Automated Medical Payments

Medical Assistance Program Bulletin

Colorado Title XIX

Fiscal Agent

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Denver, CO 80202

Medical Assistance 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

Medical Assistance Fiscal Agent Information on the Internet

http://coloradomedicaid.acs-inc.com

Medical Assistance bulletins contain important policy and billing information and should be shared promptly with billing staff.

Bulletins supplement information in the Medical Assistance 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 Retain all bulletins until published notification advises that the information is obsolete or reproduced in subsequent bulletins or provider manual updates.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 Medical Assistance Provider Services.

Distribution: All providers **January 2004**

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All Providers

HIPAA Update

The Colorado Department of Health Care Policy & Financing (HCPF) is continuing the implementation of the many changes brought about by the HIPAA legislation. The changes impact the Colorado Medical Assistance Program in a variety of ways. Providers should regularly check the fiscal agent's website at http://coloradomedicaid.acs-inc.com for the most current information during this transition period.

Transaction and Code Set Update

The following transactions are in production:

- The 270 / 271 eligibility verification transactions.
- The 837 claim transactions,
- The 835 electronic remittance advice,
- The 834 managed care enrollment transaction,
- The 820 managed care premium payment transaction,
- The 276 / 277 claim status inquiry and response transactions,

Providers cannot yet submit interactive transactions via the web portal. However, providers should submit the 837, 270 and 276 transactions by batch submission through the dial up process. The 271, 277, and 835 transactions can be retrieved via the Colorado BBS or MEVSNET.

The remaining 278 PAR transaction is in testing and scheduled for implementation in March 2004. Providers should submit electronic PARS through WINASAP until April 2004. At that time, until the transaction is ready for submission through the web portal, providers are asked to submit all PARs on paper.

Web Portal Update

The State is planning to implement the new web portal in three separate phases.

- The first phase will take place in late January 2004. This phase includes:
  - The interactive 270 / 271 eligibility verification request and response, and
  - A new design for the Department's web site. The website will serve as a single point of access to all of HCPF's sites and resources, including all related websites.
- The second phase will be in March 2004 and includes:
  - The 837 claim transactions, and
  - The 276 / 277 claim status inquiry and response transactions.
  - Report and transaction file retrieval via the web portal
- The final phase will be implemented in May 2004 and includes:
  - The 278 prior authorization transaction, and
  - Additional enhanced functionality wherever necessary.

The Colorado BBS and MEVSNET will continue to be available for a period of time after the web portal is implemented. Once the transition from the current systems to the portal is complete, reports and transaction files will only be available through the new portal.

Provider Outreach

The Department will conduct a live videoconference to update providers on HIPAA readiness and implementation of the new web portal application. The conference will focus on the implementation of the web portal, a general over view of the functionality and design of the web portal, and computer based training information. All providers and their staff will be able to access the online training according to their own schedule. The conference will also review the enrollment process, transaction testing with ACS EDI Gateway, and the HIPAA Privacy and Security Standards. Please check the fiscal agent's website in early January 2004 for more specific information on attending this conference. The videoconference is scheduled for January 15th, 2004. Providers outside of the Denver metro area can join the conference from Pueblo, Durango, and Grand Junction. There will be both a morning and an afternoon session offered on the conference date.

Providers who are interested in attending one of the two videoconferencing sessions should send an e-mail to the Department's portal information mailbox at COMedicaidweb@hcpf.state.co.us or call and leave a voice message at 303-866-2363. E-mail is the preferred method of communication.

Contingency Plan

The State's contingency plan allowing providers, submitters, billing agents and clearinghouses to submit batch claims using current systems ends February 15, 2004. From February 15, 2004 forward, EDI will only accept the new X12N HIPAA compliant transactions for batch billers. The web portal application will be implemented March 2004, and the contingency plan allowing interactive claims to be submitted through WINASAP will end April 1, 2004. WINASAP is scheduled to end in April and will no longer be available for claim submission.

Provider Enrollment and Testing

The mandatory enrollment process continues for providers who electronically bill the new HIPAA X12N transactions. Enrollment packets were mailed to all providers in October 2003. The enrollment packet is also available on the fiscal agent's website. Each provider who submits transactions, picks up files or reports and/or plans on using any of the services through the web portal, must submit the completed packet and receive a trading partner identifier from the fiscal agent. The State will use the information provided in these enrollment packets to sign-up providers for the new web portal.

Submitters are encouraged to complete the new HIPAA transactions testing with ACS EDI Gateway as soon as possible to facilitate the HIPAA compliance transition prior to termination of the contingency plan. For testing information, please see the Companion Guides posted on the fiscal agent's website. (*Providers who will use the web portal exclusively for sending and receiving the new transactions do not need to participate in transactions testing.)*

Please contact the ACS EDI Gateway Support Unit at 1-800-987-6721 for assistance with the enrollment process or transaction testing.

Local Code Replacements

The State has completed the transition from local procedure codes to national codes effective December 15, 2003. For all dates-of-service on and after December 1, 2003, providers should use only nationally recognized procedure codes and modifiers. The mapping of the local codes to national codes was sent to providers in an October 2003 special Medical Assistance Program HIPAA Newsletter. The mapping is also available on the fiscal agent's website. Please continue to check the website for future updates and the soon to be published revised code mapping. Please remember that it is the provider's responsibility to choose the correct national code when submitting claims.

The transition also impacts the Prior Authorization Request (PAR) process. The State updated PARs that spanned the December 1st implementation date, requiring both a local code submission prior to December 1 and a national code after implementation. The update process assigned the appropriate national procedure code and modifier to each individual PAR line that contained a local code. Providers do not need to submit any additional documentation for these PARs. The State is also developing a method for handling PARs that are received and approved after December 1st with a "from" date prior to December 1st. DME and Supply providers should continue to use the appropriate procedure codes **and** modifiers on both PARs and subsequent claims. HCBS/Waiver providers must enter the appropriate procedure code on the PAR and the appropriate procedure code **and** modifier on the claim. As a reminder, for some services the national code has redefined what a unit is i.e.15 minutes versus an hour, so verify that the units are accurate on your claim.

Please continue to check the fiscal agent's website for updated information. Thank you for working with the Colorado Medical Assistance Program during this period of rapid change.

Prior Authorization (PA) Conversion and Unit / Time Description

The Colorado Medical Assistance Program recently modified all active PAs that contained local codes.

There are two phases to the PA conversion process. During the first phase all local code line items with an end date after 11/30/2003 were end dated 11/30/2003. The Colorado Medical Assistance Program processing system created a new line item with the national code effective 12/01/2003. The processing system also copied the 'Approved Units', 'Approved Amount', 'Remaining Units', 'Remaining Amount' and the original 'End Date' from the local code line item to the national code line item. Depending on the date of service, the 'Remaining Units' will be subtracted from either the local code line item or the national code line item.

The State plans a final conversion after timely filing ends on March 31, 2004. The processing system will recalculate the 'Remaining Units' field from the local code line item. The system will take the total units used on the local code line item and apply any additional units that were not converted in phase one to the national code. If more units were billed and paid than were approved at the time of initial authorization, an error will occur. The State will recoup any funds that were incorrectly paid to the provider. Providers should carefully watch the unit usage for all converted PAs.

During the first phase the Medical Assistance Program processing system did **not** recalculate the units for the new codes that have different unit / time descriptions. The processing system will soon recalculate any procedure codes with changed unit and time descriptions. For example, if the local code unit/ time is 1 unit = 60 minutes and the national code is 1 unit = 15 minutes, the processing system will add the additional units to correct the unit value. In the second phase, if only 10 units remain for a local code and the time unit is 1 unit = 1 hour and the national code is 1 unit = 15 minutes, the processing system will multiply the 10 units by four and add the 40 remaining units to the national code

Please be aware that many national code descriptions change the number of units that you may bill. The table below lists some of the national codes that have different unit / time values than the local codes.

For additional information, please call Provider Services at 303-534-0416 or 1-800-237-0757.

National Codes with Different Unit / Time Values Than Local Codes

Local Code	Local Code Rate	Local Code Unit/Time	Proposed Code	Proposed Code Unit/Time	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Rate
X0114	11.89	1/hr	T1005	1/15 min	U6				2.97
X0118	54.11	1/hr	H0004	1/15 min	U6				13.52
X0119	54.11	1/hr	H0004	1/15 min	U6	HR			13.52
X0120	30.30	1/hr	H0004	1/15 min	U6	HQ			7.57
X0134	12.77	1/hr	T1019	1/15 min	U6				3.19
X1130	12.56	1/hr	S5130	1/15 min	U1				3.14
X1130	12.56	1/hr	S5130	1/15 min	UA				3.14
X1130	12.56	1/hr	S5130	1/15 min	U2				3.14
X1140	12.56	1/hr	T1019	1/15 min	U1				3.14
X1140	12.56	1/hr	T1019	1/15 min	UA				3.14
X1140	12.56	1/hr	T1019	1/15 min	U2				3.14
X1141	12.56	1/hr	T1019	1/15 min	U1	HR			3.14
X1141	12.56	1/hr	T1019	1/15 min	UA	HR			3.14
X1141	12.56	1/hr	T1019	1/15 min	U2	HR			3.14
X1151	51.94	1/day	T1005	1/15 min	U1				.54
X1151	51.94	1/day	T1005	1/15 min	UA				.54
X5715	12.00	1/hr	H004	1/15 min	HF	TH	HQ		3.00

Retrieving 271, 277, and 835 Transactions

Instructions for retrieving transaction information are in the EDI HIPAA Companion Guides posted on the fiscal agent's website, http://coloradomedicaid.acs-inc.com. There is one Companion Guide for each transaction. Providers must be enrolled with EDI to submit the transactions. Please contact the EDI Support Unit at 1-800-987-6721 for help with the enrollment process.

Late Bill Override Date (LBOD)

Currently, the LBOD is used to allow the submission of claims with dates of service outside of the timely filing period. The LBOD field is not available on the new 837 claims transactions. The LBOD field has been replaced by a new indicator called the Delay Reason Code field, loop 2300, segment CLM, element CLM20. This field will be populated with a value that identifies the reason for the late submission. Providers will also be required to include both the actual date (as directed by the Provider Billing Manuals) as well as an explanation in the Claim Notes field (NTE segment) at the header level.

The valid delay reason codes for the Colorado Medical Assistance Program are:

Code:	Description:
1	Proof of Eligibility Unknown or Unavailable
3	Authorization Delays
7	Third Party Processing Delay
8	Eligibility Determination Delay
9	Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules
11	Other

PCP Program Incentive Payment Schedule Change

PCP incentive payments and client rosters are currently generated the in the middle of the month for client enrollment in the following month. You currently receive PCP incentive payments in the month prior to the month you provide the services.

Effective February 2004, PCP Program incentive payments will be processed the first Saturday of the month, with the payments dated two Tuesdays after the Saturday. Tuesday payment dates have direct deposits made three business days later. Paper checks are received around the same time. This means you will be paid in the middle of each month for client enrollment for that same month.

Even though your PCP roster reports will be produced later than they have previously been produced, you can get up-to-date information if you use the 834 Enrollment File. This HIPAA compliant file is produced daily with newly enrolled clients and on the last business day of the month for all clients enrolled for the following month.

This change will give you:

- More accurate incentive payments since we know who is enrolled in the month rather than projecting enrollment two weeks in the future.
- An up-to-date client roster.

Your payments will also be paid later than they have previously been paid. For example, you will receive the payment for February services the third week of February instead of the end of January.

If you have questions about using the 834 Enrollment File or if you do not currently receive a monthly PCP client roster, please contact ACS' EDI Gateway at 1-800-987-6721.

* * * Additional Provider Workshops * * *

Durango Workshops

Reservations are required.

Email reservations to: workshop.reservations@acs-inc.com
or
Call Medical Assistance Program Provider Services to make reservations.
1-800-237-0757 or 303-534-0146

Press "4" to make your workshop reservation. This transfers you to a voice mail where you must leave the following information:

- Medical Assistance Program provider billing number
- The date and time of the workshop
- The number of people attending and their names
- Contact name, address and phone number

Without all of the requested information, your reservation will not be processed successfully. Your confirmation will be mailed to you within 1 week of making your reservation. If you do not receive a confirmation within 1 week please contact Provider Services and talk to a Provider Relations Representative.

Location	Date	Time and Description
Durango **Doubletree Hotel** **501 Camino Del Rio** **Durango, CO 81301** **970-382-3913**	**Wednesday** **September 15, 2004**	**8:30 AM – 1:00 PM** **Beginning Training – CO1500/UB92** This class consists of in-depth information on resources, eligibility, timely filing, reconciling claim reports, and claim completion for new Colorado Medical Assistance Program UB-92 and CO1500 billers.
		2:00 PM – 3:30 PM **FQHC/RHC** This class discusses billing procedures, common billing issues and guidelines for FQHC/RHC providers billing on the UB92 format.

Provider Billing Issues

Did you know that if the provider incorrectly bills the Colorado Medical Assistance Program:

1. It is possible that the provider may not get paid in a timely manner, and
2. The provider could end up in an Accounts Receivable status showing that money is owed to the State? This impacts the provider's taxes.

   To ensure that payments are not delayed while corrections are made, below are some helpful tips to keep in mind when billing the Colorado Medical Assistance Program . . .

   - A **"rendering" provider** is the Individual who actually provided the service to the client. A Group or Clinic cannot be a rendering provider.
   - If the provider is affiliated with one or more groups or other health care organizations:
     - The **Individual is the Rendering** provider and the **Group is the billing provider.**
   - If the provider works for a group and bills using the rendering provider number as the billing provider, there **will** be income tax issues for the provider.
   - The provider cannot fix the incorrectly submitted claim. State staff must make the correction. This delays payments to the group.

   If the provider bills incorrectly, the error is corrected and the provider makes the same mistake *again*, the provider is required to repeat the correction process. There are no exceptions. Each time the provider bills incorrectly the provider must wait for State notification, follow the instructions and wait for all corrections to be processed. The correction process is lengthy and time consuming for all parties involved.

   - Remittance Advices (RAs), Remittance Statements (RSs), and Explanation Of Benefits (EOBs) are now called **Provider Claim Reports (PCRs).** PCRs detail Medical Assistance Program payments by client and dates of service. PCRs may be downloaded each week from www.mevsnet.com (some circumstances may result in the PCR being mailed weekly). To download your PCR each week from mevsnet.com, you must be enrolled. Call EDI at 1-800-987-6721 to enroll and receive your password. **Providers should retain PCRs for their records**.

- PCRs are only available through Medical Assistance Program Provider Services. The State of Colorado, HCPF cannot fill **PCR** requests. The State may be able to help resolve problems or direct you to the appropriate resource. If you need a copy of a PCR, please contact the Medical Assistance Program Provider Services at (303) 534-0146 or toll free Colorado at 1-800-237-0757.

Rendering and Referring Providers

Rendering provider: Enter the 8-digit Medical Assistance Program provider number assigned to the provider **performing** the service.

Referring provider: If the client is enrolled in the Primary Care Physician (PCP) program and the rendering provider is not the PCP, the PCP's Medical Assistance Program provider number must be entered in the referring provider field. **PCP enrolled clients must obtain PCP referral if services are performed by a physician other than the PCP.** If the client does not have an assigned PCP, this field may be left blank.

Medical Assistance Program Payment Accuracy Measurement (PAM) Demonstration Project

The Department received a grant from the Centers for Medicare and Medicaid (CMS) to participate in a Medical Assistance Program PAM demonstration project. The goal of the project is to determine the accuracy of Medical Assistance Program claim payments at a state and national level. The Improper Payments Information Act of 2002 (Public Law 107-300) directs each executive agency, in accordance with the Office of Management and Budget guidance, to:

- Review all of its programs and activities annually,
- Identify those that may be susceptible to significant improper payments,
- Estimate the annual amount of improper payments, and
- Submit those estimates to Congress before March 31 of the following applicable year.

The project will identify and calculate rates of improper payments including underpayments as well as overpayments.

Essential parts of the review portion of this project consist of review of a sample of Medical Assistance Program claims for:

- Processing validation
- Review of the corresponding medical records
- Verifying eligibility

Beginning in January or February 2004, the Department's contractor, Tucker Alan Inc., will contact providers to obtain medical records for the services being reviewed.

We ask for your cooperation and timely response to the requests for medical records. Your cooperation will facilitate and expedite the review as well as minimize the need for repeated direct contacts to obtain records.

Failure to provide the requested records will inflate the overall payment error rate, and could result in claim payment recoupment. Requests will clearly indicate that the request is part of the PAM project. Results of the project will be shared in Provider Bulletins when the study has been completed.

Thank you in advance for your cooperation. Questions regarding this project or the sample can be directed to the Project Director at 303-866-4844.

Old Age Pension Health and Medical Care Program

On December 12, 2003, the Medical Services Board adopted rules eliminating medical benefits and reducing provider payments for the Old Age Pension (OAP) Health and Medical Care Program. Effective January 1, 2004, the following rules will be implemented to prevent overspending the program's $10,750,000 appropriation. Because the program is a state-funded program and not an entitlement, authorized spending amounts cannot be exceeded. If utilization rates continue at the same level as they have during the past six months, the program will be over the cap by nearly $2.5 million.

To counteract an over expenditure, the following services will be eliminated on January 1, 2004 for OAP Health and Medical Care Program clients:

- Inpatient hospital services

In addition, the following provider payment reductions will be effective for dates of service on and after January 1, 2004:

- Dental reduced to 50% of the Medical Assistance Program Rate
- Laboratory and x-ray reduced to 50% of the Medical Assistance Program Rate
- Outpatient payment reduced to 50% of the Medical Assistance Program Rate

- Practitioner payment reduced to 50% of the Medical Assistance Program Rate
- Transportation reduced to 50% of the Medical Assistance Program Rate
- Home health services and supplies reduced to 50% of the Medical Assistance Program Rate

Provider payment for pharmacy services will remain at 100% of the Medical Assistance Program Rate. On July 1, 2004 the inpatient hospital benefit is expected to be restored.

Clients are eligible to apply for the Colorado Indigent Care Program (CICP) benefits not covered by the OAP Health and Medical Care Program. Information on the CICP can be found on the Department's website at www.chcpf.state.co.us.

The Emergency Medical Services to Aliens Program may cover life and death emergency hospital admissions for non-citizen OAP Health and Medical Care Program clients.

Please continue to verify client eligibility through CMERS or WINASAP.

As a reminder, the current rules for the OAP Health and Medical Care Program include:

- Maximum client co-payment of $300
- Co-payment amounts for services are the same as the co-payment amounts under the Medical Assistance Program
- There are no retroactive benefits (client can only be eligible from date of application). If claim overpayments are made in error, recoveries will be made retroactively.

For questions regarding these changes, please contact:

Chris Underwood, Manager, Safety Net Financing at 303-866-5177

Dental Providers

Medical Assistance Program Oral Surgery Provider Enrollment and Billing Policy

Oral surgeons, based upon their degree and current Colorado licensure shall choose whether to enroll as a physician or as a dentist. Medical Assistance Program dental providers cannot be enrolled as two different provider types. This policy is effective January 1, 2004.

- Oral surgeons enrolled as physicians, with no specialty shall:
  - Bill CPT medical codes and receive current Medical Assistance Program reimbursement for those codes;
  - Bill on a Medical Assistance Program acceptable medical claim form;
  - Follow Medical Assistance Program medical billing rules;
  - Follow medical multiple surgery billing requirements;
  - Use medical procedure code modifiers if appropriate; and
  - Follow medical prior authorization requirements.
- Oral surgeons enrolled as dentists, with a specialty in oral surgery shall:
  - Bill ADA dental procedure codes and receive Medical Assistance Program reimbursement for those procedure codes;
  - Bill on a Medical Assistance Program acceptable ADA dental claim form;
  - Follow Medical Assistance Program and dental billing rules;
  - Not use medical procedure code modifiers; and
  - Follow Medical Assistance Program dental prior authorization requirements.
- Dentists must enroll as dentists and shall:
  - Bill ADA dental procedure codes and receive Medical Assistance Program reimbursement for dental procedure codes;
  - Bill on a Medical Assistance Program acceptable ADA dental claim form;
  - Follow Medical Assistance Program and dental billing rules;
  - Not use medical procedure code modifiers; and
  - Follow Medical Assistance Program dental prior authorization requirements.

Mental Health Providers

Mental Health Inpatient and Therapy Session Benefit Changes

Effective September 1, 2003, the Medical Assistance Program established annual limits for mental health inpatient stays and individual therapy sessions for both MHASA and fee-for-service clients. Inpatient psychiatric hospitalizations are limited to 45 days per fiscal year. Individual therapy sessions are limited to 35 sessions per fiscal year.

Individuals age 20 and under may be eligible for additional days/sessions under EPSDT if medically necessary. The MHASA must prior authorize services exceeding the limit for clients enrolled in MHASAs. The Colorado Foundation for Medical Care (CFMC), acute care utilization review contractor for the Department, must prior authorize services exceeding the limit for clients enrolled in fee-for-service.

Please note that all other types of therapy sessions such as group, family, etc. are not subject to the benefit limit. Providers should consult the list of affected codes included with this bulletin.

Court-ordered services are not subject to prior authorization requirements. Documentation of a court-ordered service must be submitted with the claim form in order to be processed for payment.

Inpatient claims that exceed the 45-day limit will be denied. It is the responsibility of the provider to rebill with the allowed days.

Prior Authorization Request (PAR) forms may be downloaded from the fiscal agent's website at: http://coloradomedicaid.acs-inc.com/. Click on Provider Services, then Forms, then Colorado Medical Assistance Program Prior Authorization (PAR) Form (02/03). Providers may print and complete the form.

Send PARs to the following address:

CFMC
P.O. Box 17300
Denver, CO 80217-0300
Phone: 303-695-3300 extension 3129, Medical Assistance Program Acute Care Review Services
Fax: 303-695-3377

The CFMC PAR process

1. The provider submits paper PARs with documentation to supporting the medical necessity of the requested service to CFMC by fax or mail.
2. The PAR must include:
   A. The client's name and Medical Assistance Program ID number.
   B. The clinic or hospital name, business address, phone number and Medical Assistance Program provider number.
   C. If inpatient services are requested, the referring physician's name, address, phone number and Medical Assistance Program provider number.
   D. If therapy services are requested, the name, professional title, business address and phone number of the rendering therapist
   E. A service plan for the client. The plan should include:
      - ✓ Information about court-ordered stay or 72-hour hold.
      - ✓ A valid psychiatric diagnosis.
      - ✓ Statement of problem
      - ✓ Interventions and modality
      - ✓ Goals of therapy
      - ✓ A statement identifying the expected number of treatments or days within a specific timeframe to meet goals.
3. The following definition shall be used to determine if a service is medically or clinically necessary (8.212.04 CCR Volume 8):
   A. A covered service shall be deemed medically or clinically necessary if, in a manner in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care, the service:
      i. Is reasonably necessary for the diagnosis or treatment of a covered mental health disorder to improve, stabilize or prevent deterioration of functioning resulting from such a disorder; and
      ii. Is furnished in the most appropriate and least restrictive setting where services can be safely provided; and
      iii. Cannot be omitted without adversely affecting the consumer's mental and/or physical health or the quality of care rendered.
4. Inpatient hospitalization is limited to 45 days per fiscal year.
5. Individual and individual brief visits are limited to 35 visits per fiscal year.
6. A PAR for **inpatient stay** should include the number of **days** requested.
7. A PAR for **individual therapy** should include the number of **sessions** requested.
8. If the request is for inpatient service, a psychiatrist must sign the PAR.
9. If the request is for individual or individual brief therapy service, a qualified therapist must sign the PAR.

This change impacts the following codes:

Outpatient Mental Health Coding Quick Reference		
RULE 8.200.2.G.	Physician services in regard to mental health are a benefit. Outpatient individual and individual brief counseling visits are limited to 35 visits per state fiscal year.	
KEY	M - Mental Health Licensed Professionals or than a Psychiatrist or PL P - Psychiatrist or Physician PL - Psychologist with a doctorate degree	
Mental Health Procedure Codes	**Listing of Fee-for-Service Mental Health Codes that count toward the 35 visit limit**	**Type of Provider**
90804	Individual psychotherapy, 20 to 30 min face/face.	P,PL,M
90805	w/ E&M services	P,PL
90806	Individual psychotherapy, 45 to 50 min face/face.	P,PL,M
90807	w/ E&M services	P,PL

Hospital Providers

Attending Physician IDs on Hospital Claims

In order to receive reimbursement, hospitals are required to include an attending physician ID on their claims. Whenever possible, this should be the ID of a Medical Assistance Program enrolled physician.

- If the attending physician is not enrolled in the Colorado Medical Assistance Program, the hospital may enter its hospital billing provider ID in the attending physician ID field.
- If a Medical Assistance Program client goes to the emergency room is seen by a triage nurse, but leaves before seeing a physician, the hospital may enter its hospital billing provider ID in the attending physician ID field.
- In a "locum tenens"case where the physician is filling in for a Medical Assistance Program enrolled physician but is not enrolled in the Medical Assistance Program, the hospital may put the enrolled physician's Medical Assistance Program ID in the attending physician ID field.

These changes in billing requirements are effective January 1, 2004.

Reminder to Send in Your Outpatient Cost-to-Charge Ratios

Medicare cost-to-charge ratios are used to calculate Medical Assistance Program reimbursement for outpatient services. It is the provider's responsibility to notify the Department of rate changes. A copy of the Medicare letter, showing the adjusted rate, must be sent to:

Domenica Blum
Department of Health Care Policy and Financing
Rates & Analysis Division
1570 Grant Street
Denver, CO 80203-1818.

Pharmacy Providers

Beginning January 27, 2004 the following changes will be made to the pharmacy program.

Atypical antipsychotics

The following Atypical antipsychotics will require prior authorization (PA) for more than once a day dosing. There are exceptions to the prior authorization as noted.

Zyprexa: A PA is required for more than once daily dosing. Exception: Zyprexa 20mg Tablet

Risperdal: A PA is required for more than once daily dosing. A prior authorization will be approved for twice a day dosing for elderly clients, clients with renal and hepatic impairment or for clients with concern of orthostatic hypotension and syncope. Exceptions: Risperdal 3mg Tablet, 4mg Tablet, Risperdal Consta 25mg, Risperdal Consta 37.5mg, Risperdal Consta 50mg, and 1mg/ml Solution

Abilify: A PA is required for more than once daily dosing. Exception: Abilify 30mg Tablet

Fentanyl

The following products will require a prior authorization as stated.

Actiq: All prescriptions need a Prior Authorization.

Duragesic Patches: A PA is required for more than 1 Patch/2 Day dosage.

Cox-2 Inhibitors (Vioxx, Celebrex, Bextra)

Cox-2 Inhibitors will require a prior authorization for clients between the ages of 18 and 65. Use of the Cox-2 inhibitors are limited to FDA approved indications and dosing guidelines:

Drug	Approved Indications	Dose
Vioxx	Osteoarthritis Rheumatoid Arthritis Acute Pain and Dysmenorrhea	12.5-25mg daily 25mg daily 50 daily for 5 days
Celebrex	Osteoarthritis Rheumatoid Arthritis Familial Adenamatous Polyposis Acute pain and Dysmenorrhea	200mg daily; 100mg BID 100mg – 200mg BID 400mg BID for 6 months 400mg day 1; 200mg BID
Bextra	Osteoarthritis Rheumatoid Arthritis Primary dysmenorrhea	10mg daily 20mg daily 20mg BID prn

Vision Providers

HIPAA Changes

Polycarbonate lens

The polycarbonate lens billing description is in the new national standardized code regulations, and instructs providers to bill polycarbonate lens in addition to the lens code(s). Under the old local codes, the payment included both the lens and the polycarbonate lens.

In addition to the prescription lens code, vision providers should bill for polycarbonate lenses using code S0580 ($3.34) for each polycarbonate lens. By billing the additional $3.34 charge, providers will be reimbursed the same amount as they were under local codes.

New Vision Guidelines

Colorado law (22-1-116, C.R.S.) mandates that public schools provide a vision screening system for students. The current *Guidelines for School Vision Screening Programs* (Colorado Department of Public Health and Environment, 1991) outlines guidelines for annual vision screening of public school children in preschool, kindergarten, first, second, third, fifth, seventh and ninth grade.

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (children's health benefits) Advisory Committee reviewed vision guidelines and recommends the new vision guidelines, *Visual Screening Guidelines: Children Birth through Five Years*, for children 5 years old and under. These guidelines are designed to supplement the 1991 guidelines for school age children.

The new guidelines were developed for Child Find Personnel by the Colorado Department of Education (CDE), and will be posted on the CDE Child Find website at the end of January 2004. Child Find is a free program designed to identify children from birth through twenty-one years who may need special education support. The program provides evaluations and assessment including vision, hearing, speech, developmental and thinking skills. The purpose of the *Visual Screening Guidelines: Children Birth through Five Years* is to assist personnel in determining an overall estimate of a child's visual status.

Please direct questions about Medical Assistance Program billing or the information in this bulletin to Medical Assistance Program Provider Services at:

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

Remember to check the both the State's website at:
http://www.chcpf.state.co.us/HIPAA/hipaaindex.htm

And the fiscal agent's website at:
http://coloradomedicaid.acs-inc.com

For HIPAA updates!