Colorado Indigent Care Program Manual

Fiscal Year 2016-17

Section II: Data Collection

Effective July 1, 2016

COLORADO
Department of Health Care Policy & Financing

The following major changes have been made to the FY 2016-17 Data Section

None.

Contents

ARTICLE I. PROGRAM OVERVIEW

Section 1.01 Program Definition

The Colorado Indigent Care Program (CICP) is a state program that partially reimburses health care providers for services rendered to qualifying Colorado residents, migrant workers and legal immigrants with limited financial resources. The CICP primarily serves non-Health First Colorado and non-Child Health Plan Plus (CHP+) eligible individuals who are uninsured or underinsured. The Colorado Department of Health Care Policy and Financing (Department) administers the CICP.

Section 1.02 Requirements for Participating CICP Providers

Please see Section I: Eligibility of this manual for details regarding provider eligibility. Only facilities with agreements to provide CICP services for the Department can receive reimbursement for care provided to CICP eligible clients.

Section 1.03 Client Eligibility

Please see Section I: Eligibility of this manual for details regarding client eligibility.

Section 1.04 Prior Authorization Requirements

There are no prior authorization requirements associated with CICP services. Health care services provided to CICP clients must be medically necessary, as determined by the CICP provider. All health care services normally provided at the hospital and/or clinic are regularly available at a discount to CICP clients unless the provider sets a standardized policy that limits available services. Providers must provide emergency services at a discount. The Department has granted waivers to limit medical services to a specific area or county. Waivers do not exclude the provider from supplying required emergency care at a discount to any CICP client, even if that client resides outside the provider's service area.

ARTICLE II. BILLING INFORMATION

Section 2.01 Definitions

CICP Data Collection System: Includes the specifications on how providers must submit inpatient and outpatient billing information to the Department. There is no electronic submission of claims, nor are paper claims accepted.

County Codes: County codes are used to track patient visits. Providers should include the patient's county code on the CICP discount card.

Indigent Patient (client): A person who meets the guidelines outlined in the Colorado Indigent Care Program Manual – Eligibility Section, which stipulates that the individual must have income and assets combined at or below 250% of the current Federal Poverty Level (FPL).

Emergency (Urgent) Care: Treatment for conditions of an acute, severe nature which are life, limb, or disability threats requiring immediate attention, where any delay in treatment would, in the judgment of the responsible physician, threaten life or loss of function of a patient or viable fetus.

Non-Emergency (Non-Urgent) Care: Treatment for any conditions not included in the emergency care definition and any additional medical care for those conditions the Department determines to be the most serious threat to the health of medically indigent persons.

Patient Liability: Client copayments are required for the CICP. Enter the amount due as a CICP copayment or copayment due from third-party insurance, whichever is lower. Enter the required copayment even if the provider did not receive full payment.

Total Charges: Total amount billed. The total charges billed to the CICP must be equal to the total charges billed to payers for equal medical services. Bill only one charge value, which is the sum of the detailed charge lines on a claim. Do not subtract Medicare or third-party payments from line charge amounts. This field cannot be negative.

Third-party Liability: Payments due from third-party insurance, including Medicare. These are not payments received, but the amount owed by the client's primary insurance. Do not include contractual adjustments as a payment due or as a liability. The CICP will reimburse for contractual adjustments.

Section 2.02 Provider Billing Information

There are three different types of billing information for the CICP:

Inpatient & Outpatient Service: All inpatient admissions and outpatient visits are billed using the CICP Data Collection System - Summary Format. This is the only required billing information and is due to the Department on a quarterly basis.

Outpatient Pharmaceutical: Providers that choose to report outpatient pharmaceutical charges to the Department shall separate Outpatient Pharmacy visits

from regular inpatient and outpatient charges. If a client has an Outpatient Pharmacy visit (prescription only) that information will be reported separately from the regular billing information. If a client receives a pharmaceutical during an outpatient visit or inpatient admission, the pharmacy charge can be included on the regular claim information and it does not need to be separated out. Your facility must notify the Department of the intent to bill for Outpatient Pharmaceuticals on the Provider Application prior to the start of each fiscal year.

Physician Charges: Hospital providers have an option to bill the CICP for physician charges. Physician charges associated with clinic visits are considered part of the outpatient service and are included in the CICP Data Collection System.

Hospital physician charges are associated with care provided at the facility for CICP clients. The physician charges must not be included in the charges submitted under the CICP Data Collection System and must not be reimbursed by another source. Prior to billing, physicians must have an appropriate contract with the facility stating that the physician will follow the statutes and rules governing the CICP. An example of this contract is provided in Section V, Miscellaneous Documents, of this CICP Manual. Physicians cannot bill the CICP directly. The provider must handle all the billing for physician charges. No provider is obligated to bill for physician charges. Prior to the start of each fiscal year, your facility must notify the Department on the Provider Application of the intent to bill for physician charges.

Section 2.03 Summary Format

The CICP Data Collection System – Summary Format includes the specifications on how providers must submit billing information to the Department. There is no electronic or paper submission of claims. The information is requested so that the Department can identify funding available to specific providers and write the CICP Annual Report for the Colorado General Assembly.

Providers must submit billing information under the Summary Format and follow the guidelines set forth in Article III Data Collection System – Summary Format. By using the Summary Format the Department does not receive claim level details, but rather summary totals for clients served at each provider. The summary information is submitted quarterly, in a year-to-date, cumulative format. The summary information can be sent to the Department as an e-mailed attachment.

Section 2.04 Timely Filing Requirement

The State fiscal year starts July 1st and ends the following June 30th. All billing information with an inpatient discharge date or an outpatient date-of-service within the fiscal year must be received by the Department prior to October 31st following the fiscal year end. In other words, for billing information with an inpatient discharge date or an outpatient date-of-service contained in Fiscal Year 2016-17 (July 1, 2016 - June 30, 2017) all billing information must be received by the Department by October 31, 2017. **It is imperative that final billing data be submitted annually by October 31st to allow the Department adequate time for completion of the CICP Annual Report, which is due to the Colorado General Assembly each year.**

Section 2.05 Retention of Billing Records

All billing records related to the contractor's or subcontractor's participation in the CICP must be maintained in a central location by the providers for a period of six State fiscal years after the expiration of each State fiscal year. This includes all the detailed information used to support the summary information submitted to the CICP. The Provider Compliance Audit mandated by the CICP requires that providers be able to identify all claims used to create the Summary Format submitted to the Department. Providers must keep the claim detail for a period of six State fiscal years to justify the information submitted to the Department.

Section 2.06 Third-party Insurance

If the client has third-party insurance, including Medicare, the provider will bill the commercial health insurance policy first for all medical expenses incurred. Providers can report contractual adjustments negotiated under commercial health insurance contracts and Medicare contractual adjustments in Total Charges. The CICP will reimburse providers for contractual adjustments. Do not include contractual adjustment under Third-party Liability.

Health Insurance Billing Examples:

Example #1: Medicare Third-party Payment with CICP as Secondary Payer

Total Charges billed to Medicare	$150 (Enter in Total Charges line in Summary)
Minus Payment due from Medicare	$100 (Enter in Third Party Liability line)
Equals Hospital Charges Remaining	$50
Minus Client Copayment	$25 (Enter in Patient Liability line)
Equals Amount Charged to CICP	$25 (Goes into Total Write Off Charges)

Example #2: Third-party Payment with CICP as Secondary Payer

Total Charges billed to Insurance	$350 (Enter in Total Charges line in Summary)
Minus Payment due from Insurance	$150 (Enter in Third Party Liability line)
Equals Hospital Charges Remaining	$200
Minus Client Copayment	$50 (Enter in Patient Liability line)
Equals Amount Charged to CICP	$150 (Goes into Total Write Off Charges)

Section 2.07 Medicare Bad Debt

A provider can declare the percentage of Medicare deductibles or coinsurance not reimbursed by the client or a state program as Medicare Bad Debt. If a client qualifies for a state low-income program, such as CICP, the debt may be deemed uncollectible without applying a reasonable collection effort (such as turning the debt over to a collection agency). From the Medicare Provider Reimbursement Manual, Chapter 3, Section 312. Indigent or Medically Indigent Patients:

> "…the provider should apply its customary methods for determining the indigence of patients to the case of the Medicare beneficiary under the following guidelines:
>
> A. The patient's indigence must be determined by the provider, not by the patient; i.e., a patient's signed declaration of his inability to pay his medical bills cannot be considered proof of indigence;

B. The provider should take into account a patient's total resources which would include, but are not limited to, an analysis of assets (only those convertible to cash, and unnecessary for the patient's daily living), liabilities, and income and expenses. In making this analysis the provider should take into account any extenuating circumstances that would affect the determination of the patient's indigence;
C. The provider must determine that no source other than the patient would be legally responsible for the patient's medical bill; e.g., title XIX, local welfare agency and guardian; and
D. The patient's file should contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination.

Once indigence is determined and the provider concludes that there had been no improvement in the beneficiary's financial condition, the debt may be deemed uncollectible without applying the §310 procedures."

The maximum a provider can collect from a CICP eligible client is the CICP copayment, even if that client has another primary insurance such as Medicare.

Reimbursement Examples:

Example #1: Client is Eligible for CICP and Pays CICP Copayment

Medicare Coinsurance	$1,000
Minus CICP Client Copayment	$100
Equals Amount Charged to CICP	$900
Minus Amount Reimbursed by CICP	$90 (assumes reimbursed at 10% of Charges)
Equals Amount Added to Bad Debt	$810
Minus Amount Reimbursed by Medicare	$648 (assumes reimbursed at 80% of Bad Debt)
Equals Total Uncompensated Charges	$162
Total Amount Received by Provider	$838 ($100 + $90 + $648)

Example #2: Client is Eligible for CICP and Fails to Pay CICP Copayment

Medicare Coinsurance	$1,000
Minus CICP Client Copayment	$100
Equals Amount Charged to CICP	$900
Minus Amount Reimbursed by CICP	$90 (assumes reimbursed at 10% of Charges)
Plus CICP Client Copayment Bad Debt	$100
Equals Amount Added to Bad Debt	$910
Minus Amount Reimbursed by Medicare	$720 (assumes reimbursed at 80% of Bad Debt)
Equals Total Uncompensated Charges	$190
Total Amount Received by Provider	$810 ($90 + $720)

Example #3: Working with Contractual Adjustments

Total Charge for Visit	$600
Minus Contractual Adjustment	$185 (Allowed to be Charged to CICP)

Minus Medicare Payment	$350
Minus Client Copayment	$20
Equals Outstanding Amount	$45
Amount Charged to CICP	$230 (Outstanding + Contractual Adjustment)
Minus Amount Reimbursed by CICP	$23 (assumes reimbursed at 10% of Charges)
Equals Amount Added to Bad Debt	$22 ($230 - $23 - $185)
Minus Amount Reimbursed by Medicare	$18 (assumes reimbursed at 80% of Bad Debt)
Equals Total Uncompensated Charges	$189
Total Amount Received by Provider	$411 ($350 + $20 + $23 + $18)

This is an example of CICP and Medicare reimbursement percentages. Please use the percentages that make sense for your facility.

Section 2.08 Medical Insurance

Charges to the CICP are secondary to all insurance programs.

1. Group and Individual Health Insurance applicants may be eligible for CICP coverage. The provider is required to bill the resource listed before submitting the claim to CICP. If the CICP provider is out of the client's primary insurance network, CICP clinic providers may seek a waiver from the Department regarding the necessity of providing proof of claim denial, prior to adjusting the patient account to reflect CICP discount and writing off charges to CICP. A waiver from this requirement is not available to CICP hospital providers.
2. Workers' Compensation applicants can participate in the CICP. However, the provider must bill Worker's Compensation before billing the CICP.
3. Victim's Compensation is the only third-party coverage billed after CICP coverage. Victim's Compensation may be used to cover the client's CICP copayment.
4. Health Maintenance Organization's (HMO) clients can participate in CICP. However, out of network services are not covered for CICP hospital providers. Services not available in the commercial HMO insurance policy and deemed medically necessary can be billed by hospital CICP providers to CICP minus the insurance copayment paid by the client. CICP clinic providers may submit write-off charges to CICP for primary care services provided to clients within an HMO, regardless if those services are a covered benefit under their HMO. If the CICP provider is out of the HMO network, CICP clinic providers may seek a waiver from the Department regarding the necessity of providing proof of claim denial, prior to adjusting the patient account to reflect CICP discount and writing off primary care charges to CICP.
5. Consolidated Omnibus Budget Reconciliation Act (COBRA) benefits are continued health plan benefits provided by the employer. Terminated employees or those who lose coverage because of reduced work hours may purchase the group coverage for themselves and families for a limited period of time. They have 60 days to accept coverage or lose all rights to these benefits. Once COBRA coverage is chosen, they will be required to pay for their coverage.

6. Medicare eligible clients have CICP coverage for amounts and services NOT covered by Medicare. Medicare has three main types of coverage:

   (1) Medicare Part A is inpatient hospital coverage available to all people over age 65;

   (2) Medicare Part B, outpatient services, requires clients to pay a monthly premium; and

   (3) Medicare Part D is for prescription drug coverage.

   (4) Some Medicare beneficiaries qualify for Health First Colorado as a Qualified Medicare Beneficiary (QMB). If an applicant has QMB coverage, they can participate in the CICP.

7. CICP can be used to satisfy the deductible or coinsurance for primary insurance, including Medicare. Clients are responsible for the CICP copayment or the copayment of the primary insurance, whichever is lower. The deductible or coinsurance should be included in Total Charges billed to the CICP. The only entry into Client Liability is the copayment required.

Section 2.09 Subsequent Insurance Payments

If clients receive coverage under the CICP, and their insurance subsequently pays for services, or if the client is awarded a settlement, the provider must document any subsequent reimbursement received when submitting their summary data information. See Section II – Data Collection, Article VI - Previously Charged Claim Adjustments for information on how to document these payments.

Section 2.10 Grants

Grants from foundations to CICP clients from non-profit, tax-exempt or charitable foundations specifically for CICP client copayments are not considered other medical insurance or income. The provider must honor these grants and not count the grant as a resource or income.

ARTICLE III. DATA COLLECTION SYSTEM – SUMMARY FORMAT

Section 3.01 Definition

Providers submitting billing information under the Summary Format must follow the guidelines set forth in this Article. In the Summary Format, the Department shall receive totals for clients served at each provider rather than claim-level detail. The summary information is submitted quarterly in a year-to-date, cumulative format. The summary information may be e-mailed to the Department.

Section 3.02 Field Description

Provide the following summary information:

Provider Name	CICP Contracting Provider's Name
Date of Service	Dates of Reporting Period. Reporting dates are as follows: July 1 – September 30 (First Submission Report) July 1 – December 31 (Second Submission Report) July 1 – March 31 (Third Submission Report) July 1 – June 30 (Fourth Submission Report & Final Submission Report)
Total Charges	Sum of the detail charge lines. This field should be gross charges and cannot be a negative figure. Do NOT subtract Medicare or third-party payments from line charge amounts
Third-party Liability	Payments due from 3rd Party Insurance, including Medicare. Do NOT include contractual adjustments.
Patient Liability	Client copayments are required for the CICP. Enter the amount due as a CICP copayment or as a copayment due from 3rd Party Insurance, whichever is lower. Enter the required copayment even if the provider did not receive full payment.

Outpatient Urgent and Emergency Charges
- Bill Type is Outpatient 131, 134, 721, 724, 711, 714, 731, 734 AND
- Admit Type is Emergency Claims
  - 1 – Emergency
  - 2 – Urgent

Outpatient Non-Urgent and Non-Emergency Charges
- Bill Type is Outpatient 131, 134, 721, 724, 711, 714, 731, 734 AND
- Admit Type is Non-Emergency Claims
  - 3 – Elective
  - 4 – Newborn

Inpatient Urgent and Emergency Charges
- Hospitals Only Bill Type is Inpatient 111, 114, 121, 124 AND
- Admit Type is Emergency Claims
  - 1 – Emergency
  - 2 – Urgent

Inpatient Non-Urgent and Non-Emergency Charges
- Hospitals Only Bill Type is Inpatient 111, 114, 121, 124 AND
- Admit Type is Non-Emergency Claims
  - 3 – Elective
  - 4 – Newborn

Total Number of Inpatient Admissions
- Hospitals Only Bill Type is Inpatient 111, 114, 121, 124

Total Number of Inpatient Days
- Hospitals Only Bill Type is Inpatient 111, 114, 121, 124

Number of Inpatient Admissions by CICP Rating
- Hospitals only Bill Type is Inpatient 111, 114, 121, 124
- Client's CICP Rating Codes (as listed on worksheet): Z, N, A, B, C, D, E, F, G, H, I, Unknown

Number of Inpatient Days by CICP Rating
- Hospitals only Bill Type is Inpatient 111, 114, 121, 124
- Client's CICP Rating Codes (as listed on worksheet): Z, N, A, B, C, D, E, F, G, H, I, Unknown
- If you have patients listed under a CICP rating code, then you should have at least as many days as there are patients listed under that code, as Inpatients are defined as staying for a period of at least 24 hours

Number of Inpatient Admissions by Age and Sex
- Hospitals only Bill Type is Inpatient 111, 114, 121, 124
- Client's sex M or F
- Age groups 0-5, 6-17, 18-24, 25-54, 55-64, 65+

Inpatient Charges by Age and Sex
- Hospitals only Bill Type is Inpatient 111, 114, 121, 124
- Client's sex M or F
- Age groups 0-5, 6-17, 18-24, 25-54, 55-64, 65+
- If you have patients listed under an Age group, then there should be corresponding charges for that Age group.

Total Number of Outpatient Visits
- Bill Type is Outpatient 131, 711, 731

Number of Outpatient Visits by CICP Rating
- Bill Type is Outpatient 131, 134, 721, 724, 711, 714, 731, 734
- Client's CICP Rating Codes (as listed on worksheet): Z, N, A, B, C, D, E, F, G, H, I, Unknown

Number of Outpatient Visits by Age & Sex
- Bill Type is Outpatient 131, 134, 721, 724, 711, 714, 731, 734
- Client's sex M or F
- Age groups 0-5, 6-17, 18-24, 25-54, 55-64, 65+

Outpatient Charges by Age and Sex
- Bill Type is Outpatient 131, 134, 721, 724, 711, 714, 731, 734
- Client's sex M or F
- Age groups 0-5, 6-17, 18-24, 25-54, 55-64, 65+
- If you have patients listed under an Age group, then there should be corresponding charges for that Age group.

Total Number of Unique Clients (not claims) by Age
- Number of distinct clients served.
- Age Groups 0-5, 6-17, 18+
- Clients should only be counted ONCE in this number, even if they have come in for both inpatient and outpatient services.

Total Number of Unique Inpatient Clients (not claims) by Age
- Hospitals only Bill Type is Inpatient 111, 114, 121, 124
- Number of distinct clients served
- Age Groups 0-5, 6-17, 18+
- If you have a client that comes in multiple times as an Inpatient, they are still only counted ONCE in this number.

Total Number of Unique Outpatient Clients (not claims) by Age
- Bill Type is Outpatient 131, 134, 721, 724, 711, 714, 731, 734
- Number of distinct clients served
- Age Groups 0-5, 6-17, 18+
- If you have a client that comes in multiple times as an Outpatient, they are still only counted ONCE in this number.

Number of Admits and Visits by County (County Code)
- Two-digit county code (See Appendix – County Codes)
- This total should match the sum of Inpatient Admits and Outpatient Visits.

Listed bill types are only examples. The CICP accepts all bill types accepted by Health First Colorado, except interim claims. The CICP accepts only final claims.

Section 3.03 Outpatient Visits

Providers are requested not to use a span date when billing for outpatient services because a bill using a span date could be mistaken as one visit under the CICP Data Collection System, whereas the client might have actually received services several times in the month. Claims with a span bill date will still be accepted.

However, when counting the number of outpatient visits, providers are requested not to count claims, since many providers use a span billing. Instead, providers should count the actual number of visits by all CICP clients. If a client had four visits on one claim, four visits should be reported.

Section 3.04 Unduplicated Client Count

The unduplicated client count is the number of unique clients served by the provider. The Total Number of Unique Clients (not claims) by Age is the unduplicated client count of all clients served by the provider. The Total Number of Unique Inpatient Clients (not claims) by Age is the unduplicated client count for all clients served on an inpatient basis. The Total Number of Unique Outpatient Clients (not claims) by Age is the unduplicated client count for all clients served on an outpatient basis. For example:

- A single client could have two inpatient admissions and six outpatient visits at the provider over the fiscal year. This client is counted once in the total unduplicated client count, only once in the unduplicated inpatient client count and only once in the unduplicated outpatient client count.
- A single client could have four outpatient visits at the provider over the fiscal year, and is counted only once in the unduplicated client count for outpatient and only once in the total unduplicated client count.

For a provider with no inpatient clients, the total number of unduplicated clients should equal the unduplicated outpatient client count. Usually, the sum of the unduplicated inpatient clients and unduplicated outpatient clients will not equal the total number of unduplicated clients. The only time this sum should equal the total number of unduplicated clients is when clients receive either inpatient or outpatient services, but not both, over the course of a year. This scenario is very unlikely.

To ensure accurate data, it is advisable that the total number of unduplicated inpatient clients should not exceed the total number of inpatient admissions. Also, the total number of unduplicated outpatient clients should not exceed the total number of outpatient visits. Therefore, the total number of unique clients served should not exceed the total number of unique inpatient plus outpatient clients.

Section 3.05 Verify Accuracy of Subset Data

In the interest of providing accurate data, providers should make a reasonable effort to ensure the subset data pulled for inpatient admits (i.e., gender and age) corresponds to the same data group submitted for inpatient charges by age and sex. As well, the outpatient visits information pulled by age and gender should reasonably correspond to the same data group submitted for outpatient charges by age and sex. For example: a provider submits summary data information listing no inpatient admits for females between the ages of 6-17 years old. However, there is a specific dollar amount reported for inpatient charges for females between the ages of 6-17 years old. This situation indicates an error in the data.

Section 3.06 Summary Information Format

The Excel template for transmitting summary information to the Department was revised in April 2014. Providers must use this new reporting form. Providers can download the current Excel template for transmitting summary information to the Department. The template is available on the CICP Website (see Section 7.01). Summary information must be e-mailed directly to: cicpcorrespondence@state.co.us

An example template is as follows:

Total Charges		**Charges**	
Total Charges	$0.00	Outpatient Urgent & Emergency	$0.00
3rd Party Liability	$0.00	Outpatient Non-Urgent & Non-Emergency	$0.00
Patient Liability	$0.00	Inpatient Urgent & Emergency	$0.00
Write-Off Amount	$0.00	Inpatient Non-Urgent & Non-Emergency	$0.00
		Total Charges	$0.00

Inpatient Admits

Total Number of Admissions

Total Number of Days

Number of Admissions by CICP Rating

- Z
- N
- A
- B
- C
- D
- E
- F
- G
- H
- I
- Unknown

Total

Number of Days by CICP Rating

- Z
- N
- A
- B
- C
- D
- E
- F
- G
- H
- I
- Unknown

Total

Number of Admits by Age & Sex

- Male
  - 0-5
  - 6-17
  - 18-24
  - 25-54
  - 55-64
  - 65+

  Total Male
- Female
  - 0-5
  - 6-17
  - 18-24
  - 25-54
  - 55-64
  - 65+

  Total Female

Total Combined

Inpatient Charges by Age & Sex

- Male
  - 0-5
  - 6-17
  - 18-24
  - 25-54
  - 55-64
  - 65+

  Total Male
- Female
  - 0-5
  - 6-17
  - 18-24
  - 25-54
  - 55-64
  - 65+

  Total Female

Total Combined

Outpatient Visits

Total Number of Visits

Number of Admissions by CICP Rating
- Z
- N
- A
- B
- C
- D
- E
- F
- G
- H
- I
- Unknown

Total

Number of Visits by Age & Sex

Male
- 0-5
- 6-17
- 18-24
- 25-54
- 55-64
- 65+

Total Male

Female
- 0-5
- 6-17
- 18-24
- 25-54
- 55-64
- 65+

Total Female

Total Combined

Outpatient Charges by Age & Sex

Male
- 0-5
- 6-17
- 18-24
- 25-54
- 55-64
- 65+

Total Male

Female
- 0-5
- 6-17
- 18-24
- 25-54
- 55-64
- 65+

Total Female

Total Combined

Unduplicated Patient Count

Total Number of Unique Clients Served (not claims) by Age
- 0-5
- 6-17
- 18+

Total

Total Number of Unique Inpatient Clients Served (not claims) by Age
- 0-5
- 6-17
- 18+

Total

Total Number of Unique Outpatient Clients Served (not claims) by Age
- 0-5
- 6-17
- 18+

Total

County Utilization

Admits & Visits by County (County code)

01 Adams
02 Alamosa
03 Arapahoe
04 Archuleta
05 Baca
06 Bent
07 Boulder
08 Chaffee
09 Cheyenne
10 Clear Creek
11 Conejos
12 Costilla
13 Crowley
14 Custer
15 Delta
16 Denver
17 Dolores
18 Douglas
19 Eagle
20 Elbert
21 El Paso
22 Fremont
23 Garfield
24 Gilpin
25 Grand
26 Gunnison
27 Hinsdale
28 Huerfano
29 Jackson
30 Jefferson
31 Kiowa
32 Kit Carson
33 Lake
34 La Plata
35 Larimer
36 Las Animas
37 Lincoln
38 Logan
39 Mesa
40 Mineral
41 Moffat
42 Montezuma
43 Montrose
44 Morgan
45 Otero
46 Ouray
47 Park
48 Phillips
49 Pitkin
50 Prowers
51 Pueblo
52 Rio Blanco
53 Rio Grande
54 Routt
55 Saguache
56 San Juan
57 San Miguel
58 Sedgwick
59 Summit
60 Teller
61 Washington
62 Weld
63 Yuma
64 Broomfield
Unknown

Total

Section 3.07 File Description

Excel Spreadsheet: A Microsoft Excel Spreadsheet is provided by the Department. Providers can download this spreadsheet from the CICP Website (see Section 7.01) and can input data directly.

Section 3.08 Filing Requirements

Effective July 1, 2002, this summary information is to be submitted quarterly. Providers will submit year-to-date, cumulative information to the Department on the following time-line:

Submission	Dates of Service	Due to Department
1st	July 1 - September 30	October 31
2nd	July 1 - December 31	January 31
3rd	July 1 -March 31	April 30
4th	July 1 - June 30	July 31
Final Submission	July 1 - June 30	October 31

When pulling the data for the submissions, data should always be freshly pulled for each report and cover the entirety of the current year. Reports for submissions 2, 3, 4, and Final should NOT simply be sums of the previous quarters. Pulling separate quarters and adding them together can cause understated costs, and can also lead to clients being counted more than once in the unduplicated counts, both of which can have an impact on the amount providers are reimbursed.

On October 31, 2016, providers will submit two reports: the Final Yearly Summary Report for FY 2015-16 covering the dates of service July 1, 2015 - June 30, 2016, and the 1st Quarter Report for FY 2016-17 covering the dates of service July 1, 2016 - September 30, 2016.

Section 3.09 Provider Summary Data Submission Extension or Waiver Request

Providers must seek an extension of the quarterly data submission's due date by written request. The request must include a reason for the request and the date the summary data will be completed. The request for an extension must be received by the Department within 30 days before the provider's quarterly summary data submission's due date.

Providers may submit a request to provide only the Final Yearly Summary Report (due October 31st). A waiver request must be submitted in writing to the Department explaining the reasons for not being able to maintain the quarterly reporting schedule. The waiver request will be reviewed by the Department and approved if proper justification is provided.

It is the responsibility of the provider to submit the request for extension or waiver to the Department at:

Department of Health Care Policy and Financing
Colorado Indigent Care Program - Summary Data
1570 Grant St.
Denver, CO 80203-1818

Or cicpcorrespondence@state.co.us

Providers that fail to submit the quarterly summary data within the due dates specified in Section 3.08 while also failing to request an extension or waiver shall be considered out of compliance. Providers that are found out of compliance in the submission of the required summary data may be subject to penalty.

It is mandatory that final billing data be submitted annually by October 31st, to allow the Department adequate time for completion of the CICP Annual Report due to the Colorado General Assembly each year.

Section 3.10 E-Mail Submission Requirements

All data submissions must be e-mailed to the Department with the following information at the top of the spreadsheet:

- Provider Name
- Reporting Period
- Name, Phone Number and E-Mail address as a contact regarding the data submission

ARTICLE IV. OUTPATIENT PHARMACEUTICAL

Section 4.01 Definition

Outpatient Pharmaceuticals: Providers are required to separate Outpatient Pharmacy visits from regular inpatient and outpatient claims (charges). If a client has an Outpatient Pharmacy visit (prescription only) that information will be reported separately from the regular claim information. If a client receives a pharmaceutical during an outpatient visit or inpatient admission, the pharmacy charge is included on the regular claim information as it does not need to be separated out. Your facility must notify the Department prior to the start of the fiscal year of the intent to bill for Outpatient Pharmaceuticals on the Provider Application.

Section 4.02 Declaring Pharmaceutical Charges

Providers will submit to the Department a completed Pharmaceutical Charges worksheet stating the following summary information:

- Total Number of Visits (or prescription claims)
- Total Charges
- 3rd Party Liability
- Patient Liability

Providers can download this spreadsheet from the CICP website (click on For Our Providers, Provider Services, Forms, Colorado Indigent Care Program (CICP), and then Pharmacy Billing Files for the appropriate year).

Section 4.03 Filing Requirements

This summary information is submitted quarterly. Providers will submit year-to-date information to the Department on the following timeline:

Submission	Dates of Service	Due to The Department
1st	July 1 - September 30	October 31
2nd	July 1 - December 31	January 31
3rd	July 1 -March 31	April 30
4th	July 1 - June 30	July 31
Final Submission	July 1 - June 30	October 31

On October 31, 2016, providers will submit two reports: the Final Yearly Summary Report for FY 2015-16 covering the dates of service July 1, 2015 - June 30, 2016, and the 1st Quarter Report for FY 2016-17 covering the dates of service July 1, 2016 - September 30, 2016.

See Section 3.09 for requests to extend due dates or for a waiver to submit final summary data only.

ARTICLE V. PHYSICIAN CHARGES

Section 5.01 Definition

Physician Charges: CICP hospital providers have the option to bill the CICP for hospital-based physician charges. These are charges associated with care provided at the hospital facility for CICP clients. The physician charges must not be included in the charges submitted under the CICP Data Collection System or be completely reimbursed by another source. Prior to billing, physicians must have an appropriate contract with the facility stating the physician will follow the statutes and rules governing the CICP. An example of this contract is provided in Section V, Miscellaneous Documents, of the CICP Manual. Providers are not obligated to bill for physician charges, but if these charges are to be billed to the CICP, they must be submitted by the provider, not the physician. Your facility must notify the Department prior to the start of the fiscal year of the intent to bill for physician charges on the Provider Application.

Section 5.02 File Description

Excel Spreadsheet: A Microsoft Excel Spreadsheet will be provided by the CICP. Providers can download this spreadsheet from the CICP website (click on For Our Providers, Provider Services, Forms, Colorado Indigent Care Program (CICP), and then Physician Billing Files for the appropriate year). This spreadsheet will allow providers to directly input data as necessary. Please provide the following summary information:

INPATIENT

Claim Information	CHARGES	Number of ADMISSIONS	Number of DAYS	Number of CLIENTS
Urgent Care	$0.00	0	0	0
Non-Urgent Care	$0.00	0	0	0
Totals	$0.00	0	0	0
Third-party Liability	$0.00			
Patient Liability	$0.00			
Medical Indigent Write-Offs	$0.00			

OUTPATIENT

Claim Information	CHARGES	Number of VISITS	Number of CLIENTS
Urgent Care	$0.00	0	0
Non-Urgent Care	$0.00	0	0
Totals	$0.00	0	0
Third-party Liability	$0.00		
Patient Liability	$0.00		
Medical Indigent Write-Offs	$0.00		

Section 5.03 Filing Requirements

This summary information will be submitted quarterly. Providers will submit year-to-date information to the Department:

Submission	Date of Service	Due to The Department
1st	July 1 – September 30	October 31
2nd	July 1 – December 31	January 31
3rd	July 1 -March 31	April 30
4th	July 1 - June 30	July 31
Final Submission	July 1 - June 30	October 31

On October 31, 2016, providers will submit two reports: the Final Yearly Summary Report for FY 2015-16 covering the dates of service July 1, 2015 - June 30, 2016, and the 1st Quarter Report for FY 2016-17 covering the dates of service July 1, 2016 - September 30, 2016.

See Section 3.09 for requests to extend due dates or for a waiver to submit final summary data only.

ARTICLE VI. PREVIOUSLY CHARGED CLAIM ADJUSTMENTS

Section 6.01 General Information

Providers who receive payment for claims that have already been reimbursed by the CICP are required to report these payments. These payments can be made under the following circumstances:

- Client became enrolled in Health First Colorado or CHP+
- Settlement of lawsuits or other court ordered action in which the client or other 3rd party was required to pay the medical bill
- Client was incorrectly included on the CICP data submission

Previously charged claim adjustments are charges that the provider submitted to the CICP in a previous fiscal year. If a charge for the current fiscal year needs to be adjusted, the provider should make that adjustment to the data prior to the October 31, 2016, data submission deadline. For example:

- The provider submits a $100 charge to the Department on its first submission report for FY 2016-17. Six (6) months later the provider learns that the client was enrolled in Health First Colorado during that period. The provider will then submit the bill to Health First Colorado for proper reimbursement and will not include the charge on the third submission report for FY 2016-17 submitted to the Department. This is allowable, since the CICP reporting is always year-to-date and providers can make adjustments to the totals submitted up to the October 31, 2017 deadline.
- The provider submits a $100 charge to the Department on its final submission report for FY 2016-17. Six (6) months later the provider learns that the client was enrolled in Health First Colorado during that period. The provider then submits the bill to Health First Colorado for proper reimbursement, but is unable to adjust its quarterly reporting to the Department since the October 31, 2017, deadline has passed. The provider will submit the required information in Section 6.02 by October 31st of the following year to correct the charge that was incorrectly submitted to the Department.

Section 6.02 Reporting Requirements

The following information is required for charges submitted to the Department that need to be adjusted after the close of the fiscal year in which the service was provided. Adjustments for different fiscal years must not be combined into one report and must be reported separately. The following information must be included in the report:

- Provider name
- Fiscal year that the claim was incorrectly reported
- Number of visits incorrectly reported
- Number of admissions incorrectly reported
- Total charges incorrectly reported
- Third-party liability incorrectly reported
- Patient liability incorrectly reported

Section 6.03 Filing Requirements

Providers are required to notify the Department of any charges that need to be adjusted. This notification should be made in a letter to be included with the Final Yearly Summary Report which is due October 31st for the previous state fiscal year. The facility's Chief Financial Officer (CFO) or Administrator should sign this letter.

ARTICLE VII. CICP INFORMATION

Section 7.01 CICP Website

The CICP Web site, Colorado.gov/hcpf, is for public use and contains general CICP information. This is the main website for the Department of Health Care Policy and Financing. Click on the "For Our Providers" link at the top menu bar. At this Web site, providers can find the templates for the billing files, documents for the Colorado Indigent Care Program and the CICP Provider Directory under Get Info, Colorado Indigent Care Program.

Section 7.02 Department Contact Information

For questions or comments, please contact:

Taryn Jorgensen
Taryn.Jorgensen@state.co.us
(303) 866-5634

Summary Data files should be sent by e-mail to:

cicpcorrespondence@state.co.us

APPENDIX-- COUNTY CODES

01 Adams
02 Alamosa
03 Arapahoe
04 Archuleta
05 Baca
06 Bent
07 Boulder
08 Chaffee
09 Cheyenne
10 Clear Creek
11 Conejos
12 Costilla
13 Crowley
14 Custer
15 Delta
16 Denver
17 Dolores
18 Douglas
19 Eagle
20 Elbert
21 El Paso
22 Fremont
23 Garfield
24 Gilpin
25 Grand
26 Gunnison
27 Hinsdale
28 Huerfano
29 Jackson
30 Jefferson
31 Kiowa
32 Kit Carson
33 Lake
34 La Plata
35 Larimer
36 Las Animas
37 Lincoln
38 Logan
39 Mesa
40 Mineral
41 Moffat
42 Montezuma
43 Montrose
44 Morgan
45 Otero
46 Ouray
47 Park
48 Phillips
49 Pitkin
50 Prowers
51 Pueblo
52 Rio Blanco
53 Rio Grande
54 Routt
55 Saguache
56 San Juan
57 San Miguel
58 Sedgwick
59 Summit
60 Teller
61 Washington
62 Weld
63 Yuma
64 Broomfield