Automated Medical Payments

Medicaid Bulletin

Colorado Title XIX

Fiscal Agent

CONSULTEC INC

600 Seventeenth Street
Suite 600 North
Denver, CO 80202

Medicaid Provider Services
303-534-0146
1-800-237-0757

Mailing Addresses
Claims & PARs
P.O. Box 30
Denver, CO 80201-0030

Correspondence, Inquiries & Adjustments
P.O Box 90
Denver, CO 80201-0090

Provider enrollment, Provider information, Changes, Signature authorization, and Claim requisitions
P.O. Box 1100
Denver, CO 80201-1100

Medicaid bulletins contain important policy and billing information and should be shared promptly with billing staff.

Bulletins supplement information in the Medicaid Provider Manual and should be retained with the provider manual for reference. Retain all bulletins until published notification advises that the information is obsolete or reproduced in subsequent bulletins or provider manual updates.

Please direct questions about bulletins and billing information to Medicaid Provider Services.

Distribution: Physicians, Osteopaths, Pharmacies, Suppliers **May 1999**

Reference: B9900014

Prior Authorization Request (PAR) submission change for some Durable Medical Equipment (DME)

Effective immediately, providers must submit paper PARs, including all supporting documentation, for the following items:

- ➢Electronic Wheelchairs
- ➢Scooters
- ➢Prosthetics
- ➢Orthotics
- ➢Augmentative Communication Devices

Most PARs are submitted electronically through WINASAP, the Colorado Medicaid interactive software. Electronic PAR transmission is usually more efficient than paper PAR submission. Once submitted, the authorizing agent reviews the PARs.

The Colorado Foundation for Medical Care (CFMC) reviews PARs for the DME listed above. When electronic PARs are submitted for these DME items, the CFMC reviewer often needs additional information from the requesting provider. Many times, the request for additional documentation lengthens the prior authorization process.

To reduce processing time and eliminate delay for both providers and clients, send paper PARs for these items directly to CFMC at the following address:

CFMC
Attention: Medicaid/DME PARs
P.O. Box 17300
Denver, Colorado 80217-0300

Revised orthotics and prosthetics questionnaire

Effective immediately, providers must complete the revised orthotics and prosthetics questionnaire and attach it to all PARs for prosthetics and orthotics. A copy of the revised form follows. Please copy the form as needed.

Colorado Department of Health Care Policy and Financing

Adult Orthotics and Prosthetics Questionnaire

This form must accompany all prior authorization requests, and may be completed by the physical therapist, prosthetist, or other medical professional familiar with the O/P needs of the client.

Client's Name: ______________________________ State ID#: ______________

Name and title of person completing this form: ______________________________

General information questions:

1. Why does the client require this equipment? (Be specific, include diagnosis, co-morbities, brief history, current condition, etc.) ______________________________

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2. If the client previously lacked this equipment, what medical repercussions has the client experienced in the past 12 months? (check all that apply)

_____ Increased disability
_____ Loss of independence
_____ Lack of rehabilitation
_____ Continuing pain/discomfort/increased use of medication
_____ Surgery
_____ Physician assessment
_____ Disability related hospitalizations
_____ Related ER care required
_____ Use of other DME support function; specify type:

____

3. In the next year, if the equipment is supplied, what medical events and costs can be avoided? (check all that apply)

_____ Surgery (CPT code) __________
_____ Medication reduction
_____ Hospitalizations
_____ Physician assessment
_____ Continuing use of durable medical equipment named in #2 above
_____ Other, Describe: ______________________________

____

4. What change in the client's condition do you anticipate if the equipment is supplied?

_____ Problem correction
_____ Problem alleviation
_____ Prevention of associated problems
_____ Potential of avoiding surgery with use of orthotic or prosthetic

Questions specific to prostheses:

5. Functional level as defined by Medicare. Circle one.

Level 0 Level 1 Level 2 Level 3 Level 4

6. What is the client's height? ______________ Weight? ______________

7. Is this a replacement? _____ Yes _____ No

If this is a replacement, in what year was the current O/P issued? ______________

If this is a new prosthesis, when was the amputation/surgery performed? Month __________ Year _____

Questions specific to orthosis:

8. Is the orthosis pre-manufactured/custom fitted? ______________ Custom fabricated? ______________

9. What is the reason a pre-manufactured device is not appropriate? ______________________________

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