Section 13

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: • 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 *must* sign and date the claim *if* authorizing the release of medical information. If "signature on file" is indicated, the provider *must* 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	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. 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: • 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	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. 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.
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	Enter a valid CPT or HCPCS code modifier for each service entered.** **HIPAA: Billing Code Modifiers** ** 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: **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') **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') **Modifier THREE & FOUR**: These fields are dedicated for modifiers that identify statistics (e.g., HV 'funded by State Addictions Agency') If you have any questions regarding the placement of Modifiers, please contact your Regional Provider Relations office for instructions.
24e	Diagnosis pointer	Conditional	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. *Do not* enter the ICD-9 diagnosis code.
24f	Charges	Required	Enter the provider's billed charges for each service.
24g	Days or units	Required	Enter the appropriate number of units or days that correspond to the "From" and "To" dates indicated in Field 24a.
24h	EPSDT family plan	Not Required	If service was rendered as part of or in response to an EPSDT panel, mark an "X" in this block.
24i	ID Qual.	Not Required	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.
24j	Rendering Provider ID#	Required	Enter the NPI number in the un-shaded area of the field.

Field Number	Field Description	Data Type	Instructions
25	Federal Tax ID number and type: • 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 *must* 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 processional 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 fro 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 MATERIAL[1]

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**
X**1**X	Inpatient (Including Medicare Part A)
X**2**X	Inpatient (Medicare Part B Only) (Includes HHA Visits Under a Part B Plan of Treatment)
X**3**X	Outpatient (Includes HHA Visits Under a Part A Plan of Treatment Including DME Under Part A)
X**4**X	Laboratory Services Provided to Non-Patients, or Home Health Not Under a Plan of Treatment
X**5**X	Intermediate Care Level 1
X**6**X	Intermediate Care Level II
X**7**X	Reserved for National Assignment
X**8**X	Swing Beds
X**9**X	Reserved for National Assignment

Third Digit – Bill Classification	**Description of Third Digit Classification for Clinics Only**
X**1**X	Rural Health Clinic
X**2**X	Clinic – Hospital Based or Independent Renal Dialysis Center
X**3**X	Freestanding
X**4**X	ORF
X**5**X	CORF
X**6**X	CMHC
X**7**X	Federally Qualified Health Center (FQHC) (effective April 1, 2010)
X**8**X	Reserved for National Assignment
X**9**X	Other

Third Digit – Bill Classification	Description of Third Digit Classification for Special Facility Only
X**1**X	Hospice (Non-hospital based)
X**2**X	Hospice (Hospital based)
X**3**X	Ambulatory Surgery Center
X**4**X	Freestanding Birthing Center
X**5**X	Critical Access Hospital
X**6**X	Residential Facility (Not used for Medicare)
X**7**X	Reserved for National Assignment
X**8**X	Reserved for National Assignment
X**9**X	Other (Not used for Medicare)

Fourth Digit – Frequency of the Bill	Description of Fourth Digit Frequency of the Bill
XX**0**	Nonpayment / Zero Claim
XX**1**	Admit through Discharge Claim
XX**2**	Interim – First Claim
XX**3**	Interim – Continuing Claim (Not valid for Medicare Inpatient Hospital PPS Claims)
XX**4**	Interim – Last Claim (Not valid for Medicare Inpatient Hospital PPS Claims)
XX**5**	Late Charges Only Claim
XX**6**	Reserved
XX**7**	Replacement of Prior Claim
XX**8**	Void / Cancel of a Prior Claim
XX**9**	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 statures

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 statures
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 form 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