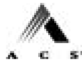
Automated Medical Payments

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 Retain all bulletins until published notification advises that the information is obsolete or reproduced in subsequent bulletins or provider manual updates.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 **September 2002**
Reference: B0200139

Updates and Changes

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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.

Electronic claim submission

Effective September 1, 2002, providers currently submitting five or more claims per month must submit claims electronically. Paper claims that should have been submitted electronically are denied with the message "Electronic Filing Required."

Exceptions to electronic filing include:

- Claims from providers who consistently submit fewer than 5 claims per month.
- Claims with service dates more than 365 days old.
- Claims that, by federal or state policy or regulation, require attachments.
- Reconsideration claims.

Please make the above change in your provider manual.

Electronic Funds Transfer (EFT)

Beginning September 30, 2002, all providers *must* receive reimbursement through Electronic Funds Transfer (EFT), also referred to as Automated Clearing House Credits (ACH). The form with instructions is included with this bulletin, and is available on the fiscal agent's web site at:

coloradomedicaid.acs-inc.com

or by calling Provider Services at: 303-534-0146 or 1-800-237-0757.

EFT deposits are made to the provider's bank account approximately one week from the date on the Remittance Statement (RS).

Example:

RS Date	**Deposit Date**
08/02/02 or 08/03/02	*08/09/02*

For some State and Federal holidays payment processing dates are changed to avoid payment delays. When the holiday falls on a Monday, claim payments are processed on Thursday instead of Friday. The processing cycle includes electronic claims accepted before 6:30 P.M. on Thursday.

The following schedule shows the remaining holiday processing cycles for 2002.

Holiday Processing Date	Holiday	Expected EFT date
Thursday 08/29/2002	Labor Day - Monday 09/02/2002	Friday 9/06/2002
Thursday 10/10/2002	Columbus Day – Monday 10/14/2002	Friday 10/18/2002
Thursday 11/07/2002	Veterans' Day – Monday 11/11/2002	Friday 11/15/2002

When the holiday falls during the week, warrants and EFT may be delayed. The following remaining 2002 holidays will affect the receipt of warrants and EFT.

Holiday		Expected EFT date
Thursday 11/28/2002	Thanksgiving Day	Monday 12/02/2002
Wednesday 12/25/2002	Christmas Day	Monday 12/30/2002
Wednesday 01/01/2003	New Year's Day	Monday 01/06/2003

Please note: For the Thanksgiving holiday, claim payments will be processed on Friday as usual.

Electronic Remittance Statements

Providers with electronic capability are required to retrieve their Remittance Statements electronically, if they have notified the Medicaid program of Internet access. Providers with electronic capabilities will no longer receive paper remittance statements from the fiscal agent. If you have questions regarding your office's ability to receive remittance statements electronically, please call EDI support at: 1-800-987-6721.

Old Age Pension-State Only (OAP-SO)

Effective September 1, 2002, approximately 3,400 clients statewide who are eligible for medical benefits under the "Old Age Pension-State Only" (OAP-SO) category are now excluded from Medicaid managed care programs (the Primary Care Physician Program - PCPP - and Medicaid HMO plans). This is the result of a policy decision by the Colorado Department of Human Services (CDHS) that manages the Old Age Pension Health Care Program (the authority and funding for the benefits of this category of eligibility). The decision was necessary to avoid overspending the funding for these medical benefits, which is limited by the Colorado Constitution annually to $10 million, plus $1 million supplement, received effective July 1, 2002. The OAP Health Care Program (OAP-SO) clients already enrolled with managed care plans were disenrolled effective August 31, 2002, and the clients were notified by letter of August 31, 2002 of the enrollment termination. These clients are still eligible for the program benefits under fee-for-service reimbursement.

If these clients have any questions regarding this they can contact the CDHS Division of Aging and Adult Services at 303-866-2668.

Returned publications and warrants

Many Medicaid publications and payments are returned to the fiscal agent because the address on the provider file is incorrect. Providers are responsible for updating and verifying their addresses on the Medicaid provider file.

To update or verify your address, notify Provider Enrollment at:

PO Box 1100
Denver, CO 80201-1100
or
Fax: 303-534-0439

Please keep address information current. Providers are reminded that Medicaid enrollment may be inactivated for returned mail when the provider fails to notify Provider Enrollment of updated address information.

Third Party Resource (TPR) contractual write-offs

Providers may bill Medicaid only the amount they have contracted with the other insurance to accept for the service. The difference between the provider's usual and customary charge and the contracted amount is not billable to the client or to Medicaid.

Enter the contracted amount in the "Total Charges" field. Enter only the actual payment made by the other insurance in the "Third Party Paid" field. Do *not* enter any amount that was applied to the deductible. If the total charge was applied to the deductible, bill the claim to Medicaid as "Other Coverage Denied".

Example:

Usual & Customary charge	=	$197.00	*Provider's charge*
Contracted amount for service	=	$123.00	*Rate agreed to with other insurance company*
U&C minus Contracted amount	=	$ 74.00	*Contractual write-off*
Other insurance paid	=	$ 75.00	*TPR payment*
Deductible amount	=	$ 48.00	*Applied to deductible Do not enter this amount on the claim.*
Total Charges	=	$123.00	*Bill to Medicaid*
TPR payment	=	$ 75.00	*Enter in appropriate field*
Net Charge	=	$ 48.00	*Enter in appropriate field*

Medicaid does not automatically pay other health insurance copayments, coinsurance, or deductibles. If the TPR benefit is the same or more than the Medicaid benefit allowance, Medicaid does not make additional payment.

HOME HEALTH AND PRIVATE DUTY NURSING PROVIDERS

New Home Health rates

Effective September 1, 2002, there are new rates for Home Health. The Medicaid fiscal agent was notified of the rate increases and will adjust any claims with dates of service on or after September 1, 2002 paid at the old rates. The emergency rules, adopted on August 9, 2002, included changes to Home Health benefits for adults (18 years and over) in Long Term Home Health. Physical, occupational, and speech language therapies are no longer a Medicaid Home Health benefit for Long Term Home Health *adults*. Private Duty Nursing rates remain at the July 1, 2002 reimbursement rates.

Reminder: *All Long Term Home Health (defined as 61 days and longer) services require a Prior Authorization Request. The Single Entry Point Agency in the client's county of residence authorizes services for Adults (18 years and over). The fiscal agent authorizes services for Children (0-17 years).*

New Home Health Rates – Effective September 1, 2002

Service	Acute HH Revenue Code	Long Term HH Revenue Code	Unit Rate	Duration
RN assess and teach	589	None	$71.42	Acute only - up to 2 ½ hours
RN/LPN	550	551	$71.42	Up to 2 ½ hours
HHA Basic	570	571	$31.66	One hour
HHA Extended	572	579	$9.46	15-30 minutes each after 1st hour
PT	420	421 (for 0-17 years LTHH)	$61.43	Up to 2 ½ hours
OT	430	431 (for 0-17 years LTHH)	$65.24	Up to 2 ½ hours
S/LT	440	441 (for 0-17 years LTHH)	$66.95	Up to 2 ½ hours
Maximum Daily Amount	$291 for Acute	$227 for Long Term		24 hours, MN to MN

Hospital providers

Inpatient/Outpatient specialty manual

The Inpatient/Outpatient specialty manual was revised in June 2002. The new manual is available on the fiscal agent's web site: coloradomedicaid.acs-inc.com. Please download the revised manual for the most current billing information. Paper manuals are available from the fiscal agent for $5.00 each. Please call Provider Services at: 303-534-0146 or 1-800-237-0757 (toll free Colorado) for ordering information.

Independent Occupational Therapists and Physical Therapists and Physical Therapy Clinics/Rehabilitation Agencies

Effective December 2001, Colorado Medicaid no longer required a physician-on-site at Physical Therapy Clinics. Beginning July 1, 2002, physical therapists and occupational therapists not employed by an agency, clinic, hospital, or physician may bill Medicaid directly. Medicaid provider enrollment packets are available from the fiscal agent. Please call Provider Services at: 303-534-0146 or 1-800-237-0757 (toll free Colorado) for additional information.

Prior Authorization Requests (PARs)

Effective October 1, 2002, Independent Occupational Therapists & Physical Therapists and Physical Therapy Clinics/Rehabilitation Agencies (***not*** hospital based clinics) must submit PARs for medically necessary services **exceeding 16 units of service**. Units of service exceeding the initial 16 will not be reimbursed without an approved PAR. One unit equals a 15-minute increment as described in the specific CPT procedure codes (See Attachment A).

The Medicaid PAR forms are available from the fiscal agent Provider Services at 303 534-0146 or 1-800-237-0757 (toll free Colorado).

Submit PARs to:

Prior Authorization Requests
Colorado Foundation to Medical Care (CFMC)
P.O. Box 17300
Denver, CO 80217
303 695-3300

PARs are approved for a 12-month period (depending on medical necessity as determined by the reviewer). Submit PARs for the **number of units** for each specific procedure code requested, ***not*** for the number of services (See Attachment B for Required Fields).

The State may perform retrospective reviews of OT and PT services for utilization control and quality control purposes.

Occupational Therapy and Physical Therapy modifiers (Effective October 1, 2002)

When billing CPTs for physical therapy, providers must use modifier GP (i.e., 97001GP – See Attachment C).
When billing CPTs for occupational therapy, providers must use modifier GO (i.e., 97003GO – See Attachment D).

Pharmacy Providers

Pharmacy program pricing changes

Effective October 1, 2002, the reimbursement calculation for payments to Colorado Medicaid Pharmacy providers will change. Colorado Medicaid is lowering the discount to 13.5% for the Average Wholesale Price (AWP). The reimbursement for all Colorado Medicaid pharmacy providers will be AWP minus 13.5%. Drugs marked with a generic product indicator will be paid at AWP minus 35%.

Any pharmacy that is the only pharmacy within a twenty-mile radius may submit an invoice to the State for the difference in price between:

Name-brand drugs:	AWP minus 13.5% *and* AWP minus 12%
Generic drugs:	AWP minus 35% *and* AWP minus 12%

The invoice must be submitted to the State within 30 days of sale. The pharmacy will be reimbursed for the difference between the two pricing methodologies.

Practitioners

EPSDT specialty manual

The EPSDT specialty manual was revised in June 2002. The new manual is available on the fiscal agent's web site: coloradomedicaid.acs-inc.com. Please download the revised manual for the most current billing information. Paper manuals are available from the fiscal agent for $5.00 each. Please call Provider Services at: 303-534-0146 or 1-800-237-0757 (toll free Colorado) for ordering information.

Attachment A

Physical Therapy/Occupational Therapy CPT* Codes

Code	Description	Code	Description
97001	Physical Therapy evaluation	97112	Neuromuscular reeducation of movement
97002	Physical Therapy re-evaluation	97113	Aquatic therapy
97010	PT – Application of a modality to one or more areas: hot or cold packs	97116	Gait training
97012	PT – Traction	97124	Massage, including effleurage
97014	PT – Electrical stimulation	97139	Unlisted therapeutic procedure
97016	Vasopneumatic devices	97140	Manual therapy techniques
97018	Paraffin bath	97150	Therapeutic procedure (group)
97020	Microwave	97504	Orthotics fitting and training
97022	Whirlpool	97520	Prosthetic training
97024	Diathermy	97530	Therapeutic activities
97026	Infrared	97542	Wheelchair management
97028	Ultraviolet	97545	Work hardening/ conditioning, initial 2 hours
97032	Application of electrical stimulation	97546	Each additional hour
97033	Iontophoresis, each 15 minutes	97601	Removal of devitalized tissue from wound
97034	Contrast baths, each 15 minutes	97602	Non-selective debridement, without anesthesia
97035	Ultrasound, each 15 minutes	97703	Checkout for orthotic/prosthetic use
97036	Hubbard tank, each 15 minutes	97750	Physical performance test or measurement
97039	Unlisted modality (specify type and time of constant attendance)	97799	Unlisted physical medicine/rehabilitation service or procedure
97110	Therapeutic procedure		
Occupational Therapy Codes			
97003	Occupational Therapy evaluation	97533	Sensory integrative techniques to enhance sensory processing
97004	Occupational Therapy re-evaluation	97535	Activities of daily living
97532	Development of cognitive skills to improve attention	97537	Community work/ reintegration training

*CPT codes, descriptions & 2 digit modifiers are copyright American Medical Association. All rights reserved.

Agency ID UHA

State of Colorado

AUTHORIZATION AGREEMENT FOR AUTOMATIC DEPOSITS (ACH CREDITS)

Check one:

New ☐ **Change** ☐

I (we) hereby authorize the Department of Health Care Policy & Financing, State of Colorado, hereinafter called the STATE, to initiate credit entries and, if necessary, reverse any incorrect EFT credit entries made in error to our bank account indicated below.

APPLICATION (Payment type) **MEDICAID TYPE (34)** **MEDICAID PROVIDER #** ____________

LEGAL NAME ____________

DBA NAME ____________

Complete one of the following (EIN or SSN) but not both

FEDERAL EIN NUMBER
(Corporation, partnership, trust, sole proprietor, etc.) ___ ___ - ___ ___ ___ ___ ___ ___ ___

or

SOCIAL SECURITY NUMBER (Individual or sole proprietor) ___ ___ ___ - ___ ___ - ___ ___ ___ ___

ADDRESS ____________

CITY, STATE, ZIP ____________

DEPOSITORY NAME ____________

ADDRESS ____________

CITY, STATE, ZIP ____________

DEPOSITORY TRANSIT NUMBER ____________

ACCOUNT NUMBER ____________

TYPE OF ACCOUNT (CHECK ONE) ☐ CHECKING ☐ SAVINGS

ATTACH VOIDED CHECK ATTACH DEPOSIT SLIP

This agreement is to remain in full force and effect until the STATE has received written notification from the PAYEE of its termination in such time and manner to afford the STATE and FINANCIAL INSTITUTION a reasonable opportunity to act on it.
It is the responsibility of the PAYEE to fill out a new agreement if the PAYEE changes banks or accounts.

Date ____________ Phone number ____________

Authorized Signature ____________

Title ____________

Authorized Signature ____________

Title ____________

For Fiscal Agent Use Only *Initials:* ________ *Date:* ____________

Completion Instructions

Agency ID UHA

State of Colorado

AUTHORIZATION AGREEMENT
FOR AUTOMATIC DEPOSITS (ACH CREDITS)

Check one:
New ☐ **Change** ☐

I (we) hereby authorize the Department of Health Care Policy & Financing, State of Colorado, hereinafter called the STATE, to initiate credit entries and, if necessary, reverse any incorrect EFT credit entries made in error to our bank account indicated below.

APPLICATION (Payment type) **MEDICAID TYPE (34)** **MEDICAID PROVIDER #** **Enter your 8 digit provider number**

LEGAL NAME **Enter only the legal name assigned to the Federal EIN or SSN below**

DBA NAME **Optional - you may enter the DBA or trade name for corporation, sole proprietor, etc.**

Complete one of the following (EIN or SSN) but not both

FEDERAL EIN NUMBER
(Corporation, partnership, trust, sole proprietor, etc.)

Complete for corporations, partnerships, etc. Enter the EIN assigned to the legal name entered above.

or

SOCIAL SECURITY NUMBER (Individual or Sole Proprietor)

Complete for individuals or sole proprietors. Enter the SSN assigned to the legal name entered above

ADDRESS **Enter the mailing address for the legal name entered above**

CITY, STATE, ZIP **Enter the City, State and ZIP for the legal name entered above**

DEPOSITORY NAME **Enter the name of the bank or financial institution where the funds will be transfered**

ADDRESS **Enter the address of the bank or financial institution**

CITY, STATE, ZIP **Enter the City, State and ZIP for the financial institution**

DEPOSITORY TRANSIT NUMBER **Enter the 9 digit number from your deposit slip or voided check (see illustrations below) or contact your financial institution for information**

ACCOUNT NUMBER **Enter the account number where the funds will be deposited**

Enter a check mark to identify the type of account where funds will be deposited

TYPE OF ACCOUNT (CHECK ONE) ☐ CHECKING ☐ SAVINGS

MUST ATTACH VOIDED CHECK *MUST ATTACH DEPOSIT SLIP*

This agreement is to remain in full force and effect until the STATE has received written notification from the PAYEE of its termination in such time and manner to afford the STATE and FINANCIAL INSTITUTION a reasonable opportunity to act on it.
It is the responsibility of the PAYEE to fill out a new agreement if the PAYEE changes banks or accounts.

Date **Enter the date the form is signed** Phone number **Enter your telephone number**

Authorized Signature **This must be the signature of the individual or sole proprietor if an SSN is used or the authorized representative of a corporation, partnership, etc.**

Title **Enter the title of the authorized representative for a corporation, partnership, etc.**

Authorized Signature **Optional - Add a second signature only if required by your organization**

Title **Enter the title of the second authorized representative for a corporation, partnership, etc.**

Transit and Account Number Illustrations

ACCOUNT OWNER NAME
1234 Main Street
Anytown, CO 00000
1234
15-0000/0000
19
Pay to the Order OF $
DOLLARS
ANYTOWN BANK
Anytown, CO 00000
For
⑆: 123456789 123412 1234

Check number

Account number

Transit number

DEPOSIT TICKET
ACCOUNT OWNER NAME
1234 Main Street
Anytown, CO 00000
08-73
15-0000/0000
DATE 19
CASH
CHECKS
TOTAL FROM OTHER SIDE
TOTAL
PLEASE ITEMIZE ADDITIONAL CHECKS ON REVERSE SIDE
ANYTOWN BANK
Anytown, CO 00000
123456789 90 001 00 15

Please note: **The completed EFT form must be submitted *with* a completed W-9.**

Please allow 30 days to process your paperwork and establish your EFT.

Attachment B

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND FINANCING

INVOICE/PAT. ACCOUNT NUMBER

MEDICAID PRIOR AUTHORIZATION REQUEST (PAR)

To avoid delay, please answer all questions completely.

EXAMPLE OF REQUIRED FIELDS

1. CLIENT NAME (Last, First, Middle Initial)	2. CLIENT IDENTIFICATION NUMBER	3. SEX	4. DATE OF BIRTH (MMDDYY)
Required	*Required*	*Required* ☐ M ☐ F	*Required*

5. CLIENT ADDRESS (Street, City, State, ZIP Code)	6. CLIENT TELEPHONE NUMBER
Required	*(Required)*

7. PRIOR AUTHORIZATION NUMBER * SYSTEM ASSIGNED	8. DATES COVERED BY THIS REQUEST FROM (MMDDYY)	THROUGH (MMDDYY)	9. DOES CLIENT RESIDE IN A NURSING FACILITY?	10. GROUP HOME NAME - IF PATIENT RESIDES IN A GROUP HOME
Leave blank - For Reviewer			☐ YES ☐ NO	

11. ICD-9-CM DIAGNOSIS CODE **and** DESCRIPTION (Must include Diagnosis Code and Description, Prognosis, Clinical Information and Other Medications presently prescribed)

Required Information

12. REQUESTING AUTHORIZATION FOR REPAIRS EQUIPMENT MUST BE OWNED BY THE CLIENT - THE SERIAL NUMBER MUST BE ENTERED

Leave blank

13. INDICATE LENGTH OF NECESSITY (IN MONTHS AND YEARS) I.E., HOW LONG WILL THIS EQUIPMENT BE NEEDED?

Leave blank

14. ESTIMATED COST OF EQUIPMENT

Leave blank

SERVICES TO BE AUTHORIZED

15. LINE NO.	16. DESCRIBE THE PROCEDURE OR SUPPLY TO BE PROVIDED — INCLUDE MODEL NUMBER FOR DME PURCHASE OR SERIAL NUMBER FOR REPAIR	17. PROCEDURE OR SUPPLY CODE	18. *UNITS* REQUESTED NUMBER OF ~~SERVICES~~	19. AUTHORIZED NO. OF SERVICES (LEAVE BLANK **)	20. APPROVED/DENIED (LEAVE BLANK **)
01	*Required*	*Required*	*Required*		
02					
03					
04					
05					

21. PRIMARY CARE PHYSICIAN (PCP) NAME		22. PRIMARY CARE PHYSICIAN ADDRESS (Street, City, State, ZIP code)
Required		*Required*
TELEPHONE NUMBER: *(Required)*	23. PCP PROVIDER NUMBER: *Required*	

24. NAME AND ADDRESS OF PHYSICIAN REQUESTING PRIOR AUTHORIZATION		25. NAME AND ADDRESS OF PROVIDER WHO WILL RENDER SERVICE	
Required		*Required*	
26. REQUESTING PHYSICIAN SIGNATURE: *Required*	27. DATE SIGNED: *Required*		
TELEPHONE NUMBER: *(Required)*	28. REQUESTING PHYSICIAN PROVIDER NUMBER: *Required*	TELEPHONE NUMBER: *(Required)*	29. ~~SERVICE~~ PROVIDER NUMBER *(BILLING #)*: *Required*

If services are provided according to the manner prescribed by State of Colorado Laws and Regulations, reimbursement will be provided for authorized services following submission of an appropriately completed Medicaid claim.

30. COMMENTS **

☐ ATTACH COPY OF THIS PAR TO CLAIM(S) **

SIGNATURE OF STATE AGENCY REPRESENTATIVE **	DATE **	31. PA NUMBER BEING REVISED **

*** THE ASSIGNED PAR NUMBER APPEARS ON THE PAR LETTER. ENTER THE PAR NUMBER FROM THE LETTER ON THE CLAIM WHEN BILLING FOR THE**

**** THESE FIELDS ARE COMPLETED BY THE AUTHORIZING AGENT**

FORM NO. 10013 **(REV. 12/98)**
COL — 106

White - AUTHORIZING AGENT Yellow - ORIGINATOR

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND FINANCING

Attachment C

MEDICAID PRIOR AUTHORIZATION REQUEST (PAR)

INVOICE/PAT. ACCOUNT NUMBER

To avoid delay, please answer all questions completely.

1. CLIENT NAME (Last, First, Middle Initial)
2. CLIENT IDENTIFICATION NUMBER
3. SEX ☐ M ☐ F
4. DATE OF BIRTH (MMDDYY)
5. CLIENT ADDRESS (Street, City, State, ZIP Code)
6. CLIENT TELEPHONE NUMBER ( )
7. PRIOR AUTHORIZATION NUMBER * SYSTEM ASSIGNED
8. DATES COVERED BY THIS REQUEST FROM (MMDDYY) THROUGH (MMDDYY)
9. DOES CLIENT RESIDE IN A NURSING FACILITY? ☐ YES ☐ NO
10. GROUP HOME NAME - IF PATIENT RESIDES IN A GROUP HOME
11. ICD-9-CM DIAGNOSIS CODE **and** DESCRIPTION (Must include Diagnosis Code and Description, Prognosis, Clinical Information and Other Medications presently prescribed)

Bill Physical Therapy codes with modifier -GP

12. REQUESTING AUTHORIZATION FOR REPAIRS EQUIPMENT MUST BE OWNED BY THE CLIENT - THE SERIAL NUMBER MUST BE ENTERED
13. INDICATE LENGTH OF NECESSITY (IN MONTHS AND YEARS) I.E., HOW LONG WILL THIS EQUIPMENT BE NEEDED?
14. ESTIMATED COST OF EQUIPMENT

SERVICES TO BE AUTHORIZED

15. LINE NO.	16. DESCRIBE THE PROCEDURE OR SUPPLY TO BE PROVIDED — INCLUDE MODEL NUMBER FOR DME PURCHASE OR SERIAL NUMBER FOR REPAIR	17. PROCEDURE OR SUPPLY CODE	18. ***UNITS*** REQUESTED NUMBER OF ~~SERVICES~~	19. AUTHORIZED NO. OF SERVICES (LEAVE BLANK **)	20. APPROVED/DENIED (LEAVE BLANK **)
01	***Manual therapy***	***97140-GP***	***30***		
02	***Therapeutic procedure***	***97110-GP***	***60***		
03	***Gate training***	***97116-GP***	***30***		
04					
05					

21. PRIMARY CARE PHYSICIAN (PCP) NAME
22. PRIMARY CARE PHYSICIAN ADDRESS (Street, City, State, ZIP code)

TELEPHONE NUMBER ( )
23. PCP PROVIDER NUMBER
24. NAME AND ADDRESS OF PHYSICIAN REQUESTING PRIOR AUTHORIZATION
25. NAME AND ADDRESS OF PROVIDER WHO WILL RENDER SERVICE
26. REQUESTING PHYSICIAN SIGNATURE
27. DATE SIGNED

TELEPHONE NUMBER ( )
28. REQUESTING PHYSICIAN PROVIDER NUMBER

TELEPHONE NUMBER ( )
29. SERVICE PROVIDER NUMBER

If services are provided according to the manner prescribed by State of Colorado Laws and Regulations, reimbursement will be provided for authorized services following submission of an appropriately completed Medicaid claim.

30. COMMENTS **

☐ ATTACH COPY OF THIS PAR TO CLAIM(S) **

SIGNATURE OF STATE AGENCY REPRESENTATIVE **
DATE **
31. PA NUMBER BEING REVISED **

* **THE ASSIGNED PAR NUMBER APPEARS ON THE PAR LETTER. ENTER THE PAR NUMBER FROM THE LETTER ON THE CLAIM WHEN BILLING FOR THE**

** **THESE FIELDS ARE COMPLETED BY THE AUTHORIZING AGENT**

White - AUTHORIZING AGENT   Yellow - ORIGINATOR

Attachment D

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND FINANCING

INVOICE/PAT. ACCOUNT NUMBER

MEDICAID PRIOR AUTHORIZATION REQUEST (PAR)

To avoid delay, please answer all questions completely.

1. CLIENT NAME (Last, First, Middle Initial)	2. CLIENT IDENTIFICATION NUMBER	3. SEX ☐ M ☐ F	4. DATE OF BIRTH (MMDDYY)

5. CLIENT ADDRESS (Street, City, State, ZIP Code)	6. CLIENT TELEPHONE NUMBER ( )

7. PRIOR AUTHORIZATION NUMBER * SYSTEM ASSIGNED	8. DATES COVERED BY THIS REQUEST FROM (MMDDYY) THROUGH (MMDDYY)	9. DOES CLIENT RESIDE IN A NURSING FACILITY? ☐ YES ☐ NO	10. GROUP HOME NAME - IF PATIENT RESIDES IN A GROUP HOME

11. ICD-9-CM DIAGNOSIS CODE **and** DESCRIPTION (Must include Diagnosis Code and Description, Prognosis, Clinical Information and Other Medications presently prescribed)

Bill Occupational Therapy codes with modifier -GO

12. REQUESTING AUTHORIZATION FOR REPAIRS EQUIPMENT MUST BE OWNED BY THE CLIENT - THE SERIAL NUMBER MUST BE ENTERED

13. INDICATE LENGTH OF NECESSITY (IN MONTHS AND YEARS) I.E., HOW LONG WILL THIS EQUIPMENT BE NEEDED?

14. ESTIMATED COST OF EQUIPMENT

SERVICES TO BE AUTHORIZED

15. LINE NO.	16. DESCRIBE THE PROCEDURE OR SUPPLY TO BE PROVIDED — INCLUDE MODEL NUMBER FOR DME PURCHASE OR SERIAL NUMBER FOR REPAIR	17. PROCEDURE OR SUPPLY CODE	18. ***UNITS*** ~~REQUESTED NUMBER OF SERVICES~~	19. AUTHORIZED NO. OF SERVICES (LEAVE BLANK **)	20. APPROVED/DENIED (LEAVE BLANK **)
01	***Therapeutic procedure***	***97110-GO***	***48***		
02	***Activities of daily living***	***97535-GO***	***30***		
03	***Cognitive skills***	***97532-GO***	***14***		
04	***Orthotics fitting and training***	***97504-GO***	***8***		
05					

21. PRIMARY CARE PHYSICIAN (PCP) NAME		22. PRIMARY CARE PHYSICIAN ADDRESS (Street, City, State, ZIP code)
TELEPHONE NUMBER ( )	23. PCP PROVIDER NUMBER	
24. NAME AND ADDRESS OF PHYSICIAN REQUESTING PRIOR AUTHORIZATION		25. NAME AND ADDRESS OF PROVIDER WHO WILL RENDER SERVICE
26. REQUESTING PHYSICIAN SIGNATURE	27. DATE SIGNED	

TELEPHONE NUMBER ( )	28. REQUESTING PHYSICIAN PROVIDER NUMBER	TELEPHONE NUMBER ( )	29. SERVICE PROVIDER NUMBER

If services are provided according to the manner prescribed by State of Colorado Laws and Regulations, reimbursement will be provided for authorized services following submission of an appropriately completed Medicaid claim.

30. COMMENTS **

☐ ATTACH COPY OF THIS PAR TO CLAIM(S) **

SIGNATURE OF STATE AGENCY REPRESENTATIVE **	DATE **	31. PA NUMBER BEING REVISED **

*** THE ASSIGNED PAR NUMBER APPEARS ON THE PAR LETTER. ENTER THE PAR NUMBER FROM THE LETTER ON THE CLAIM WHEN BILLING FOR THE** **** THESE FIELDS ARE COMPLETED BY THE AUTHORIZING AGENT**

FORM NO. 10013 **(REV. 12/98)**
COL — 106

White - AUTHORIZING AGENT Yellow - ORIGINATOR