Automated Medical Payments

Medicaid Bulletin

Colorado Title XIX

Fiscal Agent

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Denver, CO 80202

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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 Fiscal Agent Information on the Internet
coloradomedicaid.acs-inc.com

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 Retain all bulletins until published notification advises that the information is obsolete or reproduced in subsequent bulletins or provider manual updates.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.

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Frequently Asked Questions

The following questions and answers are designed to help providers with common problems that often occur when billing the Colorado Medicaid program.

Q & A

All providers

Q - What is an LBOD, and how do I use it?

A - *LBOD stands for Late Bill Override Date. The provider uses the LBOD to document compliance with timely filing requirements. Only use the LBOD if you are filing a claim with dates of service older than 120 days. Providers must keep LBOD documentation on file. For example, keep a copy of the WINASAP rejection if you are using that as your LBOD date.*

You can use an LBOD on either an electronic claim or paper claim. The original claim must have been filed within the original Medicaid timely filing period. The LBOD cannot be greater than 60 days from the last date of adverse action (denial or return).

Electronic claims:
CO-1500 - Enter the LBOD on the line item data page.
UB92 – Enter the LBOD on the Claim Data page in the LB Override Date field and enter the Occurrence Code 53.

Paper claims:
CO-1500 – Enter the LBOD in the Remarks box.
UB92 – Enter the LBOD in the Remarks box and use Occurrence Code 53.

Q - What should I do if the PHP (Pre-paid Health Plan) denies the claim for "Not a benefit"?

A – *Submit the claim to the Medicaid fiscal agent with a copy of the PHP denial.*

Q – Why am I receiving an electronic billing rejection telling me to bill on paper?

Common reasons include the following:

A - *Sterilization claims – Claim must be billed on paper with the completed Med-178 form.*

Hysterectomy claims – Claim must be billed on paper with the completed Acknowledgment/Certification Statement for a hysterectomy form.

Supply claims – You must indicate that you are billing the invoiced price. Submit the claim electronically using the -XD modifier.

Q - How do I check to see if a client is eligible for Medicaid?

A - *There are 4 ways to verify Medicaid client eligibility.*

Medicaid Authorization Card (MAC)

The MAC is mailed to Medicaid clients as proof of eligibility.
The MAC is a guarantee of the client's eligibility during the date span on the card.
The MAC is printed prior to the beginning of the month and mailed to the Medicaid client by the State.
Providers should always ***ask for and retain a current copy*** *of the MAC for their records.*

WINdows-based Automated Submission and Accelerated Payments - WINASAP

WINASAP is free interactive software available from the Medicaid fiscal agent. The software is used to submit claims, PARs, and verify eligibility electronically.
Eligibility can be verified in segments of up to four months at one time.
Response information is returned within moments of submission.
The eligibility verification response can be printed and kept on file.
When client eligibility is verified through WINASAP the client's name, social security #, and birth date are automatically added to the Client List database created by the WINASAP software.
Instructions for using WINASAP to verify eligibility are located in the WINASAP manual distributed with the software. Help is also available from Medicaid Provider Services at: 303-534-0146 or 1-800-237-0757

How do I get the software?

Download the software directly from fiscal agent's web site at coloradomedicaid.acs-inc.com.
The software can also be ordered from the EDI support unit at 1-800-987-6721. Assistance in using the software is available through Medicaid Provider Services at: 303-534-0146 or 1-800-237-0757.

Colorado Medicaid Eligibility Response System - CMERS

CMERS is an automated voice response system that provides Medicaid eligibility information to providers who cannot access eligibility through the interactive software or who do not have a fax machine. Contact CMERS at: Call (303) 534-3500 or 1-800-237-0044. The recorded voice prompts the caller for information and responds to the caller. One date of service can be verified at a time.
Up to 3 eligibility inquiries can be made during one phone call.
Instructions and corresponding prompts can be found beginning on page 4-6 of the Colorado Medicaid Provider Manual.

Fax-Back

Fax-Back is a phone number providers call to have an eligibility report automatically sent to the provider's fax machine. The Fax-Back eligibility phone number is 1-800-493-0920.
The recorded voice prompts the caller for information and responds to the caller.
One date of service can be verified at a time.
If the client is ineligible the voice informs the provider of ineligibility and no fax is sent.
Only one fax number can be affiliated with a provider number.
Instructions and corresponding prompts can be found beginning on page 4-6 of the Medicaid Provider Manual.

How do I get setup for Fax-Back?

Fax-Back information is on the page 2 of the Provider Enrollment Application. The application is available on the fiscal agent's web site at: coloradomedicaid.acs-inc.com or from Medicaid Provider Services at 303-534-0146 or 1-800-237-0757. The completed information can be faxed to Provider Enrollment at 303-534-0439 or mailed to Provider Enrollment at: PO Box 1100, Denver, CO 80201-1100. Providers may also contact Medicaid Provider Services at 303-534-0146 or 1-800-237-0757 for Fax-Back information.

Q – How do I bill Medicaid if I have a contractual write-off with an HMO?

A - *The Total charge is the providers usual and customary charge, third party payment is the total charge minus the other insurance copayment, and the net charge is the copayment amount. If what is listed as the third party payment is less than our allowable then we will pay up to our allowable towards the copayment.*

When a provider bills Medicaid for the HMO copayment, the net charge is their copayment amount.

When an HMO provider is capitated by a carrier and does not receive reimbursement on a case-by-case basis, the provider must use their usual and customary charges as the total charge. Since the provider isn't actually reimbursed by the carrier, the paid amount is the total charge minus the net charge (the usual and customary minus copayment).

Q – How do I bill Medicaid if I have a contractual write-off with another insurance?

A - *Providers must bill their usual and customary charge to Medicaid. The TOTAL CHARGES are the provider's usual and customary charges.*

The NET CHARGE (TOTAL CHARGES less THIRD PARTY PAID) is the ***payment*** *actually received* ***plus*** *the contractual write-off amount.*

If the THIRD PARTY PAID amount is less than the Medicaid allowable amount, Medicaid will pay the difference up to the Medicaid allowable amount toward the other insurance copay amount.

If the THIRD PARTY PAID amount is greater than the Medicaid allowable amount, Medicaid makes no payment.

Practitioners

Q – How do I bill for a baby's charges when the baby doesn't have a Medicaid client ID number?

A - *If the baby and the mother are both still in the hospital, you can bill using the mother's Medicaid client ID number. If the baby is still hospitalized after the mother is discharged or if the baby is transferred to another hospital, the baby's charges must be billed using the baby's Medicaid ID number.*

How to submit claims using the mother's Medicaid client ID number:

Use the mother's Medicaid client ID number

Use all of the mother's information (i.e., sex, age, and name)

Use the -XN modifier. The -XN modifier on the CO-1500 identifies the claim as the baby's.

Note: *The use of the mother's Medicaid client ID number and the –XN modifier* ***only*** *applies to charges billed on the CO-1500 for clients in the Fee for Service or Primary Care Physician Program. This does* ***not*** *apply to clients covered under Medicaid contracted HMOs.*

Q - How do I get the Medicaid drug formulary?

A - *The Colorado Medicaid Formulary is not a printed formulary. The Medicaid Formulary is an "open formulary" that includes most prescription drugs with some exceptions. Providers should refer to Volume 8.830 for Drug Benefits.*

Information about specific drugs is available from the Prescription Drug Card System (PDCS) Pharmacy Support at 1-800-365-4944.

HCBS

Q – What Place of Service codes can be used for Home and Community Based Services (HCBS)?

A - *Providers should use place of service code 12 (home).*

With procedures codes X1040 and X1120 you can use either 12 (home) or 99 (other).

Pharmacy

Q - What number do I enter in the Provider ID # field (field 3) on the paper Pharmacy claim form?

A - *Enter the seven-digit NABP provider number of the pharmacy that will receive payment for these services. See page 10-17 of The Colorado Medicaid Pharmacy Provider Manual.*

Q - What do I enter in the # of Days field (field 5) on the paper Pharmacy claim form?

A - *Enter the number of days for this prescription, the estimated number of days the prescription will last.*

Please check the fiscal agent's website at:

coloradomedicaid.acs-inc-com

for updates to Frequently Asked Questions (FAQs).

Please direct questions about Medicaid billing or the information in this bulletin to Medicaid Provider Services at:

303-534-0146 or

1-800-237-0757 (toll free Colorado).