Automated Medical Payments

Medicaid Bulletin

Colorado Title XIX

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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 Retain all bulletins until published notification advises that the information is obsolete or reproduced in subsequent bulletins or provider manual updates.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: County Medical Transportation Providers **May 2001**

Reference: B0100099

This bulletin completely replaces Medicaid Bulletin B95502230 (06/95)

Bulletin B95502230 should be discarded.

County Medical Transportation HCFA and Local Codes

The Colorado Medicaid Program uses the Health Care Financing Administration's (HCFA) Common Procedural Coding System (HCPCS) to identify Medicaid services provided to Medicaid clients. This is the County Medical Transportation HCFA and local code bulletin.

Providers should use the codes listed in this bulletin when billing county transportation services. Insert this bulletin into the Medicaid Provider Manual for reference.

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Please direct questions about the information in this bulletin to:

Medicaid Provider Services
303-534-0146
or 1-800-237-0757 (toll free Colorado)

Introduction

Colorado Medicaid claims must be submitted electronically through the Automated Medical Payments (AMP) system. Electronically mandated claims submitted on paper are processed, denied, and marked "Electronic Filing Required."

Exceptions to electronic filing include:

- Claims from providers who consistently submit fewer than 10 claims per month.
- Claims with service dates more than 365 days old ***must*** be submitted on paper with substantiating documentation.
- Claims that, by federal or state policy or regulation, require attachments.
- Reconsideration claims.

AMP claims: Submit AMP interactive transportation services on the electronic Colorado 1500 transportation format using HCPCS.

Paper claims: If paper claim submission is required, providers must submit charges on the Colorado 1500 claim form using HCPCS.

Code Column: HCFA and local codes consist of a letter followed by four numbers. Codes authorized for the Medicaid program may not correspond to codes approved for Medicare billing. This list identifies the HCFA and local codes approved for billing the Colorado Medicaid program. Transportation services and procedures not identified in this listing are not benefits of the Colorado Medicaid program.

Modifiers: Pickup/Destination (PD) Modifiers: PD modifiers are required for automobile mileage and taxi charges. PD modifiers are constructed by combining two letters to form a two-character modifier. The first letter represents the pickup location; the second letter represents the destination.

Local modifier for units exceeding 999

The Medicaid claim processing system limits the number of units that can be entered on a single detail line to 999. Electronic claims are limited to 9,999,999 units of service per detail. If the number of units exceeds the system limitation, claim information must be split and entered on more than one detail line.

Use modifier -XU with the procedure code to identify every detail line that has been split (billed separately) because of the system limitation. To avoid duplicate claim denial, the -XU modifier must be placed in the first modifier position. Place the PD modifier in the second position.

Example: Billing details for a 1009 mile trip by private vehicle.

Mod	Description
-D	Diagnostic or therapeutic site other than “P” or “H” (laboratory, radiology, ambulatory surgical center, etc.)
-E	Residential, domicilliary, or custodial facility (ICF) that is not a skilled nursing facility
-H	Hospital
-N	Skilled Nursing Facility (SNF)
-P	Physician’s office

Mod	Description
-R	Client’s residence
-U	Unclassified location. Use only if no other modifier is appropriate. Records documenting the actual location must be retained on file and produced on request.
-X	Intermediate stop at physician’s office on the way to the hospital (Destination code only)
-AS	Trip to and/or from an out-of-state hospital. ***Note:*** *When -AS is used no other modifier is needed. The -AS modifier includes* ***both*** *the pickup and destination.*
-XU	Split bill. The number of units exceeds the system limitation

Narrative Column: A description of the service. Read the entire entry to determine the benefit status of the item. When appropriate, the description defines the billing unit.

Rate Column: Displays the state reimbursable rates for county medical transportation services.

Trip Report Column: Identifies the requirements for a trip report or transportation certification. A trip report or transportation certification is a record of the trip. It must document the medical necessity for the trip and the pickup and destination locations.

Y This certificate of medical necessity or a trip report documenting the medical necessity must be maintained by the county ***and*** in the transportation provider's office. Transportation PAR records and trip reports must be available for audit & inspection upon request. However, the trip report for county medical transportation services does NOT need to be marked in the AMP software for an electronic claim or attached with a paper claim.

PAR Column: The prior authorization status of the identified service.

S = State A Prior Authorization Request (PAR) form must be submitted to the Colorado Department of Health Care Policy and Financing (HCP&F) and approved ***before the service is provided***. Claims for services that have not been prior authorized are denied.

C = County An authorization from the County Department of Social/Human Services ***must be obtained before the service is provided***. Claims for services that have not been prior authorized are denied.

N = No The service does not require prior authorization when provided to an eligible Medicaid client.

Prior Authorization Requests (PARs) must be approved before claims are submitted. ***PAR approval does not guarantee Medicaid payment and does not serve as a timely filing waiver***. PAR approval only assures that the service has been identified as medically necessary. All billing and eligibility requirements must be met before reimbursement will be made. Prior authorization does not apply to Medicare crossover claims. If Medicare approves benefits, Medicaid does not require prior authorization. If Medicare does not provide benefit for an item, all applicable Medicaid billing requirements, including prior authorization if indicated, must be met.

Mobility Van Authorization

Mobility van services must be authorized by the County Department Human/Services before services are provided. The county sends a written approval confirmation notice to the mobility van provider for all authorized trips. The approval must be retained in the mobility van provider's files and is subject to audit for a period of six years from the date of service.

Mobility van providers directly bill the fiscal agent after rendering transportation services.

When authorization is required at the County level, call the appropriate County office for approval procedures. When prior authorization is required at the State level, a completed Medicaid Prior Authorization Request (PAR) form must be sent by the county to the Department of Health Care Policy and Financing.

See the County Transportation specialty manual for prior authorization requirements and form completion instructions.

Comments Column: Expands on the description, identifies special billing instructions. The notation "Deleted" in the trip report column means that the code is invalid effective the day following the date shown in the "Comments" column. Example: Codes that are deleted 12/31/00 are invalid for billing services provided on or after 01/01/01. Newly added codes become effective on the date shown. Example: Codes showing an effective date of 01/01/01 may be submitted for services provided on or after 01/01/01.

Please direct questions about billing or the use of this listing to Medicaid Provider Services.

County transportation

Transportation for Medicaid clients to and from a medical provider is a benefit when the medical service provided is a benefit of the Colorado Medicaid Program and transportation is prior approved by the county.

County transportation benefits are prior authorized and administered by the county. Submitted claims are processed by the fiscal agent.

County transportation includes:

- Private vehicle
- Bus
- Train
- Air
- Taxi *
- Ancillary services prior authorized by CFMC
- Out-of-state transportation prior authorized by CFMC

* Taxi service is a county benefit only after all less expensive modes of transportation have been investigated, and no other less costly way to travel is available or appropriate to the client's condition. The County Department of Human/Social Services is responsible for exploring the least costly, medically appropriate means of transport for each client.

Both the county and the transportation provider must maintain records of the transportation PAR and trip report on file. These records must be available and produced for audit and inspection upon request. The authorization must cover the service dates. Submit PARs to the **C**olorado **F**oundation for **M**edical **C**are (CFMC) for amounts over the state's maximum allowable rate and bill using code X6015.

The fiscal agent updates and revises HCPCS codes through Medicaid bulletins.

A diagnosis is required on all claims. Enter 780 for all claims. Do not fill unused spaces with zeros. The diagnosis must be referenced to each detail line by placing a "1" in the diagnosis indicator field.

Code	Narrative	Rate	Trip Report	PAR	Comments
A0080	Non-emergency transportation by private vehicle	$0.14	Y	C	Owned or driven by volunteer with no vested or personal interest. Per mile.
A0090	Non-emergency transportation by private vehicle	$0.14	Y	C	Owned or driven by individual with vested interest (client, family member, neighbor, etc.). Per mile.
A0160	Non-emergency transportation by private vehicle	$0.14	Y	C	Owned or driven by case worker or social worker. Per mile.
A0100	Non-emergency transportation by taxi	UCC° <$50.00	Y	C	Per one-way trip.
A0110	Bus (local or long distance)	UCC°	Y	C	Per one-way trip. Modifier not required.
A0140	Non-emergency transportation by train or air	UCC°	Y	S	Modifier not required.
A0180	Client lodging	$29.75	Y	S	Per day. Modifier not required.
A0190	Client meals	$13.09	Y	S	Per day. Modifier not required.
A0200	Escort lodging	$29.75	Y	S	Per day. Modifier not required.
A0210	Escort meals	$13.09	Y	S	Per day. Modifier not required.
X6015	Special client transportation	By report	Y	S	Exceeds established payment maximum. Per one-way trip.
X6017	Escort transportation by bus	UCC°	Y	S	Per one-way trip. Modifier not required.
X6019	Escort transportation by train or air	UCC°	Y	S	Per one-way trip. Modifier not required.

°UCC: Usual and Customary Charge (private pay rate)