Automated Medical Payments

Medicaid Bulletin

Colorado Title XIX

Fiscal Agent

A C S

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 Retain all bulletins until published notification advises that the information is obsolete or reproduced in subsequent bulletins or provider manual updates.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

Reference: B0300163

All Providers

Correction to July 2003 Bulletin, B0300161

The telephone number to enroll in EDIFECS in the **Submitter or Business-to-Business Testing** article on page 2 is incorrect. *The correct telephone number for EDIFECS enrollment is **850-558-1630.***

We apologize for any inconvenience this may have caused.

Disability Applications

Effective August 6, 2003, DDS will no longer directly accept disability applications (the yellow forms) from outside sources, institutions, or providers.

Providers may assist clients with the application, however, the entire application packet must be sent to the county in which the client resides.

Please direct any questions about this change, to Kimberly Shreve at 303-866-4475 or kimberly.shreve@state.co.us.

HIPAA Updates

Phase 2

The second phase of HIPAA is the *Electronic Health Care Transactions and Code Sets Standards*. The compliance date for the Electronic Health Care Transactions and Code Sets Standards is October 16, 2003. Whatever electronic method a provider chooses to submit claims to Medicaid will have to be HIPAA compliant as of October 16, 2003.

HIPAA Companion Guides

When the HIPAA Companion Guides are ready, they will replace the Transaction Data Guides (TDGs) on the fiscal agent's website. As the approved companion guides are posted to the website, the TDGs will be deleted.

Revised Medicaid Provider Manual

The State has approved the revised Medicaid Provider Manual. The new Provider Manual are on the fiscal agent's website under Provider Manuals in the Provider Services section.

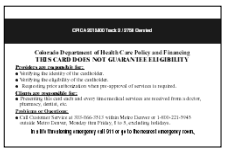
Links to the revised manual sections are located next to the current manual headings. The revised manual is divided into four sections (General Provider Information, Billing Information, Specialty Billing Information and Appendices) and contains HIPAA updates. The new HIPAA information is effective October 16, 2003. When the HIPAA Electronic Health Care Transactions and Code Sets Standards are implemented on October 16, 2003, the current manual sections will be removed from the website. Providers will be required to download and use the revised manual sections.

Remember to check the fiscal agent's web site at: http://coloradomedicaid.acs-inc.com for HIPAA updates.

Medical Identification Cards

Card Front

Card Back



Health Care Policy and Financing is proud to announce the new Medical Identification Cards. The Medical Identification Cards are permanent and will replace the monthly Medicaid Authorization Cards (MAC). Clients and providers should expect to see the new cards in early September.

Due to the temporary delay of the production of the permanent plastic Medical Identification Card, please honor the paper August card presented to you by Medicaid clients. A September paper card will not be mailed to all clients due to the transition to the plastic cards.

The Medicaid Authorization Cards (MAC) have been strictly an identification card for the last few months. Therefore, providers will need to continue to verify eligibility through CMERS, FAXBACK, WINASAP, or their eligibility vendor. The Medical Identification Card (plastic or paper) is not a guarantee of eligibility. ***As always, providers should contact the fiscal agent's Provider Services Unit at: 303-534-0146 or 1-800-237-0757 (toll free Colorado) with questions.***

Pharmacy Providers

Generic Drug Mandate

(Please note changes in italics)

Beginning July 29, 2003, the Medicaid Fee for Service and Primary Care programs will require a prior authorization for most brand-name drugs with a generic equivalent. This new requirement is a result of legislation passed in May 2003.

If a drug *with a generic* indicator is prescribed, no additional action is required. Only brand name drugs with an A rated generic require a prior authorization (where the generically equivalent drug is approved and is determined as therapeutically equivalent by the FDA). In order to prescribe a brand-name drug that has a therapeutically equivalent generic for a Medicaid client, physicians will be required to obtain a prior authorization***. If a physician is of the opinion that a transition to the generic equivalent of a brand-name drug would be unacceptably disruptive to the client's stabilized drug regimen, the physician must obtain a prior authorization, including a Med Watch form stating the reason that the brand name versus the generic drug is required.***

Prior authorization will not be required if:

1. The brand-name drug is exempted,
2. The reimbursement to the State for a brand-name drug makes the brand name drug less expensive than the cost of the generic equivalent. *A DAW 5 substitution allowed-brand as generic will be allowed only if the product being billed is a brand that is less expensive than the generic. Also, if a generic product is indicated with a brand name indicator (by First Data Bank) a provider may use a DAW 5. All claims using DAW 5 will be reviewed for brand pricing of less than generic and manufacturer product indicator.*

To request a prior authorization, the prescriber must call the PDCS prior authorization line at 1-800-365-4944 or fax a completed Med Watch form to PDCS at 1-888-772-9696. The prescriber must justify the medical reason for the brand name drug *prior* to dispensing the medication.

A limited number of brand-name drugs with generic equivalents are exempted from these new Medicaid requirements, they include:

1. Treatment of biologically based mental illness defined in 10-16- 104(5.5) CRS, which include:
   - Schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder and panic disorder.
2. Treatment of cancer
3. Treatment of epilepsy
4. Treatment of Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome

Drug Class Future Prior Authorization Notifications

The following website contains notifications of proposed future drug class prior authorizations. If you are interested and have comments on a drug being considered for prior authorization please go to: http://www.chcpf.state.co.us/Pharmacy/drug_list.html.

Comments on drug class prior authorization should be sent to:

Martha.Warner@ state.co.us.

Please Note: *On the website, comment due dates are listed by drugs.*

Private Duty Nursing (PDN)

Request for Nursing Hours

When submitting a Prior Authorization Request for PDN with the CMS-485 form, please state a range and a typical number of hours needed per day on the CMS-485.

Example:

SN-Private Duty Nursing - up to 18 hours per day/7d/w/9w. Typical number of hours per day is 12.

The top of the range is the number ordered by the physician as medically necessary. The lower number is the amount of care that may occur due to family availability or choice, holidays or vacations, absence from the home, etc.

Supply Providers

Wheelchair Prior Authorization Requests (PARs)

- Submit all PARs for new motorized wheelchairs or scooters to CFMC for review.
- Submit all PARs for new manual wheelchairs to the fiscal agent (ACS) for review.
- Submit all PARs for wheelchair repairs the fiscal agent (ACS) for review. This includes manual and motorized wheelchairs, and scooters.

  Repairs are defined as fixing or replacing with an exact or like part, a piece of a currently existing wheelchair. The PAR must contain the serial number, and clearly identify the wheelchair as a manual, motorized wheelchair or scooter. The PAR must also clearly identify the request as a *repair* of an existing wheelchair.

All requests for modifications/add-ons, and revisions to existing PARs for powered wheelchairs or scooters must be submitted to CFMC. All requests for modifications/add-ons to manual wheelchairs must be submitted to the fiscal agent (ACS).

CFMC's Mailing Address	Fiscal Agent's Mailing Address
PO Box 17300 Denver, CO 80217	PO Box 30 Denver, CO 80201-0030

Modifications or add-ons:

A change in the physical structure of the wheelchair or scooter, either altering the current structure, or adding a new feature to an existing wheelchair in order to make the equipment more medically appropriate and functional for the client. *A modification or add-on is done to a client's existing wheelchair.*

Revision or update:

Request to change an original approved PAR to correct a procedure code, revise the number of units authorized etc. *A revision or update is done on a PAR form.*

The PAR must contain the serial number of the wheelchair being modified, and clearly identify the wheelchair as a manual, motorized wheelchair or scooter. The request must also clearly identify the PAR as a request for a *modification* to an existing wheelchair.

All prior authorization requests will be automatically returned to the provider if any of the following information is missing:

1) Complete serial number of the equipment being repaired or modified if the wheelchair is an existing wheelchair and,
2) Identification of the PAR as a request for repair or replacement of parts of an existing wheelchair or, Identification of the PAR as a request for the modification or add-on to an existing wheelchair.
3) Identification of the PAR as a revision to an existing PAR with the number of the PAR being revised clearly indicated.
4) Identification of the wheelchair being repaired or modified as manual, motorized, or scooter.
5) Identification of the wheelchair or scooter as "new" or "pre-existing".
6) Indication that the wheelchair or scooter is the client's "primary" or "secondary"

Medicaid generally pays for the repair or modification of one primary motorized chair, one secondary motorized wheelchair and one manual wheelchair ***or*** a primary and secondary manual wheelchair.

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)