Automated Medical Payments

Medicaid Bulletin

Colorado Title XIX

Fiscal Agent

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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 Retain all bulletins until published notification advises that the information is obsolete or reproduced in subsequent bulletins or provider manual updates.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 **July 2002**

Reference: B0200138

Billing Clarifications

Contents

ALL PROVIDERS

Bulletins

The Colorado Medicaid Program is publishing monthly bulletins to inform affected providers of any changes and updates concerning the Medicaid Program. In addition to the monthly bulletin, high priority information will be printed on providers' Remittance Statements (RS) and posted on the fiscal agent's web site:

coloradomedicaid.acs-inc.com

Providers are reminded to always check their RS and the web site for Medicaid updates.

DENTISTS

Dental Policy Clarification

This clarifies the Colorado Medicaid program's policy for dental procedures for Medicaid-enrolled clients.

Hospitalization policy

Dental procedures requiring hospitalization and general anesthesia may be a covered benefit, if in the treating dentist's opinion, the client meets one or more of the following criteria:

1. The client has a physical, mental or medically compromising condition; or
2. The client has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or
3. The client is extremely uncooperative, unmanageable, anxious, or uncommunicative and has dental needs deemed sufficiently important that dental care cannot be deferred; or
4. The client has sustained extensive orofacial and dental trauma.

What to do

If a dentist determines that a client needs hospitalization with or without associated general anesthesia, and meets one or more of the listed criteria, the dentist should:

1. Contact the individual's HMO medical management department for prior authorization to use the hospital. The HMO may require documentation of medical necessity; or
2. If the client is not enrolled in an HMO, the dentist should make prior arrangements with the Medicaid participating hospital.

Enrollment in an HMO

Enrollment in a Medicaid HMO does not affect a client's eligibility for dental services. A client is eligible for dental services regardless of the primary care provider or the HMO. Clients enrolled in HMOs receive medical care through that HMO.

Medicaid HMOs include:

- Colorado Access
- Community Health Plan of the Rockies
- Kaiser Permanente
- United HealthCare of Colorado
- Rocky Mountain HMO

HCBS PROVIDERS

Denials for Edit 0500 *(The procedure requires prior authorization)* **when a PAR is on file**

This edit usually occurs on waiver claims when the Special Program Code on the claim does not match the Special Program Code on the approved PAR. **Example:** The approved PAR is for Special Program Code 83 (Persons Living With AIDS). The provider bills the claim with Special Program Code 82 (Elderly, Blind and Disabled - EBD). The claim denies because the claim does not match the PAR on file.

HOME HEALTH AGENCIES, PRIVATE DUTY NURSING (PDN)

New Private Duty Nursing (PDN) Regulations

On July 1, 2002, the Medical Services Board approved revised Private Duty Nursing (PDN) Regulations. The revised regulations require a physician review of all clients having only intermittent or continuous Gastric Tube feeding (including G-Tube, Mickey Button, J-Tube, NG Tube).

Some Medicaid clients require more individualized and more continuous nursing care than Medicaid Home Health (HH) or a hospital or nursing facility routinely provide. The PDN rule defines the medical criteria necessary for approval and continued stay in the program. The rule revision clarifies existing procedures and includes PDN Medical Criteria Development Committee recommendations. The revised regulation ensures that program criteria are consistent with current standards of practice. HH technology and commonplace procedures have grown. This growth required defining new criteria for PDN services in order to maintain the program and provide care for the most needy.

These changes mean that the PDN program may not be the best Medicaid health care program for the client's medical needs. It does *not* mean a loss of Medicaid or that the client's needs cannot be met. PDN service agencies should help clients switch to an appropriate Medicaid Home Health, EPSDT Extraordinary Home Health, or other community based services when medically necessary.

Those clients who have been reviewed for intermittent G Tube feedings, lesser technology and no technology in the past, will be reviewed again. Clients in these categories will be reviewed by September 30, 2002. The Utilization Review Contractor physician will determine medical necessity for nursing services through the PDN Program. The Colorado Foundation for Medical Care (CFMC) will contact agencies to request information on specific clients. Letters with the decision and alternatives for care will be sent to the clients, agencies and attending physicians.

In order to better understand utilization of PDN services, codes have been developed for the following types of service.

PDN-RN Group Code	580	$21.95 per client
PDN-LPN Group Code	581	$16.11 per client
Blended Code	582	$20.97 per client
(By request only)		

When billing these codes, the amounts shown will be paid for each one-hour unit, for each client in the group. PDN services continue to be prior authorized through the Colorado Foundation for Medical Care (CFMC).

Please refer to the Private Duty Nursing Regulations in Volume 8, sections 8.543.10 through 8.543.15.

Please direct questions about Home Health PDN to Janet L. Dauman, BSN, at:

303-866-4654, or at janet.dauman@state.co.us.

HOSPITAL PROVIDERS

New Patient Status Codes

On January 1, 2002, the Colorado Medicaid Program added the following Patient Status codes (Form Locator 22 on the UB-92 claim form) for inpatient claims *(Patient Status code 64 is effective 10/01/02)*:

Patient Status Code	Description
50	Hospice – Home
51	Hospice – Medical Facility

Patient Status Code	Description
61	Discharged to swing bed
62	Discharged to rehab
63	Discharged to long term care
64	Discharged/Transferred to a nursing facility certified under Medicaid but not certified under Medicare
71	Discharged to another institution for outpatient services
72	Discharged to this institution for outpatient services

Please add these Patient Status codes to the billing instructions in your provider manual.

Sterilizations for Non-Citizens

In September 2000, Colorado Medicaid notified providers that sterilizations for non-citizens are not a Medicaid benefit. Because providers should not have billed the sterilizations to Medicaid, the State is recovering payments for these services.

OSTEOPATHS, PHARMACIES & PHYSICIANS

Generic Clozapine

The Best Practices workgroup for updating the "Colorado Atypical Antipsychotic Medications Report and Guidelines for 2001" was requested to review the use of generic clozapine for Colorado Medicaid clients. The following statements are included in the 2001 report.

- New prescriptions for clozapine should be filled with the generic product unless there is a substantial clinical contraindication.
- Clients who are being re-started on clozapine after having discontinued it are considered re-starts and should be started on generic product. Brand name clozapine should be used on re-starts only if there is evidence of a prior problem (inadequate response, non-tolerance) with the generic product
- Clients who are hospitalized should be switched to generic clozapine while in the hospital and should be continued on the generic product post-discharge.
- Clients who are stable in the community on brand name clozapine should be switched to generic unless there is a substantial clinical contraindication. The provider should evaluate each such client individually to determine possible risks and appropriate timing of switching products.

Effective on September 1, 2002, a State Maximum Allowed Cost (SMAC) will be added to the pricing file for Colorado Medicaid.

MG	SMAC per capsule
100 mg	$1.83
25 mg	$0.70

All clients who are currently receiving the brand name, Clozaril, will be granted a six-month prior authorization to continue on the Clozaril. Prescribers should use the above guidelines to switch these clients to the generic where indicated.

Prescribers may request prior authorizations for the brand name Clozaril, for those new patients where there is a substantial clinical contraindication to the generic product.

The phone number for prior authorization requests is 1-800-365-4944.

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).