

Claims Billing Information

ValueOptions Colorado will be processing all claims for Colorado Health Partnerships, Foothills Behavioral Health Partners, and Northeast Behavioral Health Partnership, all of which are Behavioral Health Organizations (BHOs) contracted with the state of Colorado for the Medicaid Community Mental Health Services Program. For answers to questions about Billing for Professional and Facility/Program Services, call ValueOptions: **1-800-804-5040**

A. Claim Submission Requirements

Timely and accurate processing of claims is important to ValueOptions. Following the instructions below will facilitate efficient processing of your claim within acceptable timeframes.

1. ValueOptions will process claims for dates of service on or after July 1, 2009.
2. ValueOptions will accept the following types of claims. Please see Section B for Electronic Data interchange (EDI) information:
 - 837P file
 - 837I file
 - DirectClaim Submission (claims submitted individually through a secured internet access)
 - EDI Claim Link for Windows (*ValueOptions'* HIPAA compliant software)
 - HIPAA compliant file written from the Provider's Practice Management System
 - Center for Medicare and Medicaid Services/CMS-1500 (formally known as HCFA-1500)
 - Uniform Billing Form/UB04 (CMS-1450) or HCFA-1450.
3. Detailed instructions on required data elements for completing the claim forms are outlined in sections D1 and D2, below.
4. Completed claim forms may be mailed to:

ValueOptions
P.O. Box 12698
Norfolk, VA 23541
ATTN: CO Claims

5. Time Limit for Filing Claims

- a. **Claims** - Initial claims for covered services must be submitted within ninety (90) days of the date of service to be considered for reimbursement. Initial claims submitted beyond the ninety (90) day time limit may be zero paid (for timely filing) on the *ValueOptions* provider summary voucher (Explanation of Benefits, EOB).
- b. **Medicaid Claims Involving Third Party Liability (TPL)** must be submitted within ninety (90) days of the date of the other carrier's Explanation of Benefits (EOB), or notification of payment / denial. Initial claims involving TPL that are submitted

beyond ninety (90) days from the date of the other carrier's EOB may be zero paid (for timely filing) on the *ValueOptions* provider summary voucher.

6. Incomplete Claims

- a. Claims may be "zero-paid" by *ValueOptions* in the case of incorrect or incomplete required data elements.
- b. *ValueOptions* may notify the provider, via the provider summary voucher (EOB), of those data elements requiring completion or correction. The required data elements and other claim submission requirements are outlined in Sections D1 and D2 of this Section.

7. A separate claim form must be submitted for each rendering provider of service. For example, if the member has outpatient individual therapy (90806) rendered by a PhD and an outpatient group therapy session (90853) rendered by an LCSW, each of these services need to be submitted on separate claims.

8. The service location must be submitted on all claims. *ValueOptions* will use this address information in conjunction with the NPI to select the appropriate provider record for processing the claim on our system.

9. **Itemized bills are required.** All pertinent information is necessary to process a claim promptly and accurately. Please make sure to include the following elements when submitting a claim:

- Dates of service should be listed individually on CMS-1500 claim forms (NO DATE SPANS).
- Valid ICD-9 diagnosis codes (NOTE: ICD-9 diagnosis codes are required for electronically submitted claims.) The list of diagnosis codes covered under the Community Mental Health Services Program is attached.
- Rendering provider and provider billing information, including tax identification number entered in appropriate areas of UB04 and CMS1500 forms.
- Appropriate and valid place of service codes with correlating appropriate and valid CPT or HCPS codes (and Revenue codes, when billing on a UB04 (CMS-1450)).
- Accurate member/patient information including member identification number, member name and Date of Birth. Please do not use nicknames.

10. **Authorization and claim must match:** The services billed must correspond to the care that was authorized. In order for payment to occur, the procedure/revenue code and dates of service must match those authorized.

11. **Claims Payment** - For paper claims received the use of scanning by means of Optical Character Recognition (OCR) technology allows for a more automated process of capturing information. This technology enables *ValueOptions* to shorten turnaround time and improve quality. The following elements are required to take advantage of this automated process. If you do not follow the guidelines, your claim will still be processed, however, it will require manual intervention and may take longer to process.

- a. Use machine print
- b. Use original red claim forms
- c. Use black ink
- d. Print claim data within the defined boxes on the claim form
- e. Use all capital letters
- f. Use a laser printer for best results
- g. Use white out or correction tape for corrections
- h. Submit any notes on 8 1/2" x 11" paper
- i. Use an eight-digit date format (e.g., 10212006)
- j. Use a fixed width font (Courier, for example)

12. Please refer to your provider agreement for the covered services that you have been contracted for, and the definition of services included in the reimbursement rates.

13. Medicaid Claims should be submitted with the Member's Medicaid ID Number; failure to use this permanent ID number may result in the denial of the claim on the provider summary voucher (EOB).

14. Claims must be submitted with valid and complete ICD9 diagnosis codes. Claims submitted with any other diagnosis code may be zero paid on the *ValueOptions* provider summary voucher (EOB).

15. Before any payments can be made to any provider or facility, the minimum of a completed W9 Form must be on file with *ValueOptions*.

C. Electronic Media Claim Submission (EDI and DirectClaim Submission)

1. New Transaction and Code Requirements

Under the Health Insurance Portability and Accountability Act (HIPAA), all covered entities must switch to the new transaction and code standards effective October 16, 2003. Technical instructions, Implementation and Companion Guides for these electronic transactions can be found on the ValueOptions Web site at www.valueoptions.com. In using this system, ValueOptions and providers must:

- (i) Not change any definition, data condition or use of a data element or segment as proscribed in the Health and Human Services (HHS) Transaction Standard Regulation. (45 CFR 162.915(a)).
- (ii) Not add any data elements or segments to the maximum defined data set as defined in the HHS Transaction Standard Regulation. (45 CFR 162.915 (b)).
- (iii) Not use any code or data elements that are either marked "not used" in the HHS Transaction Standard's implementation specifications or are not in the HHS Transaction Standard's implementation specifications. (45 CFR 162.915 (c)).
- (iv)

- (iv) Not change the meaning or intent of any of the HHS Transaction Standard's implementation specifications. (45 CFR 162.915 (d)).
2. Please contact the EDI Help Desk at 1-888-247-9311 for assistance with becoming a *ValueOptions* EDI claim submitter or Single Claim Submitter.
 - a. The **DirectClaim Submission** feature is a web-based method of submitting one (CMS-1500) claim at a time to *ValueOptions*. This method of submitting claims is recommended for a small provider office that would submit no more than 20 claims at a time.
 - b. EDI Claims Link for Windows is an electronic claim submission process developed by *ValueOptions* and is free to providers who wish to submit electronic claims to *ValueOptions*.
 3. *ValueOptions* will accept the following HIPAA compliant claim files:
 - Files programmed by the Provider's IT Department;
 - Files submitted using *ValueOptions*' EDI Claims Link for Windows software;
 - Claims submitted using *ValueOptions*' Single Claim Submission process. **Note: Please see the *ValueOptions* Provider Guide to using DirectClaim Submission, available on the www.valueoptions.com website, under "Providers"**
 4. The following information is required from the provider prior to submitting claims electronically:
 - Completed Account Request Form;
 - Intermediary Authorization Form (if using a billing agent or clearinghouse);
 - Files must be HIPAA compliant (if using EDI Claims Link for Windows software, this software is HIPAA compliant);
 - Must submit a test file to verify accurate information is included in the file.

D. Paper Claim Submission Requirements

1. **Instructions for Completing the CMS 1500 Claim Form.** The information on the following pages must be completed or the claim may be zero-paid on the summary voucher.

| Field Number | Field Description | Data Type | Instructions |
|---|---------------------|-----------|---|
| Member Information (Fields 1-13) | | | |
| 1 | Coverage | Optional | Show the type of health insurance coverage applicable to this claim by checking the appropriate box (e.g., if a Medicaid claim is being filed, check the Medicaid box). |
| 1a | Insured's ID number | Required | List the member's CO Medicaid identification number here. Verify that the identification number corresponds to the member listed in item 4. |

| Field Number | Field Description | Data Type | Instructions |
|---------------------|---|------------------|---|
| 2 | Patient's name | Required | Enter the patient's last name, first name, and middle initial, if any. NOTE: If the patient has a last name suffix (e.g., Jr, Sr) enter it after the last name, but before the first name. Do not use any punctuation in this field. |
| 3 | Patient's birth date and gender | Required | Enter the patient's birth date and sex. Use the eight digit format (MM DD CCYY) format for date of birth. Enter an X in the correct box to indicate the sex of the patient. Only one box can be marked. If the gender is unknown, leave blank. |
| 4 | Insured's name | Optional | Enter the member's full last name, first name and middle initial. If the insured has a last name suffix (e.g., Jr, Sr) enter it after the last name, but before the first name. |
| 5 | Patient's address, city, state, zip code and telephone number | Optional | Enter the patient's mailing address and telephone number. On the first line, enter the street address (apartment number or Post Office Box number); the second line, the city and state; the third line, the ZIP code and phone number. NOTE: Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). When entering a none-digit ZIP code, include the hyphen. Do not use a hyphen or space as a separator within the telephone number. |
| 6 | Patient's relationship to the insured | Optional | Check the appropriate box for the patient's relationship to the insured when item 4 is completed. Remember that the patient's relationship to the insured is not always "self". |
| 7 | Insured's address, city, state, zip code and telephone number | Optional | Enter the member's address (apartment/PO box number, street, city, state, zip code and telephone number with area code). NOTE: Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). When entering a none-digit ZIP code, include the hyphen. Do not use a hyphen or space as a separator within the telephone number. |
| 8 | Patient status | Optional | Check the appropriate box for the patient's marital status and whether employed or a student. |
| 9 | Other insured's name | Conditional | Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the name (last name, first name, middle initial) of the person who is insured under other payer. |
| 9a | Other insured's policy or group number | Conditional | Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the other insured's policy or group number or the insured's identification number. |

| Field Number | Field Description | Data Type | Instructions |
|--------------|--|--------------|--|
| 9b | Other insured's date of birth | Conditional | Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the eight-digit date of birth in MM/DD/CCYY format and enter an "X" to indicate the sex of the other insured. Only one box can be marked. If gender is unknown, leave blank. |
| 9c | Other insured's employer's name or school name | Conditional | Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the other insured's employer's name or school. |
| 9d | Other insured's insurance plan name or program name | Conditional | Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the other insured's insurance company or program name. |
| 10a - c | Is the patient's condition related to: <ul style="list-style-type: none"> • Employment? • Auto accident? • Other accident? | Optional | Place an "X" in the box indicating whether or not the condition for which the patient is being treated is related to current or previous employment, an automobile accident or any other accident. Enter an "X" in either the YES or NO box for each question. NOTE: The state postal code must be shown if "yes" is marked in 10b for "auto accident". Any item marked yes indicates there may be other applicable insurance coverage that would be primary such as automobile liability insurance. Primary insurance information must then be shown in item 11. |
| 10d | Reserved for local use | Not required | Please leave blank. |
| 11 | Insured's policy group or FECA number | Optional | Enter the Insured's policy or group number as it appears on the insured's health care identification card. |
| 11a | Insured's date of birth and sex | Conditional | Required if the patient is not the insured. Enter the insured's eight-digit birth date in the MMDDCCYY format and sex if different from item 3. |
| 11b | Employer name or school name | Conditional | Enter the insured's employer's name, if applicable. If the insured is eligible by virtue of employment or covered under a policy as a student, enter the employer or school name. |
| 11c | Insurance plan name or program name | Conditional | Enter the member's insurance company or program name. |
| 11d | Is there another health benefit plan? | Conditional | Place an "X" in the box indicating whether there may be other insurance involved in the reimbursement of this claim. |

| Field Number | Field Description | Data Type | Instructions |
|---|---|--------------|--|
| 12 | Patient's or authorized person's signature (Medicaid/other information release) | Required | The patient <i>must</i> sign and date the claim <i>if</i> authorizing the release of medical information. If "signature on file" is indicated, the provider <i>must</i> maintain a signed release form or CMS-1500 (formally HCFA 1500). The patient's signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service or supplier, when the provider of service or supplier accepts assignment on the claim. |
| 13 | Insured's or authorized person's signature | Required | The signature in this item authorizes payment of benefits to the physician or supplier. Signature on file, SOF, or the legal signature are acceptable. If there is no signature on file leave this item blank or enter "no signature on file". |
| Provider of Service or Supplier Information (Fields 14-33) | | | |
| 14 | Date of current illness, injury or pregnancy | Not required | Not applicable. |
| 15 | If patient has had same or similar illness, give first date | Not required | Not applicable. |
| 16 | Dates patient unable to work in current occupation | Not required | Required if the patient is eligible for disability or worker's compensation benefits due to this illness. Enter the "From" and "To" dates the patient was unable to work in MMDDYY or MMDDCCYY format. |
| 17 | Name of referring physician or other source | Not required | Enter the name of the referring physician or other source if applicable. |

| Field Number | Field Description | Data Type | Instructions |
|--------------|---|--------------|---|
| 17a | ID number of referring physician | Conditional | <p>The CMS-assigned UPIN of the referring or ordering physician listed in Field 17. Enter only the seven-digit base number and the one-digit check digit.</p> <p>The other ID number of the referring provider, ordering provider, or other source should be reported in 17a in the shaded area. The qualifier indicating what the number represents should be reported in the qualifier field to the immediate right of 17a. The NUCC defines the following qualifiers, since they are the same as those used in the electronic 837 Professional 4010A1:</p> <ul style="list-style-type: none"> • 0B – State license number • 1B – Blue Shield provider number • 1C – Medicare provider number • 1D – Medicaid provider number • 1G – Provider UPIN number • 1H – CHAMPUS identification number • EI – Employer's identification number • G2 – Provider commercial number • LU – Location number • N5 – Provider plan network identification number • SY – Social Security number (The Social Security number may not be used for Medicare) • X5 – State industrial accident provider number • ZZ – Provider taxonomy – A list of the valid Taxonomy codes begins on Page 38. |
| 17b | NPI | Required | <p>Enter the NPI of the referring or ordering physician listed in item 17 as soon as it is available. The NPI may be reported as of October 1, 2006.</p> <p>NOTE: Field 17a and / or 17b is required when a service was ordered or referred by a physician. Effective May 23, 2007, and later, 17a is not to be reported but 17b MUST be reported when a service was ordered or referred by a physician.</p> |
| 18 | Hospitalization dates related to current services | Not Required | Required if this claim includes charges for services rendered during an inpatient admission. Enter dates in MMDDYY format. |
| 19 | Reserved for local use | Not Required | Not applicable. |
| 20 | Outside lab/charges | Not Required | Not applicable. |

| Field Number | Field Description | Data Type | Instructions |
|---------------------|--|---|--|
| 21.1-4 | Diagnosis or nature of illness or injury | Required (the primary diagnosis code is required) | Enter a valid ICD-9 diagnosis code, coding to the highest level of specificity (include fourth and fifth digits if applicable) that describes the principal diagnosis for services rendered. Enter up to four codes in priority order (primary, secondary, etc.) |
| 22 | Medicaid resubmission code/original reference number | Not required | List the original reference (claim) number for resubmitted claims. |
| 23 | Prior authorization number | Not required | Not applicable. |
| 24a | Dates of service | Required | Enter "From" and "To" dates of service in MMDDYY or MMDDCCYY format. Line items can include no more than two dates of service for the same procedure code. When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column C. |
| 24b | Place of service | Required | Enter the appropriate place of service code from the list provided beginning on Page 19. |
| 24c | EMG | Not required | Not applicable. |
| 24d | Procedures, services or supplies CPT/HCPCS | Required | Enter a valid CPT or HCPCS code for each service rendered. |

| Field Number | Field Description | Data Type | Instructions |
|--------------|------------------------|--------------|---|
| 24d | Modifier | Conditional | <p>Enter a valid CPT or HCPCS code modifier for each service entered.**</p> <p><u>HIPAA: Billing Code Modifiers</u></p> <p>** When submitting a CPT or HCPC code with a modifier, it is critical that the modifier be placed in its appropriate allocation. HIPAA allows up to four (4) modifiers to be used. The order of the modifiers has a particular meaning. The order of the modifiers is found below:</p> <p>Modifier ONE: This field is dedicated for modifiers that affect or define the service (e.g., TG modifier to identify a 'complex high level of care')</p> <p>Modifier TWO: This field is dedicated for modifiers that identify pricing (e.g., HA modifier to identify 'child/adolescent' or HN modifier to identify 'bachelors level')</p> <p>Modifier THREE & FOUR: These fields are dedicated for modifiers that identify statistics (e.g., HV 'funded by State Addictions Agency')</p> <p>If you have any questions regarding the placement of Modifiers, please contact your Regional Provider Relations office for instructions.</p> |
| 24e | Diagnosis pointer | Conditional | <p>Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line. When multiple services are performed, the primary reference number for each service, a 1, 2, 3 or 4, is shown. <i>Do not</i> enter the ICD-9 diagnosis code.</p> |
| 24f | Charges | Required | <p>Enter the provider's billed charges for each service.</p> |
| 24g | Days or units | Required | <p>Enter the appropriate number of units or days that correspond to the "From" and "To" dates indicated in Field 24a.</p> |
| 24h | EPSDT family plan | Not Required | <p>If service was rendered as part of or in response to an EPSDT panel, mark an "X" in this block.</p> |
| 24i | ID Qual. | Not Required | <p>If the provider does not have an NPI, enter the appropriate qualifier and identifying number in the shaded area. There will always be providers who do not have an NPI and will need to report non-NPI identifiers on their claim forms. The qualifiers will indicate the non-NPI number being reported.</p> |
| 24j | Rendering Provider ID# | Required | <p>Enter the NPI number in the un-shaded area of the field.</p> |

| Field Number | Field Description | Data Type | Instructions |
|--------------|--|--------------|---|
| 25 | Federal Tax ID number and type: <ul style="list-style-type: none"> • Social Security Number or • Employer Identification Number | Required | Enter the nine-digit Employee Identification Number (EIN) or Social Security Number under which payment for services is to be made for reporting earnings to the IRS. Enter an "X" in the appropriate box that identifies the type of ID number used for services rendered. |
| 26 | Patient's account number | Optional | Enter the unique number assigned by the provider for the patient. If entered, the patient account number will be returned to the provider on the Provider Summary Voucher. |
| 27 | Accept assignment? | Required | Enter an "X" in the appropriate box. |
| 28 | Total charge | Required | Enter the total charge for this claim. This is the total of all charges for each service noted in Field 24f. |
| 29 | Amount paid | Conditional | Enter the total amount paid by the Member for services billed on this claim. |
| 30 | Balance due | Conditional | Enter the total balance due for the services less any amount entered in Field 29. |
| 31 | Signature of physician or supplier including degrees or credentials | Required | Signature of physician or supplier including degree(s) or credentials and date of signature. NOTE: The person rendering care <i>must</i> sign and indicate licensure level. |
| 32 | Name and address of facility where services were rendered | Required | Enter name and address where services are rendered. |
| 32a | a. | Not Required | Enter the NPI of the service facility as soon as it is available. The NPI may be reported on the Form CMS-1500 (08-05) as early as October 1, 2006. |
| 32b | b. | Not Required | Not Applicable |
| 33 | Physician's/supplier's billing: name, address, zip code and phone number | Required | Enter the appropriate billing information. |
| 33a | PIN number | Required | Effective May 23, 2007, and later, enter the NPI of the billing provider or group. |
| 33b | Group number | Not Required | Not Applicable after May 23, 2007 |

Valid Place of Service Codes for the Colorado Medicaid Account (Field 24B)

| Place of Service Code(s) | Place of Service Name |
|---------------------------------|--|
| 01 | Pharmacy |
| 03 | School |
| 04 | Shelter |
| 09 | Prison / Correctional Facility |
| 11 | Office |
| 12 | Home |
| 13 | Assisted Living Facility |
| 14 | Group Home |
| 15 | Mobile Unit |
| 16 | Temporary Lodging |
| 19 | School |
| 20 | Urgent Care Facility |
| 21 | Inpatient Hospital |
| 22 | Outpatient Hospital |
| 23 | Emergency Room |
| 26 | Military Treatment Facility |
| 31 | Skilled Nursing Facility (SNF) |
| 32 | Nursing Facility |
| 33 | Custodial Care Facility |
| 34 | Hospice |
| 41 | Ambulance – Land |
| 50 | Federally Qualified Health Center (FQHC) |
| 51 | Inpatient Psychiatric Facility |
| 52 | Psychiatric Facility (Partial Hospitalization) |
| 53 | Community Mental Health Center |
| 54 | Intermediate Care Facility |
| 55 | Residential Substance Abuse Treatment Facility |
| 56 | Psychiatric Residential Treatment Facility |
| 57 | Non-residential Substance Abuse Treatment Facility |
| 71 | State or Local Public Health Clinic |
| 99 | Other Place of Service |

2. Instructions for Completing the UB04 (CMS1450) Claim Form. The information on the following pages must be completed or the claim may be zero-paid on the summary voucher.

| Field | Field description | Field type | Instructions |
|-------|--|--------------|--|
| 1 | Provider name, Address, and Telephone Number | Required | This field contains the name, and service location and telephone number of the provider submitting the bill. |
| 2 | Pay-to Name and Address | Required | This field contains the address to which payment should be sent if different from the information in Field 1. |
| 3a | Patient Control Number | Optional | Complete this field with the patient account number that allows for the retrieval of individual patient financial records. If completed, this number will be included on the Provider's Summary Voucher. |
| 3b | Medical / Health Record Number | Optional | In this field, report the patient's medical record number as assigned by the provider. |
| 4 | Type of Bill | Required | This field is for reporting the type of bill for the purposes of third-party processing of the claim such as inpatient or outpatient. The first digit is a leading zero. The fourth digit defines the frequency of the bill for professional claims. The leading zero should not be reported on electronic claims. The valid codes are at the end of this section. |
| 5 | Federal Tax Number | Required | Enter the number assigned by the federal government for tax reporting purposes. This may be either the Tax Identification Number (TIN) or the Employer Identification Number (EIN). Affiliated subsidiaries are identified using federal tax sub-IDs. |
| 6 | Statement Covers Period "From" and "Through" | Required | Use this field to report the beginning and end dates of service for the period reflected on the claim in MMDDYY format. |
| 7 | Reserved for Assignment by the NUBC | Not Required | N/A |
| 8a | Patient Identifier | Required | This field is for the patient's identification number. |
| 8b | Patient Name | Required | This field is for the patient's last, middle initial, and first name. |
| 9a | Patient Address | Required | This field is for entering the patient's street address. |
| 9b | (unlabeled field) | Required | This field is for entering the patient's city. |

| Field | Field description | Field type | Instructions |
|---------|---|-------------|--|
| 9c | (unlabeled field) | Required | This field is for entering the patient's state code. |
| 9d | (unlabeled field) | Required | This field is for entering the patient's ZIP code. |
| 9e | (unlabeled field) | Required | This field is for entering the patient's Country Code. |
| 10 | Patient Birth date | Required | This field includes the patient's complete date of birth using the eight-digit format (MMDDCCYY). |
| 11 | Sex | Required | Use this field to identify the sex of the patient. |
| 12 | Admission Date / Start of Care Date | Required | Enter the date care begins. For inpatient care, it is the date of admission. For all other services, it is the date care is initiated. |
| 13 | Admission Hour | Required | Enter the hour in which the patient is admitted for inpatient or outpatient care. NOTE: Enter using Military Standard Time (00 – 24) in top-of-the-hour times only. See valid hours at the end of this section. |
| 14 | Priority (Type) of Visit | Required | Enter the appropriate code for the priority of the admission or visit. See valid codes at the end of this section. |
| 15 | Source of Referral for Admission or Visit | Required | This field indicates the source of the referral for the visit or admission (e.g., physician, clinic, facility, transfer, etc.). See valid codes at the end of this section. |
| 16 | Discharge Hour | Conditional | This field is used for reporting the hour the patient is discharged from inpatient care. NOTE: Enter using Military Standard Time (00 – 24) in top-of-the-hour times only. See valid hours at the end of this section. |
| 17 | Patient Discharge Status | Required | Use this field to report the status of the patient upon discharge – required for institutional claims. See valid codes at the end of this section. |
| 18 – 28 | Condition Codes | Conditional | Use these fields to report conditions or events related to the bill that may affect the processing of it. See valid codes at the end of this section. |
| 29 | Accident State | Conditional | When appropriate, assign the two-digit abbreviation of the state in which an accident occurred. |

| Field | Field description | Field type | Instructions |
|--------------|-------------------------------------|-------------------|---|
| 30 | Reserved for Assignment by the NUBC | Not Required | N/A |
| 31 – 34 | Occurrence Codes and Dates | Conditional | The occurrence code and the date fields associated with it define a significant event associated with the bill that affects processing by the payer (e.g., accident, employment related, etc.). |
| 35 – 36 | Occurrence Span Codes and Dates | Conditional | This field is for reporting the beginning and end dates of the specific event related to the bill. |
| 37 | Reserved for Assignment by the NUBC | Not Required | N/A |
| 38 | Responsible Party Name and Address | Required | This field is for reporting the name and address of the person responsible for the bill. |
| 39 - 41 | Value Codes and Amounts | Required | These fields contain the codes and related dollar amounts to identify the monetary data for processing claims. This field is required by all payers. |
| 42 | Revenue code | Required | Enter the applicable revenue code for the services rendered. There are 22 lines available and should include the total line for revenue code 0001. |
| 43 | Revenue Description | Optional | This field is used to report the abbreviated revenue code categories included in the bill. |
| 44 | HCPCS / Rate / HIPPS Code | Conditional | This field is used to report the appropriate HCPCS codes for ancillary services, the accommodation rate for bills for inpatient services, and the Health Insurance Prospective Payment System rate codes for specific patient groups that are the basis for payment under a prospective payment system. |
| 45 | Service Date | Conditional | Indicates the date the outpatient service was provided and the date the bill was created using the six-digit format (MMDDYY). |
| 46 | Service Units | Required | In this field, units such as pints of blood used, miles traveled and the number of inpatient days are reported. |
| 47 | Total Charges | Required | This field reports the total charges – covered and non-covered – related to the current billing period. |
| 48 | Non-Covered Charges | Conditional | This field indicates charges that are non-covered charges by the payer as related to the revenue code. |

| Field | Field description | Field type | Instructions |
|--------------|---|-------------------|---|
| 49 | Reserved for Assignment by the NUBC | Not Required | N/A |
| 50a, b, c | Payer Name | Required | Enter the name(s) of primary, secondary and tertiary payers as applicable. Provider should list multiple payers in priority sequence according to the priority the provider expects to receive payment from these payers. |
| 51a, b, c | Health Plan Identification Number | Required | This field includes the identification number of the health insurance plan that covers the patient and from which payment is expected. |
| 52a, b, c | Release of Information Certification Indicator | Required | Enter the appropriate code denoting whether the provider has on file a signed statement form the Member to release information. Refer to Attachment B for valid codes. |
| 53a, b, c | Assignment of Benefits Certification Indicator | Required | Enter the appropriate code to indicate whether the provider has a signed form authorizing the third party insurer to pay the provider directly for the service rendered. |
| 54a, b, c | Prior Payments | Conditional | Enter any prior payment amounts the facility has received toward payment of this bill for the payer indicated in Field 50 lines a, b, c. |
| 55a, b, c | Estimated Amount Due | Not required | Enter the estimated amount due from the payer indicated in Field 50 lines a, b, c. |
| 56 | National Provider Identifier – Billing Provider | Required | This field is for reporting the unique provider identifier assigned to the provider. |
| 57 | Other Provider Identifier – Billing Provider | Not Required | The unique provider identifier assigned by the health plan is reported in this field. |
| 58a, b, c | Insured's Name (last, first name, middle initial) | Required | The name of the individual who carries the insurance benefit is reported in this field. Enter the last name, first name and middle initial. |
| 59a, b, c | Patient's Relationship to Insured | Required | Enter the applicable code that indicates the relationship of the patient to the insured. |
| 60a, b, c | Insured's Unique Identification | Required | The ID Number from the Member's Medicaid Card should be entered. |
| 61a, b, c | Group Name | Required | Enter the group or plan name of the primary, secondary and tertiary payer through which the coverage is provided to the insured. |
| 62a, b, c | Insurance Group Number | Conditional | Enter the plan or group number for the primary, secondary and tertiary payer through which the coverage is provided to the insured. |

| Field | Field description | Field type | Instructions |
|-----------|--|--------------------------------|---|
| 63a, b, c | Treatment Authorization Codes | Optional | Enter the authorization number assigned by the payer indicated in Field 50, if known. This indicates the treatment has been preauthorized. |
| 64a, b, c | Document Control Number | Not Required from the Provider | This number is assigned by the health plan to the bill for their internal control. |
| 65a, b, c | Employer Name (of the Insured) | Conditional | Enter the name of primary employer that provides the coverage for the insured indicated in Field 58. |
| 66 | Diagnosis and Procedure Code Qualifier (ICD Version Indicator) | Required | This qualifier is used to indicate the version of ICD-9-CM being used. A "9" is required in this field for the UB-04. |
| 67 | Principal Diagnosis Code | Required | Enter the valid ICD-9-CM diagnosis code (including fourth and fifth digits if applicable) that describes the principal diagnosis for services rendered. |
| 67 a - q | Other Diagnosis Codes | Conditional | This field is for reporting all diagnosis codes in addition to the principal diagnosis that coexist, develop after admission, or impact the treatment of the patient or the length of stay. |
| 68 | Reserved for Assignment by the NUBC | Not Required | N/A |
| 69 | Admitting Diagnosis | Required | Enter a valid ICD-9-CM diagnosis code (include the fourth and fifth digits if applicable) that describes the diagnosis of the patient at the time of admission. |
| 70 a - c | Patient's Reason for Visit | Conditional | The ICD-9-CM codes that report the reason for the patient's outpatient visit is reported here. |
| 71 | Prospective Payment System (PPS) Code | Not required | This code identifies the DRG based on the grouper software and is required only when the provider is under contract with a health plan. |
| 72 | External Cause of Injury (ECI) Code | Not Required | In the case of external causes of injuries, poisonings, or adverse affects, the appropriate ICD-9-CM diagnosis code is reported in this field. |
| 73 | Reserved for Assignment by the NUBC | Not Required | N/A |
| 74 a - e | Other Procedure Codes and Dates | Conditional | This field is used to report the principal ICD-9-CM procedure code covered by the bill and the related date. |
| 75 | Reserved for Assignment by the NUBC | Not Required | N/A |

| Field | Field description | Field type | Instructions |
|--------------|--|-------------------|---|
| 76 | Attending Provider Names and Identifiers | Required | This field is for reporting the name and identifier of the provider with the responsibility for the care provided on the claim. |
| 77 | Operating Physician Name and Identifiers | Conditional | Report the name and identification number of the physician responsible for performing surgical procedure in this field. |
| 78 – 79 | Other Provider Names and Identifiers | Conditional | This field is used for reporting the names and identification numbers of individuals that correspond to the provider type category. |
| 80 | Remarks Field | Not Required | This field is used to report additional information necessary to process the claim. |
| 81 a – d | Code – Code Field | Conditional | This field is used to report codes that overflow other fields and for externally maintained codes NUBC has approved for the institutional data set. |

3. UB04 (CMS1450) Reference Information

UB04 (CMS-1450) REFERENCE MATERIAL¹

Type of Bill Codes (Field 4)

This is a four-digit code; each digit is defined below.

| | |
|--------------------|--------------|
| First Digit | Leading Zero |
|--------------------|--------------|

| Second Digit – Type of Facility | Description of Second Digit |
|--|--|
| 1XX | Hospital |
| 2XX | Skilled Nursing |
| 3XX | Home Health Facility |
| 4XX | Religious Non-medical Health Care Institutions (RNHCI) – Hospital Inpatient |
| 5XX | Reserved for National Assignment |
| 6XX | Intermediate Care |
| 7XX | Clinic (Requires Special Reporting for the Third Digit) |
| 8XX | Special Facility or ASC Surgery (Requires Special Reporting for the Third Digit) |
| 9XX | Reserved for National Assignment |

| Third Digit – Bill Classification | Description of Third Digit Except for Clinics and Special Facilities |
|--|--|
| X1X | Inpatient (Including Medicare Part A) |
| X2X | Inpatient (Medicare Part B Only) (Includes HHA Visits Under a Part B Plan of Treatment) |
| X3X | Outpatient (Includes HHA Visits Under a Part A Plan of Treatment Including DME Under Part A) |
| X4X | Laboratory Services Provided to Non-Patients, or Home Health Not Under a Plan of Treatment |
| X5X | Intermediate Care Level 1 |
| X6X | Intermediate Care Level II |
| X7X | Reserved for National Assignment |
| X8X | Swing Beds |
| X9X | Reserved for National Assignment |

| Third Digit – Bill Classification | Description of Third Digit Classification for Clinics Only |
|--|--|
| X1X | Rural Health Clinic |
| X2X | Clinic – Hospital Based or Independent Renal Dialysis Center |
| X3X | Freestanding |
| X4X | ORF |
| X5X | CORF |
| X6X | CMHC |
| X7X | Federally Qualified Health Center (FQHC) (effective April 1, 2010) |
| X8X | Reserved for National Assignment |
| X9X | Other |

| Third Digit – Bill Classification | Description of Third Digit Classification for Special Facility Only |
|--|--|
| X1X | Hospice (Non-hospital based) |
| X2X | Hospice (Hospital based) |
| X3X | Ambulatory Surgery Center |
| X4X | Freestanding Birthing Center |
| X5X | Critical Access Hospital |
| X6X | Residential Facility (Not used for Medicare) |
| X7X | Reserved for National Assignment |
| X8X | Reserved for National Assignment |
| X9X | Other (Not used for Medicare) |

| Fourth Digit – Frequency of the Bill | Description of Fourth Digit Frequency of the Bill |
|---|---|
| XX0 | Nonpayment / Zero Claim |
| XX1 | Admit through Discharge Claim |
| XX2 | Interim – First Claim |
| XX3 | Interim – Continuing Claim (Not valid for Medicare Inpatient Hospital PPS Claims) |
| XX4 | Interim – Last Claim (Not valid for Medicare Inpatient Hospital PPS Claims) |
| XX5 | Late Charges Only Claim |
| XX6 | Reserved |
| XX7 | Replacement of Prior Claim |
| XX8 | Void / Cancel of a Prior Claim |
| XX9 | Final Claim for a Home Health PPS Episode |

¹ Ingenix ® *Uniform Billing Editor, March, 2009*

Sex Codes (Field 11)

| Code | Definition |
|-------------|-------------------|
| M | Male |
| F | Female |
| U | Unknown |

Type of Admission Codes (Field 14)

| Code | Definition |
|-------------|----------------------------------|
| 1 | Emergency |
| 2 | Urgent |
| 3 | Elective |
| 4 | Newborn |
| 5 | Trauma Center |
| 6 – 8 | Reserved for National Assignment |
| 9 | Information Not Available |

Source of Admission Codes Except Newborns (Field 15)

| Code | Definition |
|-------------|-------------------|
|-------------|-------------------|

| | |
|-------|--|
| 1 | Nonhealthcare Facility Point of Origin (Physician Referral) |
| 2 | Clinic Referral |
| 3 | (Discontinued) |
| 4 | Transfer From a Hospital (Different Facility) |
| 5 | Transfer from a Skilled Nursing Facility or Intermediate Care Facility |
| 6 | Transfer from Another Health Care Facility |
| 7 | Emergency Room |
| 8 | Court/Law Enforcement |
| 9 | Information Not Available |
| A | Reserved |
| B | Transfer from Another Home Health Agency (HHA) |
| C | Readmission to Same HHA |
| D | Transfer from one Distinct Unit of a Hospital to Another Distinct Unit of the Same Hospital Resulting is a Separate Claim to the Payer |
| E | Transfer From Ambulatory Surgery Center |
| F | Transfer From Hospice and is Under a Hospice Plan of care of Enrolled in a Hospice Program |
| G – Z | Reserved for National Assignment |

Additional Source of Admission Codes for Newborns (Field 15)

| Code | Definition |
|-------|----------------------------------|
| 1 – 4 | Discontinued |
| 5 | Born Inside this Hospital |
| 6 | Born Outside of this Hospital |
| 7 – 8 | Reserved for National Assignment |
| 9 | Discontinued |

Patient Status (Field 17)

| Code | Definition |
|---------|---|
| 01 | Discharged to Home or Self-Care (Routine Discharge) |
| 02 | Discharged / Transferred to a Short-Term General Hospital for Inpatient Care |
| 03 | Discharged / Transferred to a SNF with Medicare Certification in Anticipation of Covered Skilled Care |
| 04 | Discharged / Transferred to a Facility that Provides Custodial or Supportive Care (effective October 1, 2009) |
| 05 | Discharged / Transferred to a Designated Cancer Center or Children's Hospital |
| 06 | Discharged / Transferred to Home Under Care of Organized Home Health Service Organization in Anticipation of Covered Skilled Care |
| 07 | Left Against Medical Advice or Discontinued Care |
| 08 | Reserved for National Assignment |
| 09 | Admitted as an Inpatient to This Hospital |
| 10 – 19 | Reserved for National Assignment |
| 20 | Expired |
| 21 | Discharged/Transferred to Court/Law Enforcement (effective October 1, 2009) |
| 22 - 29 | Reserved for National Assignment |

| Code | Definition |
|-------------|--|
| 30 | Still a Patient |
| 31-39 | Reserved for National Assignment |
| 40 | Expired at Home (for hospice care only) |
| 41 | Expired in a Medical Facility such as a Hospital, SNF, ICF or Free-Standing Hospice (for hospice care only) |
| 42 | Expired, Place Unknown (for hospice care only) |
| 43 | Discharged / Transferred to a Federal Health Care Facility |
| 44 – 49 | Reserved for National Assignment |
| 50 | Discharged to Hospice, Home |
| 51 | Discharged to Hospice, Medical Facility |
| 52 – 60 | Reserved for National Assignment |
| 61 | Discharged / Transferred Within This Institution to a Hospital-Based Medicare Approved Swing Bed |
| 62 | Discharged / Transferred to an Inpatient Rehabilitation Facility (IRF) Including Rehabilitation Distinct Part Units of a Hospital |
| 63 | Discharged / Transferred to a Medicare Certified Long Term Care Hospital (LTCH) |
| 64 | Discharged / Transferred to a Nursing Facility Certified Under Medicaid but Not Certified Under Medicare |
| 65 | Discharged / Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital |
| 66 | Discharges / Transfers to a Critical Access Hospital |
| 67 – 69 | Reserved for National Assignment |
| 70 | Discharged / Transferred to Another Type of Healthcare Institution Not Elsewhere Defined in this Code List (Effective October 1, 2007) |
| 71 – 99 | Reserved for National Assignment |

Release of Information Indicator Codes (Field 52)

| Code | Definition |
|-------------|---|
| Y | Yes, provider has a signed statement permitting release of medical billing data related to a claim |
| I | Informed consent to release medical information for conditions or diagnoses regulated by federal statutes |

Release of Information Indicator Codes for 837i files

| Code | Definition |
|-------------|--|
| A | Appropriate release of information on file at health care service provider or at utilization review organization |
| I | Informed consent to release medical information for conditions or diagnoses regulated by federal statutes |
| M | The provider has limited or restricted ability to release data related to a claim |
| N | No, provider is not allowed to release data |
| O | On file at payer or at plan sponsor |
| Y | Yes, provider has a signed statement permitting release of medical billing data related to a claim |

Member's Relationship to the Insured Codes (Field 59)

| Code | Definition |
|-------------|--------------------|
| 01 | Spouse |
| 18 | Self |
| 19 | Child |
| 20 | Employee |
| 21 | Unknown |
| 39 | Organ Donor |
| 40 | Cadaver Donor |
| 53 | Life Partner |
| G8 | Other Relationship |

Member's Relationship to the Insured Codes for 837i files

| Code | Definition |
|-------------|---|
| 01 | Spouse |
| 04 | Grandfather or Grandmother |
| 05 | Grandson or Granddaughter |
| 07 | Nephew or Niece |
| 10 | Foster Child |
| 15 | Ward |
| 17 | Stepson or Stepdaughter |
| 18 | Self |
| 19 | Child |
| 20 | Employee |
| 21 | Unknown |
| 22 | Handicapped Dependent |
| 23 | Sponsored Dependent |
| 24 | Dependent of a Minor Dependent |
| 29 | Significant Other |
| 32 | Mother |
| 33 | Father |
| 36 | Emancipated Minor |
| 39 | Organ Donor |
| 40 | Cadaver Donor |
| 41 | Injured Plaintiff |
| 43 | Child Where Insured has no Financial Responsibility |
| 53 | Life Partner |
| G8 | Other Relationship |

Valid Taxonomy Codes

| | |
|------------|--|
| 100000000X | BH & SOCSERV PROVIDERS |
| 101YA0400X | BH & SOCIAL SERVICE, COUNSELOR, ADDICTION (SUBSTAN |
| 101YM0800X | BH & SOCIAL SERVICE, COUNSELOR, MH |
| 101YP1600X | BH & SOCIAL SERVICE, COUNSELOR, PASTORAL |
| 101YP2500X | BH & SOCIAL SERVICE, COUNSELOR, PROFESSIONAL |
| 101YS0200X | BH & SOCIAL SERVICE, COUNSELOR, SCHOOL |
| 101Y00000X | BH & SOCIAL SERVICE, COUNSELOR |
| 103GC0700X | BH & SOCIAL SERVICE, NEUROPSYCHOLOGIST, CLINICAL |
| 103G00000X | BH & SOCIAL SERVICE, NEUROPSYCHOLOGIST |
| 103TA0400X | BH & SOCIAL SERVICE, PSYCHOLOGIST, ADDICTION (SUBS |
| 103TA0700X | BH & SOCIAL SERVICE, PSYCHOLOGIST, ADULT DEVELOPME |
| 103TB0200X | BH & SOCIAL SERVICE, PSYCHOLOGIST, BEHAVIORAL |
| 103TC0700X | BH & SOCIAL SERVICE, PSYCHOLOGIST, CLINICAL |

| | |
|------------|--|
| 103TC1900X | BH & SOCIAL SERVICE, PSYCHOLOGIST, COUNSELING |
| 103TC2200X | BH & SOCIAL SERVICE, PSYCHOLOGIST, CHILD, YOUTH & |
| 103TE1000X | BH & SOCIAL SERVICE, PSYCHOLOGIST, EDUCATIONAL |
| 103TE1100X | BH & SOCIAL SERVICE, PSYCHOLOGIST, EXERCISE & SPOR |
| 103TF0000X | BH & SOCIAL SERVICE, PSYCHOLOGIST, FAMILY |
| 103TF0200X | BH & SOCIAL SERVICE, PSYCHOLOGIST, FORENSIC |
| 103TH0100X | BH & SOCIAL SERVICE, PSYCHOLOGIST, HEALTH |
| 103TM1700X | BH & SOCIAL SERVICE, PSYCHOLOGIST, MEN & MASCULINI |
| 103TM1800X | BH & SOCIAL SERVICE, PSYCHOLOGIST, MENTAL RETARDAT |
| 103TP0814X | BH & SOCIAL SERVICE, PSYCHOLOGIST, PSYCHOANALYSIS |
| 103TP2700X | BH & SOCIAL SERVICE, PSYCHOLOGIST, PSYCHOTHERAPY |
| 103TP2701X | BH & SOCIAL SERVICE, PSYCHOLOGIST, PSYCHOTHERAPY, |
| 103TR0400X | BH & SOCIAL SERVICE, PSYCHOLOGIST, REHABILITATION |
| 103TS0200X | BH & SOCIAL SERVICE, PSYCHOLOGIST, SCHOOL |
| 103TW0100X | BH & SOCIAL SERVICE, PSYCHOLOGIST, WOMEN |
| 103T00000X | BH & SOCIAL SERVICE, PSYCHOLOGIST |
| 1041C0700X | BH & SOCIAL SERVICE, SOCIAL WORKER, CLINICAL |
| 1041S0200X | BH & SOCIAL SERVICE, SOCIAL WORKER, SCHOOL |
| 104100000X | BH & SOCIAL SERVICE, SOCIAL WORKER |
| 106H00000X | BH & SOCIAL SERVICE, MARRIAGE & FAMILY THERAPIST |
| 160000000X | NURSING SERVICE |
| 163WA0400X | NURSING SERVICE, RN, ADDICTION (SUBSTANCE USE DISO |
| 163WA2000X | NURSING SERVICE, RN, ADMINISTRATOR |
| 163WC0200X | NURSING SERVICE, RN, CRITICAL CARE MEDICINE |
| 163WC0400X | NURSING SERVICE, RN, CASE MANAGEMENT |
| 163WC1400X | NURSING SERVICE, RN, COLLEGE HEALTH |
| 163WC1500X | NURSING SERVICE, RN, COMMUNITY HEALTH |
| 163WC1600X | NURSING SERVICE, RN, CONTINUING EDUCATION/STAFF DE |
| 163WC2100X | NURSING SERVICE, RN, CONTINENCE CARE |
| 163WC3500X | NURSING SERVICE, RN, CARDIAC REHABILITATION |
| 163WD0400X | NURSING SERVICE, RN, DIABETES EDUCATOR |
| 163WD1100X | NURSING SERVICE, RN, DIALYSIS, PERITONEAL |
| 163WE0003X | NURSING SERVICE, RN, EMERGENCY |
| 163WE0900X | NURSING SERVICE, RN, ENTEROSTOMAL THERAPY |
| 163WF0300X | NURSING SERVICE, RN, FLIGHT |
| 163WG0000X | NURSING SERVICE, RN, GENERAL PRACTICE |
| 163WG0100X | NURSING SERVICE, RN, GASTROENTEROLOGY |
| 163WG0600X | NURSING SERVICE, RN, GERONTOLOGY |
| 163WH0200X | NURSING SERVICE, RN, HOME HEALTH |
| 163WH0500X | NURSING SERVICE, RN, HEMODIALYSIS |
| 163WH1000X | NURSING SERVICE, RN, HOSPICE |
| 163WI0500X | NURSING SERVICE, RN, INFUSION THERAPY |
| 163WI0600X | NURSING SERVICE, RN, INFECTION CONTROL |
| 163WL0100X | NURSING SERVICE, RN, LACTATION CONSULTANT |
| 163WM0102X | NURSING SERVICE, RN, MATERNAL NEWBORN |
| 163WM0705X | NURSING SERVICE, RN, MEDICAL-SURGICAL |
| 163WM1400X | NURSING SERVICE, RN, NURSE MASSAGE THERAPIST (NMT) |
| 163WN0002X | NURSING SERVICE, RN, NEONATAL INTENSIVE CARE |
| 163WN0003X | NURSING SERVICE, RN, NEONATAL, LOW-RISK |
| 163WN0300X | NURSING SERVICE, RN, NEPHROLOGY |
| 163WN0800X | NURSING SERVICE, RN, NEUROSCIENCE |
| 163WN1003X | NURSING SERVICE, RN, NUTRITION SUPPORT |
| 163WP0000X | NURSING SERVICE, RN, PAIN MANAGEMENT |

| | |
|------------|--|
| 163WP0200X | NURSING SERVICE, RN, PEDIATRICS |
| 163WP0218X | NURSING SERVICE, RN, PEDIATRIC ONCOLOGY |
| 163WP0807X | NURSING SERVICE, RN, PSYCH/MH, CHILD & ADOLESCENT |
| 163WP0808X | NURSING SERVICE, RN, PSYCH/MH |
| 163WP0809X | NURSING SERVICE, RN, PSYCH/MH, ADULT |
| 163WP1700X | NURSING SERVICE, RN, PERINATAL |
| 163WP2201X | NURSING SERVICE, RN, AMB CARE |
| 163WR0400X | NURSING SERVICE, RN, REHABILITATION |
| 163WR1000X | NURSING SERVICE, RN, REPRODUCTIVE ENDOCRINOLOGY/IN |
| 163WS0121X | NURSING SERVICE, RN, PLASTIC SURGERY |
| 163WS0200X | NURSING SERVICE, RN, SCHOOL |
| 163WU0100X | NURSING SERVICE, RN, UROLOGY |
| 163WW0000X | NURSING SERVICE, RN, WOUND CARE |
| 163WW0101X | NURSING SERVICE, RN, WOMEN'S HC, AMB |
| 163WX0002X | NURSING SERVICE, RN, OBSTETRIC, HIGH-RISK |
| 163WX0003X | NURSING SERVICE, RN, OBSTETRIC, INPATIENT |
| 163WX0106X | NURSING SERVICE, RN, OCCUPATIONAL HEALTH |
| 163WX0200X | NURSING SERVICE, RN, ONCOLOGY |
| 163WX0601X | NURSING SERVICE, RN, OTORHINOLARYNGOLOGY & HEAD-NE |
| 163WX0800X | NURSING SERVICE, RN, ORTHOPEDIC |
| 163WX1100X | NURSING SERVICE, RN, OPHTHALMIC |
| 163WX1500X | NURSING SERVICE, RN, OSTOMY CARE |
| 163W00000X | NURSING SERVICE, RN |
| 164W00000X | NURSING SERVICE, LICENSED PRACTICAL NURSE |
| 164X00000X | NURSING SERVICE, LICENSED VOCATIONAL NURSE |
| 167G00000X | NURSING SERVICE, LICENSED PSYCHIATRIC TECHNICIAN |
| 190000000X | GROUP |
| 193200000X | GROUP, MULTI-SPECIALTY |
| 193400000X | GROUP, SINGLE SPECIALTY |
| 207LA0401X | PHYSICIAN, ANESTHESIOLOGY, ADDICTION MEDICINE |
| 207LC0200X | PHYSICIAN, ANESTHESIOLOGY, CRITICAL CARE MEDICINE |
| 207PE0004X | PHYSICIAN, EMERGENCY MEDICINE, EMERGENCY MEDICAL S |
| 207PP0204X | PHYSICIAN, EMERGENCY MEDICINE, PEDIATRIC EMERGENCY |
| 207P00000X | PHYSICIAN, EMERGENCY MEDICINE |
| 207QA0401X | PHYSICIAN, FAMILY PRACTICE, ADDICTION MEDICINE |
| 207RA0401X | PHYSICIAN, INTERNAL MEDICINE, ADDICTION MEDICINE |
| 2080P0006X | PHYSICIAN, PEDIATRICS, DEVELOPMENTAL BEHAVIORAL |
| 2084A0401X | PHYSICIAN, PSYCH & NEUR, ADDICTION MEDICINE |
| 2084F0202X | PHYSICIAN, PSYCH & NEUR, FORENSIC PSYCHIATRY |
| 2084N0600X | PHYSICIAN, PSYCH & NEUR, CLINICAL NEUROPHYSIOLOGY |
| 2084P0005X | PHYSICIAN, PSYCH & NEUR, NEURODEVELOPMENTAL DISABI |
| 2084P0800X | PHYSICIAN, PSYCH & NEUR, PSYCHIATRY |
| 2084P0802X | PHYSICIAN, PSYCH & NEUR, ADDICTION PSYCHIATRY |
| 2084P0804X | PHYSICIAN, PSYCH & NEUR, CHILD & ADOLESCENT PSYCHI |
| 2084P0805X | PHYSICIAN, PSYCH & NEUR, GERIATRIC PSYCHIATRY |
| 220000000X | RESP, REHAB, & REST SERVICE PROVIDERS |
| 221700000X | RESP, REHAB, & REST SERVICE, ART THERAPIST |
| 225A00000X | RESP, REHAB, & REST SERVICE, MUSIC THERAPIST |
| 225400000X | RESP, REHAB, & REST SERVICE, REHABILITATION PRACTI |
| 225600000X | RESP, REHAB, & REST SERVICE, DANCE THERAPIST |
| 225800000X | RESP, REHAB, & REST SERVICE, RECREATION THERAPIST |
| 226300000X | RESP, REHAB, & REST SERVICE, KINESIOTHERAPIST |
| 250000000X | AGENCIES |

| | |
|------------|--|
| 251B00000X | AGENCIES, CASE MANAGEMENT |
| 251C00000X | AGENCIES, DAY TRAINING, DEVELOPMENTALLY DISABLED S |
| 251E00000X | AGENCIES, HOME HEALTH |
| 251F00000X | AGENCIES, HOME INFUSION |
| 251G00000X | AGENCIES, HOSPICE CARE, COMMUNITY BASED |
| 251J00000X | AGENCIES, NURSING CARE |
| 251K00000X | AGENCIES, PUBLIC HEALTH OR WELFARE |
| 260000000X | AMB HC FACILITIES |
| 261QA1903X | AMB HC FACILITIES, CLINIC/CENTER, AMB SURGICAL |
| 261QC0050X | AMB HC FACILITIES, CLINIC/CENTER, CRITICAL ACCESS |
| 261QC1500X | AMB HC FACILITIES, CLINIC/CENTER, COMMUNITY HEALTH |
| 261QC1800X | AMB HC FACILITIES, CLINIC/CENTER, CORPORATE HEALTH |
| 261QD1600X | AMB HC FACILITIES, CLINIC/CENTER, DEVELOPMENTAL DI |
| 261QE0002X | AMB HC FACILITIES, CLINIC/CENTER, EMERGENCY CARE |
| 261QF0400X | AMB HC FACILITIES, CLINIC/CENTER, FEDERALLY QUALIF |
| 261QH0100X | AMB HC FACILITIES, CLINIC/CENTER, HEALTH |
| 261QM0801X | AMB HC FACILITIES, CLINIC/CENTER, MH (INCLUDING CO |
| 261QM0850X | AMB HC FACILITIES, CLINIC/CENTER, ADULT MH |
| 261QM0855X | AMB HC FACILITIES, CLINIC/CENTER, ADOLESCENT AND C |
| 261QM1300X | AMB HC FACILITIES, CLINIC/CENTER, MULTI-SPECIALTY |
| 261QM2800X | AMB HC FACILITIES, CLINIC/CENTER, METHADONE CLINIC |
| 261QP0904X | AMB HC FACILITIES, CLINIC/CENTER, PUBLIC HEALTH, F |
| 261QP0905X | AMB HC FACILITIES, CLINIC/CENTER, PUBLIC HEALTH, S |
| 261QR0400X | AMB HC FACILITIES, CLINIC/CENTER, REHABILITATION |
| 261QR0401X | AMB HC FACILITIES, CLINIC/CENTER, REHABILITATION, |
| 261QR0405X | AMB HC FACILITIES, CLINIC/CENTER, REHABILITATION, |
| 261QR1300X | AMB HC FACILITIES, CLINIC/CENTER, RURAL HEALTH |
| 261Q00000X | AMB HC FACILITIES, CLINIC/CENTER |
| 270000000X | HOSPITAL UNITS |
| 273R00000X | HOSPITAL UNITS, PSYCHIATRIC UNIT |
| 273Y00000X | HOSPITAL UNITS, REHABILITATION UNIT |
| 276400000X | HOSPITAL UNITS, REHABILITATION, SUBSTANCE USE DISO |
| 280000000X | HOSPITALS |
| 282NC0060X | HOSPITALS, GENERAL ACUTE CARE HOSPITAL, CRITICAL A |
| 282NC2000X | HOSPITALS, GENERAL ACUTE CARE HOSPITAL, CHILDREN |
| 282NR1301X | HOSPITALS, GENERAL ACUTE CARE HOSPITAL, RURAL |
| 282NW0100X | HOSPITALS, GENERAL ACUTE CARE HOSPITAL, WOMEN |
| 282N00000X | HOSPITALS, GENERAL ACUTE CARE HOSPITAL |
| 283Q00000X | HOSPITALS, PSYCHIATRIC HOSPITAL |
| 283XC2000X | HOSPITALS, REHABILITATION HOSPITAL, CHILDREN |
| 283X00000X | HOSPITALS, REHABILITATION HOSPITAL |
| 284300000X | HOSPITALS, SPECIAL HOSPITAL |
| 290000000X | LABORATORIES |
| 291U00000X | LABORATORIES, CLINICAL MEDICAL LABORATORY |
| 293D00000X | LABORATORIES, PHYSIOLOGICAL LABORATORY |
| 310000000X | NURS & CUST CARE FACILITIES |
| 3104A0625X | NURS & CUST CARE FACILITIES, ASSISTED LIVING FACIL |
| 3104A0630X | NURS & CUST CARE FACILITIES, ASSISTED LIVING FACIL |
| 310400000X | NURS & CUST CARE FACILITIES, ASSISTED LIVING FACIL |
| 310500000X | NURS & CUST CARE FACILITIES, INTERMEDIATE CARE FAC |
| 311ZA0620X | NURS & CUST CARE FACILITIES, CUSTODIAL CARE FACILI |
| 311Z00000X | NURS & CUST CARE FACILITIES, CUSTODIAL CARE FACILI |
| 311500000X | NURS & CUST CARE FACILITIES, ALZHEIMER CENTER (DEM |

| | |
|------------|--|
| 313M00000X | NURS & CUST CARE FACILITIES, NURSING FACILITY/INTE |
| 3140N1450X | NURS & CUST CARE FACILITIES, SKILLED NURSING FACIL |
| 314000000X | NURS & CUST CARE FACILITIES, SKILLED NURSING FACIL |
| 315D00000X | NURS & CUST CARE FACILITIES, HOSPICE, INPATIENT |
| 315P00000X | NURS & CUST CARE FACILITIES, INTERMEDIATE CARE FAC |
| 320000000X | RTC FACILITIES |
| 320800000X | RTC FACILITIES, COMMUNITY BASED RTC FACILITY, MENT |
| 320900000X | RTC FACILITIES, COMMUNITY BASED RESIDENTIAL TREATM |
| 322D00000X | RTC FACILITIES, RTC FACILITY, EMOTIONALLY DISTURBE |
| 323P00000X | RTC FACILITIES, PSYCHIATRIC RTC FACILITY |
| 3245S0500X | RTC FACILITIES, SA REHABILITATION FACILITY, SA TRE |
| 324500000X | RTC FACILITIES, SA REHABILITATION FACILITY |
| 32600000X | RTC FACILITIES, RTC FACILITY, MENTAL RETARDATION A |
| 330000000X | SUPPLIERS |
| 340000000X | TRANSPORTATION SERVICES |
| 3416A0800X | TRANSPORTATION SERVICES, AMBULANCE, AIR TRANSPORT |
| 3416L0300X | TRANSPORTATION SERVICES, AMBULANCE, LAND TRANSPORT |
| 3416S0300X | TRANSPORTATION SERVICES, AMBULANCE, WATER TRANSPOR |
| 341600000X | TRANSPORTATION SERVICES, AMBULANCE |
| 343800000X | TRANSPORTATION SERVICES, SECURED MEDICAL TRANSPORT |
| 343900000X | TRANSPORTATION SERVICES, NON-EMERGENCY MEDICAL TRA |
| 344600000X | TRANSPORTATION SERVICES, TAXI |
| 347B00000X | TRANSPORTATION SERVICES, BUS |
| 347C00000X | TRANSPORTATION SERVICES, PRIVATE VEHICLE |
| 347D00000X | TRANSPORTATION SERVICES, TRAIN |
| 347E00000X | TRANSPORTATION SERVICES, TRANSPORTATION BROKER |
| 360000000X | PA & APN PROVIDERS |
| 363AM0700X | PA & APN PROVIDERS, PA, MEDICAL |
| 363A00000X | PA & APN PROVIDERS, PA |
| 363LA2100X | PA & APN PROVIDERS, APN, ACUTE CARE |
| 363LC1500X | PA & APN PROVIDERS, APN, COMMUNITY HEALTH |
| 363LP0808X | PA & APN PROVIDERS, APN, PSYCH/MH |
| 363L00000X | PA & APN PROVIDERS, APN |
| 364SA2200X | PA & APN PROVIDERS, CLIN NURSE SPEC, ADULT HEALTH |
| 364SC1501X | PA & APN PROVIDERS, CLIN NURSE SPEC, COMMUNITY HEA |
| 364SP0807X | PA & APN PROVIDERS, CLIN NURSE SPEC, PSYCH/MH, CHI |
| 364SP0808X | PA & APN PROVIDERS, CLIN NURSE SPEC, PSYCH/MH |
| 364SP0809X | PA & APN PROVIDERS, CLIN NURSE SPEC, PSYCH/MH, ADU |
| 364SP0810X | PA & APN PROVIDERS, CLIN NURSE SPEC, PSYCH/MH, CHI |
| 364SP0811X | PA & APN PROVIDERS, CLIN NURSE SPEC, PSYCH/MH, CHR |
| 364SP0812X | PA & APN PROVIDERS, CLIN NURSE SPEC, PSYCH/MH, COM |
| 364SP0813X | PA & APN PROVIDERS, CLIN NURSE SPEC, PSYCH/MH, GER |
| 364SR0400X | PA & APN PROVIDERS, CLIN NURSE SPEC, REHABILITATIO |
| 364S00000X | PA & APN PROVIDERS, CLIN NURSE SPEC |
| 367500000X | PA & APN PROVIDERS, NURSE ANESTHETIST, CERTIFIED R |
| 380000000X | RESPITE CARE FACILITY |
| 385HR2050X | RESPITE CARE FACILITY, RESPITE CARE, RESPITE CARE |
| 385HR2055X | RESPITE CARE FACILITY, RESPITE CARE, RESPITE CARE, |
| 385HR2060X | RESPITE CARE FACILITY, RESPITE CARE, RESPITE CARE, |
| 385HR2065X | RESPITE CARE FACILITY, RESPITE CARE, RESPITE CARE, |
| 385H00000X | RESPITE CARE FACILITY, RESPITE CARE |

E. Clean Claims

In accordance with Senate Bill 10-16-106.3., *ValueOptions* will pay, deny or settle all electronically received health insurance claims within 63 days after initial receipt. Additionally, all claims received via hard-copy will be paid, denied or settled within 78 days after initial receipt.

In cases where *ValeuOptions* fails to pay clean claims in the time frames referenced in the above paragraph, a penalty in the amount of 10% of the total amount ultimately allowed on the claim will be paid.

Incomplete Claims Are Not Clean Claims

In accordance with Senate Bill 10-16-106.3 *ValueOptions* will notify the provider within 30 calendar days if the resolution of a claim requires additional information. As indicated in this section the provider will be given a full explanation of what additional information is needed.

Claims with invalid or incomplete information will be **denied** with an Explanation of Benefit advising the provider of the incorrect or invalid information. The provider should send a "corrected" claim to *ValueOptions* providing the updated information for reconsideration. Corrected claims received more than 60 calendar days from the date on the Provider Summary Voucher may not be considered for payment.

If *ValueOptions* is unable to locate a member's Medicaid ID provided on the claim form, the claim may be denied, with an Explanation of Payment indicating the member is "unknown". If possible, *ValueOptions* will indicate the member's name in the patient account number field, shown on your Provider Summary Voucher. The necessary corrections should be made and a new claim sent for consideration. Please be sure to send all requested information within the account-specific timely filing guidelines.

F. Claims Appeal Process

If you feel *ValueOptions* has made an incorrect payment or processing decision on a claim, you may file a claim appeal by writing a letter to *ValueOptions* and provide the reason you believe the claim should be reprocessed. In the letter be sure to include the member's name and ID number, date(s) of service, service, and provider's name. Your letter and supporting documentation should be sent to the following address:

ValueOptions
P. O. Box 1347
Latham, NY 12110
ATTN: Colorado Medicaid Claims Appeals

All appeals must be filed within 60 days of the date of the provider summary voucher (EOB) in which the claim was included.

G. Third Party Liability (TPL)

1. By Federal mandate, providers must exhaust all other insurance coverage and payment prior to billing Medicaid for covered services.
2. *ValueOptions'* service authorization procedures outlined in the Clinical Section of the Provider Manual must be followed when providing services to a member identified with TPL.
3. The Primary Carrier's Policies and Procedures must be followed in order for *ValueOptions* to coordinate benefits. For example, if the Primary Carrier requires pre-authorization and the claim was denied by the Primary Carrier because pre-authorization was not obtained, *ValueOptions* will not process the claim.
4. For any eligible member with reimbursable TPL, the third party insurance carrier must be billed prior to billing *ValueOptions*. Once the TPL carrier has responded, *ValueOptions* may then be billed. TPL claims for eligible Members must be submitted on a completed standard CMS 1500 or UB04 claim form. The claim form, along with a copy of the Explanation of Benefits or Summary Voucher received from the third party insurance carrier must be mailed to *ValueOptions*.
5. All claims involving Third Party Liability must be submitted within ninety (90) days of the date of the other carrier's EOB or notification of payment / denial, to be considered for reimbursement.
6. If it is determined that an enrollee had relevant third party coverage after *ValueOptions* has been billed, the third party insurer must be billed. Once the EOB / Summary Voucher is received, an adjustment request for the applicable claim and a copy of the relevant *ValueOptions* and Third Party EOB / Summary Voucher must be sent to *ValueOptions* according to the procedures outlined the Adjustment / Reversal Requests section.

Additional TPL Billing Instructions:

1. One copy of the Explanation of Benefits / Summary Voucher should be attached to each applicable claim.
2. Ensure the level of detail on the claim corresponds to the EOB / Summary Voucher from the primary carrier.
3. If there are multiple third party carriers, all relevant EOBs / Summary Voucher should be attached to the claim.
4. If we find the primary insurance carrier will not cover the service we require one denial from the carrier indicating the non-coverage. This denial notification will be entered as a part of our processing guidelines and additional denials from the primary carrier will not be required.

H. Adjustment / Reversal Requests

Adjustments and Reversal Requests may be requested in one of two ways:

- **Completing the Colorado Medicaid Adjustment Request form**, as described below, or
- **Submitting adjustment and reversal requests on-line using ProviderConnect**
 - <http://www.valueoptions.com/providers/Provider Connect.htm>
 - Click on the Provider tab

- Click on ProviderConnect Helpful Resources link
- Click on the Guide to Using Single Claim Submission (under Claims Resources) for instructions beginning on page 13
- If ValueOptions does not have one already, a DCS access form, located on ProviderConnect, will need to be completed before adjustment and reversal requests can be submitted using this method

Colorado Medicaid Adjustments and Reversals (original method):

1. Claims requiring reconsideration of payment amounts for any reason must be resubmitted to *ValueOptions* on an Adjustment Request Form within sixty (60) days from the date of the Summary Voucher. Electronic submissions of this form will not be accepted.
2. The Adjustment Form can be found below. One form must be completed for each original claim being adjusted. All items on the form are required. Incomplete forms will not be processed and will be returned. Please mail completed forms to:

ValueOptions
 ATTN: CO Adjustment Unit
 P.O. Box 12698
 Norfolk, VA 23541

Or fax to (757) 459-5404.

3. A copy of the Provider Summary Voucher page on which the original claim appears must be included with the Adjustment Form.
4. Any reduction in payment will be applied to the payment cycle following the processing of the form.
5. Instructions for completing the Adjustment Form:
 - a. Provider Information: Enter the name, provider number, and address of the provider to whom the payment was made.
 - b. Member Information: Enter the member's name and Member ID Number as it appears on the Provider Summary Voucher.
 - c. Claim Information: Enter the claim number and date as listed on the Provider Summary Voucher.
 - d. Reason for Adjustment: Place an "X" on the line that best describes the reason for requesting the Adjustment and enter the required information. If "Other, Please Explain" is marked, describe the reason for the request.
 - e. Provider Signature and Date: An Adjustment request cannot be processed without a typed, signed, stamped, or computer-generated signature and the date that the form was completed.

ValueOptions

Colorado Medicaid Adjustment Form

Adjustment **Reversal** **Payment Increase** **Payment Decrease**

| | |
|-------------------|-------------------|
| Provider Name: | Member Name: |
| Provider Number: | Member ID Number: |
| Provider Address: | Claim Number: |
| | Paid Date: |

Reason for Adjustment

Member Name/Member ID #:
Correct Member: _____ Correct ID # : _____

Date of Service:
Incorrect Date: _____ Correct Date: _____

Billing Code Error:
Incorrect Code: _____ Correct Code: _____

Units Incorrect:
Incorrect Units: _____ Correct Units: _____

Provider / Vendor Paid:
Incorrect Provider #: _____ Correct Provider #: _____
Incorrect Vendor #: _____ Correct Vendor #: _____

Other Reimbursement Received:
Source: _____ Amount: _____

Authorization Extended:
Authorization Number: _____

Other: (Please Explain)

Provider Signature: _____ Date: _____

ValueOptions Use Only

Processor: _____ **Code:** _____ **Date Completed:** _____

I. Resubmissions

Incomplete Claims

1. Claims may be “zero-paid” by *ValueOptions* in the case of incorrect or incomplete required data elements.
2. *ValueOptions* will notify the provider via the Provider Summary Voucher, of those data elements requiring completion or correction. The required data elements and other claim submission requirements are outlined in Sections D1 and D2 of this manual. Electronic Media Claims (EMC) submission guidelines are contained in the *ValueOptions* EDI Specifications Manual.

Re-submissions

1. Claims “zero-paid” due to incorrect or incomplete required data elements must be resubmitted for payment consideration within sixty (60) days from the date on the Summary Voucher.
2. Providers may resubmit corrected claims (which were zero paid for incomplete or incorrect required data elements) by mail or EMC.
3. Corrected claims should have a clear indication on the claim that the claim is a “Corrected Claim”.

J. Refunds and Voids

In order to process refunds and voids, please forward your check, summary voucher and any other information to the address listed below. If additional information is required please contact the Claims Department.

ValueOptions
240 Corporate Blvd
Norfolk, VA 23502
ATTN: Finance Department