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

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 Retain all bulletins until published notification advises that the information is obsolete or reproduced in subsequent bulletins or provider manual updates.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

Distribution: All providers **December 2002**
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Updates and Changes

Contents

ALL PROVIDERS

Community Health Plan of the Rockies (CHPR)

Community Health Plan of the Rockies petitioned for Chapter 11 bankruptcy protection in U.S. Bankruptcy Court. The State is requesting providers to contact us regarding non-payments, claims denials, late payments, service denials, etc.

Thank you for your cooperation,

Katie Brookler, Acting Manager, Managed Care Benefits Section
303-866-2416
katie.brookler@state.co.us
Lynn Barnard, Director, Health Benefits Division
303-866-2445
lynn.barnard@state.co.us

EFT Reminder

Effective September 30, 2002

All providers must receive reimbursement through electronic funds transfer. *Have you signed up yet?* Forms are available on the fiscal agent's web site at:

http://coloradomedicaid.acs-inc.com
or by calling
Provider Services at: 303-534-0146 or
1-800-237-0757 (Toll free Colorado).

Electronic Accept/Reject reports and Remittance Statements

Providers who have notified the fiscal agent of electronic capability are required to retrieve their Accept/Reject reports and Remittance Statements (RSs) electronically. With the exception of HMO providers and Unix vendors, providers should obtain electronic Accept/Reject reports and RSs using the MEVSNET software rather than the Bulletin Board System (BBS).

MEVSNET is a secured Intranet site where Accept/Reject reports and Remittance Statements can be retrieved electronically. MEVSNET access requires Windows software and a web browser but does not require an Internet Service Provider (ISP).

The fiscal agent will begin transferring non-HMO providers and non-Unix vendors with access to both MEVSNET and BBS to ***MEVSNET only*** in the near future. Once moved to MEVSNET, these providers will no longer be able to access the BBS.

The BBS will no longer be an option for report and RS retrieval for non-HMO providers and non-Unix vendors. All non-HMO Medicaid providers and non-Unix vendors retrieving repots and RSs electronically will have to use MEVSNET. Providers not set up for electronic report retrieval should contact ACS EDI Support Unit at 1-800-987-6721 Monday through Friday, 6:00 a.m. to 5:00 p.m. MT.

HIPAA Transaction Data Guides on the Web

Colorado has filed their extension to become HIPAA compliant by October 16, 2003. The HIPAA data guides for Transactions 270 and 271, Transaction 835, Transaction 837l, Transaction 837P and Transaction 837D are available to providers now. The documents for these transactions can be accessed from the "What's New" page and are also located in Manuals and Specifications sections of the website.

The fiscal agent's web address is:

http://coloradomedicaid.acs-inc.com

The data guides allow providers to prepare to program their systems for transactions that are HIPAA compliant and work with the Colorado Medicaid Program. The documents will contain the acceptable Colorado Medicaid Program values.

The Transaction Data Guides for 820 and 834 will be available soon.

FAMILY PLANNING PROVIDERS

Billing changes

Effective January 1, 2003, family planning services by Certified Family Planning Clinics must be billed using the fee-for-service schedule. The bundled rate codes X9001, X9002, X9003 will be end-dated effective December 31, 2002. Certified Family Planning Clinics that billed Medicaid using the bundled code rate for any clients during July 01, 2002 through December 31, 2002 should not bill Medicaid for these clients using the fee-for-service schedule until July 01, 2003.

Physician's offices, clinics, certified health agencies, Certified Family Planning Clinics, and Non-physician Practice Groups are required to use the modifier (FP) with the CPT procedure code when billing Medicaid for family planning services. An example is "**99201-FP**". If the FP modifier does not appear with the procedure code, the claim will deny.

All claims for family planning services must include one of the following family planning diagnosis codes as a primary diagnosis:

Family Planning diagnosis codes						
V25.1	V25.02	V25.09	V25.1	V25.2	V25.40	V25.41
V25.42	V25.43	V25.49	V25.5	V25.8	V25.9	

All physicians, Certified Nurse Practitioners, Nurse Practitioners, Physician Assistants, and Registered Nurses employed by Family Planning Clinics must have a Medicaid provider number. Applications for provider enrollment are available on the fiscal agent's website: http://coloradomedicaid.acs-inc.com or by calling Provider Services at 303-534-0146 or 1-800-237-0757.

HOME HEALTH PROVIDERS

Acute Home Health

1. An Acute Home Health episode is 60 days long. The 60-day threshold applies to the client, not the provider. If a client changes providers after 30 days of an Acute Home Health episode, only 30 days remain for that episode. If a client changes providers after 45 days, only 15 days remain.
2. When a provider admits a client from another home health provider, the new provider should contact the previous provider to learn if acute services were billed and the first date of service of the most current acute episode. With this information, the provider can perform and bill acute services according to the 60-day rule.
3. An Acute Home Health episode is defined as 60 consecutive days. This means sixty (60) calendar days, such as July 1 to August 29.
4. An Acute episode does ***not*** mean 60 days of services. The episode starts on the first date of service billed and continues for 60 calendar days. Hospitalizations or discharges ***do not*** restart the episode.
5. Any acute episode that began prior to July 1, 2002, will follow the previous rule of 120 days.
6. There must be 60 consecutive days without Acute services before another Acute episode may be billed.
7. As soon as the provider realizes that client will need more than 60 calendar days of care, the provider should complete a Long Term Home Health prior authorization request. Submit the PAR to the Single Entry Point Agency, if the client is 18 years old or older, or to ACS if the client is 17 years old or younger.
8. Remember to submit claims for LTHH and Acute HH revenue codes on separate claims. If the LTHH and Acute HH services are submitted on the same claim, the LTHH will be paid and the Acute will be denied. The processing system counts the denied services as part of an Acute 60 day period.

EPSDT Extraordinary Home Health

Clients age 0 to 20 that are eligible for EPSDT may also have a Long Term Home Health (LTHH) PAR on file with the fiscal agent. When the EPSDT Extraordinary Home Health PAR is submitted by CFMC, it may deny as a duplicate. The denial can occur on admission and / or transfer. To prevent denials for crossover PARs in the system:

- ***If*** the provider changes a client from LTHH to EPSDT Extraordinary HH, send the end-dated LTHH PAR with the EPSDT PAR to CFMC. End date the LTHH PAR the day before the EPSDT PAR starts. CFMC will attach the end dated PAR to the new EPSDT PAR and forward it to the fiscal agent for entry into the system.
- ***If*** the provider admits a client to EPSDT HH, call the fiscal agent PAR Assistance at 1-800-237-7647 to find out if there is a LTHH PAR in the system. Obtain the PAR number, PAR start and end dates, and services authorized. Send a LTHH PAR revision duplicating the original PAR but change the end date to the date before the EPSDT HH services begin. Send the revised LTHH PAR to CFMC with the EPSDT PAR. CFMC will attach the revised LTHH PAR to the EPSDT HH PAR and forward it to the fiscal agent for entry into the system.
- ***If*** the provider discharges a client from EPSDT HH and the date of discharge is prior to the end date of the current EPSDT HH PAR, send CFMC the discharge PAR for notification.

HOSPITAL PROVIDERS

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

Description changes

DRG	Description
001	Craniotomy Age >17 with CC
002	Craniotomy Age >17 w/o CC
014	Intracranial Hemorrhage & Stroke with Infarct
015	Nonspecific CVA & Precerebral Occlusion w/o Infarct
483	Trac with Mech Vent 96+Hrs or PDS except Face, Mouth & Neck DX

Suspended DRGS with no pricing changes

These DRG codes will be reactivated on December 17, 2002 with no changes to the pricing data.

DRG	Description
001	Craniotomy Age>17 with CC
002	Craniotomy Age >17 w/o CC
014	Intracranial Hemorrhage & Stroke with Infarct
034	Other Disorders Of Nervous System With CC
035	Other Disorders Of Nervous System W/O CC
079	Respiratory Infections & Inflammations Age >17 With CC
080	Respiratory Infections & Inflammations Age >17 W/O CC
081	Respiratory Infections & Inflammations Age 0-17
096	Bronchitis & Asthma Age >17 With CC
098	Bronchitis & Asthma Age 0-17
103	Heart Transplant
115	Perm Cardiac Pacemaker Implant With Ami, Heart Failure Or Shock, OR Aicd Lead OR Gn.
116	Other Permanent Cardiac Pacemaker Implant
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
171	Other Digestive System O.R. Procedures W/O 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
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

DRG	Description
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
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
522	Alcohol/Drug Abuse or Dependence without CC, with Rehabilitation
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 < 21
926	Depressive Neuroses Age < 21
927	Neuroses Except Depressive Age < 21
928	Disorders Of Personality & Impulse Control Age < 21

DRG	Description
929	Organic Disturbances & Mental Retardation Age < 21
930	Psychoses Age < 21
931	Childhood Mental Disorders Age < 21
932	Other Mental Disorder Diagnoses Age < 21
936	Alc/Drug Depend W Rehab Age < 21

Effective December 17, 2002, there will be a new pricing span for dates of service beginning October 01, 2002.

DRG	Relative Weight	ALOS	Trim Point
015	0.8929	3.4	30
016	1.1243	4.3	38
017	0.6043	2.1	19
104	8.9293	16.9	77
105	6.4876	11.7	54

Effective October 01, 2002, the following DRGs will be added along with their relative weights, ALOS, and trim points.

DRG	Relative Weight	ALOS	Trim Point
524	0.6556	2.3	21
525	13.0146	19.5	89

The current pricing span for the following DRGs will be end-dated on March 31, 2003.

There will be a new pricing span for dates of service beginning April 01, 2003.

DRG	Relative Weight	ALOS	Trim Point
516	2.4544	3.9	18
517	1.9609	2.1	10

Effective April 01, 2003, the following DRGs will be added along with their relative weights, ALOS, and trim points.

DRG	Relative Weight	ALOS	Trim Point
526	2.8057	3.8	17
527	2.2806	2.1	10

NURSING FACILITY PROVIDERS

Medicare crossover claims

Effective January 01, 2003, Medicaid will process carrier submitted electronic claims on the CO1500. This is a change to the current policy that requires providers to resubmit these Medicare claims on the UB92 claim form. Beginning January 1, 2003, the electronic crossover claims will pay in the Medicaid processing system as Part B crossovers.

Supply revenue codes

Effective January 1, 2003, providers will no longer be able to bill the supply revenue codes (27X) on the UB92 Medicare crossover claims.

SUPPLY PROVIDERS

Home Oxygen Pilot Program

Effective December 1, 2002 the State will begin a utilization review of the Home Oxygen Pilot Program (HOPP) through the Colorado Foundation for Medical Care (CFMC). The HOPP is a six- month case management program designed to provide case management services to a select group of clients who currently use oxygen at home. A respiratory therapist, working through a case management organization will evaluate client records to understand the individual client's condition and utilization patterns. Along with the physicians and the oxygen providers, the respiratory therapist will develop an appropriate individual care plan for oxygen therapy to ensure that appropriate services are provided.

The HOPP will run through June 30, 2003, when the State will evaluate the possibility of continuing and/or expanding the program, based on data gathered through the case management of this select group of clients. Depending on the success of the HOPP, oxygen services and equipment may become a prior authorized service in the future.

For questions related to the HOPP, please call Gloria Johnson at: 303-866-2220.

Please direct questions about information in this bulletin to Medicaid Provider Services at: 303-534-0146 or 1-800-237-0757 (toll free Colorado).