Automated Medical Payments

Medicaid Bulletin

Colorado Title XIX

Fiscal Agent

A C S

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 Retain all bulletins until published notification advises that the information is obsolete or reproduced in subsequent bulletins or provider manual updates.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

Reference: B0300157

Medicaid Updates and Changes

Copay changes!

Beginning July 1, 2003, Medicaid is changing the copay requirements for eligible clients.

Service	Copayment Amount
Inpatient Hospital Services	$10.00 per covered day or 50% of the averaged allowable daily rate whichever is less. The average allowable daily rate can be calculated using the 'total allowed charge' for the entire stay and divide by the 'calculated covered days'.
Outpatient Hospital Services	$3.00 per visit
Practitioner Services	$2.00 per visit
Optometrist Visit	$2.00 per visit
Podiatrist Visit	$2.00 per visit
Psychiatric Services	$.50 per unit of service (1 unit = 15 minutes)
Community Mental Health Center Services	$2.00 per visit
Rural Health Clinic / FQHC Services	$2.00 per date of service
Durable Medial Equipment (UB-outpatient and CO-1500 claims)	$1.00 per date of service
Laboratory (UB-outpatient and CO-1500 claims)	$1.00 per date of service
Radiological Services (UB-outpatient and CO-1500 claims)	$1.00 per date of service
Pharmacy Services (each prescription or refill)	
• Generic drugs	$1.00
• Brand name drugs	$3.00

Please Note: Practitioners and outpatient hospital providers may be responsible for the collection of copay for more than one service. For example, a practitioner seeing a client for a fall, may provide a radiology service. Then, following a diagnosis of a fracture or sprain, provide a splint. The provider would be responsible for collecting copay for the office visit ($2.00), copay for the radiology service ($1.00), and copay for the splint ($1.00).

An outpatient hospital providing services that include the outpatient visit and a lab service will be responsible for copay for the outpatient visit ($3.00) and for the lab service ($1.00).

Beginning July 1, 2003, Medicaid is eliminating the maximum copayment obligation per calendar year for clients who are not OAP – State Only eligible. The copayment maximum will remain at $300 per calendar year for OAP – State Only clients.

Copayment exempt clients and services

- Clients who are ages 18 and under.
- Clients who have satisfied the maximum copayment obligation for the calendar year prior to June 30, 2003
- Clients who are in the maternity cycle
- Clients in a nursing facility

For electronic claims, use the online help screens or batch billing specifications for claim completion instructions.

The following apply to fields on the paper claim forms:

- Clients under the age of 21 or over the age of 65 who reside in **S**killed **N**ursing **F**acilities (SNF) or **I**ntermediate **C**are **F**acilities (ICF) or reside in institutions for mental diseases.
  - Requires completion of the following claim fields.
    - ✓ Colorado 1500 Field 12: ☑ NF
    - ✓ UB-92 Condition Code 96 (form Locator 24-31).
    - ✓ Pharmacy Location Code = 03
- All services to women in the maternity cycle (including prenatal, delivery, and immediate postpartum period not to exceed six weeks) are exempt from copayment.
  - Services do not have to be pregnancy related.
  - The client must inform the provider of her condition at the time of service.
  - Physicians should note the condition on prescriptions.
  - Requires completion of the following claim fields.
    - ✓ Colorado 1500 Field 12: ☑ Maternity Cycle
    - ✓ UB-92 Condition Code 95 (form Locator 24-31)
    - ✓ Pharmacy Medical Certification Code = 4
- Emergency services delivered in any setting require indicated claim completion.
    - ✓ Colorado 1500 Field 19J: Enter "X" for each billed line
    - ✓ UB-92 Type of Admission 1 (Form Locator 19)
- Family planning services require indicated claim completion.
  - Includes oral contraceptives, which should be dispensed in a 3-month supply after a 1-month trial period.
    - ✓ Colorado 1500 Field 19K: Enter "X" for each billed line
    - ✓ UB-92 Diagnosis Coding
    - ✓ Pharmacy NDC Codes for oral contraceptives
- Copay field on the Colorado 1500

  Field 19I Complete if copayment is required of the client for this service. Enter one of the following codes:
  - **1** - Refused to pay copayment
  - **2** - Paid copayment
  - **3** - Copayment not requested
- **Copay Exemptions processed automatically for the following:**
  - Dental services
  - Home health care
  - Home and community based services
  - Transportation

Most common reasons for claims returned to providers

Each day the fiscal agent returns many claims to providers before they can be processed. The two most common reasons for these returns are:

1. The provider number on the claim form is incorrect or missing and
2. The provider did not use the *Colorado* 1500 claim form.

Providers are reminded to check all claims prior to submission. Make sure all required fields are completed and completed correctly.

Colorado Medicaid only accepts the *Colorado* 1500 claim form. Claims submitted on "superbills", the HCFA 1500 or any forms other than the *Colorado* 1500 are returned to the provider and must be resubmitted.

Colorado 1500 claim form on web

The Colorado 1500 claim form is now available on the fiscal agent's website at:

http://coloradomedicaid.acs-inc.com

The claim form is located in the Forms section under Provider Services. Providers can download the form and use it to submit claims when paper claims are required.

Hospital verification of Medicaid eligibility for the Medicare Disproportionate Share reporting

The State has been working with University of Colorado Hospital Authority, Medifax, and the fiscal agent (ACS) to develop a way to provide historical eligibility data. This capability is available for a limited time and is free of charge to providers. If the provider uses an agent to make system queries, e.g., an eligibility verification vendor or an auditing services company, there will be a $2,000 fee to help defer costs. The $2,000 fee will be charged to third parties for each hospital specific Medicare cost reporting period in question. This verification is for dates of service prior to one (1) year ago.

Please direct any questions related to the new DSH eligibility verification process to Tom Walsh at the Department of Health Care Policy of Financing at 303-866-5991 or to Thomas.Walsh@state.co.us.

For information about eligibility verification for current dates of service, (within one calendar year from present date), please call Medicaid Provider Services at 303-534-0146 or 1-800-237-0757.

Home Health

Effective July 1, 2003, Home Health providers *are no longer required to send copies of the CMS 485 form every certification period after the client has been approved for Long Term Home Health.* Single Entry Point agencies may request this form from the provider at any time. Providers must continue to submit the current CMS 485 for initial PAR approvals and PAR revisions.

As of July 1, 2003, there are **two new revenue codes for billing PT or OT evaluations for HCBS home modifications.** In the past these were billed as acute home health revenue codes 420 for PT and 430 for OT even though the client was under Long Term Home Health. One or two units of either code were requested for approval by the Single Entry Point agencies. These claims have either denied, or have been counted toward the Acute 60-day period in error.

To prevent further denials, please use the following codes when requesting authorization for PT or OT services to evaluate for HCBS home modifications.

Service	Revenue Code	Rate	Allowed units
Physical Therapy Evaluation	424	$58.36	1-2
Occupational Therapy Evaluation	434	$61.98	1-2

Medicare/Medicaid dually eligible for Home Health

Billing Home Health claims for dually eligible Medicare/Medicaid clients:

Providers must give a Medicare Advanced Beneficiary Notice (MABN) to clients when Medicare does not cover the service. The MABN informs clients that they may be liable for the cost of the provided service if Medicare considers it not medically necessary. If the provider knows that Medicare does not cover a particular service, but Medicaid will, the provider should give the client the MABN with a careful explanation. Do not influence the client to check either box A, B, or C. Provide an explanation of what each one means according to Medicare Program Memorandum Transmittal A-02-018. If all other program requirements are met and the client does not request a demand bill to Medicare, the client can check box 'C' knowing that medically necessary care will be reimbursed by Medicaid. The provider must obtain a denial from Medicare prior to billing Medicaid for these services. This process has been outlined many times in the "Medicare A Newsline".

The Medicare denials take about three months to process. However, many times Medicare will cover the services after review. Keep your Medicare Advanced Beneficiary Notices and Medicare denial letters on file with the clients' medical records.

For Medicaid timely filing, claims must be received within 60 days of the Medicare denial. Submit claims using occurrence code 53 with the denial date as the Late Bill Override Date and denial occurrence code 51 and the date of the Medicare denial. You only need one denial from Medicare to bill Medicaid for services Medicare does not cover. After one year, use occurrence code 25 with the same denial date. Use type of bill 33x on the UB-92 form.

Acute Home Health - 60-day limit

As of July 1, 2003, there is a new process for claims denied with Edit 1435 - "DOS exceeds 60 day limit/Acute HH". If you believe a claim is denied in error with reason code 1435, first contact Janet L. Dauman, BSN, Program Administrator Home Health, Hospice, and Private Duty Nursing at 303-866-4654.

You will be asked for an explanation of why you believe the claim should be paid and supporting information and documentation. All supporting documents should be faxed to:

Janet L. Dauman, BSN at 303-866-2573, or mailed to:

Janet L. Dauman, BSN
Program Administrator Home Health, Hospice, Private Duty Nursing
Department of Health Care Policy and Financing
1570 Grant Street
Denver, Colorado, 80203

*This process applies **only** to claims denied with reason code 1435. Do **not** use this process for any other type of denial.*

Newborn hearing screenings

Newborn hearing screenings are included in the hospital Delivery and Care of Newborn DRG rates. The newborn hearing screening is included in the base rate and taken into consideration when the DRG is recalibrated.

PCP Re-Contracting

Federal regulation requires that Medicaid agencies comply with the new PCP contracting standards. All PCPs will receive a new contract during the first week of July 2003.

If you do not receive the contract, please call Medicaid Provider Services at 303-534-0146 or 1-800-237-0757 (toll free Colorado) to verify that the fiscal agent has your correct address on file. All signed contracts must be received by August 1, 2003. The new PCP contract will soon be available on the fiscal agent's web site: http://coloradomedicaid@acs-inc.com in the Provider Services section under Forms.

Prescription Prior Authorization Update

Adderall (Amphetamine salts) and Adderall XR, Dexedrine, and Dextroamphetamine

1. Clients between the ages of 6 through 17 will no longer require a prior authorization.
2. Clients under 6 years of age and clients over the age of 17 will require a prior authorization and must meet the following criteria:
   - Clients must be 3 years of age and older
   - Prior history of dexedrine previously authorized (as of 11/1998)
   - Diagnosis of narcolepsy, senile depression, ADD or ADHD

Provider manual Appendix M has been updated on the fiscal agent's website to reflect these changes.

New fax number for PARs

The new fax number for all drug prior authorization requests is 1-888-772-9696.
Fax number 1-877-614-1078 is no longer valid for drug prior authorization requests.

Therapeutic Consultation Program (TCP) terminated

Please be advised that on June 3, 2003, the Department of Health Care Policy and Financing terminated the Therapeutic Consultation Program (TCP).

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)