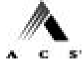
Automated Medical Payments

Medicaid Bulletin

Colorado Title XIX

Fiscal Agent



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Medicaid Provider Services

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Mailing Addresses

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Denver, CO 80201-0030

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P.O Box 90
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P.O. Box 1100
Denver, CO 80201-1100

Medicaid Fiscal Agent Information on the Internet

http://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 Retain all bulletins until published notification advises that the information is obsolete or reproduced in subsequent bulletins or provider manual updates.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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Updates and Changes

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ALL PROVIDERS

Reconsiderations

Did you know that you can submit a Reconsideration claim more than once, if necessary? If a Reconsideration claim denies for problems that you can fix, you may correct and resubmit the claim to Reconsiderations. For example, if the claim denies for incorrect date of birth, correct the date of birth and resubmit the Reconsideration claim. Costly administrative hearings may be avoided by following proper rebill procedures.

CLINIC, HOSPITAL, LABORATORY & PRACTITIONER PROVIDERS

Genotype/Phenotype Resistance Testing

Resistance tests may be useful for virologic failure in clients on antiretroviral therapy and for acute HIV infection. Resistance testing may be a useful tool in selecting active drugs when changing antiretroviral treatments for virologic failure.

HIV resistance testing is recommended for the following:

- Antiretroviral drug resistance in clients having virologic treatment failure while on antiretroviral therapy and
- For individuals who have an unfavorable initial response to antiretroviral therapy.

Effective July 1, 2002, the Colorado Medicaid Program began approving resistance testing for HIV infected clients. Prior authorization is not required. Documentation of medical necessity for this service must be maintained at the physician's office for a minimum of six years.

Clinical Recommendations for Genotype/Phenotype Resistance Testing

Clinical recommendation	Rationale
Virologic treatment failure during Highly Active AntiRetroviral Therapy (HAART)	Determine the role of resistance in drug failure and maximize the number of active drugs in the new treatment if indicated
Less than favorable management of viral load after beginning antiretroviral therapy	Determine the role of resistance and maximize the number of active drugs in the new treatment if indicated
Pregnant women	
Acute HIV infection before beginning therapy	Determine whether drug-resistant virus was transmitted and change treatment accordingly
Chronic HIV infection before beginning therapy	Uncertain frequency of resistant virus; tests may not detect minor drug-resistant species
After stopping drugs	Drug resistance mutations may become minor species without drug pressure; tests may not detect minor drug-resistant species
Plasma viral load <1000 HIV RNA copies/mL	Resistance tests may not be reliably performed because of low copy number of HIV RNA

Billing information for resistance testing

Billing Code	Procedure	Rate
87901	Genotype Human Immunodeficiency virus type-1 (HIV-1) testing (mutation analysis) for drug resistance	$337.99
87903	Phenotype HIV-1 susceptibility (covers the first 10 drugs that are tested)	$641.53
87904	Add on for each additional drug (up to five drugs) must be used in conjunction with 87903	$34.22
0023T 87901	Predictive Phenotype – infectious agent drug susceptibility phenotype prediction (must bill using both codes)	$94.22 $337.99

The provider who actually performs the laboratory test is the only one who is eligible to bill and receive payment. Physicians may only bill for tests actually performed in their office or clinic. The laboratory must bill for testing performed by independent laboratories or hospital outpatient laboratories.

Family Practice, General Practice, Internal Medicine, Obstetrics/Gynecology, Pediatrics Providers

Primary Care Physician (PCP) Program

The Colorado Medicaid program needs additional PCPs. Clients who were formerly enrolled in Medicaid HMOs need PCPs to remain enrolled in a Managed Care program. If your practice can support new clients, please consider the PCP Program. Advantages include:

- Incentive payments for case management - $3/per member/per month
- Easy identification of Medicaid clients' eligibility as members of your panel
- Guaranteed new client referrals up to the number you have specified
- Ability to limit your Medicaid caseload at any time
- 24 hour a day, 7 day a week nurse triage line available to your Medicaid clients
- Simple Medicaid client referral process to specialists in your community.
- Prompt reimbursement. If billing electronically, your office should receive Medicaid payments within 7-14 days.

If you practice in one of the following areas:

- Family Practice
- General Practice
- Internal Medicine
- Obstetrics/Gynecology
- Pediatrics

Please contact Provider Services at 303-534-0146 *or* 1-800-237-0757 for PCP Program enrollment information.
The Colorado Medicaid program needs your help.

Active Primary Care Providers

Colorado Medicaid is asking all Medicaid-enrolled Primary Care Physicians to determine if they can accept additional Medicaid clients. If you can accept additional clients, please mail your request to: Provider Enrollment, P.O. Box 1100, Denver, CO 80201-1100 or fax to: 303-534-0439. Please provide the maximum number of clients that you will accept, your current business address, and business telephone number. The panel closes automatically when the maximum number of clients that you have specified is reached.

New Version of the DRG Grouper

On December 17, 2002, DRG Grouper 20 will be installed in the Medicaid claims processing system and will be retroactive to October 1, 2002. The following versions of the Center for Medicare and Medicaid Services (CMS) Grouper will be used to process Medicaid inpatient hospital claims:

Discharge Date	Grouper
On or after October 1, 2002	Version 20.0
October 1, 2001 to September 30, 2002	Version 19.0
December 1, 2000 to September 30, 2001	Version 18.0
February 1, 2000 to November 30, 2000	Version 17.0
January 1, 1990 to January 31, 2000	Version 16.0

Claims with dates of service on and after October 1, 2002, using the following DRGs will suspend from October 1, 2002 through December 16, 2002. Claims will be processed when the Grouper version 20.0 is implemented on December 17, 2002. Any changes to the relative weights, average length of stay, and trim points will be published in the next bulletin (October 2002). The changes are effective October 1, 2002.

DRG	DESCRIPTION
01	Craniotomy Age >17 Except For Trauma
02	Craniotomy For Trauma Age >17
14	Specific Cerebrovascular Disorders Except Tia
15	Transient Ischemic Attack And Precerebral Occlusions
16	Nonspecific Cerebrovascular Disorders With CC
17	Nonspecific Cerebrovascular Disorders W/O CC
34	Other Disorders Of Nervous System With CC
35	Other Disorders Of Nervous System W/O CC
79	Respiratory Infections & Inflammations Age >17 With CC
80	Respiratory Infections & Inflammations Age >17 W/O CC
81	Respiratory Infections & Inflammations Age 0-17
96	Bronchitis & Asthma Age >17 With CC
98	Bronchitis & Asthma Age >17 W/O CC
103	Heart Transplant
104	Cardiac Valve & Other Maj Cardiothoracic Proc w/ Card Cath
105	Cardiac Valve & Other Maj Cardiothoracic Proc w/o Card Cath
115	Perm Cardiac Pacemaker Implant With Ami, Heart Failure Or Shock
116	Other Cardiac Pacemaker Implantation
120	Other Circulatory System O.R. Procedures
124	Circulatory Disorders Exc Ami, With Card Cath & Complex Diag
125	Circulatory Disorders Exc Ami, With Card Cath W/O Complex Diag
170	Other Digestive System O.R. Procedures W/O CC
171	Digestive Malignancy With CC
188	Other Digestive System Diagnoses Age >17 With CC
189	Other Digestive System Diagnoses Age >17 W/O CC
190	Other Digestive System Diagnoses Age 0-17
201	Other Hepatobiliary Or Pancreas O.R. Procedures
233	Other Musculoskelet Sys & Conn Tiss O.R. Proc With CC
234	Other Musculoskelet Sys & Conn Tiss O.R. Proc W/O CC
269	Other Skin, Subcut Tiss & Breast O.R. Proc With CC
270	Other Skin, Subcut Tiss & Breast O.R. Proc W/O CC
292	Other Endocrine, Nutrit & Metab O.R. Proc With CC
293	Other Endocrine, Nutrit & Metab O.R. Proc W/O CC
296	Nutritional & Misc Metabolic Disorders Age >17 With CC
297	Nutritional & Misc Metabolic Disorders Age >17 W/O CC
298	Nutritional & Misc Metabolic Disorders Age 0-17
303	Kidney, Ureter & Major Bladder Procedure For Neoplasm
304	Kidney, Ureter & Major Bladder Proc For Non-Neopl With CC

DRG	DESCRIPTION
305	Kidney, Ureter & Major Bladder Proc For Non-Neopl W/O CC
308	Minor Bladder Procedures With CC
309	Minor Bladder Procedures W/O CC
315	Other Kidney & Urinary Tract O.R. Procedures
316	Renal Failure
344	Other Male Reproductive System O.R. Procedures For Malignancy
365	Other Female Reproductive System O.R. Procedures
394	Other O.R. Procedures Of The Blood & Blood Forming Organs
411	History Of Malignancy W/O Endoscopy
412	History Of Malignancy With Endoscopy
424	O.R. Procedures With Principal Diagnosis Of Mental Illness
425	Acute Adjust Reaction & Disturbances Of Psychosocial Dysfunction
426	Depressive Neuroses
427	Neuroses Except Depressive
428	Disorders Of Personality & Impulse Control
429	Organic Disturbances & Mental Retardation
430	Psychoses
431	Childhood Mental Disorders
432	O.R. Procedures With Principal Diagnosis Of Mental Illness
465	Aftercare With History Of Malignancy As Secondary Dx
468	Extensive O.R. Procedure Unrelated To Princ Diagnosis
478	Other Vascular Procedures With CC
479	Other Vascular Procedures W/O CC
480	Liver Transplant
482	Tracheostomy With Mouth, Larynx, Pharynx Disorder
483	Tracheostomy Except For Mouth, Larynx, Pharynx Disorder
495	Lung Transplant
512	Simultaneous Pancreas/Kidney Transplant
513	Pancreas Transplants
514	Cardiac Defibrillator Implant with Cardiac Catheterization
515	Cardiac Defibrillator Implant without Cardiac Catheterization
516	Percutaneous Cardiovascular Procedures with Acute Myocardial Infarction (AMI
517	Percutaneous Cardiovascular Procedures without AMI, with Coronary Artery Ste
522	Alcohol/Drug Abuse or Dependence without CC, with Rehabilitation Therapy
860	Rehab - Head Injury - Mild
861	Rehab - Head Injury - Moderate
862	Rehab - Head Injury - Severe
863	Rehab - Spinal Injury C1-C4
864	Rehab - Spinal Injury C5-C7
865	Rehab - Spinal Injury T12-T1
866	Rehab - Spinal Injury, Lumbar Sacral
867	Rehab - Cerebrovascular Disorder (Stroke)
868	Rehab - Other Neurological Disorder
869	Rehab - Ventilator
871	Rehab - Not Elsewhere Classified
898	Bronchitis & Asthma, Age 0-17 W/ CC
924	O.R. Proc w/ Principal Diagnosis Of Mental Illness, Age < 21
925	Acute Adjust Reaction & Disturb Of Psychosocial Dysfunction Age <
926	Depressive Neuroses Age < 21
927	Neuroses Except Depressive Age < 21
928	Disorders Of Personality & Impulse Control Age < 21
929	Organic Disturbances & Mental Retardation Age < 21
930	Psychoses Age < 21

DRG	DESCRIPTION
931	Childhood Mental Disorders Age < 21
932	Other Mental Disorder Diagnoses Age < 21
936	Alc/Drug Depend W Rehab Age < 21

Newborn and neonatal DRGs

The DRGs listed below have new diagnosis codes as part of DRG Grouper Version 20.0. If claims are billed with the new diagnosis codes before the new Grouper is installed, the claims will deny. Providers will have to resubmit denied claims after December 17, 2002 when Version 20.0 is released. Claims for these DRGs that are submitted between October 1, 2002 and December 17, 2002, will process and pay if no new diagnosis codes are entered on the claim.

DRG	DESCRIPTION
385	Neonates, Died Or Transferred To Another Acute Care Facility
389	Full Term Neonate With Major Problems
390	Neonates With Other Significant Problems
391	Normal Newborns
801	Neonates < 1,000 Grams
802	Neonates, 1,000 - 1,499 Grams
803	Neonates, 1500 - 1,999 Grams
804	Neonates, > 2,000 Grams With Rds
805	Neonates > 2,000 Grams, Premature W/ Major Problems
810	Neonate, Low Birthweight Dx, Over 28 D. Old At Admission

INDEPENDENT OCCUPATIONAL THERAPISTS, PHYSICAL THERAPISTS AND PHYSICAL THERAPY LINICS/REHABILITATION AGENCIES

Correction to the September bulletin

Bulletin B0200139 (September 2002) announced that effective October 1, 2002, Independent Occupational Therapists and Independent Physical Therapist and Physical Therapy Clinics/Rehab Agencies (not hospital based clinics) must submit Prior Authorization Requests (PARs) for medically necessary services exceeding 16 units of service.

The maximum number of units has been changed from 16 units to 24 units. Effective October 1, 2002, Medicaid clients may receive 24 units of physical therapy and 24 units of occupational therapy before a PAR is required.

Additional information needed to process the PAR:

- Physical or occupational treatment history of the client,
- Documentation indicating whether the client has received physical or occupational therapy under the Home Health Program,
- Diagnosis,
- Prescription for services,
- Course of treatment, and
- Documentation supporting medical necessity for additional physical and occupational therapy.

*** Hospital-based clinics do not have to submit prior authorization requests for physical or occupational therapy.*

Occupational Therapy (OT) and Physical Therapy (PT) modifiers

The following table shows how Occupational Therapy (OT) and Physical Therapy (PT) procedures should be billed using the new modifiers

Provider Type	Procedure Code		*Only* Valid Modifier
Physical Therapist	**PT** CPT code	+	**GP**
Occupational Therapist	**OT** CPT code	+	**GO**
Rehabilitation agency/ PT clinic	**PT** CPT code	+	**GP**
	OT CPT code	+	**GO**

Use the GP modifier *only* with physical therapy CPT codes. Use the GO modifier *only* with occupational therapy CPT codes.

Long Term Home Health (LTHH) Information for Single Entry Point (SEP) and Home Health Agencies (HHAs)

HHAs with clients transitioning from HMOs to Fee For Service (FFS) LTHH

- Please bill Acute Home Health revenue codes from 9/1/02 until the agency receives a Prior Authorization Request (PAR) approval letter from the SEP or the fiscal agent (up to 60 days *only*).
- If the LTHH PAR for a client transitioning from an HMO to FFS is denied, the HMO will not receive a denial letter from the fiscal agent. Please send a copy of the letter to the HMO so services for the client can be arranged as necessary.
- All LTHH PAR revisions must have the original PAR dates at the top of the form with the dates of additional units or services on the line with the service and revenue code. Please write *REVISION* across the top of the form.
- HHAs should not send revisions to the SEP or the fiscal agent until they receive the initial approval letter. A revision cannot be processed until the original PAR data is entered into the processing system.
- LTHH PARs for clients turning 18 within the PAR period will have the therapy services end dated at the end of their birth date month. The fiscal agent will adjust the units. Submit the next PAR to the SEP.

Non-Emergent Medical Transportation (NEMT) Providers

Disenrollment of Non-Emergent Medical Transportation providers

Effective October 1, 2002, non-emergent medical transportation providers will be disenrolled from the Colorado Medicaid program. Beginning October 1, 2002, only the County Departments of Human/Social Services or their chosen transportation brokers will be Medicaid-enrolled and allowed to submit Medicaid claims for reimbursement. Non-emergent medical transportation providers must contract with the local County Department of Human/Social Services to provide Medicaid transportation services. The County Departments will authorize and reimburse non-emergent medical transportation providers for authorized transportation services.

Transportation providers may continue to submit claims for non-emergent medical transportation with dates of services prior to October 1, 2002. Claims will be processed and paid, but *only* until October 31, 2002. Any claims submitted by disenrolled non-emergent medical transportation providers after October 31, 2002, will be considered out of timely filing and will be denied.

If you have questions regarding this policy, please contact the Medical Transportation Administrator at:

303-866-5571, or send an email to brian.chadwick@state.co.us.

Pharmacy and Practitioner Providers

Provider manual appendix revision

Pharmacy Manual Appendix M, Colorado Medicaid Prior Authorization Criteria for Physicians and Pharmacists, was revised in September 2002. The revised appendix is available on the fiscal agent's web site:

http://coloradomedicaid.acs-inc.com.

Please download the revised appendix for the most current billing information. Paper copies of the appendix are available from the fiscal agent. For ordering information, please call Provider Services at:

303-534-0146 or 1-800-237-0757 (toll free Colorado).

Residential Treatment Centers (RTC)

New Billing Requirements

The following changes are effective for dates of service on and after November 1, 2002. Beginning November 1, 2002, every claim will require a patient status (FL 22 on the UB92).

1. Claims without a valid patient status will deny with the edit 0188, Patient Status Invalid/Missing.
2. Claims without a TOB = 89X will set edit 0383, RTC Line Not Paid/Invalid/Missing Claim Data.
3. Claims with a patient status of 30, 31, or 32 will pay for each day billed on the detail lines, including the through date of service shown at the header.

Claims with any other patient status will ***not*** pay for the through date of service if it is billed on a detail line. When a patient/client is discharged, the date of discharge is not covered.

Valid patient status values:

01	Discharge to Home or Self Care	20	Expired
05	Discharged to Another Type Institution	30	Still Patient
06	Discharged to Home under Organized Home Health Care Program (HCBS)	31	Still Patient - Waiting Transfer to Long Term Psychiatric Hospital
07	Left Against Medical Advice	32	Still Patient – Waiting Placement by Department of Social Services
09	Admitted as an Inpatient to Hospital		

Value Code 49

The second new billing requirement is Value Code 49 (score or reading) in FL 42 on the UB-92. The value amount should be a whole number of 1 or 2 or 3.

Value Code Amount	Level of Care
1.00	Level A
2.00	Level B
3.00	Level C

1. The claim will price according to the level coded in the Value Code Amount and the corresponding rate for the provider number.
2. If the claim does not have Value Code 49 and/or an amount of 1, 2, or 3, edit **1189**, RTC Claim Missing Data/Unable to Price will set and the claim will deny.

Claims with dates of service on and after November 1, 2002 will be paid with an RTC specific rate based on the value amount coded with value code 49. Claims will no longer be reimbursed based on a provider/revenue code specific rate.

Claims for dates of service prior to November 1, 2002 should be billed using the current instructions.

SINGLE ENTRY POINT (SEP) AGENCIES

New SEP Agencies

There is a change in Single Entry Point agencies for Arapahoe, Douglas, Elbert and Denver counties.

Effective September 23, 2002

County	New SEP Agency	Address	Phone	Fax
Arapahoe Douglas Elbert	Total Longterm Care, Inc.	4500 Cherry Creek Drive South Suite 500 Glendale, CO 80246	720-974-0032	720-974-0052

Effective September 30, 2002

County	New SEP Agency	Address	Phone	Fax
Denver	Total Longterm Care, Inc.	4500 Cherry Creek Drive South Suite 500 Glendale, CO 80246	720-974-0032	720-974-0052

Efforts are being made to keep clients with their current case managers. The change in the Single Entry Point agency will not affect services.

If you have any questions, please contact Total Longterm Care, Inc. at **720-974-0032** or The Department of Health Care Policy and Financing Customer Service at **303-866-3513**.

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).