

Telemedicine

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Telemedicine

Program Overview

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

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

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

Telemedicine is not itself a unique service but a means of providing selected services approved by the Colorado Medical Assistance Program. Telemedicine involves two collaborating providers: an “originating provider” and a “distant provider”. The provider where the client is located is the “originating site” or “originating provider”. In most cases the “distant provider” is a clinician who acts as a consultant to the originating provider. However, in some cases – mental health services, for example – the distant provider may be the only provider involved in the service.



Providers should refer to the Code of Colorado Regulations, [Program Rules](#) (10 CCR 2505-10, Section 8.200.4), for specific information when providing telemedicine services. For further questions please contact:

Telemedicine Program Coordinator
Colorado Department of Health Care Policy and Financing
303-866-5963 or 1-800-221-3943



Billing Information

National Provider Identifier (NPI)

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

Paper Claims

Electronic claims format shall be required unless hard copy claims submittals are specifically prior authorized by the Department of Health Care Policy and Financing (the Department). Requests for paper claim submission 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 prior approval)
- Claims that by policy require attachments
- Reconsideration claims

Electronic Claims

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

- X12N Technical Report 3 (TR3) for the 837P, 837I, or 837D (wpc-edi.com/)
- Companion Guides for the 837P, 837I, or 837D are available on the Department's website in the Provider Services [Specifications](#) section
- Web Portal User Guide (via within the Web Portal)

The Colorado Medical Assistance Program collects electronic claim information interactively through the [Colorado Medical Assistance Program Secure Web Portal](#) (Web Portal) or via batch submission through a host system. Please refer to the [Colorado 1500 General Billing Information Manual](#) for additional electronic billing information.

Medicaid Reimbursement for Telemedicine

As of October 1, 2007, the Colorado Medical Assistance Program began accepting telemedicine claims. This enables providers to be reimbursed for selected services provided via telecommunications equipment.

To receive Medicaid reimbursement, telemedicine services must be provided "live". The patient and the distant provider interact with one another in real time through an **audio-video** communications circuit. Peripherals may be included, such as transmission of a live ultrasound exam.

Exclusions

"Telemedicine" **does not** include:

- Consultations provided by telephone (interactive audio)
- Facsimile machines

Does Telemedicine Add New Services?

- Providers may only bill procedure codes which they are already eligible to bill.
- Services appropriately billed to managed care should continue to be billed to managed care. All managed care requirements must be met for services billed to managed care. Managed care may or may not reimburse telemedicine costs.
- Colorado Medicaid does not pay for provider or patient education when education is the only service provided via telemedicine.
- Services not otherwise covered by Colorado Medicaid are not covered when delivered via telemedicine.
- The use of telecommunications equipment for delivery of services does not change prior authorization requirements established for the services being provided.

Telemedicine and Managed Care



No enrolled managed care organization may require face-to-face contact between a provider and a client for services appropriately provided through telemedicine if:

- The client resides in a county with a population of 150,000 or fewer residents.
- and**
- The county has the technology necessary to provide telemedicine services.

The use of telemedicine is not required when in-person care by a participating provider is available to an enrolled client within a reasonable distance. Please refer to 10 CCR 2505-10, Section 8.200.4.B. for more information.

When Should A Provider Choose Telemedicine?

The Colorado General Assembly considers a primary purpose of telemedicine is to bring providers to people living in rural areas. Providers should weigh this advantage against quality of care and client safety considerations. They should also consider the provider’s liability. Clients may choose which is more convenient for them when providers make telemedicine available.

However, telemedicine should not be selected when face-to-face services are medically necessary. Clients should establish relationships with primary care providers who are available on a face-to-face basis.

Telemedicine Confidentiality Requirements

All Medicaid providers using telemedicine to deliver Medicaid services must employ existing quality-of-care protocols and client confidentiality guidelines when providing telemedicine services. Health benefits provided through telemedicine must meet the same standard of care as in-person care. Record-keeping should comply with Medicaid requirements in 10 CCR 2505-10, Section 8.130.

Transmissions must be performed on dedicated secure lines or must utilize an acceptable method of encryption adequate to protect the confidentiality and integrity of the transmission. Transmissions must employ acceptable authentication and identification procedures by both the sender and the receiver.



Providers of telemedicine services must implement confidentiality procedures that include, but are not limited to:

- Specifying the individuals who have access to electronic records.
- Using unique passwords or identifiers for each employee or other person with access to the client records.
- Ensuring a system to routinely track and permanently record such electronic medical information.

Waiving the Face-to-Face Requirement

The Medicaid requirement for face-to-face contact between provider and client may be waived prior to treating the client through telemedicine for the first time. The rendering provider must furnish each client with all of the following written statements which must be signed by the client or the client’s legal representative:



- The client retains the option to refuse the delivery of health care services via telemedicine at any time without affecting the client's right to future care or treatment and without risking the loss or withdrawal of any program benefits to which the client would otherwise be entitled.
- All applicable confidentiality protections shall apply to the services.
- The client shall have access to all medical information resulting from the telemedicine services as provided by applicable law for client access to his or her medical records.

These requirements do not apply in an emergency. [C. R. S. 2006, 25.5-5-320 (4) & (5)].

General Billing Instructions

Billing Providers

Telemedicine services will only be reimbursed for providers who are enrolled in the Colorado Medical Assistance Program at the time service.



The availability of services through telemedicine in no way alters the scope of practice of any health care provider; or authorizes the delivery of health care services in a setting or manner not otherwise authorized by law. [C. R. S. 2006, 25.5-5-414 (7)(a) & (b)].

Originating Site Billing

All telemedicine services are billed on the Colorado 1500 paper claim form or as an 837P transaction regardless of provider type.

The originating provider may bill for an office, outpatient or inpatient Evaluation & Management (E&M) service that precedes a telemedicine consultation and for other Medicaid-covered services. In some cases, the originating provider site will not be providing clinical services, but only providing a site and telecommunications equipment.

Originating providers bill as follows:

- If the originating provider is making a room and telecommunications equipment available but is not providing clinical services, the originating provider bills Q3014, the procedure code for the telemedicine originating site facility fee.
- If the originating provider also provides clinical services to the client, the provider bills the rendering provider’s appropriate procedure code and bills Q3014.
- The originating provider may also bill, as appropriate, on the UB-04 paper claim form or as an 837I transaction for any clinical services provided on-site on the same day that a telemedicine originating site claim is made. The originating provider must submit two separate claims for the client’s two separate services.

The following provider types may bill procedure code Q3014 (telemedicine originating site facility fee):



Physician	05
Clinic	16
Osteopath	26
Federally Qualified Health Center	32
Psychologist	37
MA Psychologist	38
Physician Assistant	39
Nurse Practitioner	41
Rural Health Clinic	45

If practitioners at both the originating site and the distant site provide the same service to the client, both providers submit claims using the same procedure code with modifier 77. (Repeat procedure by another physician.)

The originating site may not bill for assisting the distant site provider with an examination.

Distant Provider Billing

All distant site rendering providers bill the appropriate procedure code using modifier GT (interactive communication) on the Colorado 1500 paper claim form or as an 837P transaction. The previously listed provider types may bill using modifier GT. The procedure codes for billing telemedicine are listed below.

Using modifier GT adds \$5.00 to the fee for the procedure code billed.

Rendering Providers

If a rendering provider’s number is required on the claim for a face-to-face visit, it is required on the claim for a telemedicine visit.



Rural Health Clinics should leave field 19D on the Colorado 1500 paper claim form blank. Federally Qualified Health Centers, Clinics and the other provider types are required to enter the rendering provider’s Colorado Medical Assistance Program provider number in field 19D.

When an originating site bills Q3014 (originating site facility fee), there is generally no rendering provider actually involved in the service at the originating site.

However, a rendering provider number is still required and must be affiliated with the billing provider. The facility may enter either the patient’s usual provider’s number; or another provider number affiliated with that site as the rendering provider.

When the patient sees a rendering provider at the originating site and also uses the site as the telemedicine originating site, the facility bills the rendered service procedure code and Q3014 for the use of the telemedicine facility. The same rendering provider number is entered in field 19D.

Procedure/HCPCS Codes Overview

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

The Healthcare Common Procedural Coding System (HCPCS) is divided into two principal subsystems, referred to as level I and level II of the HCPCS. Level I of the HCPCS is comprised of 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, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter followed by 4 numeric digits, while CPT codes are identified using 5 numeric digits.

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

Telemedicine Procedure Coding

The following procedure codes, when billed with modifier GT by appropriate providers, pay the telemedicine transmission fee. Any other procedure codes billed with modifier GT will not pay the telemedicine transmission fee.

Procedure Codes	Description	Comments
Outpatient Mental Health		
90791	Diagnostic evaluation	If interactive complexity then report with add on code 90785

Procedure Codes	Description	Comments
90832	Psychotherapy, 30 min (actual time can be 16-37 min)	If interactive complexity then report with add on code 90785
90833	Add on Psychotherapy 30 min (actual time can be 16-37 min) Use in conjunction with appropriate E/M code	If interactive complexity then report with add on code 90785
90834	Psychotherapy 45 min (actual time can be 38-52 min)	If interactive complexity then report with add on code 90785
90836	Add on Psychotherapy 45 min (actual time can be 38-52 min) Use in conjunction with appropriate E/M code	If interactive complexity then report with add on code 90785
90837	Psychotherapy 60 min (actual time can be 53+)	Medicare crossover only
90838	Add on Psychotherapy 60 min (actual time can be 53+ Use in conjunction with appropriate E/M code	Medicare crossover only
90863	Add on Pharmacologic management code	can be added to primary psychotherapy code
90846	Family therapy – patient not present	
90847	Family therapy – patient present	
Evaluation & Management		
99201	Office or other outpatient visit, new patient, 10 minutes	
99202	Office or other outpatient visit, new patient, 20 minutes	
99203	Office or other outpatient visit, new patient, 30 minutes	
99204	Office or other outpatient visit, new patient, 45 minutes	
99205	Office or other outpatient visit, new patient, 60 minutes	
99211	Office or other outpatient visit, established patient, 5 minutes	
99212	Office or other outpatient visit, established patient, 10 minutes	
99213	Office or other outpatient visit, established patient, 15 minutes	
99214	Office or other outpatient visit, established patient, 25 minutes	
99215	Office or other outpatient visit, established patient, 40 minutes	
Obstetrical Ultrasounds		
76801	Ultrasound, pregnant uterus, real time first trimester	
76802	Each additional gestation	
76805	Ultrasound, pregnant uterus, real time after first trimester	
76810	Each additional gestation	
76811	Ultrasound, pregnant uterus, real time plus detailed fetal anatomical exam, single or first gestation	
76812	Each additional gestation	
76813	Ultrasound, pregnant uterus real time first trimester fetal nuchal translucency measurement	
76814	Each additional gestation	
76815	Ultrasound, pregnant uterus, real time, limited, one or more fetuses	
76816	Ultrasound, pregnant uterus, real time, follow-up	
76817	Ultrasound, pregnant uterus, real time, transvaginal	

Procedure Codes	Description	Comments
Other		
96116	Neurobehavior status exam	

Paper Claim Reference Table



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

Field Label	Completion Format	Special Instructions
Invoice/Pat Acct Number	Up to 12 characters: letters, numbers or hyphens	Optional Enter information that identifies the patient or claim in the provider's billing system. Submitted information appears on the Provider Claim Report.
Special Program Code	N/A	N/A
1. Client Name	Up to 25 characters: letters & spaces	Required Enter the client's last name, first name, and middle initial.
2. Client Date of Birth	Date of Birth 8 digits (MMDDCCYY)	Required Enter the patient's birth date using two digits for the month, two digits for the date, two digits for the century, and two digits for the year. . Example: 07012009 for July 1, 2009.
3. Medicaid ID Number (Client ID Number)	7 characters: a letter prefix followed by six numbers	Required Enter the client's Colorado Medical Assistance Program ID number. Each person has his/her own unique Colorado Medical Assistance Program ID number. Example: A123456
4. Client Address	Not required	Submitted information is not entered into the claim processing system.
5. Client Sex	Check box Male <input type="checkbox"/> Female <input type="checkbox"/>	Required Enter a check mark or an "x" in the correct box to indicate the client's sex.
6. Medicare ID Number (HIC or SSN)	Up to 11 characters: numbers and letters	Conditional Complete if the client is eligible for Medicare benefits. Enter the individual's Medicare health insurance claim number. The term "Medicare-Medicaid enrollees" refers to a person who is eligible for both Colorado Medical Assistance Program and Medicare benefits.

Field Label	Completion Format	Special Instructions
7. Client Relationship to Insured	Check box Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	Conditional Complete if the client is covered by a commercial health care insurance policy.
8. Client Is Covered By Employer Health Plan	Text	Conditional Complete if the client is covered by an employer health plan as policyholder or as a dependent. Enter the employer name, policyholder's name and group number. Also complete fields 9 and 9A.
9. Other Health Insurance Coverage	Text	Conditional Complete if the client has commercial health insurance coverage. Enter the name, address, policy number, and telephone numbers, if known, of the commercial health care insurer.
9A. Policyholder Name and Address	Text	Conditional Complete if the client has commercial health insurance coverage. Enter the name, address, and telephone number, if known, of the policyholder.
10. Was Condition Related To	Check box A. Client Employment Yes <input type="checkbox"/> B. Accident Auto <input type="checkbox"/> Other <input type="checkbox"/> C. Date of accident 6 digits: MMDDYY	Conditional Complete if the condition being treated is the result of employment, an automobile accident, or other accident. Enter the date of the accident.
11. CHAMPUS Sponsors Service/SSN	Up to 10 characters	Conditional Complete if the client is covered under the Civilian Health And Medical Plan of the Uniformed Services (CHAMPUS). Enter the sponsor's service number or SSN.

Field Label	Completion Format	Special Instructions
<p>12. Pregnancy</p> <p>HMO</p> <p>NF</p>	<p>Check box <input type="checkbox"/></p>	<p>Conditional Complete if the client is in the maternity cycle (i.e., pregnant or within 6 weeks postpartum).</p> <p>Conditional Complete if the client is enrolled in a Colorado Medical Assistance HMO.</p> <p>Conditional Complete if the client is a nursing facility resident.</p>
<p>13. Date of illness or injury or pregnancy</p>	<p>6 digits: MMDDYY</p>	<p>Optional Complete if information is known. Enter the following information as appropriate to the client's condition:</p> <p>Illness Date of first symptoms Injury Date of accident Pregnancy Date of Last Menstrual Period (LMP)</p>
<p>14. Medicare Denial</p>	<p>Check box <input type="checkbox"/> Benefits Exhausted <input type="checkbox"/> Non-covered services</p>	<p>Conditional Complete if the client has Medicare coverage and Medicare denied the benefits or does not cover the billed services.</p>
<p>14A. Other Coverage Denied</p>	<p>Check box No <input type="checkbox"/> Yes <input type="checkbox"/> Pay/Deny Date 6 digits: MMDDYY</p>	<p>Conditional Complete if the client has commercial health care insurance coverage. Enter the date that the other coverage paid or denied the services.</p>
<p>15. Name of Supervising Physician Provider Number</p>	<p>Text</p> <p>8 digits</p>	<p>Conditional Complete if the individual who performs the service (rendering provider) is a non-physician practitioner who requires on-premises supervision by a licensed physician (see Provider Participation). Enter the eight digit Colorado Medical Assistance Program provider number assigned to the on-premises supervising physician.</p>
<p>16. For services related to hospitalization, give hospitalization dates</p>	<p>N/A</p>	<p>N/A</p>

Field Label	Completion Format	Special Instructions						
<p>17. Name and address of facility where services rendered (If other than Home or Office)</p> <p>Provider Number</p>	<p>Text (address is optional)</p> <p>8 digits</p>	<p>Conditional</p> <p>Complete for services provided in a hospital or nursing facility. Enter the name of the hospital or nursing facility. This information is not edited.</p> <p>Complete for services provided in a hospital or nursing facility. Enter the Colorado Medical Assistance Program provider number of hospital or nursing facility, if known (This number is assigned by Colorado ACS FAS). This information is not edited.</p>						
<p>17A. Check box if laboratory work was performed outside Physician office</p>	<p>N/A</p>	<p>N/A</p>						
<p>18. ICD-9-CM</p> <p>Diagnosis or nature of illness or injury. In column F, relate diagnosis to procedure by Reference numbers 1, 2, 3, or 4</p>	<p>1 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>2 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>3 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>4 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Codes: 3, 4, or 5 characters. 1st character may be a letter.</p> <p>Text</p>	<p>Required</p> <p>At least one diagnosis code must be entered.</p> <p>Enter up to four ICD-9-CM diagnosis codes starting at the far left side of the coding area.</p> <p>Do not enter the decimal point. Do not enter zeros to fill the spaces when the diagnosis code is fewer than 5 digits.</p> <p>Example:</p> <table border="0"> <thead> <tr> <th><u>ICD-9-CM description</u></th> <th><u>Code</u></th> <th><u>Claim Entry</u></th> </tr> </thead> <tbody> <tr> <td>Fractured ankle</td> <td>824X</td> <td>824X</td> </tr> </tbody> </table> <p>Optional</p> <p>If entered, the written description must match the code(s).</p>	<u>ICD-9-CM description</u>	<u>Code</u>	<u>Claim Entry</u>	Fractured ankle	824X	824X
<u>ICD-9-CM description</u>	<u>Code</u>	<u>Claim Entry</u>						
Fractured ankle	824X	824X						
<p>Transportation Certification attached</p>	<p>N/A</p>	<p>N/A</p>						
<p>Durable Medical Equipment</p> <p>Line #</p> <p>Make</p> <p>Model</p> <p>Serial Number</p>	<p>N/A</p>	<p>N/A</p>						

Field Label	Completion Format	Special Instructions
Prior Authorization #:	6 characters	<p>Conditional</p> <p>Complete for services that require prior authorization. If the procedure code requires prior authorization, enter the prior authorization from the approved Prior Authorization Request (PAR). Do not combine services from more than one approved PAR on a single claim form. Do not attach a copy of the approved PAR unless advised to do so by the authorizing agency or the fiscal agent.</p>
19A. Date of Service	<p>From: 6 digits MMDDYY</p> <p>To: 6 digits MMDDYY</p>	<p>Required</p> <p>Enter two dates: a “beginning” or “from” date of service and an “ending” or “to” date of service.</p> <p>Single date of service</p> <p>From To</p> <p>07/05/2011</p> <p>Or</p> <p>From To</p> <p>07/05/2011 07/05/2011</p> <p>Span dates of service</p> <p>From To</p> <p>07/01/2011 07/31/2011</p> <p>Practitioner claims must be consecutive days.</p> <p>Single Date of Service: Enter the six digit date of service in the “From” field. Completion of the “To” field is not required. Do not spread the date entry across the two fields.</p> <p>Span billing: Span billing is permitted if the same service (same procedure code) is provided on consecutive dates.</p>



Field Label	Completion Format	Special Instructions
<p>19B. Place of Service</p>		<p>Required</p> <p>Enter the Place Of Service (POS) code that describes the location where services were rendered. The Colorado Medical Assistance Program accepts the CMS place of service codes.</p> <ul style="list-style-type: none"> 04 Homeless Shelter 11 Office 12 Home 15 Mobile Unit 20 Urgent Care Facility 21 Inpatient hospital 22 Outpatient hospital 23 Emergency room hospital 25 Birthing Center 26 Military Treatment Center 31 Skilled Nursing Facility 32 Nursing facility 33 Custodial Care Facility 34 Hospice 41 Transportation Land 51 Inpatient Psychiatric Facility 52 Psychiatric Facility Partial Hospitalization 53 Community mental health center 54 Intermediate Care Facility – MR 60 Mass Immunization Center 61 Comprehensive IP Rehab Facility 62 Comprehensive OP Rehab Facility 65 End Stage Renal Dialysis Trtmt Facility 71 State-Local Public Hlth Clinic 99 Other Unlisted
<p>19C. Procedure Code (HCPCS code)</p> <p>Modifier(s)</p>	<p>5 digits</p> <p>2 characters: Letters or digits</p>	<p>Required</p> <p>For originating provider use procedure code Q3014 with no modifier.</p> <p>For distant provider use an approved telemedicine procedure code + modifier -GT. Two characters may be entered in one field.</p>

Field Label	Completion Format	Special Instructions
19G. Charges	Up to 7 digits: Currency 99999.99	<p>Required</p> <p>Enter the usual and customary charge for the service represented by the procedure code on the detail line.</p> <p>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.</p> <p>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.</p> <p>Submitted charges cannot be more than charges made to non-Colorado Medical Assistance Program covered individuals for the same service.</p> <p>Do not deduct Colorado Medical Assistance Program co-payment or commercial insurance payments from usual and customary charges.</p>
19H. Days or Units	4 digits	<p>Required</p> <p>Enter the number of services provided for each procedure code.</p> <p>Enter whole numbers only.</p> <p>Do not enter fractions or decimals.</p> <p>Do not enter a decimal point followed by a 0 for whole numbers.</p>
19I. Co-pay	1 digit	<p>Conditional</p> <p>Complete if co-payment is required of this client for this service.</p> <p>1-Refused to pay co-payment 2-Paid co-payment 3-Co-payment not requested</p>
19J. Emergency	N/A	N/A
19K. Family Planning	N/A	N/A
19L. EPSDT	1 character	<p>Conditional</p> <p>A check mark indicates that the service is provided as a follow-up to or referral from an EPSDT screening examination.</p>

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

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

Field Label	Completion Format	Special Instructions
<p>27. Signature (Subject to Certification on Reverse) and Date</p>	<p>Text</p>	<p>Required</p> <p>Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent.</p> <p>A holographic signature stamp may be used <u>if</u> authorization for the stamp is on file with the fiscal agent.</p> <p>An authorized agent or representative may sign the claim for the enrolled provider <u>if</u> the name and signature of the agent is on file with the fiscal agent.</p> <p>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.</p>
<p>28. Billing Provider Name</p>	<p>Text</p>	<p>Required</p> <p>Enter the name of the individual or organization that will receive payment for the billed services.</p>
<p>29. Billing Provider Number</p>	<p>8 digits</p>	<p>Required</p> <p>Enter the eight-digit Colorado Medical Assistance Program provider number assigned to the individual or organization that will receive payment for the billed services.</p>
<p>30. Remarks</p>	<p>Text</p>	<p>Conditional</p> <p>Use to document the Late Bill Override Date for timely filing.</p>



Late Bill Override Date

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

Valid Delay Reason Codes

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



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

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

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

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

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

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



Telemedicine Originator Claim Example

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

INVOICE/PAT ACCT NUMBER

SPECIAL PROGRAM CODE

HEALTH INSURANCE CLAIM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL) Client, Ima	2. CLIENT DATE OF BIRTH 12/05/1963	3. MEDICAID ID NUMBER (CLIENT ID NUMBER) F333333
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. CLIENT SEX MALE <input type="checkbox"/> FEMALE <input checked="" type="checkbox"/>	6. MEDICARE ID NUMBER (HIC OR SSN)
TELEPHONE NUMBER	7. CLIENT RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. <input type="checkbox"/> CLIENT IS COVERED BY EMPLOYER HEALTH PLAN AS EMPLOYEE OR DEPENDENT
9. OTHER HEALTH INSURANCE COVERAGE — INSURANCE COMPANY NAME, ADDRESS, PLAN NAME, AND POLICY NUMBER(S)	10. WAS CONDITION RELATED TO: A. CLIENT EMPLOYMENT YES <input type="checkbox"/> B. ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/> C. DATE OF ACCIDENT <div style="border: 1px solid black; width: 50px; height: 15px; margin: 5px auto;"></div>	EMPLOYER NAME: _____ POLICYHOLDER NAME: _____ GROUP: _____
TELEPHONE NUMBER	9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)	11. CHAMPUS SPONSORS SERVICE/SSN
TELEPHONE NUMBER	12. PREGNANCY <input type="checkbox"/> HMO <input type="checkbox"/> NURSING FACILITY <input type="checkbox"/>	

PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF: ←	ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR FIRST PREGNANCY (LMP)	14. MEDICARE DENIAL (ATTACH THE MEDICARE STANDARD PAPER REMITTANCE (SPR) IF EITHER BOX IS CHECKED) <input type="checkbox"/> BENEFITS EXHAUSTED <input type="checkbox"/> NON-COVERED SERVICES	14A. OTHER COVERAGE DENIED <input type="checkbox"/> NO <input type="checkbox"/> YES PAY/DENY DATE: _____
15. NAME OF SUPERVISING PHYSICIAN		PROVIDER NUMBER	16. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES ADMITTED: _____ DISCHARGED: _____
17. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (IF OTHER THAN HOME OR OFFICE)		PROVIDER NUMBER	17A. CHECK BOX IF LABORATORY WORK WAS PERFORMED OUTSIDE THE PHYSICIANS OFFICE <input type="checkbox"/> YES

18. ICD-9-CM DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. IN COLUMN F, RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE NUMBERS 1, 2, 3, OR 4	TRANSPORTATION CERTIFICATION ATTACHED <input type="checkbox"/> YES
1. 2962	DURABLE MEDICAL EQUIPMENT Line # Make Model Serial Number
2. _____	
3. _____	
4. _____	PRIOR AUTHORIZATION #:

19A. DATE OF SERVICE FROM	19B. DATE OF SERVICE TO	19C. PLACE OF SERVICE	19D. PROCEDURE CODE (HCPCS)	19E. MODIFIERS	19F. RENDERING PROVIDER NUMBER	19G. REFERRING PROVIDER NUMBER	19H. DIAGNOSIS P S T	19I. CHARGES	19J. DAYS OR UNITS	19K. COPAY	19L. EMERG ENCY	19M. FAMILY PLANNING	19N. EPSDT
03/05/2013	03/05/2013	11	Q3014		12345678		1	21.73			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
											<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
											<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
											<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
											<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
											<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<p>THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE, AND COMPLETE. I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS.</p> <p>20. TOTAL CHARGES → 21.73</p> <p>27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE <i>Authorized Signature 03/05/2013</i></p> <p>28. BILLING PROVIDER NAME 123 Counseling</p> <p>29. BILLING PROVIDER NUMBER 01111111</p> <p>COL-101 FORM NO. 94320 (REV. 02/99) ELECTRONIC APPLICATION</p>	<p>21. MEDICARE PAID <div style="border: 1px solid black; width: 50px; height: 15px;"></div></p> <p>22. THIRD PARTY PAID <div style="border: 1px solid black; width: 50px; height: 15px;"></div></p> <p>23. NET CHARGE <div style="border: 1px solid black; width: 50px; height: 15px;"></div></p> <p>24. MEDICARE DEDUCTIBLE <div style="border: 1px solid black; width: 50px; height: 15px;"></div></p> <p>25. MEDICARE COINSURANCE <div style="border: 1px solid black; width: 50px; height: 15px;"></div></p> <p>26. MEDICARE DISALLOWED <div style="border: 1px solid black; width: 50px; height: 15px;"></div></p> <p style="text-align: right;">COLORADO 1500</p>
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Telemedicine Distant Claim Example

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

INVOICE/PAT ACCT NUMBER
SPECIAL PROGRAM CODE

HEALTH INSURANCE CLAIM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL) Client, Ima	2. CLIENT DATE OF BIRTH 12/02/1963	3. MEDICAID ID NUMBER (CLIENT ID NUMBER) F333333
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. CLIENT SEX MALE <input type="checkbox"/> FEMALE <input checked="" type="checkbox"/>	6. MEDICARE ID NUMBER (HIC OR SSN)
TELEPHONE NUMBER	7. CLIENT RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. <input type="checkbox"/> CLIENT IS COVERED BY EMPLOYER HEALTH PLAN AS EMPLOYEE OR DEPENDENT EMPLOYER NAME: _____
9. OTHER HEALTH INSURANCE COVERAGE — INSURANCE COMPANY NAME, ADDRESS, PLAN NAME, AND POLICY NUMBER(S)	10. WAS CONDITION RELATED TO: A. CLIENT EMPLOYMENT YES <input type="checkbox"/> B. ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/> C. DATE OF ACCIDENT <div style="border: 1px solid black; width: 80px; height: 15px; margin: 5px auto;"></div>	POLICYHOLDER NAME: _____ GROUP: _____
9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)	11. CHAMPUS SPONSORS SERVICE/SSN	
TELEPHONE NUMBER		
12. PREGNANCY <input type="checkbox"/> HMO <input type="checkbox"/> NURSING FACILITY <input type="checkbox"/>		

PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF: ←	ILLNESS (FIRST SYMPTON) OR INJURY (ACCIDENT) OR FIRST PREGNANCY (LMP)	14. MEDICARE DENIAL (ATTACH THE MEDICARE STANDARD PAPER REMITTANCE (SPR) IF EITHER BOX IS CHECKED) <input type="checkbox"/> BENEFITS EXHAUSTED <input type="checkbox"/> NON-COVERED SERVICES	14A. OTHER COVERAGE DENIED <input type="checkbox"/> NO <input type="checkbox"/> YES PAY/DENY DATE: _____
15. NAME OF SUPERVISING PHYSICIAN		16. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES ADMITTED: _____ DISCHARGED: _____	
17. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (IF OTHER THAN HOME OR OFFICE)		17A. CHECK BOX IF LABORATORY WORK WAS PERFORMED OUTSIDE THE PHYSICIANS OFFICE <input type="checkbox"/> YES	

18. ICD-9-CM DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. IN COLUMN F, RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE NUMBERS 1, 2, 3, OR 4	14A. OTHER COVERAGE DENIED <input type="checkbox"/> YES
1. 2962	DURABLE MEDICAL EQUIPMENT Line # Make Model Serial Number
2. _____	PRIOR AUTHORIZATION #:
3. _____	
4. _____	

19A. DATE OF SERVICE FROM	19A. DATE OF SERVICE TO	B. PLACE OF SERVICE	C. PROCEDURE CODE (HCPCS)	D. MODIFIERS	D. RENDERING PROVIDER NUMBER	E. REFERRING PROVIDER NUMBER	F. DIAGNOSIS P	F. DIAGNOSIS S	F. DIAGNOSIS T	G. CHARGES	H. DAYS OR UNITS	I. COPAY	J. EMERG ENCY	K. FAMILY PLANNING	L. EPSDT
03/05/2013	03/05/2013	11	90801	GT	01234567		1			\$100.00	1		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
													<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
													<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
													<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
													<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
													<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<p style="font-size: 8px;">THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE, AND COMPLETE. I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS.</p> <p>27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE <i>Authorized Signature</i> 03/05/2013</p> <p>28. BILLING PROVIDER NAME 123 Medical Home</p> <p>29. BILLING PROVIDER NUMBER 02222222</p>	<p>20. TOTAL CHARGES → \$100.00</p> <p>30. REMARKS</p>	<p>LESS ↓</p> <p>21. MEDICARE PAID <input type="text" value="\$0.00"/></p> <p>22. THIRD PARTY PAID <input type="text" value="\$0.00"/></p> <p>23. NET CHARGE <input type="text" value="\$100.00"/></p> <p>24. MEDICARE DEDUCTIBLE <input type="text" value="\$0.00"/></p> <p>25. MEDICARE COINSURANCE <input type="text" value="\$0.00"/></p> <p>26. MEDICARE DISALLOWED <input type="text" value=""/></p>
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Telemedicine Revisions Log

Revision Date	Section	Pages/ Action	Made by
01/05/2009	<i>Drafted Manual</i>	All	jg
02/22/2010	<i>General updates and revisions</i>	Throughout	vr
03/04/2010	<i>Final revisions</i>	Throughout	vr/jg
07/12/2010	<i>Updated date examples for field 19A</i> <i>Updated claim examples</i>	16 26 & 27	jg
07/14/2010	<i>Added Electronic Remittance Advice (ERA) to Special Instructions for Medicare SPR Date field and to Electronic Medicare Crossover Claims & to Medicare Denied Services in Late Bill Override Date section.</i>	19 24	jg
08/30/2011	<i>Changed authorizing agent to authorizing agency.</i>	14	crc
08/31/2011	<i>Updated hyperlink for colorado.gov/hcpf</i>	4	dc
08/31/2011	<i>Updated hyperlink for edifecs.com</i>	5	dc
08/31/2011	<i>Updated client date of birth and Medicaid ID</i>	10 & 11	dc
08/31/2011	<i>Updated diagnosis code</i>	14 & 17	dc
08/31/2011	<i>Deleted SPR/ERA when spelled out</i>	24	dc
12/06/2011	<i>Replaced 997 with 999</i> <i>Replaced wpc-edi.com/hipaa with wpc-edi.com/</i> <i>Replaced Implementation Guide with Technical Report 3 (TR3)</i>	4 3 3	ss
05/14/2013	<i>Consolidated electronic billing information</i> <i>HCPCS Added:</i> <ul style="list-style-type: none"> • 90791, 90832, 90833, 90834, 90836, 90837, 90838, 90863 <i>Deleted:</i> <ul style="list-style-type: none"> • 90801, 90804, 90805, 90806, 90807, 90808, 90809, 90862 	3 8-9	cc
05/15/2013	<i>Reformatted</i> <i>Updated TOC</i>	Throughout i	jg
09/23/2013	<i>Deleted. Codes no longer covered 99243, 99244, 99245, 99251, 99252, 99253, 99254, and 99255</i>	6-7	db
09/23/2013	<i>Reformatted</i> <i>Updated TOC</i> <i>Replaced “dually eligible” with “Medicare-Medicaid enrollees”</i>	Throughout l 7	jg

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