Private Duty Nursing

Private Duty Nursing

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 Private Duty Nursing (PDN) program provides skilled nursing services on an intermittent basis to Health First Colorado members in their place of residence. A plan of care as ordered by the attending physician is developed by the Home Health agency. The plan of care is reviewed periodically by the physician. All plan of care services are subject to post-payment review for medical necessity and regulation compliance.

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

Billing Information

National Provider Identifier (NPI)

The Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities (i.e., health plans, health care clearinghouses, and those health care providers who transmit any health information electronically in connection with a transaction for which the Secretary of Health and Human Services has adopted a standard) use NPIs in standard transactions. Certain Provider Types are not able to obtain an NPI. Those providers will be assigned a Health First Colorado provider number.

Paper Claims

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

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

Paper claims require an NPI for those provider types that can obtain one. Providers that cannot obtain an NPI are required to use an assigned Health First Colorado provider number on their claims. Electronically mandated claims submitted on paper are processed, denied, and marked with the message "Electronic Filing Required".

Electronic Claims

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

- X12N Technical Report 3 (TR3) for the 837P, 837I, or 837D (wpc-edi.com)
- Companion Guides for the 837P, 837I, or 837D in the EDI support section of the Department's website (edi-support)
- Online Portal User Guide (via within the Online Portal)

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

Interactive Claim Submission and Processing

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

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

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

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

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

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

- Accept/Reject Report
- Remittance Advice
- Health Care Claim Payment/Advice (ASC X12N 835)
- Managed Care Reports such as Primary Care Physician Rosters
- Eligibility Inquiry (interactive and batch)
- Claim Status Inquiry

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

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

General Prior Authorization Requirements

All PDN Prior Authorization Requests (PARs) must be submitted via ColoradoPAR.com. The additional forms necessary for PDN PAR submission are available in the Provider Services Forms section or from the authorizing agency. PAR forms must be completed and sent to the authorizing agency before services can be billed. Instructions for completing the PAR form are included in this manual. Authorizing agency information is listed in Appendices C and D of the Appendices in the Provider Services Billing Manuals section.

The Health First Colorado requires the completion of a PAR form for:

- All Private Duty Nursing services prior to starting services.
- Orders must specify how often treatment or visits will be and the length of visit.

- Time submitted that is outside of or different from the orders will be deducted and the units adjusted accordingly.
- Do not submit claims before a copy of the PAR is received or made available unless submission is necessary to meet timely filing requirements. Refer to the Department Program Rules - Code of Colorado Regulations located in Boards & Committees in the Medical Services Board section of the Department's website for required attachments.

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

After a PAR has been reviewed, the status of the PAR is sent to the fiscal agent and a PAR letter is sent to the provider. For approved services, allow sufficient time for the authorizing agency to enter the PAR data into the Medicaid Management Information System (MMIS) before submitting a claim for the authorized service. Submitted claim data is checked against the PAR file, therefore, **do not** submit a copy of the PAR with the claim. The authorizing agency identifies the appropriate PAR data using member identification information and the PAR number noted on the claim.

Note: When a PAR is revised, the number on the original PAR must be used on the claim. (Do not use the PAR number assigned to the revision when completing a claim. Use the original PAR number.)

General Prior Authorization Request Instructions

Submit all appropriate documentation to support your PDN request including detailed demographics, diagnosis, physician's orders, treatment plans, nursing summaries, nurse aide assignment sheets, medications, etc. via ColoradoPAR.com.

Revision must also be submitted via ColoradoPAR.com and must be completed in a timely manner prior to the expiration of the PAR Revenue Coding.

The following table identifies the only valid revenue codes for billing Private Duty Nursing to the Health First Colorado. Valid revenue codes are not always a Health First Colorado benefit. When valid non-benefit revenue codes are used, the claim must be completed according to the billing instructions for non-covered charges.

Private duty nursing providers billing on the UB-04 claim form for services provided to authorized members must use the appropriate condition code in form locators 18 through 28 (Condition Codes) and use the revenue codes listed below. Claims submitted with revenue codes that are not listed below are denied.

Private Duty Nursing Claim Example

The information in the following table provides instructions for completing form locators 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 (located after the Late Bill Override Date 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 Health First Colorado claims, including hardcopy Medicare claims, should be mailed to the correct fiscal agent address located in Appendix A in the Appendices of the Provider Services Billing Manuals section.

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 Health First Colorado for PDN claims.

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

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

Form Locator and Label	Completion Format	Instructions
4. Type of Bill	3 digits	Required **Private Duty Nursing** Effective 3/1/2017 use 32X for Home Health/Private Duty Nursing services. 33X is no longer valid. (These instructions supersede all prior publications') Use 321-324 or 341-344 for Medicare crossover claims. Enter the three-digit number indicating the specific type of bill. The three-digit code requires one digit each in the following sequences (Type of facility, Bill classification, and Frequency): Digit 1 Type of Facility 1 Hospital 2 Skilled Nursing 3 Home Health Services 4 Religious Non-Medical Health Care Institution 6 Intermediate Care 7 Clinic (Rural Health/FQHC/Dialysis Center) 8 Special Facility (Hospice, RTCs) Digit 2 Bill Classification (Except clinics & special facilities): 1 Inpatient (Including Medicare Part A) 2 Inpatient (Medicare Part B only) 3 Outpatient 4 Other (for hospital referenced diagnostic services or home health not under a plan of treatment) 5 Intermediate Care Level I 6 Intermediate Care Level II 7 Sub-Acute Inpatient (revenue code 19X required with this bill type) 8 Swing Beds 9 Other Digit 2 Bill Classification (Clinics Only): 1 Rural Health/FQHC 2 Hospital Based or Independent Renal Dialysis Center 3 Freestanding

Form Locator and Label	Completion Format	Instructions
4. Type of Bill (continued)	3 digits	Digit 3 Frequency: 0 Non-Payment/Zero Claim 1 Admit through discharge claim 2 Interim - First claim 3 Interim - Continuous claim 4 Interim - Last claim 7 Replacement of prior claim 8 Void of prior claim
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 **Private Duty Nursing** "From" date is the actual start date of services. "From" date cannot be prior to the start date reported on the initial prior authorization, if applicable, or is the first date of an interim bill. "Through" date is the actual discharge date, or final date of an interim bill. "From" and "Through" dates cannot exceed a calendar month (e.g., bill 01/15/10 thru 01/31/10 and 02/01/10 thru 02/15/10, not 01/15/10 thru 02/15/10). Dates must match the prior authorization if applicable. If member is admitted and discharged the same date, that date must appear in both fields. Detail dates of service must be within the "Statement Covers Period" dates.
8a. Patient Identifier		Submitted information is not entered into the claim processing system.
8b. Patient Name	Up to 25 characters: Letters & spaces	Required Enter the member's last name, first name and middle initial.
9a. Patient Address – Street	Characters Letters & numbers	Required Enter the member's street/post office box as determined at the time of admission.
9b. Patient Address – City	Text	Required Enter the member's city as determined at the time of admission.

Form Locator and Label	Completion Format	Instructions
9c. Patient Address – State	Text	Required Enter the member's state as determined at the time of admission.
9d. Patient Address – Zip	Digits	Required Enter the member's zip code as determined at the time of admission.
9e. Patient Address – Country Code	Text	Optional
10. Birthdate	8 digits (MMDDCCYY)	Required Enter the member's birthdate using two digits for the month, two digits for the date, and four digits for the year (MMDDCCYY format). Example: 01012009 for January 1, 2009.
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 **Private Duty Nursing** Enter the date care originally started from any funding source (e.g., Medicare, Health First Colorado, Third Party Resource, etc.).
13. Admission Hour		Not Required
14. Admission Type		Not Required
15. Source of Admission		Required
16. Discharge Hour		Not Required
17. Patient Discharge Status	2 digits	Required **Private Duty Nursing** Enter member status as ongoing member (code 30) or as of discharge date. Agencies are limited to the following codes: 01 Discharged to Home 3 Discharged/Transferred to SNF 4 Discharged/Transferred to ICF

Form Locator and Label	Completion Format	Instructions
		5 Discharged/Transferred to Another Type of Institution 6 Discharged/Transferred to organized Home Health Care Program (HCBS) 7 Left Against Medical Advice 20 Expired (Deceased - Not for Hospice use) 30 Still member (ongoing) 40 Expired at home
17. Patient Discharge Status	2 digits	41 Expired in hospital, SNF, ICF, or free-standing hospice 42 Expired - place unknown 50 Hospice - Home 51 Hospice - Medical Facility
18-28. Condition Codes	2 Digits	Conditional Use condition code A1 to bill PDN hours greater than 16 for children
29. Accident State		Optional
31-34. Occurrence Code/Date	2 digits and 6 digits	Required Use occurrence code 27 and enter the Plan of Care start date. Enter the date using MMDDYY format.
35-36. Occurrence Span Code From/ Through	None	Leave Blank
38. Responsible Party Name/ Address	None	Leave blank
39-41. Value Code and Amount	2 characters and 9 digits	Conditional Enter appropriate codes and related dollar amounts to identify monetary data or number of days using whole numbers, necessary for the processing of this claim. Never enter negative amounts. Fields and 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.

Form Locator and Label	Completion Format	Instructions
		01 Most common semiprivate rate (Accommodation Rate) 06 Medicare blood deductible 14 No fault including auto/other 15 Worker's Compensation 31 Member Liability Amount 32 Multiple Member Ambulance Transport 37 Pints of Blood Furnished 38 Blood Deductible Pints 40 New Coverage Not Implemented by HMO
39-41. Value Code and Amount (continued)	2 characters and 9 digits	Conditional 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 49 Hematocrit Reading - EPO Related 58 Arterial Blood Gas (PO2/PA2) 68 EPO-Drug 80 Covered Days 81 Non-Covered Days Enter the amount paid by indicated payer: A3 Estimated Responsibility Payer A B3 Estimated Responsibility Payer B C3 Estimated Responsibility Payer C For Rancho Coma Score bill with appropriate diagnosis for head injury.
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. Enter the appropriate Revenue code. *Private Duty Nursing services cannot be provided to Nursing Facility residents.*

Form Locator and Label	Completion Format	Instructions
43. Revenue Code Description	Text	Required Enter the revenue code description or abbreviated description.
44. HCPCS/Rates/ HIPPS Rate Codes	5 digits	Required for the following: ▪ Private Duty Nursing RN visit: Use only HCPCS code T1000 with modifier TD for revenue code 552. ▪ Private Duty Nursing LPN visit: Use only HCPCS code T1000 with modifier TE for revenue code 559. ▪ Private Duty Nursing private duty nursing RN group visit: Use only HCPCS code T1000 with modifiers HQ and TD for revenue code 580. ▪ Private Duty Nursing private duty nursing LPN group visit: Use only HCPCS code T1000 with modifiers HQ and TE for revenue code 581. When billing HCPCS codes, the appropriate revenue
45. Service Date	6 digits	Required Enter the date of service using MMDDYY format for each detail line completed.
46. Service Units	3 digits	Required Enter a unit value on each line completed. Use whole numbers only. Do not enter fractions or decimals and do not show a decimal point followed by a 0 to designate whole numbers (e.g., Do not enter 1.0 to signify one unit)
47. Total Charges	9 digits	Required Enter the total charge for each line item. Calculate the total charge as the number of units multiplied by the unit charge. Do not subtract Medicare or third party payments from line charge entries. Do not enter negative amounts. A grand total in line 23 is required for all charges.
48. Non-Covered Charges	Up to 9 digits	Conditional Enter incurred charges that are not payable by the Health First Colorado. Non-covered charges must be entered in both FL 47 (Total Charges) and FL 48 (Non-Covered Charges.) Each column requires a grand total.

Form Locator and Label	Completion Format	Instructions
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 Health First Colorado. 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	10 digits	Required Enter the provider's Health Plan ID for each payer name. Enter the Health First Colorado provider number assigned to the **billing provider**. Payment is made to the enrolled provider or agency that is assigned this number.
52. Release of Information	N/A	Submitted information is not entered into the claim processing system.
53. Assignment of Benefits	N/A	Submitted information is not entered into the claim processing system.
54. Prior Payments	Up to 9 digits	Conditional Complete when there are Medicare or third party payments. Enter third party and/or Medicare payments.
55. Estimated Amount Due	Up to 9 digits	Conditional Complete when there are Medicare or third party payments. Enter the net amount due from The Health First Colorado after provider has received other third party, Medicare or member liability amounts.

Form Locator and Label	Completion Format	Instructions
55. Estimated Amount Due (continued)	Up to 9 digits	**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)	10 digits	Required Enter the billing provider's 10-digit National Provider Identifier (NPI).
57. Other Provider ID		Optional Submitted information is not entered into the claim processing system.
58. Insured's Name	Up to 30 characters	Required Enter the member's name on the Health First Colorado line. **Other Insurance/Medicare** Complete additional lines when there is third party coverage. Enter the policyholder's last name, first name, and middle initial.
60. Insured's Unique ID	Up to 20 characters	Required Enter the insured's unique identification number assigned by the payer organization. Include letter prefixes or suffixes.
61. Insurance Group Name	14 letters	Conditional Complete when there is third party coverage. Enter the name of the group or plan providing the insurance to the insured.
62. Insurance Group Number	17 digits	Conditional Complete when there is third party coverage. Enter the identification number, control number, or code assigned by the carrier or fund administrator identifying the group under which the individual is covered.
63. Treatment Authorization Code	Up to 18 characters	Conditional Complete when the service requires a PAR. Enter the PAR/authorization number in this field, if a PAR is required and has been approved for services.
64. Document Control Number		Enter Previous ICN in field 64a

Form Locator and Label	Completion Format	Instructions
65. Employer Name	Text	Conditional Complete when there is third party coverage. Enter the name of the employer that provides health care coverage for the individual identified in FL 58 (Insured Name).
66. Diagnosis Version Qualifier		Submitted information is not entered into the claim processing system. Enter applicable ICD indicator to identify which version of ICD codes is being reported. 0 ICD-10-CM (DOS 10/1/15 and after) 9 ICD-10-CM (DOS 9/30/15 and before)
67. Principal Diagnosis Code	Up to 6 digits	Required Enter the exact diagnosis code describing the principal diagnosis that exists at the time of admission or develops subsequently and affects the length of stay. Do not add extra zeros to the diagnosis code.
67A- 67Q. Other Diagnosis	6 digits	Optional Enter the exact diagnosis code corresponding to additional conditions that co-exist at the time of admission or develop subsequently and which effect the treatment received or the length of stay. Do not add extra zeros to the diagnosis code. Enter applicable ICD indicator to identify which version of ICD codes is being reported.
69. Admitting Diagnosis Code	6 digits	Not Required Enter the 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 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	N/A	Not Required

Form Locator and Label	Completion Format	Instructions
74A. Other Procedure Code/Date	N/A	Not Required
76. Attending NPI – Required	10 digits	Health First Colorado ID Required NPI - Enter the 10-digit NPI number assigned to the physician having primary responsibility for the member's medical care and treatment. This number is obtained from the physician, and cannot be a clinic or group number. (If the attending physician is not enrolled in the Health First Colorado or if the member leaves the ER before being seen by a physician, the hospital may enter their individual numbers.) Hospitals may enter the member's regular physician's 10-digit NPI in the Attending Physician ID form locator if the locum tenens physician is not enrolled in the Health First Colorado. QUAL – Enter "1D" for Medicaid
77. Operating- NPI		Optional Submitted information is not entered into the claim processing system.
78-79. Other ID NPI – Conditional	NPI - 10 digits t	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 and Label	Completion Format	Instructions
81. Code-Code-QUAL/CODE/VALUE (a-d)		Submitted information is not entered into the claim processing system.

Institutional Provider Certification

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

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

Signature: _____ *Date:* _____

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

Private Duty Nursing Claim Example

Note: Medicare crossover claims are valid only with Medicare claims for visits rather than episodes. LUPA payments not episode case mix payment.

Home Health Agency 100 Saginaw Street Anytown, CO 80201 303-333-3333								321	10/01/2016 10/21/2016
Client, Ima D.				Anytown			CO	88888	
02/13/1948	F	10/01/2016		1		30			
27	10/01/2016						10/01/2016	10/21/2016	

552	Registered Nurse	T1000 TD	10/01/2016	1	60.00	
552	Registered Nurse	T1000 TD	10/11/2016	3	180.00	
552	Registered Nurse	T1000 TD	10/21/2016	1	60.00	
	PAGE 1 OF 1		CREATION DATE	TOTALS	300.00	

D - Medicaid	1234567890			300.00	
Client, Ima D.		A123456			

E119			
0			
76 ATTENDING NPI 1234567890	LAST Provider	FIRST Ima	
77 OPERATING NPI	LAST	FIRST	
78 OTHER NPI	LAST	FIRST	
79 OTHER NPI	LAST	FIRST	

NUBC

Timely Filing

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

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

Private Duty Nursing Revisions Log

Revision Date	Additions/Changes	Pages	Made by
12/01/2016	*Manual revised for interChange implementation. Form annual revisions prior to 12/01/2016 Please refer to*	*All*	*HPE (now DXC)*
12/27/2016	*Updates based on Colorado iC Stage II Provider Billing Manual Comment Log v0_2.xlsx*	*8, 13*	*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)*
3/8/2017	*Added Type of Bill 32x to row 4 of the Private Duty Nursing Claim example table*	*6*	*RC*
3/13/2017	*Updated the Type of Bill section in the Paper Claims Table to reflect the NUBC manual*	*6*	*RC*
3/14/2017	*Updated the type of bill in the paper claim example*	*18*	*RC*
5/26/2017	*Updates based on Fiscal Agent name change from HPE to DXC*	*1*	*DXC*

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