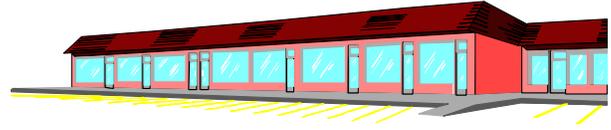


Nursing Facility

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

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

The Nursing Facility program provides skilled and maintenance services to clients meeting long term care guidelines. Long term care guidelines are based on a client'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.

Billing Information

National Provider Identifier (NPI)

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

Paper Claims



Electronic claims format shall be required unless hard copy claims submittals are specifically prior authorized by the Department of Health Care Policy and Financing (the Department). Requests may be sent to the fiscal agent, Xerox State Healthcare, P.O. Box 30, Denver, CO 80201-0090. The following claims can be submitted on paper and processed for payment:

- Claims from providers who consistently submit 5 claims or fewer per month (requires prior approval)
- Claims that, by policy, require attachments
- Reconsideration claims

Paper claims do not require an NPI, but do require the Colorado Medical Assistance Program provider number. In addition, the UB-04 Certification document must be completed and attached to all claims submitted on the paper UB-04. Electronically mandated claims submitted on paper are processed, denied, and marked with the message "Electronic Filing Required".

Electronic Claims

Instructions for completing and submitting electronic claims are available through the following:

- X12N Technical Report 3 (TR3) for the 837P, 837I, or 837D (www.wpc-edi.com/)
- Companion Guides for the 837P, 837I, or 837D (in the Provider Services [Specifications](#) section of the Department's Web site.

- Web Portal User Guide (found within the portal)

The Colorado Medical Assistance Program collects electronic claim information interactively through the Colorado Medical Assistance Program Secure Web Portal (Web Portal) or via batch submission through a host system.

Interactive Claim Submission and Processing

Interactive claim submission through the Web Portal is a real-time exchange of information between the provider and the Colorado Medical Assistance Program. Colorado Medical Assistance Program providers may create and transmit HIPAA compliant 837P (Professional), 837I (Institutional), and 837D (Dental) claims electronically one at a time. These claims are transmitted through the Colorado Medical Assistance Program OnLine Transaction Processor (OLTP).



The Colorado Medical Assistance Program OLTP reviews the claim information for compliance with Colorado Medical Assistance Program billing policy and returns a response to the provider's personal computer about that single transaction. If the claim is rejected, the OLTP sends a rejection response that identifies the rejection reason.

If the claim is accepted, the provider receives an acceptance message and the OLTP passes accepted claim information to the Colorado Medical Assistance Program claim processing system for final adjudication and reporting on the Colorado Medical Assistance Program Provider Claim Report (PCR).



The Web Portal contains online training, user guides and help that describe claim completion requirements, a mechanism that allows the user to create and maintain a data base of frequently used information, edits that verify the format and validity of the entered information, and edits that assure that required fields are completed.

Because a claim submitter connects to the Web Portal through the Internet, there is no delay for "dialing up" when submitting claims. The Web 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 Provider Claim Report to providers. The Web Portal also provides access to reports and transactions generated from claims submitted via paper and through electronic data submission methods other than the Web Portal. The reports and transactions include:

- Accept/Reject Report
- Provider Claim Report
- 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 Web Portal. Access the Web Portal through Secured Site at colorado.gov/hcpf. For help with claim submission via the Web Portal, please choose the *User Guide* option available for each Web Portal transaction. For additional electronic billing information, please refer to the appropriate Companion Guide located in the Provider Services [Specifications](#) section.

Batch Electronic Claims Submission



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

All batch claim submission software must be tested and approved by the Colorado Medical Assistance Program fiscal agent.

Any entity sending electronic claims to **Xerox State Healthcare** Electronic Data Interchange (EDI) Gateway for processing where reports and responses will be delivered must complete an EDI enrollment package. This provides Xerox State Healthcare EDI Gateway the information necessary to assign a Logon Name, Logon ID, and Trading Partner ID, which are required to submit electronic claims. The entity may obtain an EDI enrollment package by contacting the Medical Assistance Program fiscal agent or by downloading it from the Provider Services [EDI Support](#) section.

The X12N 837 Professional, Institutional, or Dental transaction data will be submitted to the EDI Gateway, 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 Medicaid Management Information System (MMIS), the interchange will reject and a TA1 along with the data will be forwarded to the Xerox State Healthcare State Healthcare Clearinghouse (SHCH) Technical Support for review and follow-up with the sender. An X12N 999 Functional Acknowledgement is generated when a file that has passed the header and trailer check passes through the Xerox State Healthcare SHCH.

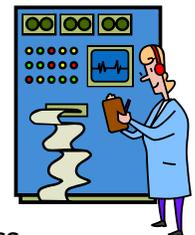
If the file contains syntactical error(s), the segment(s) and element(s) where the error(s) occurred will be reported. After validation, the Xerox State Healthcare SHCH will then return the X12N 835 Remittance Advice containing information related to payees, payers, dollar amount, and payments. These X12N transactions will be returned to the Web Portal for retrieval by the trading partner, following the standard claims processing cycle.

Testing and Vendor Certification

Completion of the testing process must occur prior to submission of electronic batch claims to Xerox State Healthcare EDI Gateway. Assistance from Xerox State Healthcare EDI business analysts 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.

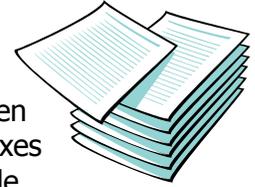
The number of required test transmissions depends on the number of format errors on a transmission and the relative severity of these errors. Additional testing may be required in the future to verify any changes made to the MMIS system have not affected provider submissions. Also, changes to the ANSI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

In order to expedite testing, Xerox State Healthcare EDI Gateway requires providers to submit all X12N test transactions to EDIFECS prior to submitting them to Xerox State Healthcare EDI Gateway. The EDIFECS service is free to providers to certify X12N readiness. EDIFECS offers submission and rapid result turnaround 24 hours a day, 7 days a week. For more information, go to www.edifecs.com.



General Prior Authorization Requirements

The Uniform Longterm Care (ULTC) 100.2 form must include medical information from the medical provider. Forms are available in the [Long-Term Care Case Management Tools](#) in the Partners & Researchers Long-Term Care Partners section of the Department's Web site. 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 100.2 and approves the care, a confirmation number is assigned and the approval is faxed to the nursing facility. When the facility receives the 5615 form from the county eligibility technician, the facility faxes the 5615 and the 100.2 certification page with a confirmation number to the Statewide Utilization Review Contractor (URC). This Prior Authorization Request (PAR) is electronically submitted to the fiscal agent by the URC.



Nursing facility claims submitted without an approved PAR in the Medical Assistance Program claims processing system will be denied. Submitted claim data is checked against the dates in the Medical Assistance Program PAR processing system.

Approval of a ULTC 100.2 does not guarantee Colorado Medical Assistance Program payment and does not serve as a timely filing waiver. Authorization only assures that the approved service is a medical necessity and is considered a benefit of the Colorado Medical Assistance Program. All claims, including those for prior authorized services, must meet eligibility and claim submission requirements before payment can be made (e.g., timely filing, Primary Care Physician information completed appropriately, third party resources payments pursued, required attachments included, etc.).

Special Benefits/Limitations/Exclusions

Nursing facility care is a Colorado Medical Assistance Program benefit only after review and certification by the URC.

Medicare Crossover Claims



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

If a crossover claim does not appear on the Medical Assistance Program Provider Claim Report (PCR) within 30 days after the Medicare processing date, a provider must submit the crossover either electronically through the Web Portal or on paper. Nursing facility services are a Medicare Part A benefit if the client is discharged after a hospital stay of at least three days, and qualifies for a 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 Colorado Medical Assistance Program 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
31 - 34	Occurrence Codes - Enter code 50 (Medicare paid) or code 51 (Medicare denied) and the Medicare Remittance Advice (RA) date.
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 Colorado Medical Assistance Program (Medicare Coinsurance); A3 is the amount Medicare paid.
42	Revenue Code – Enter appropriate revenue code.
44	Rates - Enter Nursing Facility's Colorado Medical Assistance Program per diem rate.
50	Payer Name - Enter Colorado Medical Assistance Program on the appropriate payer line.
51	Health Plan ID - Enter the Nursing Facility's eight digit Colorado Medical Assistance Program provider number on the line selected for the Colorado Medical Assistance Program.
60	Insured's Unique ID - Enter the client's Colorado Medical Assistance Program State ID number on the line selected for Colorado Medical Assistance Program.

Medicare Part B Crossover Claims



Some dually eligible clients do not qualify for comprehensive skilled nursing care as defined by Medicare, but do qualify 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 when submitting a Medicare Part B paper-based crossover claim:

Form Locator	Instructions
31 – 34	Occurrence Codes - Enter code 50 (Medicare paid) or code 51 (Medicare denied) and the Medicare RA date.
39 – 41	Value Codes - 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 coinsurance; A3 is the amount Medicare paid.
42	Revenue Code – Enter appropriate revenue code.
50	Payer Name- Enter Colorado Medical Assistance Program on the appropriate payer line.
51	Health Plan ID - Enter the Nursing Facility's eight digit Colorado Medical Assistance Program provider number on the line selected for Colorado Medical Assistance Program.
60	Insured's Unique ID - Enter the client's Colorado Medical Assistance Program State ID number on the line selected for Colorado Medical Assistance Program.

Medical Leave Days

Medical leave days are days that the client 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.



Nursing facility medical leave days are not a Colorado Medical Assistance Program 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 patient's plan of care.

Excessive Non-Medical Leave Days

The Colorado Medical Assistance Program pays for a total of 42 non-medical leave days per calendar year. With physician approval, clients may pay for room reservations in excess of the combined total 42 non-medical leave days per calendar year.

Patient Liability Amount

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



The personal needs allowance and other approved deductions are determined by County Income Maintenance Technicians. The patient liability amount must be applied to the client's care.

When reporting the patient liability amount for the entire month, regardless of the number of days in that month, apply the total patient liability amount.

Use the per diem rate calculation to calculate the correct amount when reporting patient liability amount amounts for less than one full month of care. The per diem rate calculation is the number of days in the facility, excluding the date of discharge, times the facility's per diem rate.

To calculate patient liability amount for a partial month:

- Calculate the Colorado Medical Assistance amount by multiplying the number of days for payment times the per diem amount.
- If the Colorado Medical Assistance amount exceeds the patient liability amount, the partial month's patient liability amount remains the same as the regular patient liability amount.
- If the patient liability amount is more than the Colorado Medical Assistance amount, the partial month's patient liability amount is considered the same as the Colorado Medical Assistance amount. The excess of the patient liability amount over the partial month's patient liability amount belongs to the resident and, if it has already been paid to the facility, shall be refunded to the resident.



Revenue Coding

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

Nursing Facility Revenue Codes

Revenue code	Description
119	Private room (Colorado Medical Assistance Program reimburses the facility for a client in a private room at the semi-private per diem rate. There is no additional reimbursement for a client in a private room.)
129	Semi-private room
182	Non-Medical leave days
185	Medical Leave days
42X	Physical Therapy
43X	Occupational Therapy
44X	Speech Therapy

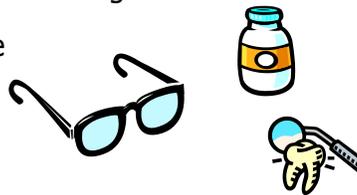
Post-Eligibility Treatment of Income (PETI)

In addition to the above codes, five State-specific revenue codes for PETI can be billed on nursing facility claims. PETI services include services that are medically necessary but are not covered by the Colorado Medical Assistance Program (e.g., hearing aids, eye glasses). PETI services are paid via the client’s patient liability amount.

PETI services can only be billed on claims that have an accommodation line item revenue code and a patient liability amount greater than zero. PETI charges exceeding \$400 per year must be prior authorized by the Department of Health Care Policy and Financing (the Department). All health insurance premiums, manually priced services, hospice resident requests, and any services not listed on the PETI fee schedule must also be submitted to the Department for review and determination.

PETI Revenue Codes

Revenue code	Description
259	Non-covered prescription drugs
479	Hearing and ear care
962	Vision and eye care
969	Dental services
999	Health insurance premiums and other approved services



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 Colorado Medical Assistance Program 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 Colorado Medical Assistance Program. The appropriate code values listed in this manual must be used when billing the Colorado Medical Assistance Program.

The UB-04 Certification document (located after the Late Bill Override instructions and in the Provider Services [Forms](#) section) must be completed and attached to all claims submitted on the paper UB-04. Completed UB-04 paper Colorado Medical Assistance Program claims, including hardcopy Medicare claims, should be mailed to the correct fiscal agent address located in Appendix A of the Appendices 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 Web Portal.

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 Colorado Medical Assistance Program for nursing facility services.

Form Locator and Label	Completion Format	Instructions
1. Billing Provider Name, Address, Telephone Number	Text	Required Enter the provider or agency name and complete mailing address of the provider who is billing for the services: Street/Post Office box City State Zip Code Abbreviate the state using standard post office abbreviations. Enter the telephone number.
2. Pay-to Name, Address	Text	Required if different from FL 1. Enter the provider or agency name and complete mailing address of the provider who will receive payment for the services: Street/Post Office box City State Zip Code Abbreviate the state using standard post office abbreviations.
3a. Patient Control Number	Up to 20 characters: Letters, numbers or hyphens	Optional Enter information that identifies the client or claim in the provider's billing system. Submitted information appears on the Provider Claim Report.
3b. Medical	17 digits	Optional

Form Locator and Label	Completion Format	Instructions
Record Number		Enter the number assigned to the patient to assist in retrieval of medical records.
4. Type of Bill	3 digits	Required First two digits, use 22 for Skilled NF or 62 for Intermediate Care Facility Third digit must be one of the following: <u>Digit 3 = frequency:</u> 1 - Admit thru Discharge Claim 2 - Interim - First Claim 3 - Interim - Continuing Claim 4 - Interim - Last Claim
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 Through (ending) date of service covered by this bill using MM/DD/YY format. "From" date is the actual start date of services, and <u>cannot</u> be prior to the start date on the prior authorization; 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 01/15/08 thru 01/31/08 and 02/01/08 thru 02/15/08 rather than 01/15/08 thru 02/15/08). Match dates to the prior authorization. The end date of one prior authorization and the begin date of the following authorization cannot be billed on the same claim. If a client is admitted and discharged on the same date, that date appears in both form locators.
8a. Patient Identifier		Submitted information is not entered into the claim processing system.
8b. Patient Name	Up to 25 characters: Letters & spaces	Required Enter the client’s last name, first name and middle

Form Locator and Label	Completion Format	Instructions
		initial.

9a. Patient Address – Street	Characters Letters & numbers	Required Enter the client's street/post office box exactly as it appears on the eligibility verification or as determined at the time of admission.
9b. Patient Address – City	Text	Required Enter the client'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 client'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 client's zip code exactly as it appears on the eligibility verification or as determined at the time of admission.
9e. Patient Address – Country Code	Digits	Optional
10. Birthdate	8 digits (MMDDCCYY)	Required Enter the client's birthdate using two digits for the month, two digits for the date, and four digits for the year (MMDDCCYY format). Example: 01012015 for January 1, 2015. 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 client's sex.

Form Locator and Label	Completion Format	Instructions																																																				
12. Admission Date	6 digits	Required Enter the date the client was <u>admitted to the nursing facility</u> using MM/DD/YY format.																																																				
13. Admission Hour	6 digits	Optional <table border="0" data-bbox="808 485 1211 1598"> <thead> <tr> <th data-bbox="808 485 878 516"><u>Code</u></th> <th data-bbox="1068 485 1138 516"><u>Time</u></th> </tr> </thead> <tbody> <tr><td>00</td><td>12:00-12:59 am</td></tr> <tr><td>01</td><td>1:00-1:59 am</td></tr> <tr><td>02</td><td>2:00-2:59 am</td></tr> <tr><td>03</td><td>3:00-3:59 am</td></tr> <tr><td>04</td><td>4:00-4:59 am</td></tr> <tr><td>05</td><td>5:00-5:59 am</td></tr> <tr><td>06</td><td>6:00-6:59 am</td></tr> <tr><td>07</td><td>7:00-7:59 am</td></tr> <tr><td>08</td><td>8:00-8:59 am</td></tr> <tr><td>09</td><td>9:00-9:59 am</td></tr> <tr><td>10</td><td>10:00-10:59 am</td></tr> <tr><td>11</td><td>11:00-11:59 am</td></tr> <tr><td>12</td><td>12:00-12:59 pm</td></tr> <tr><td>13</td><td>1:00-1:59 pm</td></tr> <tr><td>14</td><td>2:00-2:59 pm</td></tr> <tr><td>15</td><td>3:00-3:59 pm</td></tr> <tr><td>16</td><td>4:00-4:59 pm</td></tr> <tr><td>17</td><td>5:00-5:59 pm</td></tr> <tr><td>18</td><td>6:00-6:59 pm</td></tr> <tr><td>19</td><td>7:00-7:59 pm</td></tr> <tr><td>20</td><td>8:00-8:59 pm</td></tr> <tr><td>21</td><td>9:00-9:59 pm</td></tr> <tr><td>22</td><td>10:00-10:59 pm</td></tr> <tr><td>23</td><td>11:00-11:59 pm</td></tr> <tr><td>99</td><td>Unknown</td></tr> </tbody> </table>	<u>Code</u>	<u>Time</u>	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
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22	10:00-10:59 pm																																																					
23	11:00-11:59 pm																																																					
99	Unknown																																																					
14. Admission Type	1 digit	Optional																																																				
15. Source of Admission	1 digit	Required Complete if the client has been admitted or readmitted during the billing period. Use one of the following codes:																																																				

Form Locator and Label	Completion Format	Instructions
		1 Physician referral 2 Clinic referral 3 Referred from HMO 4 Transfer from a hospital 5* Transfer from a skilled nursing facility
15. Source of Admission (continued)	1 digit	6 Transfer from another health care facility 7 Emergency Room 8 Court/Law Enforcement 9 Information Not Available * Use code 5 if the client is a nursing facility resident transfer or is changing from private pay to Colorado Medical Assistance Program pay.
16. Discharge Hour	2 digits	Optional See FL 13 for valid codes.

Form Locator and Label	Completion Format	Instructions
17. Patient Discharge Status	2 digits	<p>Required</p> <p>Enter the appropriate patient status code as of the discharge date or billing period "through date."</p> <p>Use one of the following codes:</p> <ul style="list-style-type: none"> 01 Discharged to Home 03 Discharged/Transferred to SNF 04 Discharged/Transferred to ICF 05 Discharged/Transferred to Another Type of Institution 06 Discharged/Transferred to organized Home and Community Based Services Program (HCBS) 07 Left Against Medical Advice 08 Discharged/Transferred to Home Under Care of Home Health Provider 20 Deceased 30 Still a Patient 64 Discharged/Transferred to a nursing facility certified under the Colorado Medical Assistance Program but not certified under Medicare.
18-28. Condition Codes	2 Digits	<p>Conditional</p> <p>Enter the code that corresponds to the client's other resources for reimbursement.</p>
18-28. Condition Codes (continued)	2 Digits	<p>Use the following codes:</p> <ul style="list-style-type: none"> 01 Military Service Related 02 Employment Related 04 HMO Medicare Enrollee 05 Lien Has Been Filed 06 ESRD Patient - First Year Entitlement
29. Accident State		Optional

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

Form Locator and Label	Completion Format	Instructions
		<p>line C</p> <p><i>*Other Payer occurrence codes 24 and 25 must be used when applicable. The claim must be submitted with appropriate third party information.</i></p>
35-36. Occurrence Span Code From/ Through	2 digits and 6 digits	<p>Conditional</p> <p>Complete if nursing facility bills PETI service code(s) on the claim.</p> <p>Enter occurrence span code 76.</p> <p>Enter the "from" and "through" dates for the PETI services in MM/DD/YY format.</p>
38. Responsible Party Name/ Address	None	Leave blank
39-41. Value Codes and Amount	2 characters and 9 digits	<p>Conditional</p> <p>Enter appropriate codes and related dollar amounts to identify monetary data or number of days using whole numbers, necessary for the processing of this claim.</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> <p>01 Most common semiprivate rate (Accommodation Rate)</p> <p>06 Medicare blood deductible</p> <p>14 No fault including auto/other</p> <p>15 Worker's Compensation</p> <p>31 Patient Liability Amount (see below)*</p>

Form Locator and Label	Completion Format	Instructions
<p>39-41. Value Codes and Amount (continued)</p>	<p>2 characters and 9 digits</p>	<p>32 Multiple Patient Ambulance Transport 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 B1 Deductible Payer B C1 Deductible Payer C <i>Enter the amount applied to client's co-insurance by indicated payer:</i> A2 Coinsurance Payer A B2 Coinsurance Payer B C2 Coinsurance Payer C <i>Enter the amount paid by indicated payer:</i> A3 Estimated Responsibility Payer A B3 Estimated Responsibility Payer B C3 Estimated Responsibility Payer C Medicare & TPL - See A1-A3, B1-B3 , & C1-C3 above</p>

Form Locator and Label	Completion Format	Instructions
<p>39-41. Value Codes and Amount (continued)</p>		<p>* Patient Liability Amount is payment made by the client for care, after the personal needs allowance and other approved expenses are deducted. The personal needs allowance and other approved deductions are determined by County Income Maintenance Technicians. This patient liability amount must be applied to the client's care.</p> <p>When reporting patient liability amount for the entire month, regardless of the number of days in that month, apply the total patient liability amount.</p> <p>When reporting patient liability amount amounts for less than one full month of care, use the per diem calculation to calculate the correct amount.*</p> <p>The per diem calculation is the number of days in the facility, excluding the date of discharge, times the facility's per diem rate.</p> <p>* To calculate patient liability amount:</p> <ol style="list-style-type: none"> 1. Calculate the Colorado Medical Assistance amount by multiplying the number of days for payment times the per diem amount. 2. If the Colorado Medical Assistance amount exceeds the patient liability amount, the partial month's patient liability amount remains the same as the regular patient liability amount. 3. If the patient liability amount is more than the Colorado Medical Assistance Program amount, the partial month's patient liability amount is considered the same as the Colorado Medical Assistance amount. The excess of the patient liability amount over the partial month's patient liability amount belongs to the resident and, if it has already been paid to the facility, shall be refunded to the resident. <p>When client has Medicare "Part B only" coverage, and the provider is billing for the Colorado Medical Assistance Program 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.</p>



Form Locator and Label	Completion Format	Instructions
<p>42. Revenue Code</p>	<p>3 digits</p>	<p>Required</p> <p>Enter the revenue code that identifies the specific accommodation or ancillary service provided. List revenue codes in ascending order.</p> <p>A <u>revenue code</u> must appear only <u>once</u> per date of <u>service</u>. * If more than one of the same service is provided on the same day, combine the <u>units</u> and charges on one line accordingly.</p> <p><i>Nursing Facility</i></p> <p>Use only the revenue codes listed below for Nursing Facility claims.</p> <p>119 Private 129 Semi-Private 182 Non-medical Leave 185 Medical Leave</p> <p>For Medicare Part B crossover claims:</p> <p>42X Physical Therapy 43X Occupational Therapy 44X Speech Therapy</p> <p>For PETI claims:</p> <p>259 Non-covered prescription drugs 479 Hearing and ear care 962 Vision and eye care 969 Dental Services 999 Health insurance premiums and other approved services</p>
<p>43. Revenue Code Description</p>	<p>Text</p>	<p>Required</p> <p>Enter the revenue code description or abbreviated description.</p>
<p>44. HCPCS/Rates/HIPPS Rate Codes</p>	<p>5 digits</p>	<p>Required</p> <p>Enter the rates (Dollar amounts) for per diem or PETI.</p>

Form Locator and Label	Completion Format	Instructions
45. Service Date	6 digits	Conditional Enter the first date of service for PETI service code(s)
46. Service Units	3 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. Example: Do not enter 1.0 to signify one unit.
47. Total Charges	9 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 in line 23 is required for all charges.
48. Non-Covered Charges		Leave Blank
50. Payer Name	1 letter and text	Required Enter the payment source code followed by name of each payer organization from which the provider might expect payment. At least one line must indicate The Colorado Medical Assistance Program. Source Payment Codes <ul style="list-style-type: none"> B Workmen's Compensation C Medicare D Colorado Medical Assistance Program E Other Federal Program F Insurance Company G Blue Cross, including Federal Employee Program H Other - Inpatient (Part B Only) I Other Line A Primary Payer Line B Secondary Payer Line C Tertiary Payer

Form Locator and Label	Completion Format	Instructions
51. Health Plain ID	8 digits	<p>Required</p> <p>Enter the provider's Health Plan ID for each payer name.</p> <p>Enter the eight digit Colorado Medical Assistance Program provider number assigned to the billing provider. Payment is made to the enrolled provider or agency that is assigned this number.</p>
52. Release of Information	None	Submitted information is not entered into the claim processing system.
53. Assignment of Benefits	None	Submitted information is not entered into the claim processing system.
54. Prior Payments	Up to 9 digits	<p>Conditional</p> <p>Complete when there are Medicare or third party payments made prior to submission to the Colorado Medical Assistance Program.</p> <p>Enter third party and/or Medicare payments.</p>
55. Estimated Amount Due	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 Colorado Medical Assistance Program after provider has received other third party, Medicare or patient liability amounts on the Colorado Medical Assistance Program line.</p> <p>Medicare Crossovers</p> <p>Enter the sum of the Medicare coinsurance plus Medicare deductible less third party payments and patient liability amounts.</p>
56. National Provider Identifier (NPI)	10 digits	<p>Optional</p> <p>Enter the billing provider's 10-digit National Provider Identifier (NPI).</p>
57. Other Provider ID		Submitted information is not entered into the claim processing system.

Form Locator and Label	Completion Format	Instructions
58. Insured's Name	Up to 30 characters	Required Enter the client's name on the Colorado Medical Assistance Program line.
58. Insured's Name (continued)	Up to 30 characters	<i>Other Insurance/Medicare</i> 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	Up to 20 characters	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	14 letters	Conditional Complete when there is third party coverage. Enter the name of the group or plan providing the insurance to the insured exactly as it appears on the health insurance card.
62. Insurance Group Number	17 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	Up to 18 characters	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.
64. Document Control Number		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

Form Locator and Label	Completion Format	Instructions
		health care coverage for the individual identified in FL 58 (Insured Name).
66. Diagnosis Version Qualifier		Submitted information is not entered into the claim processing system. Enter applicable ICD indicator to identify which version of ICD codes is being reported. 0 ICD-10-CM (DOS 10/1/15 and after) 9 ICD-9-CM (DOS 9/30/15 and before)
67. Principal Diagnosis Code	Up to 6 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	Up to 6 digits	Optional Complete when there are additional conditions that affect treatment
69. Admitting Diagnosis Code	Up to 6 digits	Required Enter the ICD-10-CM diagnosis code as stated by the physician at the time of admission
70. Patient Reason Diagnosis		Submitted information is not entered into the claim processing system.
71. PPS Code		Submitted information is not entered into the claim processing system.
72. External Cause of Injury Code (E-code)	6 digits	Optional Enter the ICD-10-CM diagnosis code for the external cause of an injury, poisoning, or adverse effect. This code must begin with an "E".
74. Principal Procedure Code/ Date	7 characters and 6 digits	Not Required
74A. Other Procedure Code/Date	7 characters and 6 digits	Not Required
76. Attending	NPI - 10 digits	NPI - Enter the 10-digit NPI assigned to the physician having primary responsibility for the

Form Locator and Label	Completion Format	Instructions
<p>NPI – Conditional QUAL - Conditional ID - (Colorado Medical Assistance Provider #) – Required</p>	<p>QUAL – Text Medicaid ID - 8 digits</p>	<p>patient's medical care and treatment. QUAL – Enter "1D" for Medicaid followed by the provider's eight-digit Colorado Medical Assistance Program provider ID. Medicaid ID - Enter the eight-digit Colorado Medical Assistance Program provider number assigned to the physician having primary responsibility for the patient's medical care and treatment.</p>
<p>76. Attending (continued) ID - (Colorado Medical Assistance Provider #) – Required Attending- Last/ First Name</p>		<p>Numbers are obtained from the physician, and <u>cannot</u> be a clinic or group number. (If the attending physician is not enrolled in the Colorado Medical Assistance Program or if the client leaves the ER before being seen by a physician, the hospital may enter their individual numbers.) Enter the attending physician's last and first name. This form locator must be completed for all services.</p>
<p>77. Operating- NPI/QUAL/ID</p>		<p>Submitted information is not entered into the claim processing system.</p>
<p>78-79. Other ID NPI – Conditional QUAL - Conditional ID - (Colorado Medical Assistance Provider #) – Conditional</p>	<p>NPI - 10 digits QUAL – Text Medicaid ID - 8 digits</p>	<p>Conditional Complete when attending physician is not the PCP or to identify additional physicians. Enter up to two 10-digit NPI and eight digit physician Colorado Medical Assistance Program provider numbers, when applicable. This form locator identifies physicians other than the attending physician. If the attending physician is not the primary care physician (PCP) or if a clinic is a PCP agent, enter the PCP eight digit Colorado Medical Assistance Program provider number in FL 78. The name of the Colorado Medical Assistance Program client's PCP appears on the eligibility verification. The Colorado Medical Assistance Program does not require that the primary care physician number appear more than once on each claim submitted. The "other" physician's last and first name are optional.</p>
<p>80. Remarks</p>	<p>Text</p>	<p>Enter specific additional information necessary to</p>

Form Locator and Label	Completion Format	Instructions
		process the claim or fulfill reporting requirements.
81. Code-Code-QUAL/CODE/VALUE (a-d)		Submitted information is not entered into the claim processing system.

Late Bill Override Date

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

Valid Delay Reason Codes

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



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

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

Billing Instruction Detail	Instructions
<p>LBOD Completion Requirements</p>	<ul style="list-style-type: none"> • Electronic claim formats provide specific fields for documenting the LBOD. • Supporting documentation must be kept on file for 6 years. • For paper claims, follow the instructions appropriate for the claim form you are using. <ul style="list-style-type: none"> ➢ <i>UB-04:</i> Occurrence code 53 and the date are required in FL 31-34. ➢ <i>Colorado 1500:</i> Indicate "LBOD" and the date in box 30 - Remarks. ➢ <i>2006 ADA Dental:</i> Indicate "LBOD" and the date in box 35 - Remarks.
<p>Adjusting Paid Claims</p>	<p>If the initial timely filing period has expired and a previously submitted claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was paid and now needs to be adjusted resulting in additional payment to the provider.</p> <p>Adjust the claim within 60 days of the claim payment. Retain all documents that prove compliance with timely filing requirements.</p> <p><i>Note: There is no time limit for providers to adjust paid claims that would result in repayment to the Colorado Medical Assistance Program.</i></p> <p>LBOD = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the payment.</p>

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

Billing Instruction Detail	Instructions
<p>Delayed Notification of Eligibility</p>	<p>The provider was unable to determine that the patient had Colorado Medical Assistance Program coverage until after the timely filing period expired.</p> <p>File the claim within 60 days of the date of notification that the individual had Colorado Medical Assistance Program coverage. Retain correspondence, phone logs, or a signed Delayed Eligibility Certification form (see Appendix H of the Appendices in the Provider Services Billing Manuals section) that identifies the client, indicates the effort made to identify eligibility, and shows the date of eligibility notification.</p> <ul style="list-style-type: none"> • Claims must be filed within 365 days of the date of service. No exceptions are allowed. • This extension is available only if the provider had no way of knowing that the individual had Colorado Medical Assistance Program coverage. • Providers who render services in a hospital or nursing facility are expected to get benefit coverage information from the institution. • The extension does not give additional time to obtain Colorado Medical Assistance Program billing information. • If the provider has previously submitted claims for the client, it is improper to claim that eligibility notification was delayed. <p>LBOD = the date the provider was advised the individual had Colorado Medical Assistance Program benefits.</p>
<p>Electronic Medicare Crossover Claims</p>	<p>An electronic claim is being submitted for Medicare crossover benefits within 120 days of the date of Medicare processing/ payment. (Note: On the paper claim form (only), the Medicare SPR date field documents crossover timely filing and completion of the LBOD is not required.)</p> <p>File the claim within 120 days of the Medicare processing/ payment date shown on the Standard Paper Remit (SPR) or Provider Claim Report. Maintain a copy of the SPR or Provider Claim Report on file.</p> <p>LBOD = the Medicare processing date shown on the SPR or Provider Claim Report.</p>
<p>Medicare Denied Services</p>	<p>The claim is for Medicare denied services (Medicare non-benefit services, benefits exhausted services, or the client does not have Medicare coverage) being submitted within 60 days of the date of Medicare processing/denial.</p> <p><i>Note: This becomes a regular Colorado Medical Assistance Program claim, not a Medicare crossover claim.</i></p> <p>File the claim within 60 days of the Medicare processing date shown on the Standard Paper Remit (SPR) or Provider Claim Report. Maintain a copy of the SPR or Provider Claim Report on file.</p> <p>LBOD = the Medicare processing date shown on the SPR or Provider Claim Report.</p>
<p>Commercial Insurance</p>	<p>The claim has been paid or denied by commercial insurance.</p>

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





Institutional Provider Certification

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

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

Signature: _____

Date: _____

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

Nursing Facility - Medicare Part A Crossover Claim Example

1	2	3a PAT. CNTRL # b. MED. REC. #	SM000123	4 TYPE OF BILL 623
1	Nursing Care Facility 100 Saginaw Street Anytown, CO 80201 303-333-3333	5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 10/1/15	7 THROUGH 10/31/15
8	PATIENT NAME a	9	PATIENT ADDRESS a	123 Main Street
b	Client, Ima D.	c	Anytown	d
10	BIRTHDATE 02/13/1950	11	SEX F	12
13	DATE 10/06/15	14	ADMISSION TYPE 5	15
16	SRG 30	17	DHR 30	18
19	STAT 30	20	18	21
22	22	23	24	25
26	26	27	27	28
29	29	30	30	30
31	OCCURRENCE DATE 50	32	OCCURRENCE DATE 10/15/15	33
34	OCCURRENCE DATE	35	OCCURRENCE DATE	36
37	OCCURRENCE DATE	38	OCCURRENCE DATE	39
40	OCCURRENCE DATE	41	OCCURRENCE DATE	42
43	OCCURRENCE DATE	44	OCCURRENCE DATE	45
46	OCCURRENCE DATE	47	OCCURRENCE DATE	48
49	OCCURRENCE DATE	50	OCCURRENCE DATE	51
52	OCCURRENCE DATE	53	OCCURRENCE DATE	54
55	OCCURRENCE DATE	56	OCCURRENCE DATE	57
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Nursing Facility with Medical Leave Days Claim Example

1 Nursing Care Facility 100 Saginaw Street Anytown, CO 80201 303-333-3333		2		3a PAT. CNTL. # b. MED. REC. # 5 FED. TAX NO.		1111110060		4 TYPE OF BILL 223			
8 PATIENT NAME a Client, Ima D.				9 PATIENT ADDRESS a 123 Main Street				c CO		d 88888	
10 BIRTHDATE 02/13/1950		11 SEX F		12 DATE 10/06/15		13 HR		14 TYPE 05		15 SRC	
16 DHR		17 STAT 30		18		19		20		21	
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NF Revisions Log

Revision Date	Additions/Changes	Pages	Made by
02/13/2008	<i>Electronic Claims – Updated first two paragraphs with bullets</i>	1	<i>pr-z</i>
02/20/2009	<i>Updated Web site addresses</i>	<i>Throughout</i>	<i>jg</i>
02/20/2009	<i>Changed language for private room reimbursement</i>	7	<i>jg</i>
03/26/2009	<i>General updates</i>	<i>Throughout</i>	<i>jg</i>
01/19/2010	<i>Updated Web site links</i>	<i>Throughout</i>	<i>jg</i>
02/17/2010	<i>Replaced EOMB with SPR</i>	25	<i>jg</i>
03/04/2010	<i>Added link to Program Rules</i>	1	<i>jg</i>
07/14/2011	<i>Replaced Medicare Part B Crossover Claim Example</i>	30	<i>Jg</i>
12/06/2011	<i>Replaced 997 with 999 Replaced www.wpc-edi.com/hipaa with www.wpc-edi.com/ Replaced Implementation Guide with Technical Report 3 (TR3)</i>	3 1 1	<i>Ss</i>
09/24/2015	<i>Replaced mentions of ICD-9 with ICD-10. Updated Claims examples</i>	<i>Throughout</i> <i>Throughout</i>	<i>JH</i>
10/1/2015	<i>Made grammatical changes. Reviewed manual by Cathy Fielder and Susan Love. Updated Post-Eligibility Treatment of Income per Cathy Fielder and Susan Love. Changed out references of ACS with Xerox State Healthcare</i>	<i>Throughout</i> 7 <i>Throughout</i>	<i>JH</i>

Note: *In many instances when specific pages are updated, the page numbers change for the entire section. Page numbers listed above, are the page numbers on which the updates/changes occur.*