Home and Community Based Services Brain Injury (BI), Community Mental Health Supports (CMHS), Elderly, Blind and Disabled (EBD)

Home and Community Based Services i
Brain Injury (BI), Community Mental Health Supports (CMHS), Elderly, Blind and Disabled (EBD) i
Home and Community Based Services (HCBS) 1
Brain Injury (BI), Community Mental Health Supports (CMHS), and Elderly, Blind, and Disabled (EBD) 1
General Information 1
Prior Authorization Requests (PARs) 1
PAR Submission 3
Consumer Directed Attendant Support Services (CDASS) 3
Financial Management Services (FMS) Agencies 3
PAR Form Instructional Reference Table 3
BI PAR Example 7
CMHS PAR Example 8
EBD PAR Example 9
Claim Submission 10
Paper Claims 10
Electronic Claims 10
Procedure/HCPCS Codes Overview 10
Persons with a Brain Injury (HCBS-BI) 11
HCBS-BI Procedure Code Table 11
HCBS- BI Paper Claim Reference Table 13
HCBS-BI Claim Example 21
Community Mental Health Supports (CMHS), and Persons who are Elderly, Blind, and Disabled (EBD) 22
The HCBS-EBD program offers the following additional services: 23
HCBS-CMHS Procedure Code Table 24
HCBS-EBD Procedure Code Table 25
HCBS-CMHS and EBD Paper Claim Reference Table 27
HCBS-CMHS Claim Example 35
HCBS-EBD Claim Example 36
Late Bill Override Date 37

Home and Community Based Services (HCBS)

Brain Injury (BI), Community Mental Health Supports (CMHS), and Elderly, Blind, and Disabled (EBD)

General Information

Medicaid is a health care program for low income Coloradans. Applicants must meet eligibility criteria for one of the Medicaid Program categories in order to qualify for benefits. Major program categories include:

- Aid to Families with Dependent Children/Medicaid Only
- Aid to the Needy Disabled
- Baby Care/Kids Care
- Colorado Works/TANF (Temporary Assistance for Needy Families)
- Aid to the Blind
- Old Age Pension

Waiver programs provide additional Medicaid benefits to specific populations who meet special eligibility criteria.

Level of care determinations are made annually by the case management agencies (aka Single Entry Points). Members must meet financial, medical, and program criteria to access services under a waiver. The applicant must be at risk of placement in a nursing facility, hospital, or ICF/IID (Intermediate Care Facility for Individuals with an Intellectual Disability). To utilize waiver benefits, members must be willing to receive services in their homes or communities. A member who receives services through a waiver is also eligible for all basic Medicaid covered services except nursing facility and long-term hospital care. When a member chooses to receive services under a waiver, the services must be provided by certified Medicaid providers or by a Medicaid contracting managed care organization (MCO).

Each waiver has an enrollment limit. Applicants may apply for more than one waiver, but may only receive services through one waiver at a time.

Prior Authorization Requests (PARs)

Unless otherwise noted, all HCBS services require prior approval before they can be reimbursed by the Colorado Medical Assistance Program. Case management agencies/single entry points complete the Prior Approval and/or Cost Containment requests for their specific programs according to instructions published in the regulations for the Department of Health Care Policy and Financing (the Department). All HCBS-Developmental Disability (DD), services must be prior authorized by the Division for Intellectual and Developmental Disabilities (DIDD).

The telephone numbers are listed in Appendix A of the Appendices in the Provider Services Billing

Manuals section.

DDD transmits electronic PAR information to the Medicaid Management Information System (MMIS) for the Comprehensive Services waiver, the Supported Living Services waiver, the Children's Extensive Support waiver, and Targeted Case Management authorizations.

For the Home and Community Based Services Brain Injury (HCBS-BI) waiver, the following services must be submitted by the case management agency (CMA)/single entry point (SEP) and approved by the Brain Injury Waiver Coordinator with the Department of Health Care Policy and Financing:

- Mental Health Counseling (more than 30 cumulative visits)
- Respite Care (Nursing Facility)
- Substance Abuse Counseling (more than 30 cumulative visits)
- Assistive Technology above and beyond medication reminders
- All services above cost containment

Providers may contact the CMA/SEP for the status of the PAR or inquire electronically through the Colorado Medical Assistance Program Web Portal.

The CMAs/SEPs responsibilities include, but not limited to:

- Informing members and/or legal guardian of the eligibility process.
- Submitting a copy of the approved Enrollment Form to the County department of human/social services for a Colorado Medical Assistance Program member identification number.
- Developing the appropriate Prior Approval and/or Cost Containment Record Form of services and projected costs for approval.
- Submitting a copy of the Prior Authorization and/or Cost Containment document to the authorizing agent. A list of authorizing agents can be found by referring to Appendix D of the Appendices in the Provider Services Billing Manuals section.
- Assessing the member's health and social needs.
- Arranging for face-to-face contact with the member within 30 calendar days of receipt of the referral.
- Monitoring and evaluating services.
- Reassessing each member.
- Demonstrating continued cost effectiveness whenever services increase or decrease.

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

Prior approvals must be completed thoroughly and accurately. If an error is noted on an approved request, it should be brought to the attention of the member's case manager for corrections. Procedure codes, quantities, etc., may be changed or entered by the member's case manager.

The authorizing agent or case management agency/single entry point is responsible for timely submission and distribution of copies of approvals to agencies and providers contracted to provide services.

PAR Submission

The HCBS-BI, CMHS, and EBD forms are fillable electronically and are located on the Forms web page→ Prior Authorization Request (PAR) Forms→ HCBS PAR Forms-BI, CMHS, EBD, SCI, CHCBS, CLLI, and CWA of the Department's website. Mail all New, Continued Stay Review (CSR), and Revised PARs to the Department's fiscal agent, Xerox State Healthcare at:

Xerox State Healthcare
PARs
P.O. Box 30
Denver, CO 80201-0030

Note: If submitted to the Department's fiscal agent, the following correspondence will not be returned to case managers, outreach will not be performed to fulfill the requests, and all such requests will be recycled: 1) Paper PAR forms that do not clearly identify the case management agency in the event the form(s) need to be returned and/or 2) PAR revision requests not submitted on Department approved PAR forms, including typed letters with revision instructions. Should questions arise about what fiscal agent staff can process, please contact the appropriate Department Waiver manager.

Consumer Directed Attendant Support Services (CDASS)

For members authorized to receive CDASS, case managers will need to enter the data into one of the web based systems in addition to sending a PAR to the Department's fiscal agent. Members have the option to receive Financial Management Services (FMS) from one (1) of three (3) FMS vendors:

- ACES$
- Morning Star
- Public Partnerships, LLC (PPL)

Financial Management Services (FMS) Agencies

Financial Management Service agencies offer CDASS members the choice of two (2) FMS models: Fiscal/Employer Agent (F/EA) and Agency with Choice (AwC). The F/EA and AwC models reflect different Per Member, Per Month (PM/PM) payments to the FMS agency, which are noted by varying modifiers next to the T2040 administrative procedure code/service line. The F/EA model section requires no additional modifier. The AwC model does not require a CG modifier on the T2040 service line. This modifier should populate once the AwC model is selected on the PAR in the FMS web based system.

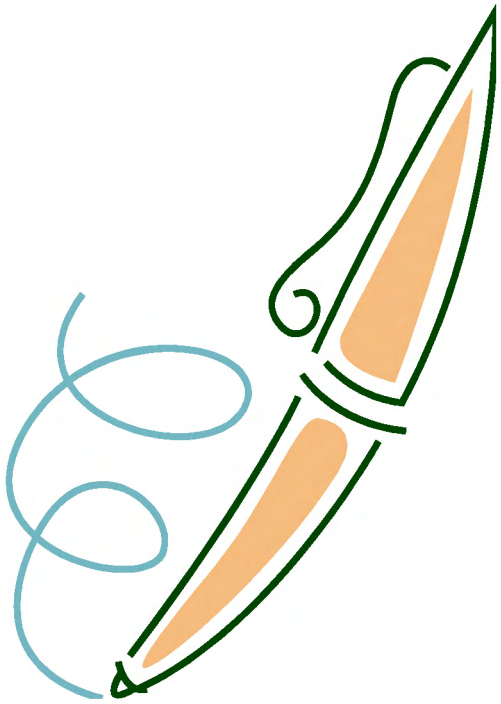
PAR Form Instructional Reference Table

Field Label	Completion Format	Instructions
PA Number being revised		Conditional Complete if PAR is a revision. Indicate original PAR number assigned.
Revision	Check box ☐ Yes ☐ No	Required Check the appropriate box.
Client Name	Text	Required Enter the member's last name, first name and middle initial. Example: Adams, Mary A.

Field Label	Completion Format	Instructions
Client ID	7 characters, a letter prefix followed by six numbers	Required Enter the member's state identification number. This number consists of a letter prefix followed by six numbers. Example: A123456
Sex	Check box ☐ M ☐ F	Required Check the appropriate box.
Birthdate	6 numbers (MM/DD/YY)	Required Enter the member's birth date using MM/DD/YY format. Example: January 1, 2010 = 01/01/10.
Requesting Physician Provider #	8 numbers	Required Enter the eight-digit Colorado Medical Assistance Program provider number of the requesting provider.
Client's County	Text	Required Enter the member's county of residence
Case Number (Agency Use)	Text	Optional Enter up to 12 characters, (numbers, letters, hyphens) which helps identify the claim or member.
Dates Covered (From/Through)	6 numbers for from date and 6 numbers for through date (MM/DD/YY)	Required Enter PAR start date and PAR end date.
Services Description	Text	Not required List of approved procedure codes for qualified and demonstration services.
Provider	Text	Optional (SEP use) Enter up to 12 characters to identify provider.
Modifier	2 Letters	Required The alphanumeric values in this column are standard and static and cannot be changed.
Max # Units	Number	Required Enter the number of units next to the services being requested for reimbursement.
Cost Per Unit	Dollar Amount	Required Enter cost per unit of service.
Total $ Authorized	Dollar Amount	Required The dollar amount authorized for this service automatically populates.

Field Label	Completion Format	Instructions
Comments	Text	Optional Enter any additional useful information. For example, if a service is authorized for different dates than in "Dates Covered" field, please include the HCPCS procedure code and date span here.
Total Authorized HCBS Expenditures	Dollar Amount	Required Total automatically populates.
Plus Total Authorized Home Health Expenditures (Sum of Authorized Home Health Services during the HCBS Care Plan Period)	Dollar Amount	Required Enter the total Authorized Home Health expenditures.
Equals Client's Maximum Authorized Cost	Dollar Amount	Required The sum of HCBS Expenditures + Home Health Expenditures automatically populates.
Number of Days Covered	Number	Required The number of days covered automatically populates.
Average Cost Per Day	Dollar Amount	Required The member's maximum authorized cost divided by number of days in the care plan period automatically populates.
CDASS Effective Date Monthly Allocation Amt.	Date (MM/DD/YY) Dollar Amount	Required for CMHS and EBD Enter CDASS information (All CDASS information must be entered in PPL's web portal).
Immediately prior to HCBS enrollment, this client lived in a long-term care facility	Check box ☐ Yes ☐ No	Required Check the appropriate box.
Case Manager Name	Text	Required Enter the name of the Case Manager.
Agency	Text	Required Enter the name of the agency.
Phone #	10 Numbers 123-456-7890	Required Enter the phone number of the Case Manager.
Email	Text	Required Enter the email address of the Case Manager.
Date	6 Numbers (MM/DD/YY)	Required Enter the date completed.
Case Manager's Supervisor Name	Text	Required Enter the name of the Case Manager's Supervisor.

Field Label	Completion Format	Instructions
Agency	Text	Required Enter the name of the agency.
Phone #	10 Numbers 123-456-7890	Required Enter the phone number of the Case Manager's Supervisor.
Email	Text	Required Enter the email address of the Case Manager's Supervisor.
Date	6 Numbers (MM/DD/YY)	Required Enter the date of PAR completion.



BI PAR Example

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

REQUEST FOR ADULT HOME AND COMMUNITY BASED SERVICES (HCBS) PRIOR APPROVAL AND COST CONTAINMENT

HCBS - Persons with a Brain Injury (BI) Waiver

BI - U6

PA Number being revised:

Revision? ☐ Yes ☑ No

1. CLIENT NAME		2. CLIENT ID	3. SEX	4. BIRTHDATE
Client, Ima		N555555	☑ M ☐ F	6/26/1990
5. REQUESTING PROVIDER #	6. CLIENT'S COUNTY	7. CASE NUMBER (AGENCY USE)	8. DATES COVERED	
0000000001	Douglas		From: 07/01/13	Through: 06/30/14

STATEMENT OF REQUESTED SERVICES

9. Description		10. Provider	11. Modifier	12. Max # Units	13. Cost Per Unit	14. Total $ Authorized	15. Comments
S5102 Adult Day Services (U6)							
T2029 Assistive Technology, Per Purchase (U6)							
H0025 Behavioral Programming (U6)							
T2025 CDASS (Cent/ Unit) (U6)							
T2040 CDASS Per Member/ Per Month (PMPM) (U6)							
H2018 Day Treatment (U6)				365	$78.79	$28,758.35	
S5165 Home Modifications (U6)							
T2013 Independent Living Skills Training (ILST) (U6)				1825	$25.50	$46,537.50	
H0004 Mental Health Counseling, Family (U6)			HR				
H0004 Mental Health Counseling, Group (U6)			HQ				
H0004 Mental Health Counseling, Individual (U6)							
A0100 Non Medical Transportation (NMT), Taxi (U6)							
A0120 NMT, Mobility Van	Mileage Band 1 (0-10 miles) (U6)						
A0120 NMT, Mobility Van To and From Adult Day	Mileage Band 1 (0-10 miles) (U6)		HB				
A0130 NMT, Wheelchair Van	Mileage Band 1 (0-10 miles) (U6)						
A0130 NMT, Wheelchair Van to and From Adult Day	Mileage Band 1 (0-10 miles) (U6)		HB				
T1019 Personal Care (U6)							
T1019 Personal Care, Relative (U6)			HR				
S5160 Personal Emergency Response System (PERs) Install/Purchase (U6)							
S5161 PERs, Monitoring (U6)							
S5150 Respite Care, In Home (U6)							
H0045 Respite Care, NF (U6)							
T1006 Substance Abuse Counseling, Family (U6)			HR, HF				
H0047 Substance Abuse Counseling, Group (U6)			HQ, HF	104	$32.46	$3,375.84	
H0047 Substance Abuse Counseling, Individual (U6)			HF				
T2033 Supported Living Program, (U6)							
T2016 Brain Injury Transitional Living (U6)	Acuity Tier 3 (U6)		HE				
A							
B							
C							
D							
E							
F							
G							
H							

16. TOTAL AUTHORIZED HCBS EXPENDITURES (SUM OF AMOUNTS IN COLUMN 14 ABOVE)	$78,671.69
17. PLUS TOTAL AUTHORIZED HOME HEALTH EXPENDITURES (SUM OF AUTHORIZED HOME HEALTH SERVICES DURING THE HCBS CARE PLAN PERIOD)- Excludes In-Home Support Services amounts	$0.00
18. EQUALS CLIENT'S MAXIMUM AUTHORIZED COST (HCBS EXPENDENITURES + HOME HEALTH EXPENDITURES)	$78,671.69
19. NUMBER OF DAYS COVERED (FROM FIELD 8 ABOVE)	365
20. AVERAGE COST PER DAY (Client's maximum authorized cost divided by number of days in the care plan period)	$215.54
A. Monthly State Cost Containment Amount	$0.00
B. Divided by 30.42 days = Daily Cost Containment Ceiling	$0.00

21. CDASS (amounts must match client's allocation worksheet)		Effective Date:		Monthly Allocation Amt:	
22. Immediately prior to HCBS enrollment, this client lived in a:	☐ Long-Term Care Facility	☐ No	☐ Hospital	☐ No	
23. CASE MANAGER NAME	24. AGENCY	25. PHONE #	26. EMAIL		27. DATE
23A. CASE MANAGER SIGNATURE:	BI Agency	303-333-3333	Joan.Doe@BIAgency.com		6/30/2013
28. CASE MANAGER'S SUPERVISOR NAME	29. AGENCY	30. PHONE #	31. EMAIL		32. DATE
28A. CASE MANAGER'S SUPERVISOR SIGNATURE:	BI Agency	303-333-333	Joan.Doe@BIAgency.com		6/30/2013

DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY

33. CASE PLAN: ☐ Approved Date: ☐ Denied Date: Return for correction- Date:

34. REGULATION(S) upon which Denial or Return is based:

35. DEPARTMENT APPROVAL SIGNATURE: 36. DATE:

CMHS PAR Example

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

REQUEST FOR ADULT HOME AND COMMUNITY BASED SERVICES (HCBS) PRIOR APPROVAL AND COST CONTAINMENT

HCBS - Community Mental Health Supports (CMHS) Waiver

CMHS- UA

PA Number being revised:

Revision? ☐ Yes ☑ No

1. CLIENT NAME	2. CLIENT ID	3. SEX	4. BIRTHDATE
Clint, Ima	H222222	☐ M ☑ F	9/12/1972

5. REQUESTING PROVIDER #	6. CLIENT'S COUNTY	7. CASE NUMBER (AGENCY USE)	8. DATES COVERED		
00000002	Mesa		From:	07/15/13	Through: 07/14/14

STATEMENT OF REQUESTED SERVICES

9. Description		10. Provider	11. Modifier	12. Max # Units	13. Cost Per Unit	14. Total $ Authorized	15. Comments:
S5105 Adult Day Services, Basic (UA)							
S5105 Adult Day Services. Specialized (UA)			TF				
T2031 Alternative Care Facility (ACF) (UA)							
T2025 CDASS (Cent/ Unit) (UA)							
T2040 CDASS Per Member/ Per Month (PM/PM) (UA)							
S5165 Home Modifications (UA)							
S5130 Homemaker (UA)				732	$3.76	$2,752.32	1hr/2wk for 26 wks
T2029 Medication Reminder, Install/Purchase (UA)							
S5185 Medication Reminder, Monitoring (UA)							
A0100 NMT, Taxi (UA)							
A0120 NMT, Mobility Van	Mileage Band 1 (0-10 miles) (UA)						
A0120 NMT, Mobility Van To and From Adult Day	Mileage Band 1 (0-10 miles) (UA)		HB				
A0130 NMT, Wheelchair Van	Mileage Band 1 (0-10 miles) (UA)						
A0130 NMT, Wheelchair Van To and From Adult Day	Mileage Band 1 (0-10 miles) (UA)		HB				
T1019 Personal Care (UA)				3900	$3.76	$14,664.00	1.15hr/1wk for 52 wks
T1019 Personal Care, Relative (UA)			HR				
S5160 Personal Emergency Response System (PERs) Install/Purchase (UA)							
S5161 PERs, Monitoring (UA)							
S5151 Respite Care, ACF (UA)							
H0045 Respite Care, NF (UA)							
A							
B							
C							
D							
E							
F							
G							
H							

16. TOTAL AUTHORIZED HCBS EXPENDITURES (SUM OF AMOUNTS IN COLUMN 14 ABOVE)	$17,416.32
17. PLUS TOTAL AUTHORIZED HOME HEALTH EXPENDITURES (SUM OF AUTHORIZED HOME HEALTH SERVICES DURING THE HCBS CARE PLAN PERIOD)- Excludes In-Home Support Services amounts	$0.00
18. EQUALS CLIENT'S MAXIMUM AUTHORIZED COST (HCBS EXPENDENITURES +HOME HEALTH EXPENDITURES)	$17,416.32
19. NUMBER OF DAYS COVERED (FROM FIELD 8 ABOVE)	365
20. AVERAGE COST PER DAY (Client's maximum authorized cost divided by number of days in the care plan period)	$47.72
A. Monthly State Cost Containment Amount	$5,361.22
B. Divided by 30.42 days = Daily Cost Containment Ceiling	$176.24

21. CDASS (amounts must match client's allocation worksheet) — Effective Date: — Monthly Allocation Amt: $0.00

22. Immediately prior to HCBS enrollment, this client lived in a long term care facility? ☐ Yes ☑ No

23. CASE MANAGER NAME	24. AGENCY	25. PHONE #	26. EMAIL	27. DATE
Jane Doe	CMHS Agency	303-333-3333	Jane.Doe@CMHSAgency.com	7/1/2013
23A. CASE MANAGER SIGNATURE: *Jane Doe*				
28. CASE MANAGER'S SUPERVISOR NAME	**29. AGENCY**	**30. PHONE #**	**31. EMAIL**	**32. DATE**
Joan Doe	CMHS Agency	303-333-3333	Joan.Doe@CMHSAgency.com	7/1/2013
28A. CASE MANAGER'S **SUPERVISOR** SIGNATURE: *Joan Doe*				

DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY

33. CASE PLAN: ☐ Approved Date: ☐ Denied Date: Return for correction- Date:

34. REGULATION(S) upon which Denial or Return is based:

35. DEPARTMENT APPROVAL SIGNATURE: 36. DATE:

EBD PAR Example

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

REQUEST FOR ADULT HOME AND COMMUNITY BASED SERVICES (HCBS) PRIOR APPROVAL AND COST CONTAINMENT — **EBD-U1**

HCBS - Persons who are Elderly, Blind, and Disabled (EBD) Waiver

PA Number being revised:

Revision? ☐ Yes ☐ No

1. CLIENT NAME		2. CLIENT ID	3. SEX	4. BIRTHDATE
Client, Ima		**H555555**	☑ M ☐ F	**4/14/1958**
5. REQUESTING PROVIDER #	6. CLIENT'S COUNTY	7. CASE NUMBER (AGENCY USE)	8. DATES COVERED	
00000001	**Adams**		From: **08/01/13**	Through: **07/31/14**

STATEMENT OF REQUESTED SERVICES

9. Description		10. Provider	11. Modifier	12. Max # Units	13. Cost Per Unit	14. Total $ Authorized	15. Comments:
S5105 Adult Day Services, Basic (U1)							
S5105 Adult Day Services, Specialized (U1)			TF	416	$30.13	$12,534.08	
T2031 Alternative Care Facility (ACF) (U1)							
T2038 Community Transition Services, Coordinator (U1)							
A9900 Community Transition Services, Items Purchased (U1)							
T2025 Consumer Directed Assistance Support Services (CDASS) (Cent/ Unit) (U1)				700000	$0.01	$7,000.00	
T2040 CDASS Per Member/ Per Month (PM/PM) (U1)				12	$310.00	$3,720.00	
S5165 Home Modifications (U1)							
S5130 Homemaker (U1)							
H0038 IHSS Health Maintenance Activities (U1)							
S5130 IHSS Homemaker (U1)			KX				
T1019 IHSS Personal Care (U1)			KX				
T1019 IHSS Relative Personal Care (U1)			HR, KX				
T2029 Medication Reminder, Install/Purchase (U1)							
S5185 Medication Reminder, Monitoring (U1)							
A0100 NMT, Taxi (U1)							
A0120 NMT, Mobility Van	Mileage Band 1 (0-10 miles) (U1)						
A0120 NMT, Mobility Van To and From Adult Day	Mileage Band 1 (0-10 miles) (U1)		HB				
A0130 NMT, Wheelchair Van	Mileage Band 1 (0-10 miles) (U1)						
A0130 NMT, Wheelchair Van To and From Adult Day	Mileage Band 1 (0-10 miles) (U1)		HB				
T1019 Personal Care (U1)							
T1019 Personal Care, Relative (U1)			HR				
S5160 Personal Emergency Response System (PERs) Install/Purchase (U1)							
S5161 PERs, Monitoring (U1)							
S5151 Respite Care, ACF (U1)							
S5150 Respite Care, In Home (U1)							
H0045 Respite Care, NF (U1)				30	$124.03	$3,720.90	
A							
B							
C							
D							
E							
F							
G							
H							

16. TOTAL AUTHORIZED HCBS EXPENDITURES (SUM OF AMOUNTS IN COLUMN 14 ABOVE)	**$26,974.98**
17. PLUS TOTAL AUTHORIZED HOME HEALTH EXPENDITURES (SUM OF AUTHORIZED HOME HEALTH SERVICES DURING THE HCBS CARE PLAN PERIOD)- Excludes In-Home Support Services amounts	**$0.00**
18. EQUALS CLIENT'S MAXIMUM AUTHORIZED COST (HCBS EXPENDENITURES + HOME HEALTH EXPENDITURES)	**$26,974.98**
19. NUMBER OF DAYS COVERED (FROM FIELD 8 ABOVE)	**365**
20. AVERAGE COST PER DAY (Client's maximum authorized cost divided by number of days in the care plan period)	**$73.90**
A. Monthly State Cost Containment Amount	**$5,082.88**
B. Divided by 30.42 days = Daily Cost Containment Ceiling	**$167.09**

21. CDASS (amounts must match client's allocation worksheet) — Effective Date: — Monthly Allocation Amt: **$0.00**

22. Immediately prior to HCBS enrollment, this client lived in a long term care facility? ☐ Yes ☐ No

23. CASE MANAGER NAME	24. AGENCY	25. PHONE #	26. EMAIL	27. DATE
John Doe	**EBD Agency**	**303-333-3333**	John.Doe@EBDAgency.com	**7/30/2013**
23A. CASE MANAGER SIGNATURE: *John Doe*				
28. CASE MANAGER'S **SUPERVISOR** NAME	29. AGENCY	30. PHONE #	31. EMAIL	32. DATE
Joan Doe	**EBD Agency**	**303-333-3333**	**Joan.Doe@EBDAgency.com**	**7/31/2013**
28A. CASE MANAGER'S **SUPERVISOR** SIGNATURE: *Joan Doe*				

DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY

33. CASE PLAN: ☐ Approved Date: ☐ Denied Date: Return for correction- Date:

34. REGULATION(S) upon which Denial or Return is based:

35. DEPARTMENT APPROVAL SIGNATURE: 36. DATE:

Claim Submission

Paper Claims

Electronic claims format shall be required unless hard copy claims submittals are specifically authorized by the Department. Requests may be sent to the Department's fiscal agent, Xerox State Healthcare, 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 approval)
- Claims that, by policy, require attachments
- Reconsideration claims

For more detailed Colorado 1500 billing instructions, please refer to the CMS 1500 General Billing Information manual in the Provider Services Billing Manuals section.

Electronic Claims

Instructions for completing and submitting electronic claims are available through the 837 Professional (837P) Web Portal User guide via the Web Portal and also on the Department's Colorado Medical Assistance Program Web Portal page.

Electronically mandated claims submitted on paper are processed, denied, and marked with the message "Electronic Filing Required."

The Special Program Indicator (SPI) must be completed on claims submitted electronically. Claims submitted electronically and on paper are identified by using the specific national modifiers along with the procedure code. The appropriate procedure codes and modifiers for each HCBS waiver are noted throughout this manual. When the services are approved, the claim may be submitted to the Department's fiscal agent. For more detailed billing instructions, please refer to the CMS 1500 General Billing Information in the Provider Services Billing Manuals section.

Procedure/HCPCS Codes Overview

The Department develops procedure codes that are approved by the Centers for Medicare & Medicaid Services (CMS). The codes are used to submit claims for services provided to Colorado Medical Assistance Program members. The procedure codes 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 CPT (Current Procedural Terminology), 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. These include ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DME/Supplies) 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. CPT codes are identified using 5 numeric digits.

Persons with a Brain Injury (HCBS-BI)

The Home and Community Based Services Brain Injury (HCBS-BI) waiver program provides a variety of services to qualified members with brain injury as an alternative to inpatient hospital and rehabilitation facility placement. Members meeting program eligibility requirements are certified as medically eligible for HCBS-BI by the case manager.

HCBS-BI Procedure Code Table

Providers may bill the following procedure codes for HCBS-BI services:

HCBS-BI Procedure Code Table (Special Program Code 89)			
Description	**Procedure Code + Modifier(s)**		**Units**
Adult Day Services	S5102	U6	1 unit = 1 day
Assistive Technology	T2029	U6	Negotiated by case manager through prior authorization
Behavioral Programming	H0025	U6	1 unit= 30 minutes
Brain Injury Transitional Living Program (BI TLP) Acuity Tier 1	T2016	U6	1 unit = 1 day
Brain Injury Transitional Living Program (BI TLP) Acuity Tier 2	T2016	U6, HB	1 unit = 1 day
Brain Injury Transitional Living Program (BI TLP) Acuity Tier 3	T2016	U6, HE	1 unit = 1 day
Brain Injury Transitional Living Program (BI TLP) Acuity Tier 4	T2016	U6, HK	1 unit = 1 day
Brain Injury Transitional Living Program (BI TLP) Acuity Tier 5	T2016	U6, HB, HE	1 unit = 1 day
Consumer Directed Attendant Support Services (CDASS) (Cent/Unit)	T2025	U6	Negotiated by case manager through prior authorization.
CDASS Per Member/Per Month (PM/PM)	T2040	U6	Negotiated by case manager through prior authorization.
Day Treatment	H2018	U6	1 unit = 1 day
Home Modifications	S5165	U6	1 unit = per service
Independent Living Skills Training (ILST)	T2013	U6	1 unit = 1 hour
Mental Health Counseling, Family	H0004	U6, HR	1 unit = 15 minutes
Mental Health Counseling, Group	H0004	U6, HQ	1 unit = 15 minutes

HCBS-BI Procedure Code Table (Special Program Code 89)			
Mental Health Counseling, Individual	H0004	U6	1 unit = 15 minutes
Non-Medical Transportation (NMT), Taxi	A0100	U6	1 unit=one way trip
NMT, Mobility Van			
Mileage Band 1 (0-10 miles)	A0120	U6	1 unit=one way trip
Mileage Band 2 (11-20 miles)	A0120	U6, TT	1 unit=one way trip
Mileage Band 3 (over 20 miles)	A0120	U6, TN	1 unit=one way trip
NMT, Mobility Van, To and From Adult Day			
Mileage Band 1 (0-10 miles)	A0120	U6, HB	1 unit=one way trip
Mileage Band 2 (11-20 miles)	A0120	U6, TT, HB	1 unit=one way trip
Mileage Band 3 (over 20 miles)	A0120	U6, TN, HB	1 unit=one way trip
NMT, Wheelchair Van			
Mileage Band 1 (0-10 miles)	A0130	U6	1 unit=one way trip
Mileage Band 2 (11-20 miles)	A0130	U6, TT	1 unit=one way trip
Mileage Band 3 (over 20 miles)	A0130	U6, TN	1 unit=one way trip
NMT, Wheelchair Van, To and From Adult Day			
Mileage Band 1 (0-10 miles)	A0130	U6, HB	1 unit=one way trip
Mileage Band 2 (11-20 miles)	A0130	U6, TT, HB	1 unit=one way trip
Mileage Band 3 (over 20 miles)	A0130	U6, TN, HB	1 unit=one way trip
Personal Care	T1019	U6	1 unit = 15 minutes
Personal Care, Relative	T1019	U6, HR	1 unit = 15 minutes
Personal Emergency Response System (PERs) Install/Purchase	S5160	U6	Negotiated by case manager through prior authorization.
PERs, Monitoring	S5161	U6	Negotiated by case manager through prior authorization.
Respite Care, In Home	S5150	U6	1 unit = 15 minutes
Respite Care, Nursing Facility (NF)	H0045	U6	1 unit = 1 day
Substance Abuse Counseling, Family	T1006	U6	1 unit = 1 hour
Substance Abuse Counseling, Group	H0047	U6, HQ	1 unit = 1 hour
Substance Abuse Counseling, Individual	H0047	U6, HF	1 unit = 1 hour

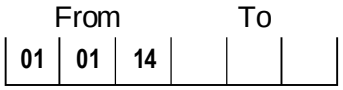
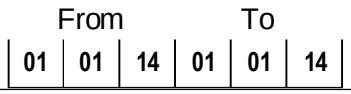
HCBS- BI Paper Claim Reference Table

The following paper form reference table gives required and/or conditional fields for the paper CMS 1500 claim form for HCBS-BI claims:

CMS Field #	Field Label	Field is?	Instructions
1	**Insurance Type**	Required	Place an "X" in the box marked as Medicaid.
1a	**Insured's ID Number**	Required	Enter the member's Colorado Medical Assistance Program seven-digit Medicaid ID number as it appears on the Medicaid Identification card. Example: A123456.
2	**Patient's Name**	Required	Enter the member's last name, first name, and middle initial.
3	**Patient's Date of Birth / Sex**	Required	Enter the patient's birth date using two digits for the month, two digits for the date, and two digits for the year. Example: 070114 for July 1, 2014. Place an "X" in the appropriate box to indicate the sex of the member.
4	**Insured's Name**	Not Required	
5	**Patient's Address**	Not Required	
6	**Patient's Relationship to Insured**	Not Required	
7	**Insured's Address**	Not Required	
8	**Reserved for NUCC Use**		
9	**Other Insured's Name**	Not Required	

CMS Field #	Field Label	Field is?	Instructions
9a	**Other Insured's Policy or Group Number**	Not Required	
9b	**Reserved for NUCC Use**		
9c	**Reserved for NUCC Use**		
9d	**Insurance Plan or Program Name**	Not Required	
10a-c	**Is Patient's Condition Related to?**	Not Required	
10d	**Reserved for Local Use**		
11	**Insured's Policy, Group or FECA Number**	Not Required	
11a	**Insured's Date of Birth, Sex**	Not Required	
11b	**Other Claim ID**	Not Required	
11c	**Insurance Plan Name or Program Name**	Not Required	
11d	**Is there another Health Benefit Plan?**	Not Required	
12	**Patient's or Authorized Person's signature**	Required	Enter "Signature on File", "SOF", or legal signature. If there is no signature on file, leave blank or enter "No Signature on File".

CMS Field #	Field Label	Field is?	Instructions
			Enter the date the claim form was signed.
13	**Insured's or Authorized Person's Signature**	Not Required	
14	**Date of Current Illness Injury or Pregnancy**	Not Required	
15	**Other Date**	Not Required	
16	**Date Patient Unable to Work in Current Occupation**	Not Required	
17	**Name of Referring Physician**	Not Required	
18	**Hospitalization Dates Related to Current Service**	Not Required	
19	**Additional Claim Information**	Conditional	**LBOD** Use to document the Late Bill Override Date for timely filing.
20	**Outside Lab?** **$ Charges**	Not Required	
21	**Diagnosis or Nature of Illness or Injury**	Required	Enter at least one but no more than twelve diagnosis codes based on the member's diagnosis/condition. Enter applicable ICD indicator to identify which version of ICD codes is being reported. 9 ICD-9-CM 0 ICD-10-CM **HCBS**

CMS Field #	Field Label	Field is?	Instructions
			HCBS may use 799.9
22	**Medicaid Resubmission Code**	Conditional	List the original reference number for resubmitted claims. When resubmitting a claim, enter the appropriate bill frequency code in the left-hand side of the field. 7 Replacement of prior claim 8 Void/Cancel of prior claim This field is not intended for use for original claim submissions.
23	**Prior Authorization**	Conditional	**HCBS** Leave blank
24	**Claim Line Detail**	Information	The paper claim form allows entry of up to six detailed billing lines. Fields 24A through 24J apply to each billed line. **Do not enter more than six lines of information** on the paper claim. If more than six lines of information are entered, the additional lines will not be entered for processing. Each claim form must be fully completed (totaled). **Do not file continuation claims** (e.g., Page 1 of 2).
24A	**Dates of Service**	Required	The field accommodates the entry of two dates: a "From" date of services and a "To" date of service. Enter the date of service using two digits for the month, two digits for the date and two digits for the year. Example: 010114 for January 1, 2014  Or 

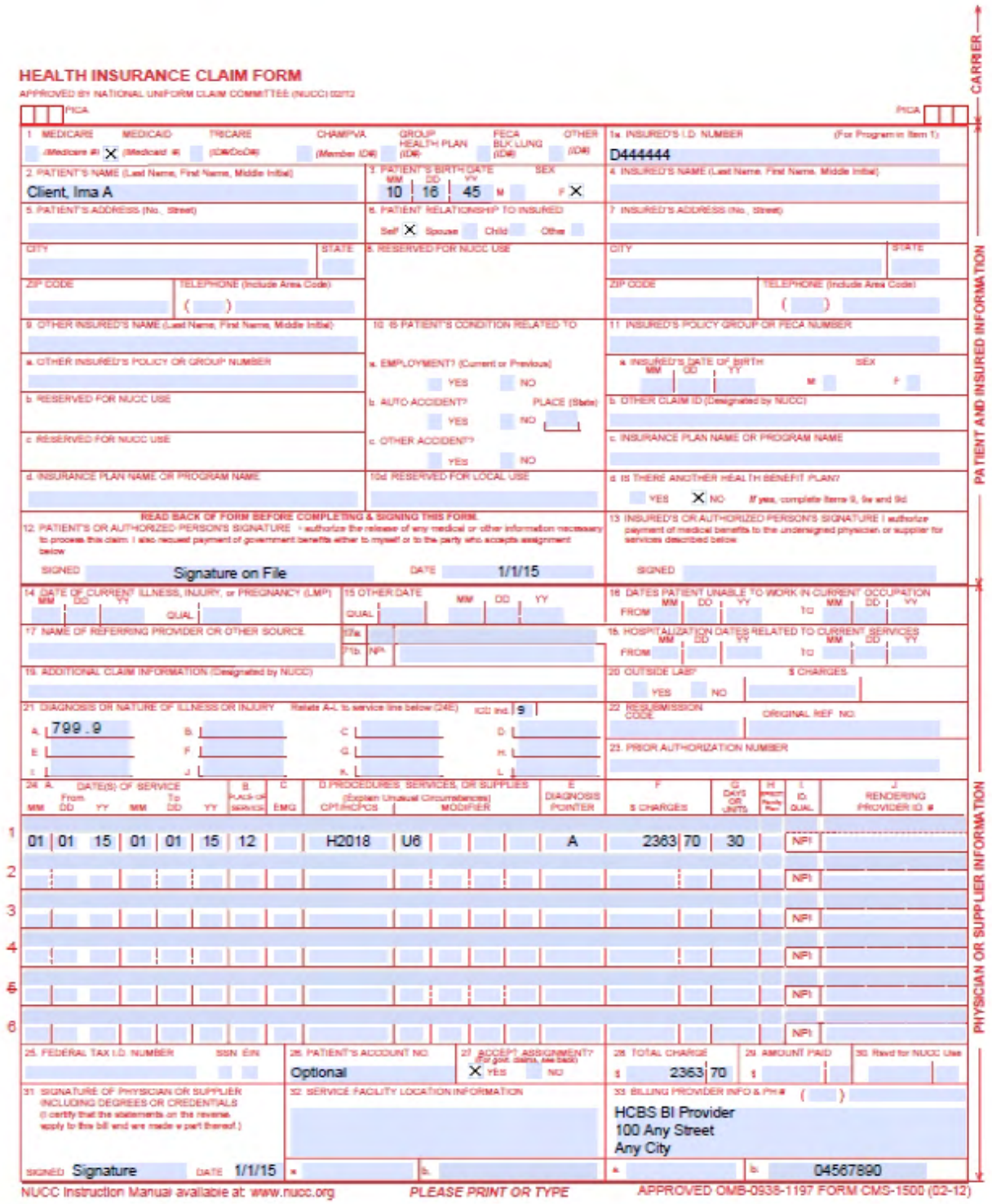
CMS Field #	Field Label	Field is?	Instructions
			Span dates of service From To 01 01 14 01 31 14 Single Date of Service: Enter the six digit date of service in the "From" field. Completion of the "To field is not required. Do not spread the date entry across the two fields. Span billing: permissible if the same service (same procedure code) is provided on consecutive dates.
24B	**Place of Service**	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. 11 Office 12 Home
24C	**EMG**	Not Required	
24D	**Procedures, Services, or Supplies**	Required	Enter the HCPCS procedure code that specifically describes the service for which payment is requested. **HCBS** Refer to the BI procedure code tables.
24D	**Modifier**	Conditional	Enter the appropriate procedure-related modifier that applies to the billed service. Up to four modifiers may be entered when using the paper claim form. **HCBS** Refer to the BI procedure code tables.
24E	**Diagnosis Pointer**	Required	Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis. At least one diagnosis code reference letter must be entered. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow.

CMS Field #	Field Label	Field is?	Instructions
			This field allows for the entry of 4 characters in the unshaded area.
24F	**$ Charges**	Required	Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number. 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 the usual and customary charges.
24G	**Days or Units**	Required	Enter the number of services provided for each procedure code. Enter whole numbers only- do not enter fractions or decimals.
24G	**Days or Units**	General Instructions	A unit represents the number of times the described procedure or service was rendered. Except as instructed in this manual or in Colorado Medical Assistance Program bulletins, the billed unit must correspond to procedure code descriptions. The following examples show the relationship between the procedure description and the entry of units. **Home & Community Based Services** Combine units of services for a single procedure code for the billed time period on one detail line. Dates of service do not have to be reported separately. Example: If forty

CMS Field #	Field Label	Field is?	Instructions
			units of personal care services were provided on various days throughout the month of January, bill the personal care procedure code with a From Date of 01/03/XX and a To Date of 01/31/XX and 40 units.
24H	**EPSDT/Family Plan**	Not Required	**EPSDT** (shaded area) Not Required **Family Planning** (unshaded area) Not Required
24I	**ID Qualifier**	Not Required	
24J	**Rendering Provider ID #**	Not Required	
25	**Federal Tax ID Number**	Not Required	
26	**Patient's Account Number**	Optional	Enter information that identifies the patient or claim in the provider's billing system. Submitted information appears on the Provider Claim Report (PCR).
27	**Accept Assignment?**	Required	The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.
28	**Total Charge**	Required	Enter the sum of all charges listed in field 24F. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
29	**Amount Paid**	Not Required	
30	**Rsvd for NUCC Use**		
31	**Signature of Physician or Supplier Including**	Required	Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent.

CMS Field #	Field Label	Field is?	Instructions
	Degrees or Credentials		A holographic signature stamp may be used if authorization for the stamp is on file with the fiscal agent. An authorized agent or representative may sign the claim for the enrolled provider if the name and signature of the agent is on file with the fiscal agent. Each claim must have the date the enrolled provider or registered authorized agent signed the claim form. Enter the date the claim was signed using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. **Unacceptable signature alternatives:** Claim preparation personnel may not sign the enrolled provider's name. Initials are not acceptable as a signature. Typed or computer printed names are not acceptable as a signature. "Signature on file" notation is not acceptable in place of an authorized signature.
32	**32- Service Facility Location Information** **32a- NPI Number** **32b- Other ID #**	Not Required	
33	**33- Billing Provider Info & Ph. #** **33a- NPI Number** **33b- Other ID #**	Required	Enter the name of the individual or organization that will receive payment for the billed services in the following format: 1st Line Name 2nd Line Address 3rd Line City, State and ZIP Code 33a- NPI Number Not Required 33b- Other ID # Enter the eight-digit Colorado Medical Assistance Program provider number of the individual or organization.

HCBS-BI Claim Example



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1 MEDICARE X (Medicare #) | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): D444444

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Client, Ima A

3. PATIENT'S BIRTH DATE: 10 16 45 SEX: M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street):

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street):

CITY | STATE | ZIP CODE | TELEPHONE (Include Area Code)

8. RESERVED FOR NUCC USE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (Current or Previous) YES NO
b. AUTO ACCIDENT? PLACE (State) YES NO
c. OTHER ACCIDENT? YES NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH SEX

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: Signature on File DATE: 1/1/15

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED:

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) QUAL

15. OTHER DATE QUAL

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. 9
A. 799.9 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	01	01	15	01	01	15	12		H2018	U6	A	2363 70	30		NPI
2															NPI
3															NPI
4															NPI
5															NPI
6															NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. Optional

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE $ 2363 70

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED Signature DATE 1/1/15

32. SERVICE FACILITY LOCATION INFORMATION
a. b.

33. BILLING PROVIDER INFO & PH # ( )
HCBS BI Provider
100 Any Street
Any City
a. b. 04567890

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

Community Mental Health Supports (CMHS), and Persons who are Elderly, Blind, and Disabled (EBD)

- The HCBS-CMHS and EBD waiver programs provide a variety of services to the Elderly, Blind and Disabled (EBD), and Community Mental Health Supports (HCBS-CMHS), formally known as Persons with Major Mental Illness (MI), as an alternative to nursing facility, inpatient hospital, and rehabilitation facility placement to qualified members. Members meeting program eligibility requirements are certified by the case management agency/single entry point as medically eligible for these HCBS waiver programs. These three waivers offer all of the following services:
- Alternative Care Facility - Alternative Care Services means, but is not limited to, a package of personal care and homemaker services provided in a state-certified alternative care facility including: assistance with bathing, skin, hair, nail and mouth care, shaving, dressing, feeding, ambulation, transfers, and positioning, bladder & bowel care, medication reminding, accompanying, routine housecleaning, meal preparation, bed making, laundry and shopping.
- Reimbursement shall be per unit, with one unit equaling one day of care.
- Adult Day Services– Services furnished between three (3) – five (5) or more hours per day on a regularly scheduled basis, for one or more days per week. Services provided in an outpatient setting, encompassing both health and social services needed to assure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a “full nutritional regimen” (3 meals per day). Physical, occupational and speech therapies indicated in the individual’s plan of care would be furnished as component parts of this service if such services are not being provided in the participant’s home.
- Electronic Monitoring/Personal Emergency Response Systems – An electronic device, which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable “help” button to allow for mobility. The system is connected to the person’s phone and programmed to signal a response center once a “help” button is activated. Monitoring of the device is included in the PERS service. The response center is staffed by trained professionals.
- Homemaker – Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker. Provided when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.
- Home Modification are specific modifications, adaptations or improvements in an eligible member's existing home setting which, based on the member’s medical condition are necessary to ensure the health, welfare and safety of the member, enable the member to function with greater independence in the home, are required because of the member's illness, impairment or disability, as documented on the ULTC-100.2 form and the care plan and prevents institutionalization of the member. There shall be a lifetime cap of $10,000.00 per member.
- Personal Care – Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. These services may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the service plan, this service may also include such housekeeping chores as bed making, dusting and vacuuming. Services are incidental to the care furnished, or are essential to the health and welfare of the individual,

rather than the individual's family. Payment will not be made for services furnished to a minor by the child's parent (or step parent), or to an individual by the person's spouse.

- Relative Personal Care – Personal Care providers may be members of the individual's family. The number of Medicaid personal care units for provided by any single member of the member's family shall not exceed the equivalent of 444 personal care units per annual certification. Payment will not be made for services furnished to an individual by an individual's spouse employed by a Personal Care agency.
- Respite care means services provided to an eligible member on a short-term basis because of the absence or need for relief of those persons normally providing the care. The unit of reimbursement shall be a unit of one day for care provided in a Nursing Facility or Alternative Care Facility. Individual respite providers shall bill according to an hourly rate or daily institutional rate, whichever is less.
- Non-Medical Transportation – Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the service plan. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State Plan, defined at 42 CFR 440.170 (a) (if applicable), and shall not replace them.
- Non-Medical Transportation will be limited to two (2) round-trips per week. Trips to and from adult day programs are not subject to this cap.

The HCBS-EBD program offers the following additional services:

Note: HCBS-CMHS offers CDASS and Medication Reminders as well.

Consumer Directed Attendant Support Services (CDASS) – CDASS is a service delivery option that offers HCBS-EBD and HCBS-CMHS members the opportunity to direct personal care, homemaker and health maintenance tasks. Members may also designate an authorized representative to direct these activities on their behalf.

In-Home Support Services (IHSS) – IHSS includes health maintenance activities, support for activities of daily living or instrumental activities of daily living, personal care service and homemaker services. Additionally, IHSS providers are required to provide the core independent living skills. This service is only available for EBD and CHCBS members.

Community Transition Services (CTS) – CTS assists Medical Assistance Program members in transitioning from nursing facilities to community-based residences. CTS are administered by provider specialty Transition Coordination Agency (TCA). TCAs have to provide at least two Independent Living Core Services and have to be certified by the Department to provide CTS.

Medication Reminders – Medication reminders are devices, controls, or appliances which enable an individual at high risk of institutionalization to increase their abilities to perform activities of daily living, such as medication administration. Medication reminders shall include devices or items that remind or signal the member to take prescribed medications. Medication reminders may include other devices necessary for the proper functioning of such items, and may also include durable and non-durable medical equipment not available as a State plan benefit.

HCBS-CMHS Procedure Code Table

Providers may bill the following procedure codes for HCBS-CMHS services:

HCBS-CMHS Procedure Code Table (Special Program Code 94)			
Description	**Procedure Code**	**Modifier(s)**	**Units**
Adult Day Services, Basic	S5105	UA	1 unit = 3-5 hours
Adult Day Services, Specialized	S5105	UA, TF	1 unit = 3-5 hours
Alternative Care Facility	T2031	UA	1 unit =1 day
Consumer Directed Attendant Support Services (CDASS) (Cent/Unit)	T2025	UA	Negotiated by case manager through prior authorization.
CDASS Per Member/Per Month (PM/PM)	T2040	UA	Negotiated by case manager through prior authorization.
Home Modifications	S5165	UA	1 unit =1 modification
Homemaker	S5130	UA	1 unit = 15 minutes
Medication Reminder, Install/Purchase	T2029	UA	1 unit = 1 purchase
Medication Reminder, Monitoring	S5185	UA	1 unit per month
Non-Medical Transportation (NMT), Taxi	A0100	UA	1 unit=one way trip
NMT, Mobility Van			
Mileage Band 1 (0-10 miles)	A0120	UA	1 unit=one way trip
Mileage Band 2 (11-20 miles)	A0120	UA, TT	1 unit=one way trip
Mileage Band 3 (over 20 miles)	A0120	UA, TN	1 unit=one way trip
NMT, Mobility Van, To and From Adult Day			
Mileage Band 1 (0-10 miles)	A0120	UA, HB	1 unit=one way trip
Mileage Band 2 (11-20 miles)	A0120	UA, TT, HB	1 unit=one way trip
Mileage Band 3 (over 20 miles)	A0120	UA, TN, HB	1 unit=one way trip
NMT, Wheelchair Van			
Mileage Band 1 (0-10 miles)	A0130	UA	1 unit=one way trip
Mileage Band 2 (11-20 miles)	A0130	UA, TT	1 unit=one way trip
Mileage Band 3 (over 20 miles)	A0130	UA, TN	1 unit=one way trip
NMT, Wheelchair Van, To and From Adult Day			
Mileage Band 1 (0-10 miles)	A0130	UA, HB	1 unit=one way trip
Mileage Band 2 (11-20 miles)	A0130	UA, TT, HB	1 unit=one way trip
Mileage Band 3 (over 20 miles)	A0130	UA, TN, HB	1 unit=one way trip
Personal Care	T1019	UA	1 unit = 15 minutes
Personal Care, Relative	T1019	UA, HR	1 unit = 15 minutes

HCBS-CMHS Procedure Code Table (Special Program Code 94)			
Description	**Procedure Code**	**Modifier(s)**	**Units**
Personal Emergency Response System (PERs) Install/Purchase	S5160	UA	1 unit = purchase and installation
PERs, Monitoring	S5161	UA	1 unit =1 month of service
Respite Care, Alternative Care Facility (ACF)	S5151	UA	1 unit = 1 day
Respite Care, Nursing Facility (NF)	H0045	UA	1 unit =1 day

HCBS-EBD Procedure Code Table

Providers may bill the following procedure codes for HCBS-EBD services:

HCBS-EBD Procedure Code Table (Special Program Code 82)			
Description	**Procedure Code**	**Modifier(s)**	**Units**
Adult Day Services, Basic	S5105	U1	1 unit = 3-5 hours
Adult Day Services, Specialized	S5105	U1, TF	1 unit = 3-5 hours
Alternative Care Facility	T2031	U1	1 unit =1 day
Community Transition Services, Coordinator	T2038	U1	1 unit = 1 transition
Community Transition Services, Items Purchased	A9900	U1	1 unit = purchase
Consumer Directed Attendant Support Services (CDASS) (Cent/Unit)	T2025	U1	Negotiated by case manager through prior authorization.
CDASS Per Member/Per Month (PM/PM)	T2040	U1	Negotiated by case manager through prior authorization.
Home Modifications	S5165	U1	1 unit =1 modification
Homemaker	S5130	U1	1 unit = 15 minutes
IHSS Health Maintenance Activities	H0038	U1	1 unit = 15 minutes
IHSS Personal Care Service	T1019	U1, KX	1 unit = 15 minutes
IHSS Relative Personal Care	T1019	U1, HR, KX	1 unit = 15 minutes
IHSS Homemaker Service	S5130	U1, KX	1 unit = 15 minutes
Medication Reminder, Install/Purchase	T2029	U1	1 unit = 1 purchase
Medication Reminder, Monitoring	S5185	U1	1 unit per month
Non-Medical Transportation (NMT), Taxi	A0100	U1	1 unit=one way trip

HCBS-EBD Procedure Code Table (Special Program Code 82)			
Description	**Procedure Code**	**Modifier(s)**	**Units**
NMT, Mobility Van			
Mileage Band 1 (0-10 miles)	A0120	U1	1 unit=one way trip
Mileage Band 2 (11-20 miles)	A0120	U1, TT	1 unit=one way trip
Mileage Band 3 (over 20 miles)	A0120	U1, TN	1 unit=one way trip
NMT, Mobility Van, To and From Adult Day			
Mileage Band 1 (0-10 miles)	A0120	U1, HB	1 unit=one way trip
Mileage Band 2 (11-20 miles)	A0120	U1, TT, HB	1 unit=one way trip
Mileage Band 3 (over 20 miles)	A0120	U1, TN, HB	1 unit=one way trip
NMT, Wheelchair Van			
Mileage Band 1 (0-10 miles)	A0130	U1	1 unit=one way trip
Mileage Band 2 (11-20 miles)	A0130	U1, TT	1 unit=one way trip
Mileage Band 3 (over 20 miles)	A0130	U1, TN	1 unit=one way trip
NMT, Wheelchair Van, To and From Adult Day			
Mileage Band 1 (0-10 miles)	A0130	U1, HB	1 unit=one way trip
Mileage Band 2 (11-20 miles)	A0130	U1, TT, HB	1 unit=one way trip
Mileage Band 3 (over 20 miles)	A0130	U1, TN, HB	1 unit=one way trip
Personal Care	T1019	U1	1 unit = 15 minutes
Personal Care, Relative	T1019	U1, HR	1 unit = 15 minutes
Personal Emergency Response System (PERs) Install/Purchase	S5160	U1	1 unit = purchase and installation
PERs, Monitoring	S5161	U1	1 unit =1 month of service
Respite Care, Alternative Care Facility (ACF)	S5151	U1	1 unit = 1 day
Respite Care, In Home	S5150	U1	1 unit = 15 minutes
Respite Care - Nursing Facility (NF)	H0045	U1	1 unit =1 day

HCBS-CMHS and EBD Paper Claim Reference Table

The following paper form reference table gives required and/or conditional fields for the paper CMS 1500 claim form for HCBS-CMHS and HCBS-EBD claims:

CMS Field #	Field Label	Field is?	Instructions
1	**Insurance Type**	Required	Place an "X" in the box marked as Medicaid.
1a	**Insured's ID Number**	Required	Enter the member's Colorado Medical Assistance Program seven-digit Medicaid ID number as it appears on the Medicaid Identification card. Example: A123456.
2	**Patient's Name**	Required	Enter the member's last name, first name, and middle initial.
3	**Patient's Date of Birth / Sex**	Required	Enter the patient's birth date using two digits for the month, two digits for the date, and two digits for the year. Example: 070114 for July 1, 2014. Place an "X" in the appropriate box to indicate the sex of the member.
4	**Insured's Name**	Not Required	
5	**Patient's Address**	Not Required	
6	**Patient's Relationship to Insured**	Not Required	
7	**Insured's Address**	Not Required	
8	**Reserved for NUCC Use**		
9	**Other Insured's Name**	Not Required	

CMS Field #	Field Label	Field is?	Instructions
9a	**Other Insured's Policy or Group Number**	Not Required	
9b	**Reserved for NUCC Use**		
9c	**Reserved for NUCC Use**		
9d	**Insurance Plan or Program Name**	Not Required	
10a-c	**Is Patient's Condition Related to?**	Not Required	
10d	**Reserved for Local Use**		
11	**Insured's Policy, Group or FECA Number**	Not Required	
11a	**Insured's Date of Birth, Sex**	Not Required	
11b	**Other Claim ID**	Not Required	
11c	**Insurance Plan Name or Program Name**	Not Required	
11d	**Is there another Health Benefit Plan?**	Not Required	
12	**Patient's or Authorized Person's signature**	Required	Enter "Signature on File", "SOF", or legal signature. If there is no signature on file, leave blank or enter "No Signature on File".

CMS Field #	Field Label	Field is?	Instructions
			Enter the date the claim form was signed.
13	**Insured's or Authorized Person's Signature**	Not Required	
14	**Date of Current Illness Injury or Pregnancy**	Not Required	
15	**Other Date**	Not Required	
16	**Date Patient Unable to Work in Current Occupation**	Not Required	
17	**Name of Referring Physician**	Not Required	
18	**Hospitalization Dates Related to Current Service**	Not Required	
19	**Additional Claim Information**	Conditional	**LBOD** Use to document the Late Bill Override Date for timely filing.
20	**Outside Lab?** **$ Charges**	Not Required	
21	**Diagnosis or Nature of Illness or Injury**	Required	Enter at least one but no more than twelve diagnosis codes based on the member's diagnosis/condition. Enter applicable ICD indicator to identify which version of ICD codes is being reported. 9 ICD-9-CM 0 ICD-10-CM **HCBS** HCBS may use 799.9

CMS Field #	Field Label	Field is?	Instructions
22	**Medicaid Resubmission Code**	Conditional	List the original reference number for resubmitted claims. When resubmitting a claim, enter the appropriate bill frequency code in the left-hand side of the field. 7 Replacement of prior claim 8 Void/Cancel of prior claim This field is not intended for use for original claim submissions.
23	**Prior Authorization**	Conditional	**HCBS** Leave blank
24	**Claim Line Detail**	Information	The paper claim form allows entry of up to six detailed billing lines. Fields 24A through 24J apply to each billed line. **Do not enter more than six lines of information** on the paper claim. If more than six lines of information are entered, the additional lines will not be entered for processing. Each claim form must be fully completed (totaled). **Do not file continuation claims** (e.g., Page 1 of 2).
24A	**Dates of Service**	Required	The field accommodates the entry of two dates: a "From" date of services and a "To" date of service. Enter the date of service using two digits for the month, two digits for the date and two digits for the year. Example: 010114 for January 1, 2014 From To 01 01 14 | | | Or From To 01 01 14 01 01 14 Span dates of service From To 01 01 14 01 31 14 Single Date of Service: Enter the six digit date of service in the "From" field. Completion of the

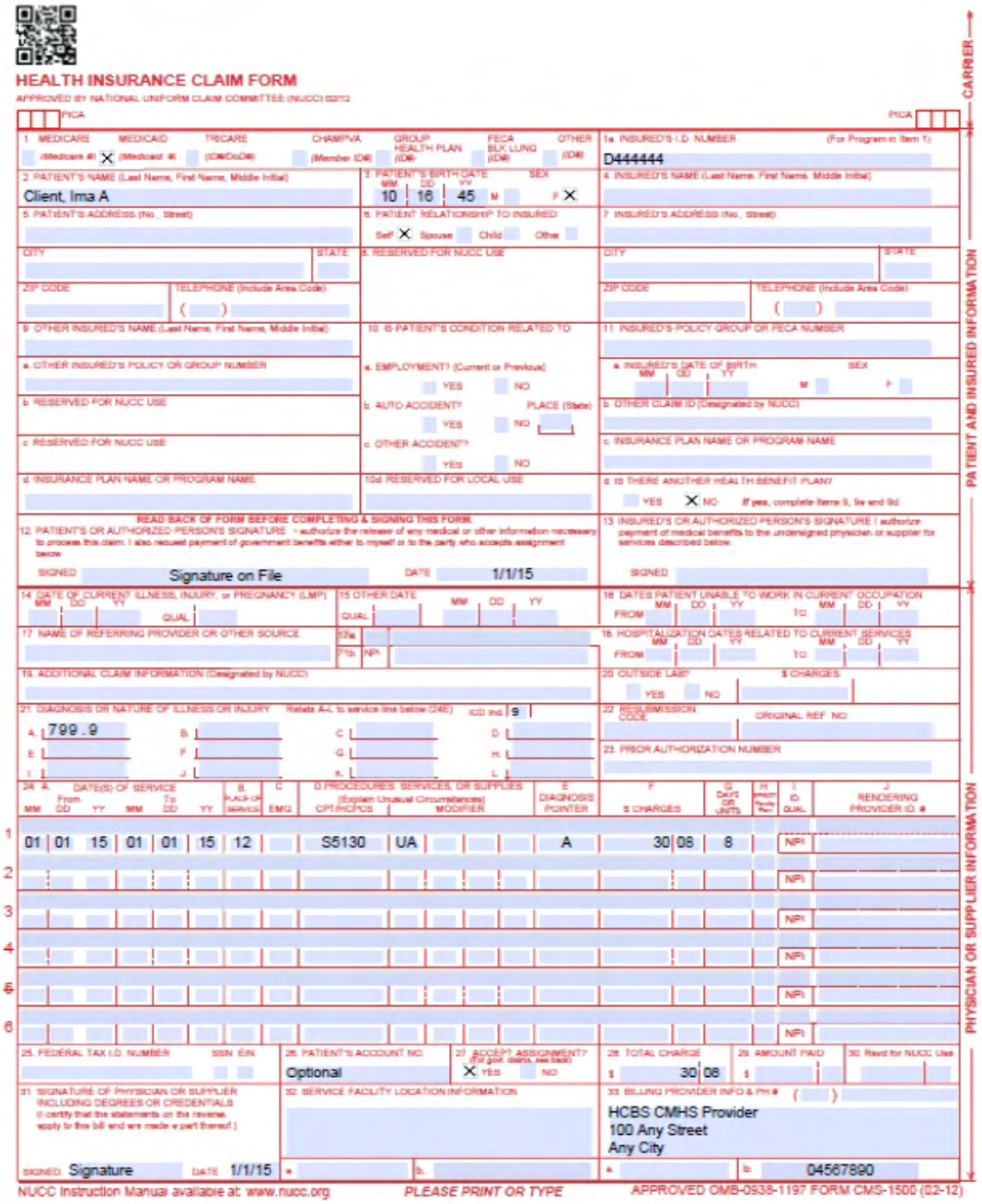
CMS Field #	Field Label	Field is?	Instructions
			"To field is not required. Do not spread the date entry across the two fields. Span billing: permissible if the same service (same procedure code) is provided on consecutive dates.
24B	**Place of Service**	Required	Enter the Place of Service (POS) code that describes the location where services were rendered. The Colorado Medical Assistance Program accepts the CMS place of service codes. 12 Home **NOTE:** Use POS Code 12 (Home) for Alternative Care Facility, Adult Day Program, or Respite in the Facility
24C	**EMG**	Not Required	
24D	**Procedures, Services, or Supplies**	Required	Enter the HCPCS procedure code that specifically describes the service for which payment is requested. **HCBS** Refer to the HCBS-EBD or HCBS-CMHS procedure code tables.
24D	**Modifier**	Conditional	Enter the appropriate procedure-related modifier that applies to the billed service. Up to four modifiers may be entered when using the paper claim form. **HCBS** Refer to the BI procedure code tables.
24E	**Diagnosis Pointer**	Required	Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis. At least one diagnosis code reference letter must be entered. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. This field allows for the entry of 4 characters in the unshaded area.

CMS Field #	Field Label	Field is?	Instructions
24F	**$ Charges**	Required	Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number. 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 the usual and customary charges.
24G	**Days or Units**	Required	Enter the number of services provided for each procedure code. Enter whole numbers only- do not enter fractions or decimals.
24G	**Days or Units**	General Instructions	A unit represents the number of times the described procedure or service was rendered. Except as instructed in this manual or in Colorado Medical Assistance Program bulletins, the billed unit must correspond to procedure code descriptions. The following examples show the relationship between the procedure description and the entry of units. **Home & Community Based Services** Combine units of services for a single procedure code for the billed time period on one detail line. Dates of service do not have to be reported separately. Example: If forty units of personal care services were provided on various days throughout the month of January, bill the personal care procedure code with a From Date of 01/03/XX and a To Date of 01/31/XX and 40 units.

CMS Field #	Field Label	Field is?	Instructions
24H	**EPSDT/Family Plan**	Not Required	**EPSDT** (shaded area) Not Required **Family Planning** (unshaded area) Not Required
24I	**ID Qualifier**	Not Required	
24J	**Rendering Provider ID #**	Not Required	
25	**Federal Tax ID Number**	Not Required	
26	**Patient's Account Number**	Optional	Enter information that identifies the patient or claim in the provider's billing system. Submitted information appears on the Provider Claim Report (PCR).
27	**Accept Assignment?**	Required	The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.
28	**Total Charge**	Required	Enter the sum of all charges listed in field 24F. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
29	**Amount Paid**	Not Required	
30	**Rsvd for NUCC Use**		
31	**Signature of Physician or Supplier Including Degrees or Credentials**	Required	Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent. A holographic signature stamp may be used if authorization for the stamp is on file with the fiscal agent. An authorized agent or representative may sign the claim for the enrolled provider if the name

CMS Field #	Field Label	Field is?	Instructions
			and signature of the agent is on file with the fiscal agent. Each claim must have the date the enrolled provider or registered authorized agent signed the claim form. Enter the date the claim was signed using two digits for the month, two digits for the date and two digits for the year. Example: 070114 for July 1, 2014. **Unacceptable signature alternatives:** Claim preparation personnel may not sign the enrolled provider's name. Initials are not acceptable as a signature. Typed or computer printed names are not acceptable as a signature. "Signature on file" notation is not acceptable in place of an authorized signature.
32	**32- Service Facility Location Information** **32a- NPI Number** **32b- Other ID #**	Not Required	
33	**33- Billing Provider Info & Ph. #** **33a- NPI Number** **33b- Other ID #**	Required	Enter the name of the individual or organization that will receive payment for the billed services in the following format: 1st Line Name 2nd Line Address 3rd Line City, State and ZIP Code 33a- NPI Number Not Required 33b- Other ID # Enter the eight-digit Colorado Medical Assistance Program provider number of the individual or organization.

HCBS-CMHS Claim Example



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): D444444

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Client, Ima A

3. PATIENT'S BIRTH DATE: 10 16 45 SEX: M | F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street):

6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street):

CITY | STATE | ZIP CODE | TELEPHONE (Include Area Code)

8. RESERVED FOR NUCC USE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (Current or Previous) YES NO
b. AUTO ACCIDENT? PLACE (State) YES NO
c. OTHER ACCIDENT? YES NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH SEX

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: Signature on File DATE: 1/1/15

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED:

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) QUAL

15. OTHER DATE QUAL

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. 9
A. 799.9 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 01 01 15	01 01 15	12		S5130	UA	A	30 08	8		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. Optional

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE $ 30 08

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED Signature DATE 1/1/15

32. SERVICE FACILITY LOCATION INFORMATION
a. b.

33. BILLING PROVIDER INFO & PH #
HCBS CMHS Provider
100 Any Street
Any City
a. b. 04567890

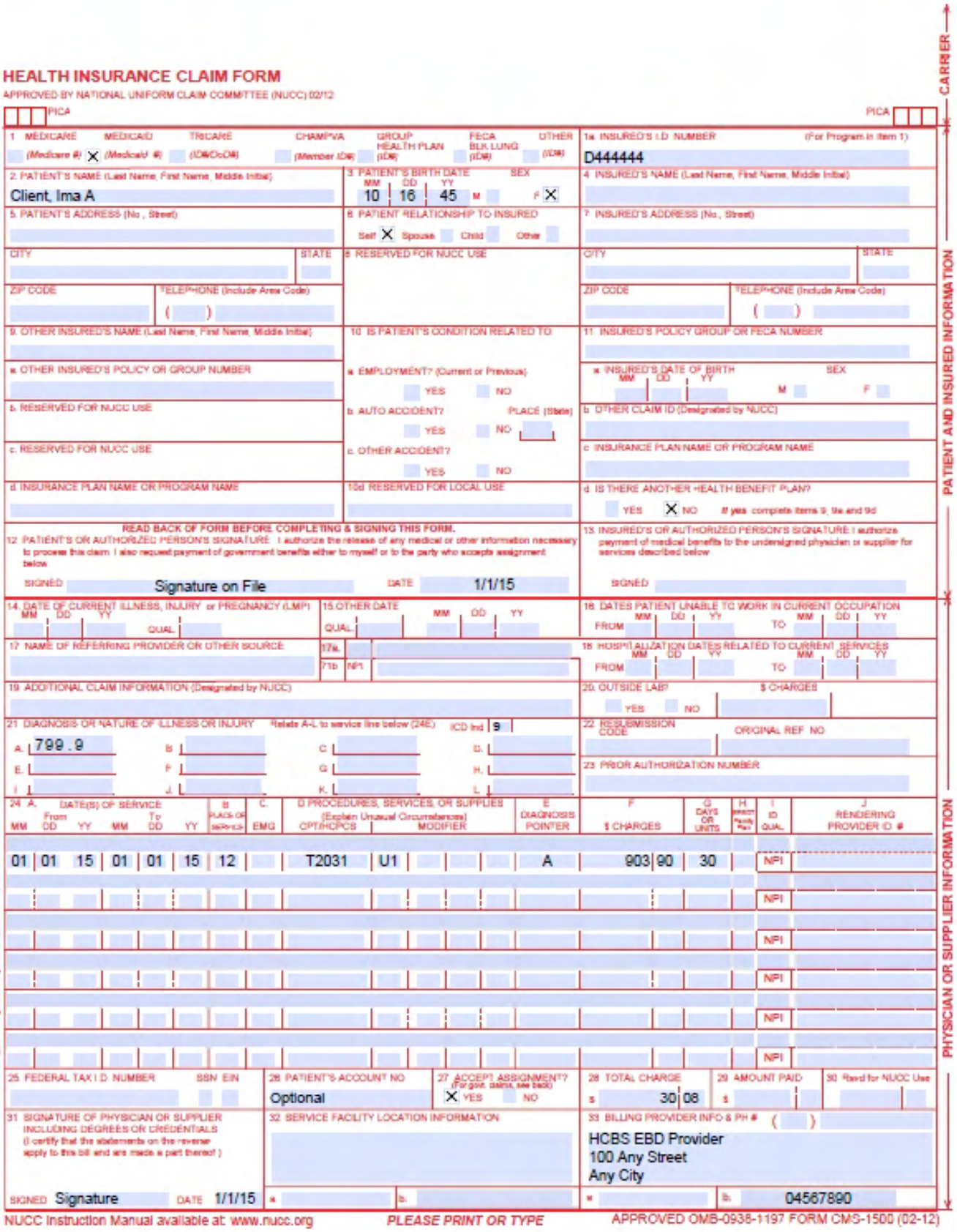
CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

HCBS-EBD Claim Example



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1 MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): D444444

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Client, Ima A

3. PATIENT'S BIRTH DATE MM 10 DD 16 YY 45 SEX M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE 1/1/15

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. 9

A. 799.9 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	01	15	01	01	15	12		T2031	U1	A	903 90	30		NPI
2															NPI
3															NPI
4															NPI
5															NPI
6															NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. Optional

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO

28. TOTAL CHARGE $ 30 08

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Signature DATE 1/1/15

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

HCBS EBD Provider
100 Any Street
Any City

a. b. 04567890

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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
LBOD Completion Requirements	• Electronic claim formats provide specific fields for documenting the LBOD. • Supporting documentation must be kept on file for 6 years. • For paper claims, follow the instructions appropriate for the claim form you are using. ➢ *UB-04*: Occurrence code 53 and the date are required in FL 31-34. ➢ *CMS 1500*: Indicate "LBOD" and the date in box 19 – Additional Claim Information. ➢ *2006 ADA Dental*: Indicate "LBOD" and the date in box 35 - Remarks
Adjusting Paid Claims	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. **Adjust the claim within 60 days** of the claim payment. Retain all documents that prove compliance with timely filing requirements. *Note: There is no time limit for providers to adjust paid claims that would result in repayment to the Colorado Medical Assistance Program.* **LBOD** = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the payment.

Billing Instruction Detail	Instructions
Denied Paper Claims	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. **Correct the claim errors and refile within 60 days** of the claim denial or rejection. Retain all documents that prove compliance with timely filing requirements. **LBOD** = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the denial.
Returned Paper Claims	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. **Correct the claim errors and re-file within 60 days** of the date stamped on the returned claim. Retain a copy of the returned claim that shows the receipt or return date stamped by the fiscal agent. **LBOD** = the stamped fiscal agent date on the returned claim.
Rejected Electronic Claims	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. **Correct claim errors and refile within 60 days** of the rejection. Maintain a printed copy of the rejection notice that identifies the claim and date of rejection. **LBOD** = the date shown on the claim rejection report.
Denied/Rejected Due to Member Eligibility	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. **File the claim within 60 days** of the date of the rejected eligibility verification response. Retain a printed copy of the rejection notice that identifies the member and date of eligibility rejection. **LBOD** = the date shown on the eligibility rejection report.
Retroactive Member Eligibility	The claim is for services provided to an individual whose Colorado Medical Assistance Program eligibility was backdated or made retroactive. 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: • Identifies the patient by name • States that eligibility was backdated or retroactive • Identifies the date that eligibility was added to the state eligibility system. **LBOD** = the date shown on the county letter that eligibility was added to or first appeared on the state eligibility system.

Billing Instruction Detail	Instructions
Delayed Notification of Eligibility	The provider was unable to determine that the patient had Colorado Medical Assistance Program coverage until after the timely filing period expired. **File the claim within 60 days** of the date of notification that the individual had Colorado Medical Assistance Program coverage. Retain correspondence, phone logs, or a signed Delayed Eligibility Certification form (see Certification & Request for Timely Filing Extension in the Provider Services Forms section) that identifies the member, indicates the effort made to identify eligibility, and shows the date of eligibility notification. • Claims must be filed within 365 days of the date of service. No exceptions are allowed. • This extension is available only if the provider had no way of knowing that the individual had Colorado Medical Assistance Program coverage. • Providers who render services in a hospital or nursing facility are expected to get benefit coverage information from the institution. • The extension does not give additional time to obtain Colorado Medical Assistance Program billing information. • If the provider has previously submitted claims for the member, it is improper to claim that eligibility notification was delayed. **LBOD** = the date the provider was advised the individual had Colorado Medical Assistance Program benefits.
Electronic Medicare Crossover Claims	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.) **File the claim within 120 days** of the Medicare processing/ payment date shown on the SPR/ERA. Maintain the original SPR/ERA on file. **LBOD** = the Medicare processing date shown on the SPR/ERA.
Medicare Denied Services	The claim is for Medicare denied services (Medicare non-benefit services, benefits exhausted services, or the member does not have Medicare coverage) being submitted within 60 days of the date of Medicare processing/denial. *Note: This becomes a regular Colorado Medical Assistance Program claim, not a Medicare crossover claim.* **File the claim within 60 days** 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. **LBOD** = the Medicare processing date shown on the SPR/ERA.
Commercial Insurance Processing	The claim has been paid or denied by commercial insurance. **File the claim within 60 days** of the insurance payment or denial. Retain the commercial insurance payment or denial notice that identifies the patient, rendered services, and shows the payment or denial date. 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

Billing Instruction Detail	Instructions
	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. **LBOD** = the date commercial insurance paid or denied.
Correspondence LBOD Authorization	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 member, claim, services, or circumstances. **File the claim within 60 days** of the date on the authorization letter. Retain the authorization letter. **LBOD** = the date on the authorization letter.
Member Changes Providers during Obstetrical Care	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. **File the claim within 60 days** of the last OB visit. Maintain information in the medical record showing the date of the last prenatal visit and a notation that the patient transferred to another provider for continuation of OB care. **LBOD** = the last date of OB care by the billing provider.

HCBS-BI, CMHS, and EBD Specialty Manuals Revisions Log

Revision Date	*Section/Action*	*Pages*	*Made by*
07/12/2013	*Created*	*All*	*cc, sm, jg*
12/30/2013	*Added CDASS services to BI*	*11*	*cc*
03/19/2013	*Removed all PLWA content*	*Throughout*	*mm*
08/4/2014	*Revised all web links to reflect new Department website*	*Throughout*	*Mm*
08/08/2014	*Added new services to BI Procedure Code table*	*11*	*Mm*
08/08/2014	*Added revised BI PAR Example*	*9*	*Mm*
8/8/14	*Replaced all CO 1500 references with CMS 1500*	*Throughout*	*ZS*
8/8/14	*Updated Professional Claim Billing Instructions section with CMS 1500 information.*		*ZS*
8/8/14	*Replaced all references of client to member*	*Throughout*	*ZS*
11/21/14	*Removed Appendix H information, added Timely Filing document information*	*39*	*rm*
12/04/14	*Added CDASS and FMS information*	*5*	*Mc*