Automated Medical Payments

Medicaid Bulletin

Colorado Title XIX

Fiscal Agent

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 Retain all bulletins until published notification advises that the information is obsolete or reproduced in subsequent bulletins or provider manual updates.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

Distribution: All Providers **June 2002**

Reference: B0200136

Urgent - Read Immediately!

Updated Colorado Medicaid Information & Rule Changes

This bulletin contains information for all providers and for specific provider groups. Please check the headings for the articles that apply to your provider type.

Contents

ALL PROVIDERS

Auditing contractors

The State has contracted with two new vendors who will help support the proper use of Medicaid funds for the best, cost effective care to qualified low-income Coloradoans. The auditors' post payment auditing will help the State determine billing trends and practices, overpayment of funds, and fraud or abuse of the Medicaid program.

The audits should improve current recovery efforts and help identify the need for:

- Additional educational support to providers and
- Possible Medicaid rule clarifications.

The audits are scheduled to begin after July 1, 2002.

The contracted auditors will notify providers when audits are scheduled, are underway, or when post-payment reviews are completed. Audits may be desk audits, onsite audits or any combination of the two. The objectives are to:

- Audit credit balances for recovery of overpayments and return those funds to the Colorado Medicaid program,
- Support providers regarding Medicaid rules application,
- Identify billing practices that result in overpayment, and

- Identify and report trends in payment, billing and provider services, focusing on fraud or abuse of the Medicaid program.

During the audit, providers will be able to reach the contracted auditors by a toll free telephone number. Providers may discuss the audit process, any issues that appear, and any questions. In addition, the State contract managers will be available to assist providers:

Pam Kurth BSN, RN
HCPF Quality Improvement Section
Program Integrity Unit
303-866-2649
Contract Manager for the HealthWatch Technologies, Inc. *Focusing on post payment review of providers*.

Nancy Pickett BSN, RN
HCPF Quality Improvement Section
Program Integrity Unit
303-866-2816
Contract Manager for the Health Management Systems, Inc. *Focusing on credit balance auditing of hospitals & nursing facilities*.

Margaret Mohan, BSN, RN
HCPF Quality Improvement Section
Program Integrity Unit
Supervisor
303-866-5421

The State of Colorado Department of Health Care Policy and Financing (HCPF) is responsible for purchasing cost effective health care for qualified, low-income Coloradoans. Providers, clients, advocacy groups, vendors, counties, other local government units, taxpayers, the Governor's Office and General Assembly are important to our success.

New program to provide guidelines for compliance reviews

Colorado Medicaid is starting a pilot program to assist providers with Medicaid compliance. The program has three parts:

1. Provider Self-Disclosure,
2. Provider Self-Audit, and
3. Corrective Action Plans.

The program is a guide for providers to:

- Do their own reviews of record-keeping, claims submission procedures, and other compliance issues, and
- Complete a plan to correct identified problems.

The State may consider reductions in penalties or interest owed for providers who successfully participate in the pilot program.

Self-disclosure

Providers may be eligible for *self-disclosure* when they identify compliance errors during their own review. When providers find compliance errors, they should contact the Department of Health Care Policy and Financing (HCPF) - Program Integrity for instructions on *self-disclosure*.

Self-audit

If possible compliance errors are discovered through a State review, the provider may be asked to conduct a *self-audit.* The State will identify areas for review and send instructions on how to proceed with the *self-audit.*

Corrective action plan

The State may ask the provider to follow the self-disclosure or self-audit process with a *corrective action plan*. The *corrective action plan* is the provider's response, with solutions, to the compliance issues identified by the State.

All self-disclosures, self-audits, and corrective action plans are subject to approval by the State. For more information, please contact:

Carol Strini
DHCPF Quality Improvement - Program Integrity Unit at:
303-866-3148 or 1-800-221-3943.

ALL PROVIDERS BILLING ON THE COLORADO 1500 CLAIM FORM

Processing changes for Medicare Part B crossover claims

On July 1, 2002, Medicare Part B crossover claims processing will change. Lower Of Pricing (LOP) will be applied line by line, rather than to the entire claim. This change should more correctly apply LOP for all claims.

Beginning with July 2002 dates of service, each line item on a claim will process individually to determine if the line item pays:

- Medicare LOP or
- Medicare coinsurance plus Medicare deductible.

The line item reimbursement amount is determined by comparing the Medicaid Allowed - Medicare Paid to the sum of the Medicare Coinsurance + Medicare Deductible. Medicaid pays the lower amount.

The Medicare lower of pricing logic formula

1. The claims processing system compares the submitted charge to the Medicaid rate on file. The Medicaid allowed amount is the lesser of the two.
2. The processing system compares:
   - Medicaid allowed - Medicare paid amount to
   - Medicare coinsurance and Medicare deductible

   And pays the lower of the two amounts.

Exceptions to LOP –

1. If the procedure code on a line is exempt from Medicare LOP, Medicaid pays the coinsurance plus deductible. Medicare line items are shown even when the procedure codes are not a Medicaid benefit. If the client is ***not*** a QMB client, non-benefit line procedure codes are denied and reduce the provider's payment. Non-Medicaid benefits on claims for QMB clients will not deny. The State is required to pay coinsurance and deductible according to the State formula for those clients. Providers must submit *Medicaid only* codes to Medicaid separately.
2. Differences in claim line item pricing will continue to occur between carrier or intermediary submitted claims and all other claim submission formats (i.e. paper, interactive and provider submitted electronic batches). Carrier or intermediary-submitted claims contain all Medicare-related information for each line. All other claim submissions contain the Medicare paid amount, and coinsurance and deductible information for the total claim amount, not for each line. Claims with Medicare information for the total claim amount require additional processing to determine the Medicare paid amount for each line.

Effective July 1, 2002

- For dates of service on and after July 1, 2002, reimbursement will be calculated for each line on the claim to determine if Medicaid pays LOP or Medicare coinsurance plus Medicare deductible.
- For dates of service prior to July 1, 2002, LOP processing is based on applying LOP to the total charge instead of to each line.
- Psychotherapy crossover claims with procedure codes 90801 - 90899 will be processed using lower of pricing. Claims currently pay submitted coinsurance and deductible and are exempt from LOP. In order to implement LOP, these codes will have a rate set at 60% of the Medicare fee schedule published in 2001. The new claims processing method applies to all psychotherapy crossover claims billed on the CMS 1500. The following examples show how the line item pricing will work for non-carrier / intermediary submitted claim line items with dates of service on or after July 1, 2002.

Example 1 - Medicare paid with coinsurance

Medicare Amounts	Amount
Total Medicare Paid Amount	$182.87
Total Coinsurance Amount	$ 45.72

Line Item (LI)	Submitted Charge	Medicaid Calculated Allowed Charge	Medicaid Allowed	Medicare Paid	Medicare Coinsurance
1 – E1390	198.01	175.00	175.00	157.65	39.41
2 – A4402	45.72	28.00	28.00	25.22	6.31
Total	--	--	203.00	182.87	45.72

The Medicaid reimbursement will be calculated by comparing the Medicaid - Medicare Paid to the sum of the Medicare Coinsurance + Medicare Deductible, Medicaid pays the provider whichever is less (unless the procedure is exempt from LOP):

LI	Medicaid - Medicare	Max Medicare Allow (coin + deductible)	Medicaid Reimbursement
1 - E1390	17.35	39.41	17.35
2 - E0431	2.78	6.31	2.78
Totals			20.13

Example 2 - Medicare Paid with Coinsurance and Deductible

Medicare Amounts	Amount
Total Medicare Paid Amount	$104.74
Total Coinsurance Amount	$ 26.19
Total Deductible Amount	$58.55

Line Item (LI)	Submitted Charge	Medicaid Calculated Allowed Charge	Medicaid Allowed	Medicare Paid	Medicare Coinsurance	Medicare Deductible
1 – E0260	160.00	112.00	112.00	85.01	39.41	47.52
2 – A4310	26.00	26.00	26.00	19.73	4.94	11.03
Total	--	--	138.00	104.74	26.19	58.55

LI	Medicaid - Medicare	Max Medicare Allow (coin + deductible)	Medicaid Reimbursement
1 – K0280	26.99	86.93	26.99
2 – A4402	6.27	15.97	6.27
Totals			33.26

Example 3 - Medicare Deductible Only

Medicare Amounts	Amount
Total Medicare Paid Amount	$0.00
Total Coinsurance Amount	$ 0.00
Total Deductible Amount	$58.76

Line Item (LI)	Submitted Charge	Medicaid Calculated Allowed Charge	Medicaid Allowed	Medicare Paid	Medicare Coinsurance	Medicare Deductible
1 - K0280	18.24	18.24	18.24	0.00	0.00	25.39
2 – A4402	15.20	3.30	3.30	0.00	0.00	4.59
3 – A4358	25.32	20.68	20.68	0.00	0.00	28.78
Total	--	--	42.22	0.00	0.00	58.76

LI	Medicaid - Medicare	Max Medicare Allow (coin + deductible)	Medicaid Reimbursement
1 – K0280	18.24	25.39	18.24
2 – A4402	3.30	4.59	3.30
3 – A4358	20.68	28.78	20.68
Totals			42.22

HOSPITAL PROVIDERS

Hospital rate changes

Effective September 1, 2002, the reimbursement calculation for some hospitals will change.

Affected hospital rates include:

- Rural, non-critical hospital base rates will decrease by 2%.
- Urban, non-critical and rehabilitation hospital base rates will decrease by 6.98%

HOME HEALTH PROVIDERS

Home Health rate changes

The following rates will be effective *for services provided on or after* ***July 1, 2002,*** for the State Fiscal Year 2002-2003. The new rates reflect a 5% decrease with the exception of the Acute Certified Nurse Aide (CNA) rate. The Acute CNA rate has been set at the average amount paid by commercial insurers. Please note that there is no need to revise any current Prior Authorization Request (PAR) because the State's fiscal agent pays the rates automatically. Please note that Colorado Foundation for Medical Care will assign new rates for the Private Duty Nursing program.

Home Health rule changes

Additional changes have been made to the Home Health regulations and the Home and Community Based Services regulations in Volume 8.

Other changes are:

- Acute Home Health is now defined as home health services provided for a period of 60 consecutive days or less.
- Long Term Home Health is now defined as home health services provided for a period of 61 consecutive days or more.
- Long Term Home Health Prior Authorization Requests (PARs) for all clients 18 years old and over must be submitted to the Single Entry Point Agency (SEP) for the clients' county.
- Until further notice, Long Term Home Health PARs for clients up to 18 years old will be submitted tothe fiscal agent.

- Long Term Home Health clients with a current PAR on file with the fiscal agent will be transitioned to the SEP agency before the PAR ends.
- Rule changes for the Private Duty Nursing program include:
  - Language clarifying the information necessary to show rapid desaturation
  - Intermittent gastric tube feedings will be reviewed more critically
  - Prior Authorizations may be requested for up to one year, depending upon the individuals medical necessity

Please continue to send CMS Form 485-7 every 60 days to the SEP agency.

If you have any questions, please contact Janet Dauman at 303-866-4654.

Services	New Rate	Acute Revenue Code	Long Term Revenue Code	Unit
Nursing	$67.85	550	551	Visit, up to 2 ½ hours
Nursing visits for assess and teach *only*	$67.85	589	Not a benefit for Long Term Home Health clients	Visit, up to 2 ½ hours
Home Health Aide Basic Units	Acute: $22.37 Long Term: $30.08	570	571	The first portion of a visit, up to one hour in length. Visits of less than 15 minutes are not reimbursable.

Services	New Rate	Acute Revenue Code	Long Term Revenue Code	Unit
Home Health Aide Extended Units	$8.99	572	579	For visits lasting more than one hour, extended units may be billed in addition to the first basic unit. An extended unit is up to half an hour. Extended units of less than 15 minutes are not reimbursable.
Physical Therapy	$58.36	420	421	Visit, up to 2 ½ hours
Occupational Therapy	$61.98	430	431	Visit, up to 2 ½ hours
Speech Therapy	$63.60	440	441	Visit, up to 2 ½ hours

Maximum daily amounts

Acute Home Health	Long Term Home Health	Comment
$270	$211	Total allowable amount for all services combined in one 24 hour period, midnight to midnight

Private duty nursing rates

Service	New Rate	Revenue Code	Unit
PDN-RN	$29.20	552	Hour
PDN-LPN	$21.02	559	Hour
PDN-RN (group)	$21.95 (per client)	552	Hour
PDN-LPN (group)	$16.11 (per client)	559	Hour
"Blended" Rate*	$20.97 (per client)	559	Hour

* The "blended" rate is available on request for a Home Health Agency that provides Private Duty Nursing to multiple clients in a group care setting. All Private Duty Nursing provided in those settings is billed at the same rate and revenue code for an RN or LPN. Any Home Health Agency interested in billing the blended rate for a group care setting may request it on the PAR.

MANAGED CARE

Managed care enrollment choice period

House Bill 02-1292 changes the managed care enrollment choice period for Medicaid clients from 65 days to 30 days effective July 1, 2002. The change allows clients to be enrolled more quickly into Medicaid managed care plans (a Medicaid HMO or the Primary Care Physician Program). Providers should always verify a client's managed care status through WINASAP or by checking the Medicaid Authorization Card (MAC) prior to accepting a client and providing services.

PHYSICAL AND OCCUPATIONAL THERAPISTS

Physical and occupational therapists to bill Medicaid directly

Effective July 1, 2002, physical and occupational therapists in private practice will be able to bill services directly to Medicaid. Therapists employed by a hospital based clinic, home health agency, physician clinic, or other facility will not be allowed "direct bill." The facility employing the therapist remains responsible for billing the Medicaid program.

When claims processing system changes are completed, physical and occupational therapy services will require prior authorization. Therapists will be notified prior to the start of required prior authorizations that are tentatively scheduled to begin August 1, 2002. Current Medicaid enrolled OT and PT providers will be changed from non-billing (rendering) to billing providers.

PHARMACY PROVIDERS

Pricing changes for the pharmacy program

Effective July 1, 2002 the reimbursement calculation for payments to Colorado Medicaid Pharmacy providers is changing.

Colorado Medicaid is raising the discount to 14% for the Average Wholesale Price (AWP). The reimbursement for all Colorado Medicaid pharmacy providers will be AWP minus 14%. Drugs marked with a generic product indicator will be paid at AWP minus 45%.

Any pharmacy that is the only pharmacy within a twenty-five mile radius may submit an invoice to the State for the difference in price between AWP minus 14% and AWP minus 12% for name-brand drugs and AWP minus 45% and AWP minus 12% for generic drugs. The invoice must be submitted to the State within 30 days of sale. The pharmacy will be reimbursed for the difference between pricing methodologies.

The Department of Health Care Policy and Financing
Acute Care Rates
1575 Sherman St,
5th Floor
Denver, CO 80203-1714

All other reimbursement formulas remain the same.

Colorado Medicaid uses pricing methodology that allows the lowest price.

Please direct questions about these changes to PDCS Pharmacy Support at: 1-800-365-4944

RADIOLOGY AND LABORATORY PROVIDERS

Radiology and clinical & anatomical laboratory rates

Effective July 1, 2002, the reimbursement calculation for radiological and clinical and anatomical laboratory services will change. Payment for these services will be decreased by 5%.

SUPPLY AND PHARMACY PROVIDERS

Durable Medical Equipment (DME) and disposable supply rates

Effective July 1, 2002, reimbursement for durable medical equipment and disposable supplies will be decreased by 5%. Wheelchairs, wheelchair-related equipment and items not on a fixed fee schedule (by invoice).are excluded from the 5% rate reduction.

TRANSPORTATION PROVIDERS

County and emergency transportation services

Effective July 1, 2002, reimbursement for Non-Emergent Medical Transportation (NEMT) and emergency transportation services will be decreased by 5%. Transportation services reimbursed at the usual and customary rate are excluded from the 5% rate reduction.

County Departments of Human / Social Services must prior authorize all non-emergent medical transportation. If the request is for out-of-state travel for medically necessary services and / or for ancillary services for the client or an escort, the county must obtain prior authorization from the Colorado Foundation for Medical Care (CFMC).

For over-the-cap prior authorization, procedure code X6015, the county must contact the Transportation Administrator by phone at 303-866-5571, or by mail at:

The Department of Health Care Policy and Financing
Acute Care Benefits
1575 Sherman St, 5th Floor
Denver, CO 80203-1714

The electronic submission of transportation Prior Authorization Requests (PARs) will not be accepted as of July 1, 2002. All electronic PAR submissions on and after July 1, 2002 will not be reviewed or processed. This does not include electronic claim submissions.

Transportation providers will be disenrolled at the time of County Departments of Human / Social Services transportation broker implementation. As the State is notified of broker contracts, transportation providers in the affected areas will become invalid providers within the Medicaid claims processing system. Transportation providers will be required to submit claims and receive reimbursement from the county broker. In the counties not contracting with a transportation broker, (i.e. choosing to administer the program themselves) the transportation providers will become invalid within the following month.

As stated in the May 2001 bulletin (B0100098), the following codes require an approved PAR from the county or transportation broker: A0130, A0426, A0428, A0425, X6005, A0422, and X6007. Procedure Code A0160 (vehicle mileage, county DSS employee) and A0170 (parking and tolls) are no longer valid codes.

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).