

# Vision Care and Eyewear Manual

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# Vision Care & Eyewear Services

## **Benefits**

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 Colorado Medical Assistance Program reimburses providers for medically necessary medical and surgical services furnished to eligible clients.

Providers should refer to the Code of Colorado Regulations, [Program Rules](#) (10 CCR 2505-10), for specific information when providing medical/surgical services.

### **Clients Ages 21 and Older**

Medically necessary eye examinations are benefits for Colorado Medical Assistance Program clients ages 21 and older. Eyeglasses and contact lenses are benefits following eye surgery only and do not require prior authorization. The surgery may have been performed at any time during the patient's life. The modifier -55 must be used with eyewear codes to identify surgery-related eyewear (1 unit per lens).

### **Clients Ages 20 and Younger**

The Early Periodic Screening Diagnosis and Treatment (EPSDT) Program provides the following vision benefits for clients age 20 and under:

- Standard eyeglasses (one or two single or multifocal vision clear glass lenses with one standard frame). Colorado Medical Assistance Program provides payment for one standard frame.
- Glasses dispensed by an optician are a benefit when ordered by an ophthalmologist or optometrist.
- Replacement or repair of frames or lenses (standard eyeglasses), not to exceed the cost of replacement.
- Contact lenses must be medically necessary and prior authorized unless provided for vision correction after surgery. Contact lenses, supplies, and contact lens insurance are not benefits.
- Ocular prosthetics are a benefit if services are prior authorized. A statement of medical necessity must accompany the Prior Authorization Request (PAR).
- There is no yearly maximum for eye exams or eyeglasses.

### **Additional options**

If a client requests a deluxe frame, the provider must discuss the need for additional charges to the client, and the provider must obtain written agreement from the client to pay the non-covered costs.

Allowable non-covered costs that may be charged to the client are those representing the difference between the provider's retail usual and customary charges for the Colorado Medical Assistance Program allowable frames and the retail amount for the upgraded frames requested by the client. This guideline also applies to the repair or replacement of eyeglasses. Providers must bill S1001, Deluxe item, (list in addition to code for basic item).



## 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 Affiliated Computer Services (ACS), P.O. Box 90, 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. 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/](http://wpc-edi.com/) (HIPAA EDI Technical Report 3)
- Companion Guides for the 837P, 837I, or 837D are available on the Department's Web site in the Provider Services [Specifications](#) section.
- Web Portal User Guide (within the Web 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](#) located at [colorado.gov/hcpf](http://colorado.gov/hcpf), Secured Site. 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 in the Provider Services [Specifications](#) section.



**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 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 ACS Electronic Data Interchange (EDI) Gateway for processing where reports and responses will be delivered must complete an EDI enrollment package. This provides ACS EDI Gateway the information necessary to assign a Logon Name, Logon ID, and Trading Partner ID, which are required to submit electronic claims. You may obtain an enrollment package by contacting the Colorado Medical Assistance Program fiscal agent or by downloading it from the Provider Services [EDI Support](#) section of the Department's Web site. 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 ACS 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 ACS 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 ACS 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 ACS EDI Gateway. Assistance from ACS 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 have not affected provider submissions. Also, changes to the ANSI formats may require additional testing.

In order to expedite testing, ACS EDI Gateway requires providers to submit all X12N test transactions to Edifecs prior to submitting them to ACS 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 [edifecs.com](http://edifecs.com) (Edifecs).



**Prior Authorization Requests (PARs) for Vision Services**

Prior authorization is not required for vision correction after surgery. Providers must identify claims for vision correction after surgery with the approximate date and the modifier -55 for each eyewear procedure code. Eye surgery may have been performed at any time during the patient’s life.

Prior authorizations are required for designated items including:



- Contact lenses.
- Low vision aids.

- Ocular prosthetics (EPSDT clients only) with a statement of medical necessity and the type of prosthetic eye.
- Tint, anti-reflective coating, U-V, oversize, occluder, and progressive lenses.

**General Requirements**

All PARs must be submitted and approved before rendering services. Providers should not bill for or render services until the PAR has been approved. The claim must contain the PAR number for payment.

Providers are encouraged to submit PARs electronically. Electronic submission of PARs offers Providers:

- Immediate assignment of a PAR number
- Faster PAR processing
- Online PAR status inquiries



Software Help screens give instructions for completing and submitting electronic PARs.

Use them to enter the required PAR information online. Electronically submitted PARs lacking the minimally required information are rejected and require resubmission.

Providers may opt to submit a paper PAR instead of an electronic PAR. A copy of the paper Prior Authorization Request form and accompanying instructions follow. Fill out paper PAR forms completely and accurately. Mail paper PARs to the address listed in Appendix C. Paper-submitted PARs lacking the minimally required information are refused and require resubmission.

The authorizing agency reviews all completed PARs. The authorizing agency approves or denies, by individual line item, each requested service or supply listed on the PAR. The results of the PAR review are posted online and included in PAR letters sent to both the provider and the client. **Read the results carefully as some line items may be approved and others denied.**

**Approval of a PAR does not guarantee Colorado Medical Assistance Program payment and does not serve as a timely filing waiver.** An approved PAR only assures that the service or supply is a medical necessity and is a benefit of the Colorado Medical Assistance Program.

All claims, including those for prior authorized services or supplies, must meet eligibility and claim submission requirements (e.g., required attachments included, timely filing, provider information completed appropriately, etc.) before payment can be made.

The services must be rendered by a provider who is enrolled in the Colorado Medical Assistance Program and who is identified on the approved PAR, and rendered services must match the approved services exactly.

After the PAR is approved, submit the claim to the authorizing agency.

If the provider notes an error on an approved PAR, contact the authorizing agency for correction. Procedure codes, quantities, etc. may be changed or entered by the authorizing agency.

If the PAR is denied, direct inquiries to the authorizing agent.

**Paper PAR Instructional Reference**

Field Label	Completion Format	Instructions
The upper margin of the PAR form must be left blank. This area is for fiscal agent use only.		
<b>Invoice/Pat Account Number</b>	Text	Optional Enter up to 12 characters (numbers, letters, hyphens) that help identify the claim or client.
<b>1. Client Name</b>	Text	Required Enter the client's last name, first name, and middle initial. Example: Adams, Mary A.
<b>2. Client Identification Number</b>	7 characters, a letter prefix followed by six numbers	Required Enter the client's state identification number. This number consists of a letter prefix followed by six numbers. Example: A123456.

Field Label	Completion Format	Instructions
3. Sex	Check box <input type="checkbox"/> M <input type="checkbox"/> F	Required Enter an "X" in the appropriate box.
4. Date of Birth	6 numbers	Required Enter the client's birth date using MMDDYY format. Example: January 1, 2010 = 010110.
5. Client Address	Characters: numbers and letters	Required Enter the client's full address: Street, city, state, and zip code.
6. Client Telephone Number	10 numbers	Optional Enter the client's telephone number.
7. Prior Authorization Number		System Assigned Do not write in this area. The authorizing agent reviews the PAR and approves or denies the services  Enter this PAR number or the system-assigned PAR number in the appropriate field on the claim form when billing for prior authorized services.
8. Dates Covered by This Request	6 numbers for from date and 6 numbers for through date (MMDDYY)	Required Enter the date(s) within which service(s) will be provided. If left blank, the authorizing agent enters the dates. Authorized services must be rendered within these dates.
9. Does Client Reside in a Nursing Facility?	Check Box <input type="checkbox"/> Yes <input type="checkbox"/> No	Required Check the appropriate box.
10. Group Home Name if Patient Resides in a Group Home	Text	Conditional Complete if client resides in a group home. Enter the name of the group home or residence.

Field Label	Completion Format	Instructions
11. <b>Diagnosis</b>	Text	<p>Required</p> <p>Enter the diagnosis code and sufficient relevant diagnostic information to justify the PAR and include the prognosis. Provide relevant clinical information, other drugs or alternative therapies tried in treating the condition, results of tests, etc. to justify a Colorado Medical Assistance Program determination of medical necessity. Approval of the PAR is based on documented medical necessity. Attach documents as required.</p>
12. <b>Requesting Authorization for Repairs</b>	None	Not Required
13. <b>Indicate Length of Necessity</b>	None	Not Required
14. <b>Estimated Cost of Equipment</b>	None	Not Required
15. <b>Services To Be Authorized</b>	None	<p>Preprinted</p> <p>Do not alter preprinted lines. No more than five items can be requested on one form.</p>
16. <b>Describe Procedure, Supply, or Drug to be Provided</b>	Text	<p>Required</p> <p>Enter the description of the service/procedure to be provided.</p>
17. <b>Procedure, Supply or Drug Code</b>	HCPCS code	<p>Required</p> <p>Enter the procedure code for each item that will be billed on the claim form. The authorizing agency may change any code.</p> <p>The approved code(s) on the PAR form must be used on the claim form.</p>
18. <b>Requested Number of Services</b>	Numbers	<p>Required</p> <p>Enter the number of units for supplies or services requested. The authorizing agent completes this field if left blank.</p>

Field Label	Completion Format	Instructions
19. <b>Authorized No. of Services</b>	None	Leave Blank The authorizing agency indicates the number of services authorized that may or may not equal the number requested in Field 18 (Number Of Services).
20. <b>A=Approved D=Denied</b>	None	Leave Blank Providers should check the PAR on-line or refer to the PAR letter.
21. <b>Primary Care Physician (PCP) Name</b>	None	Not Required
<b>Telephone Number</b>		Not Required
22. <b>Primary Care Physician Address</b>	Text	Not Required
23. <b>PCP Provider Number</b>	8 numbers	Not Required
24. <b>Name and Address of Provider Requesting Prior Authorization</b>	Text	Required Enter the complete name and address of the provider requesting the PAR.  If the clinic is requesting a PAR, enter the provider's complete name and address
25. <b>Name and Address of Provider Who will Render Service</b>	Text	Required Enter the complete name and address of the provider requesting prior authorization. (The physician ordering/writing the prescription.)
26. <b>Requesting Physician Signature</b>  <b>Telephone Number</b>	Text	Required The physician requesting the service must sign the PAR. A rubber stamp facsimile signature is not acceptable on the PAR. Required Enter the telephone number of the physician requesting the service.
27. <b>Date Signed</b>	6 numbers	Required Enter the date the PAR form is signed by the requesting physician.
28. <b>Requesting Physician Provider Number</b>	8 numbers	Required Enter the eight-digit Colorado Medical Assistance Program provider number of the requesting provider.

Field Label	Completion Format	Instructions
29. <b>Service Provider Number</b>	8 numbers	Required Enter the eight-digit Colorado Medical Assistance Program provider number of the State designated entity. The rendering provider must be enrolled in the Colorado Medical
30. <b>Comments or Reasons For Denial of Benefits</b>	Completed by Authorizing Agent	Leave Blank Refer to the PAR response for comments submitted by the authorizing agency.
31. <b>PA Number Being Revised</b>	None	Leave Blank This field is completed by the authorizing agent

**PAR Form Example**



STATE OF COLORADO  
DEPARTMENT OF  
HEALTH CARE POLICY AND  
FINANCING

WORKER/PATIENT NUMBER
SPECIAL PROGRAM CODE

**HEALTH INSURANCE CLAIM**

**PATIENT AND INSURED (SUBSCRIBER) INFORMATION**

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL)	2. CLIENT DATE OF BIRTH	3. MEDICAID ID NUMBER (CLIENT ID NUMBER)
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. CLIENT SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	6. MEDICARE ID NUMBER (IHC OR SSN)
TELEPHONE NUMBER	7. CLIENT RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. <input type="checkbox"/> CLIENT IS COVERED BY EMPLOYER HEALTH PLAN AS EMPLOYEE OR DEPENDENT EMPLOYER NAME: _____ POLICYHOLDER NAME: _____ GROUP: _____
9. OTHER HEALTH INSURANCE COVERAGE — INSURANCE COMPANY NAME, ADDRESS, PLAN NAME, AND POLICY NUMBER(S)	10. WAS CONDITION RELATED TO: A. CLIENT EMPLOYMENT YES <input type="checkbox"/> B. ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/> C. DATE OF ACCIDENT _____	11. CHAMPUS SPONSORS SERVICE(S)
12. PREGNANCY <input type="checkbox"/> HMO <input type="checkbox"/> NURSING FACILITY <input type="checkbox"/>		

**PHYSICIAN OR SUPPLIER INFORMATION**

13. DATE OF: ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR FIRST PREGNANCY (LMP)	14. MEDICARE DENIAL (ATTACH THE MEDICARE STANDARD PAPER REMITTANCE (SPR) IF EITHER BOX IS CHECKED) <input type="checkbox"/> BENEFITS EXHAUSTED <input type="checkbox"/> NON-COVERED SERVICES	14A. OTHER COVERAGE DENIED <input type="checkbox"/> NO <input type="checkbox"/> YES PAYMENT DATE: _____
15. NAME OF SUPERVISING PHYSICIAN	PROVIDER NUMBER	15B. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES ADMITTED: _____ DISCHARGED: _____
17. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (IF OTHER THAN HOME OR OFFICE)	PROVIDER NUMBER	17A. CHECK BOX IF LABORATORY WORK WAS PERFORMED OUTSIDE THE PHYSICIAN'S OFFICE <input type="checkbox"/> YES

18. ICD-9-CM DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. IN COLUMN F, RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE NUMBERS 1, 2, 3, OR 4

1.	
2.	
3.	
4.	

TRANSPORTATION CERTIFICATION ATTACHED  YES

DURABLE MEDICAL EQUIPMENT  
Line #    Make    Model    Serial Number

PRIOR AUTHORIZATION #:

16A. DATE OF SERVICE FROM TO	B. PLACE OF SERVICE	C. PROCEDURE CODE (ICD-9-CM)	D. MODIFIERS	E. RENDERING PROVIDER NUMBER	F. REFERRING PROVIDER NUMBER	G. DIAGNOSIS P I S T	H. CHARGES	I. DAYS OR UNITS	J. COPY	K. EMERG ENCY	L. FAMILY PLANING	M. EPIDEM
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE, AND COMPLETE. I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION OR CONCEALMENT OF ANY MATERIAL FACT MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS.

27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE

28. BILLING PROVIDER NAME

28. BILLING PROVIDER NUMBER

29. TOTAL CHARGES →

25. MEDICARE PAID

26. THIRD PARTY PAID

27. NET CHARGE

24. MEDICARE DEDUCTIBLE

25. MEDICARE COINSURANCE

26. MEDICARE DISALLOWED

29. MEDICARE SPR DATE

COL-101  
FORM NO. 8433 (REV. 0399)  
ELECTRONIC APPLICATION

**COLORADO 1500**

## Procedure/HCPCS Codes Overview

The Department accepts procedure codes that are approved by the Centers for Medicare & Medicaid Services (CMS). The codes are used for submitting claims for services provided to Colorado Medical Assistance Program clients and represent services that may be provided by enrolled certified Colorado Medical Assistance Program providers.

The Healthcare Common Procedural Coding System (HCPCS) is divided into two principal subsystems, referred to as level I and level II of the HCPCS. Level I of the HCPCS is comprised of Current Procedural Terminology (CPT), a numeric coding system maintained by the American Medical Association (AMA). The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter followed by 4 numeric digits, while CPT codes are identified using 5 numeric digits.

HIPAA requires providers to comply with the coding guidelines of the AMA CPT Procedure Codes and the International Classification of Disease, Clinical Modification Diagnosis Codes. If there is no time designated in the official descriptor, the code represents one unit or session. Providers should regularly consult monthly bulletins located in the Provider Services [Provider Bulletins](#) section. To receive electronic provider bulletin notifications, an email address can be entered into the Web Portal in the (MMIS) *Provider Data Maintenance* area or by completing and submitting a [Publication Email Preference Form](#) in the Provider Services [Forms](#) section. Bulletins include updates on approved procedures codes as well as the maximum allowable units billed per procedure.

## Paper Claim Reference Table

The following paper form reference table shows required, optional, and conditional fields and detailed field completion instructions for the Colorado 1500 claim form.

Field Label	Completion Format	Special Instructions
<b>Invoice/Pat Acct Number</b>	Up to 12 characters: letters, numbers or hyphens	Optional Enter information that identifies the patient or claim in the provider's billing system. Submitted information appears on the Provider Claim Report.
<b>Special Program Code</b>	N/A	N/A
<b>1. Client Name</b>	Up to 25 characters: letters & spaces	Required Enter the client's last name, first name, and middle initial.
<b>2. Client Date of Birth</b>	Date of Birth 8 digits (MMDDCCYY)	Required Enter the patient's birth date using two digits for the month, two digits for the date, two digits for the century, and two digits for the year. Example: 07012010 for July 1, 2010.

Field Label	Completion Format	Special Instructions
<b>3. Medicaid ID Number (Client ID Number)</b>	7 characters: a letter prefix followed by six numbers	Required Enter the client's Colorado Medical Assistance Program ID number. Each person has his/her own unique Colorado Medical Assistance Program ID number. Example: A123456
<b>4. Client Address</b>	Not required	Submitted information is not entered into the claim processing system.
<b>5. Client Sex</b>	Check box Male <input type="checkbox"/> Female <input type="checkbox"/>	Required Enter a check mark or an "x" in the correct box to indicate the client's sex.
<b>6. Medicare ID Number (HIC or SSN)</b>	Up to 11 characters: numbers and letters	Conditional Complete if the client is eligible for Medicare benefits. Enter the individual's Medicare health insurance claim number.  The term "dually eligible" refers to a person who is eligible for both Colorado Medical Assistance Program and Medicare benefits.
<b>7. Client Relationship to Insured</b>	Check box Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	Conditional Complete if the client is covered by a commercial health care insurance policy. Enter a check mark or an "x" in the box that identifies the person's relationship to the policyholder.
<b>8. Client Is Covered By Employer Health Plan</b>	Text	Conditional Complete if the client is covered by an employer health plan as policyholder or as a dependent. Enter the employer name policyholder's name and group number. Also complete fields 9 and 9A.
<b>9. Other Health Insurance Coverage</b>	Text	Conditional Complete if the client has commercial health insurance coverage. Enter the name, address, policy number, and telephone numbers, if known, of the commercial health care insurer.
<b>9A. Policyholder Name and Address</b>	Text	Conditional Complete if the client has commercial health insurance coverage. Enter the name, address, and telephone number, if known, of the policyholder.

Field Label	Completion Format	Special Instructions
<b>10. Was Condition Related To</b>	Check box A. Client Employment Yes <input type="checkbox"/> B. Accident Auto <input type="checkbox"/> Other <input type="checkbox"/> C. Date of accident 6 digits: MMDDYY	Conditional Complete if the condition being treated is the result of employment, an automobile accident, or other accident. Enter a check mark or an "x" in the appropriate box. Enter the date of the accident in the marked boxes.
<b>11. CHAMPUS Sponsors Service/SSN</b>	Up to 10 characters	Conditional Complete if the client is covered under the Civilian Health And Medical Plan of the Uniformed Services (CHAMPUS). Enter the sponsor's service number or SSN.
<b>Durable Medical Equipment Model/serial number (unlabeled field)</b>	N/A	N/A
<b>12. Pregnancy</b>  <b>HMO</b>  <b>NF</b>	Check box <input type="checkbox"/>	Conditional Complete if the client is in the maternity cycle (i.e., pregnant or within 6 weeks postpartum).  Conditional Complete if the client is enrolled in a Colorado Medical Assistance HMO.  Conditional Complete if the client is a nursing facility resident.
<b>13. Date of illness or injury or pregnancy</b>	6 digits: MMDDYY	Optional Complete if information is known. Enter the following information as appropriate to the client's condition: Illness            Date of first symptoms Injury              Date of accident Pregnancy        Date of Last Menstrual Period (LMP)
<b>14. Medicare Denial</b>	Check box <input type="checkbox"/> Benefits Exhausted <input type="checkbox"/> Non-covered services	Conditional Complete if the client has Medicare coverage and Medicare denied the benefits or does not cover the billed services.



Field Label	Completion Format	Special Instructions						
<b>18. ICD-9-CM</b>	1 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 2 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 3 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 4 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Codes: 3, 4, or 5 characters. 1 <sup>st</sup> character may be a letter.	Required At least one diagnosis code must be entered. Enter up to four ICD-9-CM diagnosis codes starting at the far left side of the coding area. Do not enter the decimal point. Do not enter zeros to fill the spaces when the diagnosis code is fewer than 5 digits. Example:(May require 4 <sup>th</sup> or 5 <sup>th</sup> digits) <table border="0" style="width: 100%;"> <tr> <td style="text-align: left;"><b><u>ICD-9-CM description</u></b></td> <td style="text-align: center;"><b><u>Code</u></b></td> <td style="text-align: center;"><b><u>Claim Entry</u></b></td> </tr> <tr> <td>Chalazion</td> <td style="text-align: center;">3732</td> <td style="text-align: center;">3732</td> </tr> </table>	<b><u>ICD-9-CM description</u></b>	<b><u>Code</u></b>	<b><u>Claim Entry</u></b>	Chalazion	3732	3732
<b><u>ICD-9-CM description</u></b>	<b><u>Code</u></b>	<b><u>Claim Entry</u></b>						
Chalazion	3732	3732						
<b>Diagnosis or nature of illness or injury. In column F, relate diagnosis to procedure by Reference numbers 1, 2, 3, or 4</b>	Text	Optional If entered, the written description must match the code(s).						
<b>Transportation Certification attached</b>	N/A	N/A						
<b>Durable Medical Equipment Line # Make Model Serial Number</b>	N/A	N/A						
<b>Prior Authorization #:</b>	6 characters	Conditional Complete for services or supplies that require prior authorization. Enter the seven character PAR number from the approved PAR. Do not use the preprinted PAR number (if any). Do not combine line items from more than one approved PAR on a single claim form. Do not attach a copy of the approved PAR unless asked to do so by the authorizing agent or the fiscal agent.						

Field Label	Completion Format	Special Instructions
<p><b>19A. Date of Service</b></p> 	<p>From: 6 digits MMDDYY</p> <p>To: 6 digits MMDDYY</p>	<p>Required</p> <p>Enter two dates: a “beginning” or “from” date of service and an “ending” or “to” date of service.</p> <p>Single date of service</p> <p>From To</p> <p>06/06/2011</p> <p>Or</p> <p>From To</p> <p>06/06/2011 06/06/2011</p> <p>Span dates of service</p> <p>From To</p> <p>06/06/2011 06/20/2011</p> <p>Practitioner claims must be consecutive days.</p> <p>Single Date of Service: Enter the six digit date of service in the “From” field. Completion of the “To” field is not required. Do not spread the date entry across the two fields.</p> <p>Span billing: Span billing is permitted if the same service (same procedure code) is provided on consecutive dates.</p>
<p><b>19B. Place of Service</b></p>	<p>2 digits</p>	<p>Required</p> <p>Enter the Place Of Service (POS) code that describes the location where services were rendered. The Colorado Medical Assistance Program accepts the CMS place of service codes.</p> <ul style="list-style-type: none"> <li>04 Homeless Shelter</li> <li>11 Office</li> <li>12 Home</li> <li>15 Mobile Unit</li> <li>20 Urgent Care Facility</li> <li>21 Inpatient hospital</li> <li>22 Outpatient hospital</li> <li>23 Emergency room hospital</li> <li>25 Birthing Center</li> <li>26 Military Treatment Center</li> <li>31 Skilled Nursing Facility</li> <li>32 Nursing facility</li> <li>33 Custodial Care Facility</li> <li>34 Hospice</li> <li>41 Transportation Land</li> <li>51 Inpatient Psychiatric Facility</li> <li>52 Psychiatric Facility Partial Hospitalization</li> </ul>

Field Label	Completion Format	Special Instructions
<b>19B. Place of Service (continued)</b>	2 digits	Required Enter the Place Of Service (POS) code that describes the location where services were rendered. The Colorado Medical Assistance Program accepts the CMS place of service codes. 53 Community mental health center 54 Intermediate Care Facility – MR 60 Mass Immunization Center 61 Comprehensive IP Rehab Facility 62 Comprehensive OP Rehab Facility 65 End Stage Renal Dialysis Trtmt Facility 71 State-Local Public Hlth Clinic 99 Other Unlisted
<b>19C. Procedure Code (HCPCS code)</b>	5 digits	Required Enter the procedure code that specifically describes the service for which payment is requested.
<b>Modifier(s)</b>	2 characters: Letters or digits May enter up to two 2 character modifiers	Conditional Enter the appropriate procedure related modifier that applies to the billed service. Two modifiers may be entered. Always enter modifiers that change the way that claim payment is calculated in the first position.
	<p style="text-align: center;"><b>-24</b></p> <p style="text-align: center;"><b>26</b></p>	<p><b>Unrelated Evaluation/Management (E/M) service by the same physician during a postoperative period</b></p> Use with E/M codes to report unrelated services by the same physician during the postoperative period. Claim diagnosis code(s) must identify a condition unrelated to the surgical procedure. <p><b>Professional component</b></p> Use with diagnostic codes to report professional component services (reading and interpretation) billed separately from technical component services. Report separate professional and technical component services <u>only</u> if different providers perform the professional and technical portions of the procedure. Read CPT descriptors carefully. Do not use modifiers if the descriptor specifies professional or technical components.

Field Label	Completion Format	Special Instructions
<b>Modifier(s) (continued)</b>	<b>-51</b>	<b>Multiple Procedures</b> Use to identify additional procedures that are performed on the same day or at the same session by the same provider. Do not use to designate “add-on” codes.
	<b>-55</b>	<b>Postoperative Management only Surgery related eyewear</b> Use with eyewear codes (lenses, lens dispensing, frames, etc.) to identify eyewear provided after eye surgery. Benefit for eyewear, including contact lenses, for clients over age 20 must be related to surgery. Modifier -55 takes the place of the required claim comment that identifies the type and date of eye surgery. The provider must retain and, upon request, furnish records that identify the type and date of surgery.
	<b>-59</b>	<b>Distinct Procedural Service</b> Use to indicate a service that is distinct or independent from other services that are performed on the same day. These services are not usually reported together but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system or separate lesion or injury.
	<b>-62</b>	<b>Two surgeons</b> Use when two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons
	<b>-76</b>	<b>Repeat procedure or service by <u>same</u> physician/provider/other qualified health care professional</b> Use to identify subsequent occurrences of the same service on the same day by the same provider. Not valid with E/M codes.
	<b>-77</b>	<b>Repeat procedure by <u>another</u> physician/provider/other qualified health care professional</b> Use to identify subsequent occurrences of the same service on the same day by different rendering providers.

Field Label	Completion Format	Special Instructions
<p><b>Modifier(s) (continued)</b></p>	<p><b>-79</b></p> <p><b>-80</b></p> <p><b>-GY</b></p> <p><b>-KX</b></p>	<p><b>Unrelated procedure or service by the same surgeon during the postoperative period</b>                      Unrelated procedures or services (other than E/M services) by the surgeon during the postoperative period. Use to identify unrelated services by the operating surgeon during the postoperative period. Claim diagnosis code(s) must identify a condition unrelated to the surgical procedure.</p> <p><b>Assistant surgeon</b>                      Use with surgical procedure codes to identify assistant surgeon services. Note: Assistant surgeon services by non-physician practitioners, physician assistants, perfusionists, etc. are not reimbursable.</p> <p><i>Item or services statutorily excluded or does not meet the Medicare benefit.</i>                      Use with podiatric procedure codes to identify routine, non-Medicare covered podiatric foot care. Modifier -GY takes the place of the required provider certification that the services are not covered by Medicare. The Medicare non-covered services field on the claim record must also be completed.</p> <p><b>Specific required documentation on file</b>                      Use with laboratory codes to certify that the laboratory's equipment is not functioning or the laboratory is not certified to perform the ordered test. The -KX modifier takes the place of the provider's certification, "I certify that the necessary laboratory equipment was not functioning to perform the requested test ", or "I certify that this laboratory is not certified to perform the requested test."</p>
<p><b>19D. Rendering Provider Number</b></p>	<p>8 digits</p>	<p>Required                      Enter the eight-digit Colorado Medical Assistance Program provider number assigned to the <u>individual</u> who actually performed or rendered the billed service. This number cannot be assigned to a group or clinic.</p>

Field Label	Completion Format	Special Instructions			
<b>19E. Referring Provider Number</b>	8 digits	Conditional Complete for clients enrolled in the Primary Care Physician (PCP) program if: The rendering or billing provider is not the primary care provider and the billed service requires PCP referral. Enter the PCP's eight-digit Colorado Medical Assistance Program provider number. Entry of the PCP's provider number represents the provider's declaration that he/she has a referral from the PCP.			
<b>19F. Diagnosis</b>	<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px; text-align: center;">P</td> <td style="width: 20px; text-align: center;">S</td> <td style="width: 20px; text-align: center;">T</td> </tr> </table> 1 digit per column	P	S	T	Required From field 18 To field(s) 19F For each billed service, indicate which of the diagnoses in field 18 are <u>P</u> rietary, <u>S</u> econdary, or <u>T</u> ertiary. Example: (May require 4 <sup>th</sup> or 5 <sup>th</sup> digit) 1 <u>7</u> <u>8</u> <u>5</u> <u>5</u> <u>9</u> ↓ 2 824X <u>P</u> <u>S</u> <u>T</u> 3 2765X                              Line 1 <u>1</u> <u>3</u> <u>4</u> 4 V22X                                Line 2 <u>2</u> <u> </u> <u> </u> Line 3 <u>4</u> <u>2</u> <u> </u>
P	S	T			
<b>19G. Charges</b>	Up to 7 digits: Currency 99999.99	Required Enter the usual and customary charge for the service represented by the procedure code on the detail line. Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one procedure from the same group is billed, special multiple pricing rules apply. The base procedure is the procedure with the highest allowable amount. The base code is used to determine the allowable amounts for additional CPT surgical procedures when more than one procedure from the same grouping is performed. Submitted charges cannot be more than charges made to non-Colorado Medical Assistance Program covered individuals for the same service. Do not deduct Colorado Medical Assistance Program co-payment or commercial insurance payments from usual and customary charges.			

Field Label	Completion Format	Special Instructions
<b>19H. Days or Units</b>	4 digits	Required <u>Lens materials</u> One lens equals one unit of service. If two lenses of the same strength are provided, complete one billing claim line, entering two units of service and the total charge for both lenses. Lenses of different strengths are billed on separate claim lines. <u>Lens dispensing</u> A dispensing fee is allowed for each lens. For two lenses, complete one claim line with two units of service and charge for both lenses.
<b>19I. Co-pay</b>	1 digit	Conditional Complete if co-payment is required of the client for the service. 1-Refused to pay co-payment 2-Paid co-payment 3-Co-payment not requested
<b>19J. Emergency</b>	1 character	Conditional Enter a check mark or an "x" in the column to indicate the service is rendered for a life-threatening condition or one that requires immediate medical intervention. If checked, the service on this detail line is exempt from co-payment and from PCP Program referral requirements.
<b>19K. Family Planning</b>	N/A	N/A
<b>19L. EPSDT</b>	1 character	Conditional A check mark indicates that the service is provided as a follow-up to or referral from an EPSDT screening examination.

Field Label	Completion Format	Special Instructions
<b>Medicare SPR Date (unlabeled field)</b>	6 digits: MMDDYY	Conditional Complete for Medicare crossover claims. Enter the date of the Medicare Standard Paper Remit (SPR) or Electronic Remittance Advice (ERA). <ul style="list-style-type: none"> <li>▪ Do not complete this field if Medicare denied all benefits.</li> <li>▪ Do not combine items from several SPRs/ERAs on a single claim form.</li> <li>▪ Bill for as many crossover items as appear on a single SPR/ERA up to a maximum of 6 lines. Complete separate claim forms for additional lines on the SPR/ERA.</li> </ul> Providers must submit a copy of the SPR/ERA with paper claims. Be sure to retain the original SPR/ERA for audit purposes.
<b>20. Total Charges</b>	Up to 7 digits: Currency 99999.99	Required Enter the sum of all charges listed in field 19G (Charges). Each claim form must be completed as a full document. Do not use the claim form as a continuation billing (e.g., Page 1 or 2, etc.).
<b>21. Medicare Paid</b>	Up to 7 digits: Currency 99999.99	Conditional Complete for Medicare crossover claims. Enter the Medicare payment amount shown on the Medicare payment voucher.
<b>22. Third Party Paid</b>	Up to 7 digits: Currency 99999.99	Conditional Complete if the client has commercial health insurance and the third party resource has made payment on the billed services. Enter the amount of the third party payment shown on the third party payment voucher. Do <b>not</b> enter Colorado Medical Assistance Program co-payment in this field or anywhere else on the claim form.

Field Label	Completion Format	Special Instructions
<p><b>23. Net Charge</b></p>	<p>Up to 7 digits: Currency 99999.99</p>	<p>Required</p> <p><b>Colorado Medical Assistance Program claims (Not Medicare Crossover)</b></p> <p>Claims without third party payment. Net charge equals the total charge (field 20).</p> <p>Claims with third party payment. Net charge equals the total charge (field 20) minus the third party payment (field 22) amount.</p> <p><b>Medicare Crossover claims</b></p> <p>Crossover claims without third party payment. Net charge equals the sum of the Medicare deductible amount (field 24) plus the Medicare coinsurance (field 25) amount.</p> <p>Crossover claims with third party payment. Net charge equals the sum of the Medicare deductible amount (field 24) plus the Medicare coinsurance (field 25) amount minus the third party payment (field 22) amount.</p>
<p><b>24. Medicare Deductible</b></p>	<p>Up to 7 digits: Currency 99999.99</p>	<p>Conditional</p> <p>Complete for Medicare crossover claims.</p> <p>Enter the Medicare deductible amount shown on the Medicare payment voucher.</p>
<p><b>25. Medicare Coinsurance</b></p>	<p>Up to 7 digits: Currency 99999.99</p>	<p>Conditional</p> <p>Complete for Medicare crossover claims.</p> <p>Enter the Medicare coinsurance amount shown on the Medicare payment voucher.</p>
<p><b>26. Medicare Disallowed</b></p>	<p>Up to 7 digits: Currency 99999.99</p>	<p>Conditional</p> <p>Complete for Medicare crossover claims.</p> <p>Enter the amount Medicare disallowed, if any, shown on the Medicare payment voucher.</p>

Field Label	Completion Format	Special Instructions
<p><b>27. Signature</b>  <b>(Subject to Certification on Reverse) and Date</b></p>	<p>Text</p>	<p>Required</p> <p>Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent.</p> <p>A holographic signature stamp may be used <u>if</u> authorization for the stamp is on file with the fiscal agent.</p> <p>An authorized agent or representative may sign the claim for the enrolled provider <u>if</u> the name and signature of the agent is on file with the fiscal agent</p> <p><b>Unacceptable signature alternatives:</b></p> <p>Claim preparation personnel may not sign the enrolled provider’s name.</p> <p>Initials are not acceptable as a signature.</p> <p>Typed or computer printed names are not acceptable as a signature.</p> <p>“Signature on file” notation is not acceptable in place of an authorized signature.</p>
<p><b>28. Billing Provider Name</b></p>	<p>Text</p>	<p>Required</p> <p>Enter the name of the individual or organization that will receive payment for the billed services.</p>
<p><b>29. Billing Provider Number</b></p>	<p>8 digits</p>	<p>Required</p> <p>Enter the eight-digit Colorado Medical Assistance Program provider number assigned to the individual or organization that will receive payment for the billed services.</p>
<p><b>30. Remarks</b></p>	<p>Text</p>	<p>Conditional</p> <p>Use to document the Late Bill Override Date for timely filing.</p>

## 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 fine and imprisonment under state and/or federal law.

Billing Instruction Detail	Instructions
<b>LBOD Completion Requirements</b>	<ul style="list-style-type: none"> <li>• Electronic claim formats provide specific fields for documenting the LBOD.</li> <li>• Supporting documentation must be kept on file for 6 years.</li> <li>• For paper claims, follow the instructions appropriate for the claim form you are using.                             <ul style="list-style-type: none"> <li>➢ <i>UB-04</i>: Occurrence code 53 and the date are required in FL 31-34.</li> <li>➢ <i>Colorado 1500</i>: Indicate “LBOD” and the date in box 30 - Remarks.</li> <li>➢ <i>2006 ADA Dental</i>: Indicate “LBOD” and the date in box 35 - Remarks.</li> </ul> </li> </ul>
<b>Adjusting Paid Claims</b>	<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><b>Adjust the claim within 60 days</b> 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> <ul style="list-style-type: none"> <li>• <b>LBOD</b> = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the payment.</li> </ul>

Billing Instruction Detail	Instructions
<p><b>Denied Paper Claims</b></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><b>Correct the claim errors and refile within 60 days</b> of the claim denial or rejection. Retain all documents that prove compliance with timely filing requirements.</p> <p><b>LBOD</b> = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the denial.</p>
<p><b>Returned Paper Claims</b></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><b>Correct the claim errors and refile within 60 days</b> 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><b>LBOD</b> = the stamped fiscal agent date on the returned claim.</p>
<p><b>Rejected Electronic Claims</b></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><b>Correct claim errors and refile within 60 days</b> of the rejection. Maintain a printed copy of the rejection notice that identifies the claim and date of rejection.</p> <p><b>LBOD</b> = the date shown on the claim rejection report.</p>
<p><b>Denied/Rejected Due to Client Eligibility</b></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><b>File the claim within 60 days</b> 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><b>LBOD</b> = the date shown on the eligibility rejection report.</p>
<p><b>Retroactive Client Eligibility</b></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"> <li>• Identifies the patient by name</li> <li>• States that eligibility was backdated or retroactive</li> <li>• Identifies the date that eligibility was added to the state eligibility system.</li> </ul> <p><b>LBOD</b> = 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><b>Delayed Notification of Eligibility</b></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><b>File the claim within 60 days</b> 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) 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"> <li>• Claims must be filed within 365 days of the date of service. No exceptions are allowed.</li> <li>• This extension is available only if the provider had no way of knowing that the individual had Colorado Medical Assistance Program coverage.</li> <li>• Providers who render services in a hospital or nursing facility are expected to get benefit coverage information from the institution.</li> <li>• The extension does not give additional time to obtain Colorado Medical Assistance Program billing information.</li> <li>• If the provider has previously submitted claims for the client, it is improper to claim that eligibility notification was delayed.</li> </ul> <p><b>LBOD</b> = the date the provider was advised the individual had Colorado Medical Assistance Program benefits.</p>
<p><b>Electronic Medicare Crossover Claims</b></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/ERA date field documents crossover timely filing and completion of the LBOD is not required.)</p> <p><b>File the claim within 120 days</b> of the Medicare processing/ payment date shown on the SPR/ERA. Maintain the original SPR/ERA on file.</p> <p><b>LBOD</b> = the Medicare processing date shown on the SPR /ERA.</p>
<p><b>Medicare Denied Services</b></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><b>File the claim within 60 days</b> of the Medicare processing date shown on the SPR/ERA. Attach a copy of the SPR/ERA if submitting a paper claim and maintain the original SPR/ERA on file.</p> <p><b>LBOD</b> = the Medicare processing date shown on the SPR/ERA.</p>

Billing Instruction Detail	Instructions
<p><b>Commercial Insurance Processing</b></p>	<p>The claim has been paid or denied by commercial insurance.</p> <p><b>File the claim within 60 days</b> 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><b>LBOD</b> = the date commercial insurance paid or denied.</p>
<p><b>Correspondence LBOD Authorization</b></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><b>File the claim within 60 days</b> of the date on the authorization letter. Retain the authorization letter.</p> <p><b>LBOD</b> = the date on the authorization letter.</p>
<p><b>Client Changes Providers during Obstetrical Care</b></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><b>File the claim within 60 days</b> 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><b>LBOD</b> = the last date of OB care by the billing provider.</p>

# Vision Claim Example

**STATE OF COLORADO  
DEPARTMENT OF  
HEALTH CARE POLICY AND  
FINANCING**

INVOICED/PAY ADJUST NUMBER
SPECIAL PROGRAM CODE

## HEALTH INSURANCE CLAIM

**PATIENT AND INSURED (SUBSCRIBER) INFORMATION**

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL) <b>Evans, Emily</b>	2. CLIENT DATE OF BIRTH <b>03/05/1960</b>	3. MEDICAD ID NUMBER (CLIENT ID NUMBER) <b>D654321</b>
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. CLIENT SEX MALE <input type="checkbox"/> FEMALE <input checked="" type="checkbox"/>	6. MEDICARE ID NUMBER (MC OR SW)
7. CLIENT RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. <input type="checkbox"/> CLIENT IS COVERED BY EMPLOYER HEALTH PLAN AS EMPLOYEE OR DEPENDENT EMPLOYER NAME: _____ POLICYHOLDER NAME: _____ GROUP: _____	
9. OTHER HEALTH INSURANCE COVERAGE — INSURANCE COMPANY NAME, ADDRESS, PLAN NAME, AND POLICY NUMBER(S)  TELEPHONE NUMBER: _____	10. WAS CONDITION RELATED TO: A. CLIENT EMPLOYMENT YES <input type="checkbox"/> B. ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/> C. DATE OF ACCIDENT <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0;"></div>	
9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)  TELEPHONE NUMBER: _____	11. CHAMPUS SPONSORS SERVICES BY	
12. PREGNANCY <input type="checkbox"/> HMO <input type="checkbox"/> NURSING FACILITY <input type="checkbox"/>		

**PHYSICIAN OR SUPPLIER INFORMATION**

13. DATE OF <b>06/10/2011</b>	14. MEDICARE DENIAL (ATTACH THE MEDICARE STANDARD POWER REMITTANCE (SPR) IF DENIED TO BE CHECKED) <input type="checkbox"/> DENIAL IS EXHAUSTED <input type="checkbox"/> HIGH-COVERED SERVICES	15. OTHER COVERAGE DENIED <input type="checkbox"/> NO <input type="checkbox"/> YES PAYMENT DATE: _____
13A. NAME OF SUPERVISING PHYSICIAN	PROVIDER NUMBER	16. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES ADMITTED: _____ DISCHARGED: _____
17. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (IF OTHER THAN HOME OR OFFICE)	PROVIDER NUMBER	17A. CHECKBOX IF LABORATORY WORK WAS PERFORMED OUTSIDE THE PHYSICIAN'S OFFICE <input type="checkbox"/> YES
18. ICD-9-CM DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. IN COLUMN F, RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE NUMBERS 1, 2, 3, OR 4. <b>1. 3732</b>		TRANSPORTATION CERTIFICATION ATTACHED <input type="checkbox"/> YES
19. DURABLE MEDICAL EQUIPMENT Use #    Make    Model    Serial Number		PRIOR AUTHORIZATION #:

19A. DATE OF SERVICE FROM	19B. PLACE OF SERVICE	19C. PROCEDURE CODE (HICPCS)	19D. MODIFIERS	19E. RENDERING PROVIDER NUMBER	19F. REFERRING PROVIDER NUMBER	19G. DIAGNOSIS P S T	19H. CHARGES	19I. DAYS OR UNITS	19J. COPAY	19K. EMERG. SHCY	19L. FAMILY PLANED	19M. EPISOD
06/01/2011	06/01/2011	11	65205	87654321		1	\$100.00	1		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

20. TOTAL CHARGES → <b>\$100.00</b>	LESS ↓ 21. MEDICARE PAID <div style="border: 1px solid black; width: 100px; height: 20px; margin: 2px 0;"></div> 22. THIRD PARTY PAID <div style="border: 1px solid black; width: 100px; height: 20px; margin: 2px 0; text-align: center;">\$ .00</div> 23. NET CHARGE <div style="border: 1px solid black; width: 100px; height: 20px; margin: 2px 0; text-align: center;">\$ 100.00</div>
27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERS (C)) DATE <i>Authorized Signature</i> <b>06/27/2011</b> 28. BILLING PROVIDER NAME <b>Oliver O'Brien, M.D.</b> 29. BILLING PROVIDER NUMBER <b>12345678</b>	30. REMARKS  24. MEDICARE DEDUCTIBLE <div style="border: 1px solid black; width: 100px; height: 20px; margin: 2px 0; text-align: center;">\$ .00</div> 25. MEDICARE COINSURANCE <div style="border: 1px solid black; width: 100px; height: 20px; margin: 2px 0; text-align: center;">\$ .00</div> 26. MEDICARE DISALLOWED <div style="border: 1px solid black; width: 100px; height: 20px; margin: 2px 0;"></div>

I HEREBY CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE, AND COMPLETE. I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FRAUDULENT, OR CONSPIRACIOUS, ACTS WILL BE PROSECUTED UNDER FEDERAL AND STATE LAWS.

CCL-101  
 FORM NO. 04320 (REV. 02/06)  
 ELECTRONIC APPLICATION

COLORADO 1500

### Vision and Eyewear Revisions Log

Revision Date	Section/Action	<u>Pages</u>	Made by
<i>Created 06/2011</i>	<i>Created separate manual from combined Colorado 1500 billing manual</i>	<i>29</i>	<i>ah/jg</i>
<i>12/06/2011</i>	<i>Replaced 997 with 999 Replaced wpc-edi.com/hipaa with wpc-edi.com/ Replaced Implementation Guide with Technical Report 3 (TR3)</i>	<i>3 2 2</i>	<i>ss</i>
<i>01/27/2012</i>	<i>Changed authorizing agent to authorizing agency</i>	<i>Throughout</i>	<i>jg</i>
<i>07/31/2012</i>	<i>Removed "Orthoptic vision treatment services are a benefit only when prior authorized." This is not a benefit as of August 1, 2012.</i>	<i>1</i>	<i>jg</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.