Automated Medical Payments

Medicaid Bulletin

Colorado Title XIX

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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 Retain all bulletins until published notification advises that the information is obsolete or reproduced in subsequent bulletins or provider manual updates.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 **March 2003**

Reference: B0300150

Important Medicaid Billing Information

Contents

ALL PROVIDERS

Changes for Legal Immigrants Effective April 2003

Beginning April 1, 2003, with the signing of HB 03-176, Medicaid eligibility requirements for persons with an immigration status will have new limitations. The state law will impact current Medicaid clients and new applicants. The following groups of legal immigrants will be affected by these changes:

Legal Permanent Residents –

- Under the prior law and regulations, legal permanent residents could be eligible for Medicaid after the first five years in the United States.
- With this legislative change, a legal permanent resident, after the five-year ban, must have 40 quarters of work history in the United States. That is the equivalent of 10 years of work.

During March 2003 County Departments of Social Services will be re-determining eligibility for all legal immigrants currently receiving Medicaid. Effective April 1st eligibility will change for many of these individuals. Medicaid providers are reminded to verify eligibility through CMERS, the fax-back eligibility system, or WINASAP.

Eligibility for the following legal immigrants, who previously had no time limit on the length of eligibility, will be limited to eligibility for their **first seven years** in this country:

?? Refugees
?? Asylees
?? Aliens whose deportation has been withheld
?? Cuban or Haitian entrants
?? Amerasians

Pregnant women eligible for the State-Only Prenatal Program

As of April 1, 2003, this program is no longer available. However, due to the women's pregnancy status and financial eligibility they are eligible for ***emergency only*** benefits to cover their labor and delivery.

Medicaid HMO Clients

Beginning with the March Medicaid Authorization Cards (MACs), the name, address and phone number of the HMO will *not* appear on the MAC. When applicable, the name and phone number of the MHASA and name and phone number of the PCPP will continue to appear on the MAC.

For current and accurate Medicaid information, providers must check CMERS, Faxback eligibility or WINASAP to verify the client's Medicaid eligibility and enrollment.

CMERS	303-534-3500 Denver Metro; or 1-800-237-0044 Toll free Colorado
Faxback	1-800-493-0920 Toll free
WINASAP	Free interactive software – Contact EDI Support 1-800-987-6721

Claims Denied with Edit 0375

All providers submitting claims with diagnosis codes V25.1-25.9 will not be paid unless they use the FP modifier. If the provider submitted claims with diagnosis codes V25.1-V25.9 without the FP modifier and the claims were denied, please ***rebill*** the claims using the Family Planning modifier FP.

The FP modifier is required on *each line item* billed. If the FP modifier does not appear with the procedure code, the claim will be denied.

INDEPENDENT PHYSICAL THERAPISTS, OCCUPATIONAL THERAPISTS, SPEECH THERAPISTS AND REHABILITATION AGENCIES

2003 Physical Therapy & Occupational Therapy Procedure Codes and Rates

2003 CPT* Codes	2003 Reimbursement	Maximum # Units per code per day	Physical Therapist (PT) Occupational Therapist (OT)	Modifier Required
97001	$ 33.60	1	PT	GP
97002	$ 22.68	1	PT	GP
97003	$ 33.60	1	OT	GO
97004	$ 22.68	1	OT	GO
97010	$ 4.20	1	PT / OT	GP / GO
97012	$ 9.45	1	PT / OT	GP / GO
97014	$ 7.35	1	PT / OT	GP / GO
97016	$ 9.45	1	PT / OT	GP / GO
97018	$ 6.30	1	PT / OT	GP / GO
97020	$ 6.30	1	PT / OT	GP / GO
97022	$ 9.45	1	PT / OT	GP / GO
97024	$ 6.30	1	PT / OT	GP / GO
97026	$ 4.20	1	PT / OT	GP / GO
97028	$ 8.40	1	PT / OT	GP / GO
97032	$ 9.45	2	PT / OT	GP / GO
97033	$ 10.50	4	PT / OT	GP / GO
97034	$ 8.40	4	PT / OT	GP / GO
97035	$ 8.40	4	PT / OT	GP / GO
97036	$ 11.55	4	PT / OT	GP / GO
* 97039	By Report		PT / OT	GP / GO
97110	$ 10.50	4	PT / OT	GP / GO
97112	$ 10.50	4	PT / OT	GP / GO
97113	$ 9.45	4	PT / OT	GP / GO
97116	$ 8.40	4	PT / OT	GP / GO
97124	$ 11.55	4	PT / OT	GP / GO
* 97139	By Report		PT / OT	GP / GO
97140	$ 12.60	4	PT / OT	GP / GO

2003 CPT* Codes	2003 Reimbursement	Maximum # Units per code per day	Physical Therapist (PT) Occupational Therapist (OT)	Modifier Required
* 97150	$ 10.50	2	PT / OT	GP / GO
97504	$ 10.08	4	PT / OT	GP / GO
97520	$ 10.08	4	PT / OT	GP / GO
97530	$ 10.50	4	PT / OT	GP / GO
97532	$ 19.74	2	PT / OT	GP / GO
97533	$ 19.74	2	PT / OT	GP / GO
97535	$ 15.75	4	PT / OT	GP / GO
97537	$ 15.75	1	PT / OT	GP / GO
97542	$ 15.75	2	PT / OT	GP / GO
97545	$ 50.40	1	PT / OT	GP / GO
97546	$ 25.20	1	PT / OT	GP / GO
97601	$ 46.20	1	PT / OT	GP / GO
* 97602	By Report		PT / OT	GP / GO
* 97703	$ 15.75	1	PT / OT	GP / GO
* 97750	$ 19.95	4	PT / OT	GP / GO
* 97799	By Report		PT / OT	GP / GO

The client's first 24 units of therapy do not require a prior authorization. Please refer to the September 2002 Medicaid Bulletin, Reference #B0200139 for Prior Authorization Requirements (PAR) and appropriate forms. A maximum of five units of therapy are allowed per date of service. Procedure codes 97001-97799 require modifiers. Use modifier GP for physical therapy procedure codes and modifier GO for occupational therapy procedure codes.

* Codes requiring a Prior Authorization Request (PAR). These codes will not be reimbursed without a PAR, *including* first 24 units.

2003 Speech Therapy Procedure Codes & Rates

2003 CPT* Codes	2003 Reimbursement	Maximum # Units per code	Speech Therapist (ST)	Modifier Required
92506	$ 30.88	1	ST	None
92507	$ 18.90	3	ST	None
92508	$ 9.46	1	ST	None
92526	$ 23.10	1	ST	None
99201	$ 24.78	1	ST	None
99211	$ 12.18	1	ST	None

A maximum of five therapy units allowed per date of service.

HOME HEALTH

Revised Manual

The Home Health & Private Duty Nursing Specialty Manual has been revised and is available on the fiscal agent's web site.

http://coloradomedicaid.acs-inc.com

Please download the revised manual for the most current billing information. Paper copies of the manual are available from the fiscal agent for $5.00 each. For ordering information, please call Provider Services at:

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

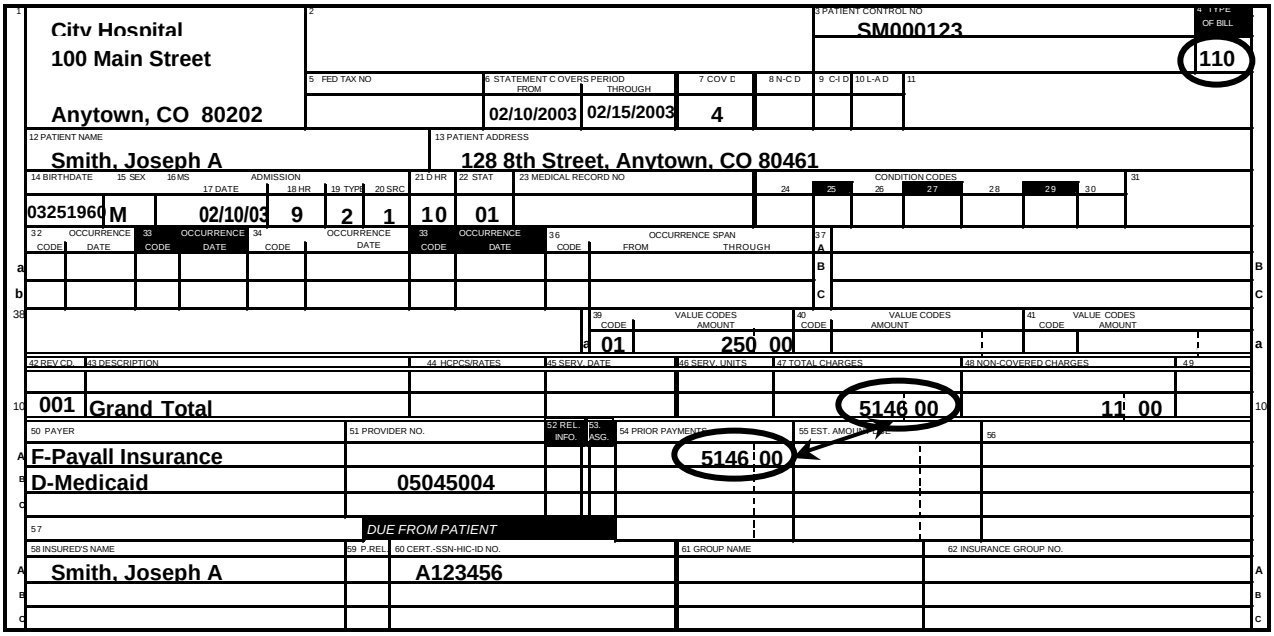
INPATIENT HOSPITAL

Billing Changes for Inpatient DRG Claims with Third Party Resources

The following changes are effective for inpatient claims with discharge dates on or after April 1, 2003. Medicare crossover claims are *not* included in these changes.

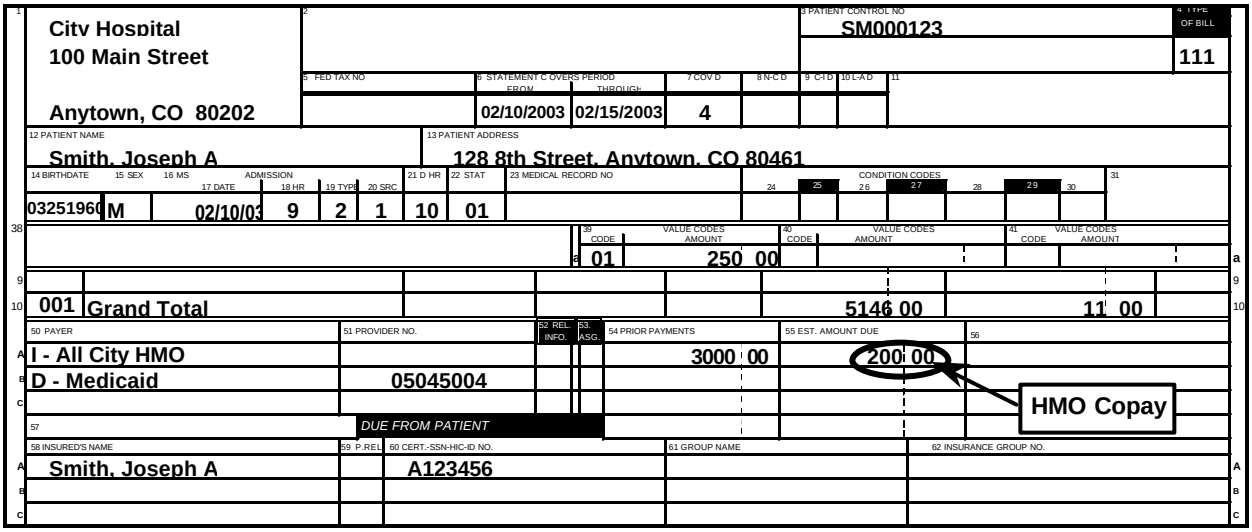
1. Use Type Of Bill (TOB) 110 or 120 on inpatient claims to indicate the charge is submitted for reporting purposes only and no payment is requested. The '0' as the third digit in the TOB means that the claim will pay with no reimbursement amount.

Example of TOB 110/120



2. To bill an HMO copayment amount when the client is enrolled in a commercial HMO, enter the copayment amount in the Estimated Amount Due field of the third party payer line. This line will **not** have a payer source code of D or C. The claim will pay the copayment amount only.

Example of HMO copay

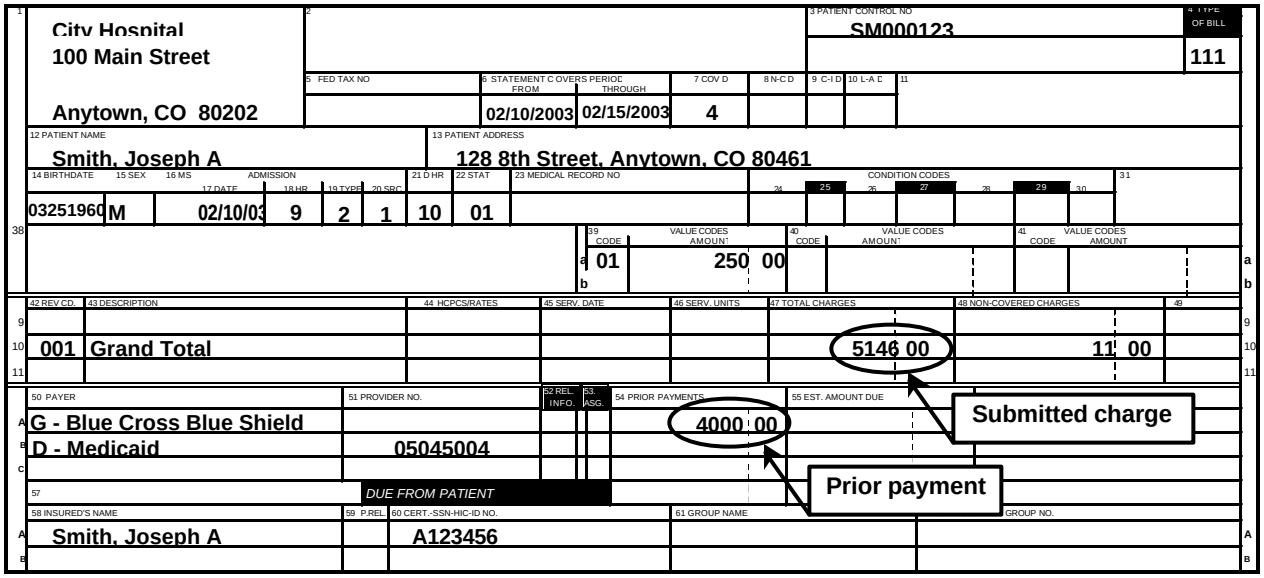


3. DRG claims for clients with third party coverage will pay using new payment logic. The claim payment will not exceed the submitted charges. The claim will pay which ever is less:

   - The difference between the DRG allowed amount and the prior payment ***or***
   - The difference between the submitted charges and the prior payment.

   If the DRG allowed amount is less than the prior payment no additional payment will be made.

Example of Third Party payment logic



Difference between the DRG amount & prior payment		Difference between the submitted charges & prior payment	
DRG allowed amount	$6,000.00	Submitted charges	$5,146.00
Prior payment	$4,000.00	Prior payment	$4,000.00
Difference	$2,000.00	Difference	$1,146.00

Medicaid pays the lesser of difference between the DRG allowed amount and the prior payment ***or*** the difference between the submitted charges and the prior payment. The Medicaid payment = $1,146.00.

Billing Instructions for Medicare Exhausted Claims

When submitting Medicare exhausted claims, enter the Medicare payment in the prior payment field for Payer source **H**. Providers should use Occurrence Code A3 for "Benefits Exhausted" and not enter any Value Codes for the deductible or coinsurance. Please replace page 10 in the Inpatient / Outpatient Specialty Manual with the attached revised page, dated 03 / 03. The Inpatient / Outpatient Specialty Manual has also been revised on the fiscal agent's web site: http://coloradomedicaid.acs-inc.com.

PHARMACY AND SUPPLY PROVIDERS

DME PARs

All Prior Authorization Requests (PARs) require a physician's signature. The PAR may be submitted without the physician's signature *if* the provider has a signed prescription on file. If the physician has not signed the PAR, the provider must submit a copy of the signed prescription with the PAR.

An attached physician signed prescription replaces the physician signature field on the PAR. There is no need to return the PAR to the physician for signature.

Oral Nutritional Supplement and Enteral Formula

Oral nutritional supplement and enteral formula procedure codes that were changed in the October 2002 Medicaid Supply bulletin must be submitted on PARs as follows:

- Old codes must have an end date of 09 / 30 / 2002,
- New codes must have start date of 10 / 01 / 2002.

PAR dates may continue to cover a one-year span. Both old and new codes may be submitted on the same PAR.

If you have any questions, please call the PAR line at 303-534-0279 or 1-800-237-7647.

Upcoming Therapeutic Consultation Program

In the early spring of 2003, the Colorado Medicaid will implement a highly focused Therapeutic Consultation Pharmacy (TCP) Program. The TCP Program is intended to reduce unnecessary, duplicate, or even dangerous drug therapies for Medicaid clients.

The TCP process occurs only when a client exceeds eight (8) prescriptions in a month. To ensure that this program does not intervene when it is inappropriate, the program exempts several classes of medications from the eight prescription limit including:

HIV medications	Contraceptives	Hypoglycemia rescue agents	Total Parenteral Nutrition agents
Chemotherapy agents	Anti-psychotics	Blood glucose lowering drugs	

The prescriber must call the TCP pharmacists to determine if alternative treatments are available. A TCP pharmacist, knowledgeable on the diseases and conditions affecting Colorado's Medicaid population and familiar with the therapy options for each client, will consult with a physician. The pharmacist will suggest different options to modify the drug therapy each time a client exceeds the eight (8) prescription limit. All claims reviewed by the TCP process will undergo an entire drug treatment review for the specific client. Please watch for additional information about and time frames for the TCP Program in future bulletins.

Updated Pharmacy Appendix & Forms

The following documents have been revised and are posted on the fiscal agent's web site:

- Appendix M (Pharmacy 03-03) - Prior Authorization Criteria for Physicians and Pharmacists.
- Colorado Medicaid Prior Authorization Criteria for Oxycontin/Oxycodone ER (03/03) - Physicians must complete this form when billing for Oxycontin/Oxycodone ER
- Colorado Medicaid Prior Authorization Criteria for PPI & H2 Blocker B (revised 03/03) Physicians must complete this form when billing for PPI & H2 Blocker B

http://coloradomedicaid.acs-inc.com

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)

Special Instructions for Labor and Delivery Claims

If a sterilization is performed in conjunction with delivery without the proper consent form (MED-178), the coding and charges for sterilization must be omitted from the claim. Only the codes and charges for the delivery can be billed.

Sterilization is not a covered benefit for non-citizens. If sterilization is performed in conjunction with the delivery for a non-citizen, only the codes and charges for the delivery can be billed.

Medicare Part B only coverage

Providers should submit a claim to Medicare for any inpatient services covered by Medicare. When Medicaid denies automatic crossovers for Part B services, submit an inpatient claim to Medicaid. This is *not* a crossover claim.

- Complete the Type of Bill field using 11*X*.
- Enter Payer source code H for the Medicare Part B payer.
- Enter the Medicare Part B payment in the Prior Payments field for Payer source H.
- Deduct the Medicare Part B payment from the total charges to show the Estimated Amount Due.

Medicaid pays the Medicaid inpatient allowable amount minus the Medicare Part B payment, minus any commercial insurance payment (if applicable) and minus any Medicaid copayment.

Exhausted Medicare reserve days

Providers should submit a claim to Medicare for any inpatient services covered by Medicare. Submit claims to Medicaid when all Medicare days have been exhausted, including lifetime reserve days.

- Use Occurrence Code A3 for "Benefits Exhausted"
- Do not enter any Value Codes for the deductible or coinsurance.
- Enter the Medicare payment in the prior payment field for Payer source **H**.
- Deduct the Medicare payment from the total charges to show the Estimated Amount Due.

Medicaid pays the Medicaid inpatient allowable amount minus the Medicare payment, minus any commercial insurance payment (if applicable) and minus any Medicaid copayment.

Professional fees

Costs associated with professional services by salaried or contracted physicians are included in the hospital's rate structure and cannot be billed separately to the Medicaid program. Do not bill professional fees (revenue codes 960-989) for emergency and outpatient services on the UB-92 claim form.

Psychiatric/Psychological Services

All providers are reminded to verify Medicaid eligibility and MHASA enrollment before providing any non-emergency mental health services. Remember to obtain prior authorization of the client's MHASA before providing non-emergency mental health services.

Inpatient psychiatric benefits

- Acute inpatient psychiatric care.
- Inpatient psychiatric care for clients under the age of 21 when:
- Services are provided in an institution accredited as a psychiatric hospital by Joint Commission on Accreditation of Hospitals (JCAH),
    1. Services are provided under the direction of a physician and
    2. Services are received by a client of qualifying age
- Long term inpatient care for clients who are 65 years of age or older, when services are provided in an approved psychiatric institution.