nursing Facility**
  - **Nursing Facility**
  - **Intermediate Care Facility**

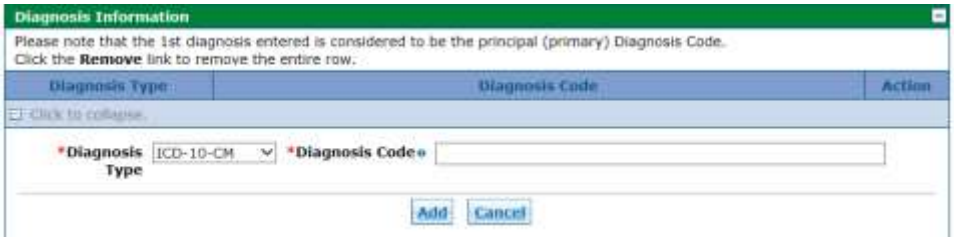
In the Diagnosis Information Box: (required)

- Diagnosis Type should be **ICD-10-CM**
- Select Diagnosis Code from the list below.
  - **Y9209 Other Non-Institutional Residence as Place**
  - **Y9212 Nursing Home as Place**

- **Y9219 Other Residential Institution as Place**
- **Y92531 Health Care Provider Office as Place**
- **Y929 Unspecified Place or Not Applicable**

- Type in the Diagnosis Code **NUMBER** with a capital letter and click **ADD**.
  Only one diagnosis code is required.

- The diagnosis appears in the light blue line under the table headers. If incorrect, use the Remove Link to remove the code and add the correct code.



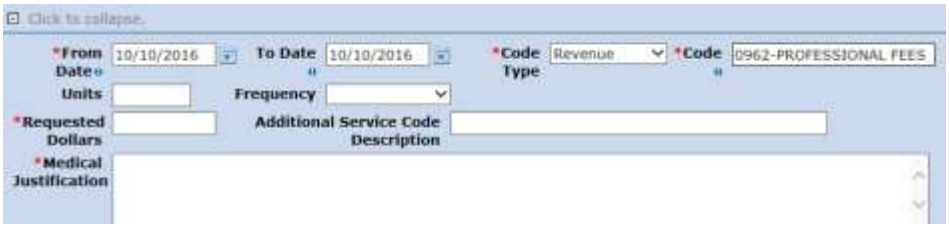
The Service Details box (required) is split into three parts.

A) Service Details (top section)
B) Service Provider Information (middle section)
C) Attachments (bottom section)

Only one service request is permitted per NF PETI Request.

A) Service Details (required)

- Using the Calendar Icon, fill in the **FROM DATE** and the **TO DATE**
  - This date can be the date of service if provided before today's date.
  - Or the current date.
  - Or a date range that is not in the future.
- Use the drop down arrow and change the Code Type to **REVENUE**
- Select Code from the list below.
  - **0259 – Pharmacy Other Drugs (non-prescription drugs)**
  - **0479 – Audiology Other (hearing)**
  - **0949 – Acupuncture**
  - **0962 – Professional Fees Ophthalmology (vision/glasses)**
  - **0969 – Professional Fees Other (dental, etc.)**
  - **0982 – Professional Fees Outpatient Services**
  - **0999 – Patient Convenience Items (Health Insurance)**
- Type in the Code **NUMBER** and when the name associated with the number appears, **click on the name**.
- Options within the service details box will change because the Revenue code type was selected. (Modifier lines will disappear)



- Fill in the number of Units (cannot be zero).
  - If eye glasses – units should be 1
  - If hearing aids – units should be 1 or 2
  - If health insurance premium – units should be 1 to 12, the number of months being requested.
  - If other type of service – use the appropriate unit measurement or 1.
- Requested Dollars (cannot be zero).
  - Type in the full amount being requested, should match the invoice total.
  - For health insurance premium, it should be the monthly amount times the number of months.
- Fill in the Medical Justification (cannot be blank).
  - If health insurance premium – the note should be the monthly premium dollar amount and the number of months being requested. (Example: Health Insurance $150 for 6 months).
  - For anything other than health insurance, select from the following list.
    - New request for…
    - Replacement for…
    - Second request for...
    - Other Incurred Medical Expense

B) Service Provider Information (required) (Rendering Provider)
- Select the Check Box, if you are the rendering provider.
- Or use the drop down box to Select From Favorites
- Or if a new rendering provider, use the Magnifier Search Icon to locate the provider.

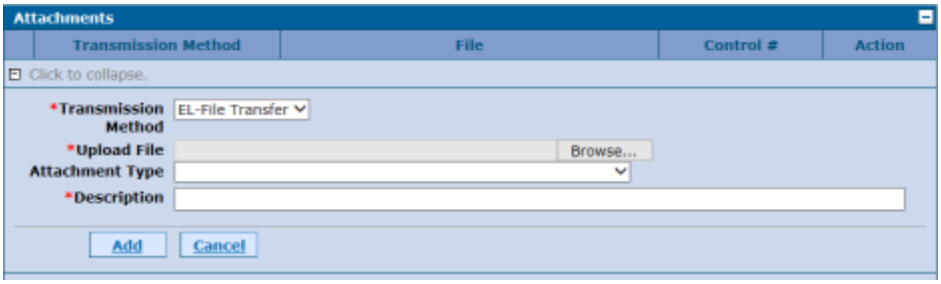
Note: when provider is selected, make sure the taxonomy box populates. If not, try selecting the provider again.
- Use the drop down box to select the Location from the list below.
  - **If the member is on Hospice, choose HOSPICE**
  - For any member not on hospice, select from the following list.
    - **Mobile Unit**
    - **Independent Clinic**
    - **Public Health Clinic**
    - **Rural Health Clinic**
    - **Skilled Nursing Facility**
    - **Nursing Facility**
    - **Intermediate Care Facility**

C) Attachments (make sure to attach *all required documents* or PAR will be denied).

- Click on the + sign on the right side of the blue box titled Attachments.

- Attachment box opens and is ready for uploading required documents.

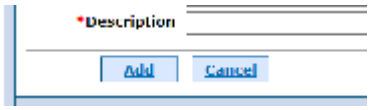
- Click on the + sign on the left side, next to the Click to add attachment statement.



- Browse for the attachment to upload. This is where the processor has stored the document on their computer.
  - **Documents to upload should include:**
    - **Hospice**
    - **Signed Medical Necessity form**
    - **Invoice with treatment codes**
    - **Audiology report**
- Use the drop down arrow to select one of the following Attachment Type options:
  - **AT – Purchase Order Attachment (itemized invoice for service/item)**
  - **B2 – Prescription**
  - **B3 – Physician Order**
  - **CK – Consent Forms (signed medical necessity form)**
  - **DG – Diagnosis Report (audiology/hearing report)**
  - **77 – Support Data for Verification**
- **Type** in the Description by selecting one of the following options associated with the Attachment Type.
  - **AT – Itemized invoice for…**
  - **B2 – Vision Prescription**

- **B3 – Sign Physician Order**
- **CK – Medial necessity form**
- **DG – Audiology/hearing report**
- **77 – Insurance premium data, supporting documents**

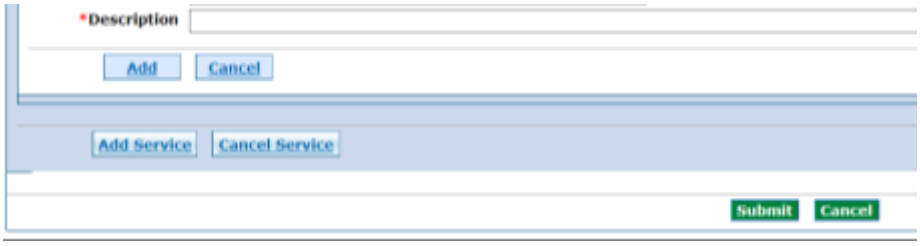
➢ Click the **ADD button** located directly below the Description field.



➢ The attachment(s) appear in the light blue line under the table headers. If incorrect, use the Remove Link to remove the attachment and add the correct attachment.

Once A, B and C have been completed the Service Details section is complete.

➢ Click the **ADD SERVICE** button on the bottom left of the page.

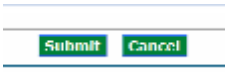


➢ The Service Details box will change. The service added now appears in the light blue line under the table headers. If incorrect, use the Remove Link to remove the service and add the correct service.

Only one service request is permitted per NF PETI Request.

➢ To view information submitted, click the + sign next to the line number. Click the – sign to close it.

After all the information has been entered into the authorization form, click the **SUBMIT** button on the bottom right. Click **CANCEL** to cancel the authorization request.



If the Submit button doesn't change to Confirm, error messages will appear in RED somewhere on the page (usually at the top). Work through the errors and click the Submit button again.

If the Submit button changes to Confirm, request is ready for final review by the processor. The displayed page will be a condensed authorization form. Use the + and – signs to open and close the various sections.

Once quality checked by the processor, click the **CONFIRM** button. Use the **BACK** button to make corrections or the **CANCEL** button to cancel the request.

The Authorization Receipt box will appear.

- Make note of the **AUTHORIZATION TRACKING NUMBER**. This is how you can track the status of the request.

- Click on the **PRINT PREVIEW** button
  - This will display the PAR submitted for Department approval/denial.
  - Open all the boxes with + signs to display all the PETI/IME details.
  - **PRINT** this page for your records and for audit purposes. The form and all attachments should be kept for six years.

The PAR is now in the Pending – State Review status.

View PAR Status

The processor can view the status of the PAR through the Provider Web Portal.

- Click on the Care Management tab
- Click on the View Authorization Status link
- Type in the Authorization Tracking Number and click Search
- Scroll down the page to see the PAR and its current status.

PETI/IME Determination

The Department's Nursing Facility Operations Specialist or designee will determine if the PETI/IME request meets the requirements necessary to approve the request. The status will

change to approved, approved – with revisions or denied. The Online Portal is instantly updated with the determination and a letter is system generated for mailing the next day.

If PETI/IME request is denied. Submit a whole new request and include any missing information. The denied request can't be re-opened.

Billing Medicaid for PETI/IME

Once the PAR status has been changed to approved or approved – with revisions, the facility can bill Medicaid for the service or item.

There are seven State-specific revenue codes for PETI/IME that can be billed on nursing facility claims.

PETI/IME Revenue Codes

Revenue Code	Description
0259	Non-covered Prescription Drugs
0479	Hearing and Ear Care
0949	Acupuncture
0962	Vision and Eye Care
0969	Dental Services *
0982	Other Outpatient Services
0999	Health Insurance Premiums and Other Approved Services

*Dental Services only applicable after the $1,000 State Benefit has been exhausted or Medicaid has denied the service.

NF Manual Revisions Log

Revision Date	Additions/Changes	Pages	Made By
12/16/2016	*Manual revised for interChange implementation. For manual revisions prior to 12/16/2016 Please refer to Archive. (Replaced Nursing Facility Billing Manual dated 07/2016.)*	*All*	*cf*
12/27/2016	*Updates based on Colorado iC Stage II Provider Billing Manual Comment Log v0_2.xlsx*	*7*	*HPE (now DXC)*
1/10/2017	*Updates based on Colorado iC Stage II Provider Billing Manual Comment Log v0_3.xlsx*	*Multiple*	*HPE (now DXC)*
1/19/2017	*Updates based on Colorado iC Stage II 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)*
2/2/17	*Changed Type of Bill to 3 digits. Dropped leading 0.*	*12*	*TC*
2/23/17	*Updates based on Provider feedback to Policy SME during February 2017 NFAC meeting. (pages 3,4,8,9,10,11,12,20,24,35,38,43)*	*Multiple*	*CF*
5/26/2017	*Updates based on Fiscal Agent name change from HPE to DXC*	*3, 44*	*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.