Medical Assistance Program Bulletin

Colorado Title XIX

Fiscal Agent

600 Seventeenth Street
Suite 600 North
Denver, CO 80202

Medical Assistance Program 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 Program
Fiscal Agent Information
on the Internet
www.chcpf.state.co.us

Click on the Provider Services tab at the top of the web page

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

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 Retain all bulletins until published notification advises that the information is obsolete or reproduced in subsequent bulletins or provider manual updates.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

Distribution: All providers | **June 2004**
Reference: B0400177

All Providers

The Provider Web Portal Is Almost Here!

The Colorado Medical Assistance Program is about to implement its new Web Portal! Providers will access the portal through a secure web site www.chcpf.state.co.us.

Providers who have completed the enrollment process with ACS EDI Gateway, and who have indicated an interest in the portal, will be receiving a letter from the State. This letter will contain the appropriate user names and passwords for accessing the portal. Once this letter has been received, providers should be able to begin utilizing the portal.

The first transactions that will be available through the portal will be the Client Eligibility Verification Inquiry and Response.

The remaining transactions, including the claim formats, claim status inquiry, and prior authorization will be available through the portal at a later time.

The Department of Health Care Policy & Financing will continue to operate the current WINASAP system until the portal is fully functional. Also, the CMERS and FAXBACK systems will continue to be maintained as additional options for eligibility verification. Once the portal is fully functional, WINASAP will be turned-off. CMERS and FAXBACK will remain available.

When the portal is fully operational, MEVSNET, NECS and the BBS will no longer be available. Reports that are now available in MEVSNET or the BBS will then be available through the portal.

Colorado Benefits Management System (CBMS) Implementation

The development of the Colorado Benefits Management System (CBMS) is a joint effort between the Colorado Department of Human Services (CDHS) and the Colorado Department of Health Care Policy & Financing (HCPF). CBMS is replacing six current legacy systems. This new system is designed to streamline eligibility determination for medical assistance (Medicaid and Child Health Plan+), cash assistance (welfare), and food assistance (food stamps). Implementation of the new eligibility system will take place in the near future.

CBMS will provide both Medicaid and Child Health Plan + eligibility data to the State's Medicaid Management Information System (MMIS). Following the implementation of CBMS, both Medicaid and CHP+ eligibility data will be available to health care providers when they submit eligibility inquiries. Providers will continue to have both the Colorado Medical Eligibility Response System (CMERS) and FaxBack available for eligibility verification.

For providers, the transition from the legacy systems to CBMS should be seamless. Providers will continue to verify eligibility and submit claims in the manner that they are now. The implementation of CBMS will not affect anyone's ability to provide services. Also, the use of the Medical Identification Cards (MIDs) will remain the same.

The CBMS system should not be confused with the Department of Health Care Policy & Financing's soon to be implemented provider Web Portal. It is the portal that will actually be used by providers to verify eligibility and submit claims. It is the provider Web Portal that will eventually replace the current WINASAP system.

Correction to bulletin B0400171

Please make the following corrections in the Family Planning section on page 35 of the Practitioner CMS Codes bulletin:

Procedure code A4266 – Delete the statement "May only be billed by Family Planning Clinics."

Replace the last paragraph with:

> Clinics certified as a family planning clinic or non-physician practitioner group for the purposes of providing family planning services may dispense birth control pills directly to the client if they are licensed as an outlet pharmacy. Birth control pills will be reimbursed at $14.00 per monthly supply. For more costly oral contraceptives, the clinics may choose to write a prescription to be filled by a pharmacist. All other practitioners must prescribe oral contraceptives through a pharmacy.

We apologize for any inconvenience this may have caused.

Contact Reminder

Providers should remember that their calls for assistance should be directed to the fiscal agent call center. Providers should not contact the HCPF Customer Service Office for eligibility verification inquiries. On the other hand, *clients* seeking help with Medical Assistance Program questions should contact the Customer Service Information Line at the Department of Health Care Policy & Financing (HCPF) at:

303-866-3513 or 1-800-221-3943 (Toll free)

or their county of residence. Providers should not encourage clients to contact the fiscal agent directly.

Billing the Colorado Medical Assistance Program When a Medicare HMO is the Primary Insurer

Medicare Managed Care enrollment is not the same as commercial managed care enrollment. Clients enrolled with a Medicare Managed Care program receive Medicare benefit services from a Medicare contracted Prepaid Health Plan (PHP). An example of a Medicare HMO is Secure Horizons.

A Medicare HMO crossover claim is a Medical Assistance Program claim for the balance after the Medicare HMO has completed processing.

The provider should submit claims with a Medicare HMO payment the same way as claims with a Medicare payment. For example, on the Colorado 1500 claim form:

1. Enter the Providers charge in Field 20 (TOTAL CHARGES).
2. Enter the amount paid by the Medicare HMO in Field 21 (MEDICARE PAID).
3. Enter the NET CHARGE or HMO CO-PAY amount in Field 23 (NET CHARGE).

For more information, including Medical Assistance Program billing examples for commercial HMO, Medicare, and Medicare HMO clients, please see the December 2000 All Provider Bulletin, B0000085. This document is available on the Department's website:

www.chcpf.state.co.us

Select PROVIDER SERVICES on the gray menu bar. Then select the blue BULLETINS button on the left-hand side. Scroll-down the list of bulletins until you find B0000085.

Primary Care Physician Program (PCPP) Incentive Payments Eliminated/Reimbursement Increases

During the 2004 legislative session, the Legislature eliminated the $3.00 per member per month PCPP payments effective July 1, 2004. The savings from the $3.00 payments will be used to increase reimbursement for CPT Evaluation and Management code 99213 - Office or Other Outpatient Visit. Reimbursement for code 99213 will be increased from $32.62 to $39.57, a 21% increase.

Managed Care Enrollment Reports

Enrollment information for clients assigned to a group practice will still be available through the PCP Roster List and the new HIPAA 834 Managed Care Enrollment transaction. For further information on these reports / transactions, please contact ACS EDI Gateway at 1-800-987-6721.

Dental Providers

Prefabricated Stainless Steel Crown PAR Example

The example below applies **only** to clients age 20 and under, requiring six (6) or more pre-fabricated crowns, hospitalization, general anesthesia/deep sedation **when the <u>required</u> x-rays and photographs cannot be submitted with the PAR**

The example below is ***only an illustration*** *of what should be entered on the PAR.* Providers should explain *in their own words* in Field 38 (Remarks for unusual services) the reasons for:

1. The needed crowns,
2. The need for hospitalization
3. The need to do more than 5 prefabricated crowns in one visit
4. The reason for not being able to submit x-rays or photographic images of the dentition with the PAR
5. And any additional information justifying the treatment

27. First visit date current series | 28. Place of treatment: Office, Hosp. (X), ECF, Other | 29. Radiographs or models enclosed? No / Yes / How many? | 35. Is treatment for orthodontics? | If service already commenced enter: Date appliances placed / Mos. treatment remaining

36. Identify missing teeth with "x" (FACIAL, LINGUAL, UPPER, LOWER, RIGHT, LEFT, PRIMARY, PERMANENT)

37. Examination and treatment plan – List in order from tooth no. 1 through tooth no. 32 – Using charting system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo. Day Year	Procedure number	Fee
A		Prefabricated stainless steel crown - primary tooth		D2930	
B		Prefabricated stainless steel crown - primary tooth		D2930	
C		Prefabricated stainless steel crown with resin window		D2933	
E		Prefabricated resin crown		D2932	
H		Prefabricated stainless steel crown with resin window		D2933	
I		Prefabricated stainless steel crown - primary tooth		D2930	
J		Prefabricated stainless steel crown - primary tooth		D2930	
K		Prefabricated stainless steel crown - primary tooth		D2930	
T		Prefabricated stainless steel crown - primary tooth		D2930	
19		Prefabricated stainless steel crown – permanent tooth		D2931	

For administrative use only

Example ONLY

38. Remarks for unusual services
<u>**Example of PAR information:**</u>
Medical Necessity: *Unmanageable behavior*
Dental Necessity: *Rampant multi-surface decay*
Hospitalization with general anesthesia, photos/radiographs

39. **I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.**

Signed (Treating Dentist) | License Number | Date

40. Address where treatment was performed | City | State | Zip

41. Total Fee Charged
42. Payment by other plan
Max. Allowable
Deductible
Carrier %
Carrier pays
Patient pays

©American Dental Association, 1994
J510 (Same as ADA Dental Claim Form - J504, J511, J512)

Oxygen Providers

Please be sure to include Modifier RR, Rental (Durable Medical Equipment), whenever you are submit claims for oxygen equipment rental. This modifier is used to calculate the appropriate reimbursement rate for a particular product. Providers should be sure to check the most recent version of the billing manuals in the Provider Services section of the Department's website: www.chcpf.state.co.us

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Pharmacy Providers

Correction to December 2003 Bulletin B0300165

The December 2003 bulletin stated that the limit of Emend Tripaks is 5 paks per 30-day period. This is incorrect. The correct limit for Emend Tripaks is **2 paks (6 tablets) per 30-day period**.

The December 2003 bulletin can be found on the Department's website:

www.chcpf.state.co.us

Select PROVIDER SERVICES on the gray menu bar. Then select the blue BULLETINS button on the left-hand side. Scroll-down the list of bulletins until you find B0300165.

Prior Authorizations for Zyprexa, Risperdal and Abilify

No Prior Authorization is required for Zyprexa, Risperdal and Abilify if a client receives one tablet of any strength. Even if the client receives multiple strengths of the same medication, no Prior Authorization is required. For example, Zyprexa 20 mg, Risperdal 3 mg or 4 mg, or Abilify 30 mg do not require a Prior Authorization. If a medication requires Prior Authorization, the physician should call the Prescription Drug Card System (PDCS) Prior Authorization Desk at 1-800-365-4944.

A pharmacy provider may use Medical Certification Code 1 for a 3-day supply of a medication while the physician is waiting for Prior Authorization. This is considered an emergency fill. This should only be used when the drug requires Prior Authorization.

Pharmacy Post-Payment Reviews

Recently, several post-payment claim reviews were conducted on a variety of pharmacy issues. These reviews identified claims paid between January 5, 2000 and April 11, 2003 that appeared to have errors related to package size, quantity dispensed and/or days supplied.

Billing errors can amount to overpayments in the thousands of dollars. The additional cost to the Colorado Medical Assistance Program is considerable. Overpayments affect all providers when money is sent to those who bill incorrectly.

The most common errors noted in the pharmacy audits were:

- Billing for quantities greater than prescribed.
- Billing for quantities that were excessive for days supplied.
- Billing the incorrect NDC.
- Entering the unit of measure into the quantity dispensed field. This was seen most often when the prescription was in the form of a package, tube or vial.

The Department anticipates conducting additional pharmacy claim reviews in August 2004. One review will include claims exhibiting apparent billing errors related to Inhalers, Pulmicort, Lovenox and rounding errors. If you receive results of this review, please note the time frame allowed for response and submission of documentation.

Pharmacy and Supply Providers

Procedure Code A4200 (Gauze pad(s) sterile or non-sterile, medicated or non-medicated, each) will be end-dated December 31, 2004. The future end-date allows the use of active PARs for code. Code A4200 has not been mapped to any other national code. Providers should begin using the most appropriate code that identifies this product as soon as possible.

Physical & Occupational Therapy Providers

Updated Procedure Codes and Rates

Effective July 1, 2004 Physical and Occupational Therapists, Physical Therapy Clinics and Rehabilitation Agencies **including hospital based clinics,** must submit Prior Authorization Requests (PARs) for medically necessary services **exceeding 24 units of service.**

UB-92 Billing – In addition to billing the 420 or 430 revenue code, procedure codes must be listed on the billing form. If the procedure codes are not listed on the UB-92 billing form, the claim will deny. Example: revenue code 420 and procedure code 97003 must be listed for a physical medicine re-evaluation.

CO-1500 Billing – List all relevant procedure codes. The procedure codes will be compared to the approved PAR codes. If the procedure code is not authorized, the procedure will deny.

The client's first 24 units of PT or OT therapy services do not require a prior authorization. Prior Authorization Requests are required for all additional visits. A maximum of five units of therapy are allowed per date of service unless specified in the table below. Procedure codes 97001-97799 require modifiers of GP for physical therapy procedure codes. Occupational therapy procedure codes require modifier GO.

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

Procedure Codes	Description	Reimbursement	Maximum # UNITS – Per Day	Provider Modifier
97001	PT Evaluation	$33.60	1	GP
97002	PT Re-Evaluation	$22.68	1	GP
97003	OT Evaluation	$33.60	1	GO
97004	OT Re-Evaluation	$22.68	1	GO
97010	Application Hot or Cold Packs	$ 4.20	2	GP/GO
97012	Mechanical Traction	$ 9.45	1	GP/GO
97014	Electric Stimulation Therapy	$ 7.35	1	GP/GO
97016	Vasopneumatic Devices	$ 9.45	1	GP/GO
97018	Paraffin Bath	$ 6.30	1	GP/GO
97020	Microwave	$ 6.30	1	GP/GO
97022	Whirlpool	$ 9.45	1	GP/GO
97024	Diathermy	$ 6.30	1	GP/GO
97026	Infrared	$ 4.20	1	GP/GO
97028	Ultraviolet	$ 8.40	1	GP/GO
97032	Ap Modality One or More Areas	$ 9.45	2	GP/GO
97033	Iontophoresis	$10.50	4	GP/GO
97034	Contrast Baths	$ 8.40	4	GP/GO
97035	Ultrasound	$ 8.40	4	GP/GO
97036	Hubbard Tank	$11.55	4	GP/GO
97039	Unlisted Modality	Manual Price		GP/GO
97110	Thera Proc, One or More Areas	$10.50	4	GP/GO
97112	Neuromuscular Re-education	$10.50	4	GP/GO
97113	Aquatic therapy	$ 9.45	4	GP/GO
97116	Gait Training	$ 8.40	4	GP/GO
97124	Massage	$11.55	4	GP/GO
97139	Unlisted Therapeutic Procedure	Manual Price	4	GP/GO
97140	Manual Therapy Techniques	$12.60	4	GP/GO
97150	Therapeutic Procedure, Group	$10.50	2	GP/GO
97504	Orthotics Fitting & Training	$10.08	4	GP/GO
97520	Prosthetic Training	$10.08	4	GP/GO
97530	Therapeutic Activities	$10.50	4	GP/GO
97532	Development of Cognitive Skills	$19.74	2	GP/GO
97533	Sensory Integrative Techniques	$19.74	2	GP/GO
97535	Self Care/Home Mgmt	$15.75	4	GP/GO
97537	Comm/Work Reintegration	$15.75	1	GP/GO
97542	Wheelchair Management	$15.75	2	GP/GO

Procedure Codes	Description	Reimbursement	Maximum # UNITS – Per Day	Provider Modifier
97545	Work Conditioning	$50.40	1	GP/GO
97546	Work Con, Each Add Hour	$25.20	1	GP/GO
97703	Checkout for Ortho/Prosthetics	$15.76	2	GP/GO
97750	Physical Performance Test	$19.96	2	GP/GO

Speech Therapy Providers

Updated Procedure Codes and Rates

Procedure Codes	Description	Reimbursement	Maximum # UNITS – Per Day
92506	Speech Evaluation	$30.88	1
92507	Treatment Speech Disorder	$18.90	1
92508	Speech, Group, Two or More	$ 9.46	1
92525	Evaluation of Swallowing	$43.99	1
92526	Treatment of Swallowing	$23.10	1
** 96110	Developmental Testing	$34.33	1
** 97112	Neuromuscular Re-Education	$10.50	4
** 97532	Development of Cognitive Skill	$19.74	2
** 92597	Evaluation for Voice Prosthetic	$55.83	1
* 99201	Office or OP Visit New Patient	Not billable Effective July 1, 2004	
* 99211	Office or OP Visit Established Patient	Not billable Effective July 1, 2004	

*Deleted code ** Added code

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

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Prior Authorization Requests (PARs)

The Medicaid PAR forms are available from the fiscal agent Provider Services at 303-534-0146 or 1-800-237-0757 (toll free Colorado). PAR forms are also available on the Department of Health Care Policy and Financing website at www.chcpf.state.co.us, under the provider services tab.

Submit PARs to:
Prior Authorization Requests
Colorado Foundation for Medical Care (CFMC)
P.O. Box 17300
Denver, CO 80217
303 695-3300

PARs are approved for a 12-month period (depending on medical necessity as determined by the reviewer). Submit PARs for the **number of units** for each specific procedure code requested, ***not*** for the number of services.

The State may perform OT and PT services reviews for utilization control and quality control purposes.

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 Department's website at: http://www.chcpf.state.co.us

For Provider Updates and News