Medical Assistance Program Bulletin

Colorado Title XIX

Fiscal Agent

A C S

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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 Retain all bulletins until published notification advises that the information is obsolete or reproduced in subsequent bulletins or provider manual updates.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 **September 2004**

Reference: B0400181

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All Providers

CBMS Goes Live September 1, 2004

The new Colorado Benefits Management System (CBMS), which has been in the planning and development stage since 1996, will go live September 1, 2004! This new, state of the art system allows clients to go to one agency, file a benefits request and learn immediately the programs for which they are eligible. No other state has a system that brings so many programs under one umbrella.

In addition to determining Medical Assistance Program and CHP+ eligibility, an applicant can find out if they qualify for the following programs:

- Adult cash assistance for the needy
- Colorado Works employment and cash assistance programs
- Food assistance
- Child welfare recipients
- Medical Assistance Program long term care and home services
- Benefits for the working disabled

To make sure that clients don't lose benefits as the old system is replaced; benefits will remain fixed until county eligibility technicians are able to verify all client eligibility data. Providers who verify eligibility for existing clients should continue to use the options available to them, i.e., CMERS, FAXBACK, 270/271, and WINASAP. This eligibility information is obtained from the Medicaid Management Information System and will not be affected.

In the event there are eligibility issues when CBMS is implemented, there may be clients who are eligible for medical assistance whose eligibility cannot be verified by current methods. In those instances, clients will be given a state-approved letter by their eligibility technician as proof of eligibility. Keep your claims timely and maintain a copy of your accept/reject reports as evidence of timely filing when claims reject for eligibility edits 250 and 129. You may experience a delay in payment due to the transition to this new system.

Presumptive Eligibility (PE) Issue: Presumptive eligibility determination ends August 31, 2004. Those clients who were determined to be PE eligible between August 25 through 31, 2004 will be presumptively eligible through September 30, 2004. Providers will be able to bill these claims when eligibility can be electronically verified.

Providers should watch for updates on Provider Claim Reports and on Provider Services section of the web site at http://www.chcpf.state.co.us/ACS/Provider_Services/provider_services.asp for updates regarding this transition. If providers experience billing problems, they should call the fiscal agent's Provider Services at 303-534-0146, Denver Metro or 1-800-237-0757, toll free Colorado.

Electronic Provider Reports Now Available Through the Web Portal

Beginning mid **September 2004**, providers will retrieve any electronic reports and/or transactions by accessing the Department's Web Portal. Access the Department's Home Page at http://www.chcpf.state.co.us/, click on the Secured Sites tab on the navigation bar, top right hand corner. Log in using your **Web Portal user name and password** to access the menu page.

The **File and Report Service** replaces the current BBS/MEVSNET system for electronic reports. Providers will continue to have access to the reports they currently receive at this new location, using the web technology. The current BBS/MEVSNET used for retrieving reports and transactions will remain functional until **60 days after the File and Report Service is implemented**. It will be discontinued at that time and the Web Portal will be the only source for electronic reports and/or transactions.

If you completed and submitted the required enrollment form and have not received a letter with your trading partner ID, please call EDI provider customer service at 800-987-6721 to verify receipt of your form.

Providers/submitters who received their trading partner identification number from EDI should have received a Web Portal log on and password letter from the Colorado Department of Health Care Policy and Financing. If you have not received this document, please e-mail the Department at COMEDICAIDWEB@hcpf.state.co.us. Submitters who do not have access to e-mail may leave a message on our message line at 303-866-2363. Please provide your trading partner identification number as well as your Provider ID in the e-mail or voice mail so that your request can be researched.

Providers and submitters who have not submitted their EDI reenrollment form may download one from the Internet at http://www.chcpf.state.co.us/ACS/Enrollment/enrollment.asp.

Old Age Pension Health and Medical Care Program

The January 2004 Medical Assistance Program bulletin (Reference: B0300166) notified providers of the medical benefits elimination and provider payments reduction for the Old Age Pension Health and Medical Care Program. The OAP Health and Medical Care Program was also known as the Modified Medical Plan and OAP State Only Program.

The bulletin also stated that the inpatient hospital benefit might be restored and provider reimbursements could be modified on July 1, 2004. No changes to the benefit package or provider reimbursements were made on July 1, 2004. The Department is expected to present options to modify the benefit package and provider reimbursements to the Medical Services Board at their October 8, 2004 meeting. Providers will receive details of any changes to the OAP Health and Medical Care Program adopted by the Medical Services Board in the November 2004 Medical Assistance Program bulletin.

Inpatient hospital medical benefit services for OAP Health and Medical Care Program clients were eliminated on January 1, 2004 and remain eliminated until further notice.

The following provider payment reductions were effective for dates of service on and after January 1, 2004 and remain in effect until further notice:

- Dental services reimbursed at 50% of the Medical Assistance Program rate
- Laboratory and x-ray services reimbursed at 50% of the Medical Assistance Program rate
- Outpatient services reimbursed at 50% of the Medical Assistance Program rate
- Practitioner services reimbursed at 50% of the Medical Assistance Program rate
- Transportation services reimbursed at 50% of the Medical Assistance Program rate
- Home health services (including hospice services) and supplies reimbursed at 50% of the Medical Assistance Program rate
- Pharmacy services reimbursed at 100% of the Medical Assistance Program rate.

Clients are eligible to apply for the Colorado Indigent Care Program (CICP) for benefits not covered by the OAP Health and Medical Care Program. Information about 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 the Web Portal, Faxback, 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 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.**

October Denver Billing Workshops
Beginning Billing and Specialty Billing!

General Information for *All* Workshops

Provider billing workshops include both Medical Assistance Program billing instructions and a review of Medical Assistance Program billing procedures.

These workshops do *not* include in-depth training for the Web Portal.

Reservation Information for *All* Workshops

Yes, reservations are necessary for *all workshops*. We require reservations in order to provide adequate space for all workshop participants.

Email reservations to: workshop.reservations@acs-inc.com

or

Call Medical Assistance Program Provider Services to make reservations.

1-800-237-0757 (toll free Colorado) 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 cannot be processed successfully.

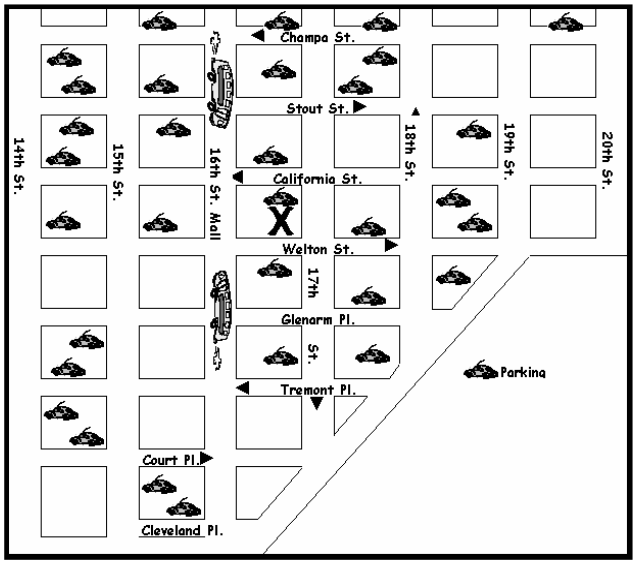
Your confirmation will be mailed to you within one week of making your reservation. If you do not receive a confirmation within one week, please contact Provider Services and talk to a Provider Relations Representative.

Location for *All* Denver Workshops

All Denver workshops are located at:

ACS

Dominion Plaza Building
600 Seventeenth Street
Suite 600 N (6th Floor, North Tower)
Denver, CO 80202



Driving directions:

Take Interstate 25 to Exit 210 A – Colfax. Go East
Take Colfax 0.8 miles to Welton – seventh light.
Go North
Take Welton 0.4 miles to 16th Street – Third light.

ACS is located in the Dominion Plaza building, on the west side of Welton, between 16th and 17th Streets.

Parking:

Parking is not provided and is limited in the Downtown Denver area. Providers attending workshops are urged to carpool and arrive early to secure parking or use public transportation.

Commercial parking lots are available throughout the downtown area and the daily rates range from approximately $5 - $10.

October "Beginning Billing" Denver Workshops Update

Who Should Attend?

New and experienced receptionists, front desk personnel, admission personnel, office managers, billing services, and other billing staff should attend the appropriate workshops. Anyone who has not participated in a Beginning Class and intends to participate in upcoming (October 2004 or May 2005) Specialty Training Classes should also attend.

Beginning Billing Class Descriptions

Beginning Training CO1500/ 837P

This class is for new Colorado Medical Assistance Program billers submitting Professional claims. The class consists of in-depth information on resources, eligibility, timely filing, reconciling Provider Claim Reports (PCRs), and CO1500 claim completion.

Beginning Training UB92/ 837I

This class is for new Colorado Medical Assistance Program billers submitting Institutional claims. The class consists of in-depth information on resources, eligibility, timely filing, reconciling your Provider Claim Reports (PCRs), and UB92 claim completion.

October 2004 Beginning Billing Class Schedule

Beginning Billing UB92/837I	Thursday - October 7, 2004, 9am-3pm
Beginning Billing CO1500/837P	Friday - October 8, 2004, 9am-3pm

October Denver Specialty Billing Workshops

Who Should Attend?

Experienced receptionists, front desk personnel, admission personnel, office managers, and billing service personnel should attend.

Denver Specialty Class Descriptions

Practitioners

This class is for billers who submit claims on the Colorado 1500 format. The session covers billing procedures, common billing issues and guidelines for these specific provider types:

- Ambulance
- Anesthesiologists
- ASC
- Family Planning
- Independent Labs
- Independent Radiologists
- NPs
- OB/GYN
- Physical and Occupational Therapists
- Physical Therapists
- Physician Assistant
- Physicians, Surgeons

Dental

This class is for billers who submit claims on the ADA claim format. The session covers billing procedures, common billing issues and guidelines for these specific provider types:
Dentists, Dental Hygienists
(This is not the class for FQHC/RHC – please refer to FQHC/RHC Class)

Dialysis

This class is for billers who submit claims on the CO1500/UB92 claim formats. The session covers billing procedures, common billing issues and guidelines for Dialysis providers.

EPSDT

This class is for billers who submit claims on the EPSDT claim format. The session covers billing procedures, common billing issues and guidelines for EPSDT Providers.
(This is not the class for FQHC/RHC – please refer to FQHC/RHC Class)

FQHC/RHC

This class is for billers who submit claims on the UB92 format. The session covers billing procedures, common billing issues and guidelines for FQHC/RHC providers.

HCBS

This class is for billers who submit claims on the CO1500 claim format for the following services; Adult Day Care, Non-Medical Transportation, Home Electronics, Home Modifications and Personal Care. The session covers billing procedures, common billing issues and guidelines for these specific provider types:

- HCBS – EBD
- HCBS – MI
- HCBS – PLWA
- HCBS – CMW
- HCBS – BI

Home Health

This class is for billers who submit claims on the UB92 format. The session covers billing procedures, common billing issues and guidelines for Home Health providers.

Hospice

This class is for billers who submit claims on the UB92 format. The session covers billing procedures, common billing issues and guidelines for Hospice providers.

Hospital
This class is for billers who submit claims on the UB92 format. The session covers billing procedures, common billing issues and guidelines specifically for In-patient Hospital and Out-patient Hospital providers.
(This is not the class for FQHC/RHC – please refer to FQHC/RHC Class)

Nursing Facility
This class is for billers who submit claims on the UB92 claim format. The session covers billing procedures, common billing issues, PETI, Medicare Crossovers and guidelines for Nursing Facility providers.

Pharmacy/Infusion Therapy
This class is for billers who submit claims on the Pharmacy claim format/Point of Sale. The session covers billing procedures, common billing issues and guidelines for these specific provider types:
Pharmacies, Home Infusion Providers.

RTC
This class is for billers who submit claims on the UB92 claim format. The session covers billing procedures, common billing issues and guidelines for RTC providers.

Supply/DME
This class is for billers who submit claims on the CO1500 claim format. The session covers billing procedures, common billing issues and guidelines for Supply/DME providers.

Vision
This class is for billers who submit claims on the CO1500 claim format. The session covers billing procedures, common billing issues and guidelines for Vision providers.

Denver Specialty Training Schedule	
Specialty	**Date and Time**
Practitioners	Tuesday - October 12, 2004, 8:30-11:30
Dental	Thursday - October 14, 2004, 10:00-11:00
Dialysis	Friday - October 15, 2004, 11:00-12:00
EPSDT	Tuesday - October 12, 2004, 2:30-3:30
FQHC/RHC	Friday - October 15, 2004, 1:00-2:00
HCBS	Wednesday - October 13, 2004, 1:30-2:30
Home Health	Monday - October 11, 2004, 1:00-2:00
Hospice	Monday - October 11, 2004, 10:30-11:30
Hospital	Wednesday - October 13, 2004, 11:00-12:00
Nursing Facility	Monday - October 11, 2004, 8:30-10:00
Pharmacy/Infusion Therapy	Thursday - October 14, 2004, 1:00-2:00
RTC	Tuesday - October 12, 2004, 1:00- 2:00
Supply/DME	Wednesday - October 13, 2004, 8:30-10:30
Transportation	Friday - October 15, 2004, 8:30-10:30
Vision	Thursday - October 14, 2004, 8:30-9:30

Getting Help When You Need It

The Department's Website - www.chcpf.state.co.us:

1. Provider Services section
   - ✓ Billing Manuals
   - ✓ Bulletins
   - ✓ EDI Support
   - ✓ Enrollment Forms
   - ✓ FAQs
   - ✓ Forms
   - ✓ Manuals
   - ✓ Physician News and Updates
   - ✓ Software Downloads
   - ✓ Specifications
   - ✓ Training/Workshop Information
   - ✓ Updates
   - ✓ What's New
2. The Secured Sites link
   - ✓ Eligibility
   - ✓ Reports – After September 1, 2004
   - ✓ Claim submissions will be available through the Secured Sites link in the future

For Web Portal questions

1. Call 303-866-2363 or
2. Send an e-mail to: comedicaidweb@hcpf.state.co.us**.**

For technical questions when you have your Web Portal Log-On ID and password

1. Call: 1-888-538-4275
2. Send an e-mail to: helpdesk.HCG.central.us@cgi.com

Call the fiscal agent's Call Center for any billing questions

Claim status, claim adjudication, benefits and policy

1. Denver Metro: 303-534-0146
2. Toll Free Colorado: 1-800-237-0757

Call the fiscal agent's PAR unit for PAR status or help

Denver Metro: 303-594-0279
Toll Free Colorado: 1-800-237-7647

Call ACS EDI Gateway for problems with technical issues, Mevsnet Passwords, Batch Billing, EDI X12N Packets or submission

1-800-987-6721

For client enrollment questions

Call the county in which the client resides.

Hospital Providers

Newborn Billing When the Mother is not Eligible for Medical Assistance Program Benefits

Effective September 1, 2004, when the mother is not eligible for Medical Assistance Program benefits, the baby's well baby care charges may be billed to the Medical Assistance Program if:

- The baby is eligible for Medical Assistance Program benefits and
- The baby has an active Medical Assistance Program client ID number

If the mother's insurance pays for any portion of the well baby care, this must be included on the claim as a third party payment.

Non-Emergent Medical Transportation Providers

On July 1, 2004 Non-Emergent Medical Transportation (NEMT) changed from a medical benefit to an administrative service per HB 04-1220. Counties/State Designated Entities (SDE) will continue to approve and arrange for client transportation services. However, beginning August 1, 2004 the Department of Health Care Policy and Financing (the Department) is responsible for paying transportation providers directly. The counties/SDE are no longer accountable for NEMT payments. Counties/SDE will continue to submit claims for personal vehicle mileage and bus fare. Transportation providers should enroll as regular Medical Assistance Program providers as soon as possible to direct bill the Medical Assistance Program for transportation services.

NEMT to and/or from non-emergent, pre-planned medical treatment must be the most direct route to and/or from the medical appointment with the closest qualified provider. The service must be a benefit of the Colorado Medical Assistance Program. The transportation services should be the most cost effective and must be provided within the scope of the provider's certification and license. Transportation providers must have authorization from the County/SDE to provide and receive payment for NEMT.

Types of NEMT Transportation:

- A **Wheelchair Van** is a vehicle that is specifically designed, constructed, modified or equipped to meet the needs of wheelchair users. Wheelchair Van services may be available when the client's condition prevents the use of public or private transportation or less costly means of Medical Assistance Program transportation. Wheelchair Van transportation is only for wheelchair-confined clients. Wheelchair van transportation cannot be used for patient, caregiver or provider convenience. Wheelchair van providers that are enrolled without a Public Utilities Commission (PUC) permit cannot receive reimbursement for T2001 or any other procedure code for a client's attendant or any person **not** using a wheelchair.
- A **Mobility Vehicle** is any common or contract carrier with authority from the PUC to operate as
  - ✓ A call and demand limousine service and must operate in compliance with their PUC authority, or
  - ✓ A specialized intra-governmental agency bus substitute service or
  - ✓ Specialized mobility service.

Mobility vehicles include mobility vans, mini-buses, mountain area transport and other non-profit transportation systems. A Mobility Vehicle is a vehicle for hire, including those designed, constructed, modified, or equipped to meet the needs of passengers with medical, physical, or mobility impairments and, when necessary, their escorts. A Mobility Vehicle may or may not be wheelchair equipped.

- **Non-emergent ambulance** transportation is the use of an ambulance vehicle to transport bed-bound clients for non-emergency, pre-planned medical treatment. Non-emergent ambulance transportation should be used only when the client's condition requires an ambulance for safe transport and it is the least costly mode of transportation to do so.

Transportation providers must use the following codes to bill for services:

2004 CPT Codes	2004 Reimbursement per Unit	One Unit Equals	Description	Who Can Bill	Effective Date	Comments
A0100	$ 50.00	One-Way Trip	Non-Emergency Transportation-Taxi	Taxi	07/01/04	
A0120	$ 12.20	One-Way Trip 12 miles or less	Non-Emergency Transportation-Other Common Carrier	Mobility Vehicle (see description)	07/01/02	May **not** be billed with T2003 for same DOS
A0130	$ 15.19	Per Trip, loading fee	Non-Emergency Transportation, Wheelchair Van	Wheelchair Van	07/01/02	
S0209	$ 0.61	Per Mile	Wheelchair van, Mileage	Wheelchair Van	07/01/02	May be billed with A0130 for same DOS
T2003	$ 1.33	Per Mile; Trip More than 12 Miles	Non-Emergency Transportation	Mobility Vehicle	01/01/04	May **not** be billed with A0120 for same DOS

Over-the-cap mobility vehicle trips no longer require a Prior Authorization Request (PAR) – procedure code T2003. Bill per mile for procedure code T2003.

The County/SDE must bill personal mileage using one of the following procedure codes:

2004 CPT Codes	2004 Reimbursement per Unit	One Unit Equals	Description	Who Can Bill	Effective Date
A0080	$ .13 to .30	Per mile	Non-emergency transportation, per mile – vehicle provided by volunteer (individual or organization), with no vested interest.	County/SDE	04/01/04
A0090	$ .13 to .30	Per mile	Non-emergency transportation, per mile – vehicle provided by individual (family member, self, neighbor) with vested interest.	County/SDE	04/01/04

The County/SDE must bill bus fare using the following procedure code.

2004 CPT Codes	2004 Reimbursement per Unit	One Unit Equals	Description	Who Can Bill	Effective Date
A0110	UCC	1 unit = 1 way trip	Non-emergency transportation and bus, intra- or interstate carrier.	County/SDE	04/01/04

Providers with questions should contact Brian Chadwick at Brian.Chadwick@state.co.us. Please do not include any protected health information in emails.

INDEPENDENT OCCUPATIONAL THERAPY AND PHYSICAL THERAPY PROVIDERS

Physical Therapy Clinics/Rehabilitation Agencies and Outpatient Hospital Clinics

The following replaces information published in previous bulletins B0200139, B0200140, B0300150, and B0400179.

Effective December 2001, Colorado Medical Assistance Program no longer required a physician-on-site at Physical Therapy Clinics/Rehabilitation Agencies.

Beginning July 1, 2002, physical therapists and occupational therapists not employed by an agency, clinic, hospital, or physician could bill the Medical Assistance Program directly. Medical Assistance Program provider enrollment packets are available in the Provider Services section of the Department's website or from the fiscal agent. Please call Provider Services at: 303-534-0146 or 1-800-237-0757 (toll free Colorado) for additional information.

Prior Authorization Requests (PARs)

Effective October 1, 2002, Independent Occupational Therapists & Physical Therapists and Physical Therapy Clinics/Rehabilitation Agencies must submit PARs for medically necessary services:

1. Exceeding 24 units of service provided by a physical therapist, or
2. Exceeding 24 units provided by an occupational therapist.

Effective July 1, 2004, hospital based clinics must also follow the PAR submission guidelines. Clients may receive 24 units of physical therapy and 24 units of occupational therapy before a PAR is required. Units of service exceeding the initial 24 units provided by either therapist type will not be reimbursed without an approved PAR.

The Medical Assistance Program PAR forms are available in the Provider Services section of the Department's website or from the fiscal agent's Provider Services at 303 534-0146 or 1-800-237-0757 (toll free Colorado).

Submit PARs to:

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

PARs are approved for up to a 12-month period (depending on medical necessity determined by the reviewer). Submit PARs for the **number of units** for each specific procedure code requested, ***not*** for the number of services and include the modifiers. Additional information needed to process the PAR includes:

- The client's physical or occupational treatment history, including current treatments.
- Documentation indicating if the client has received physical or occupational therapy under the Home Health Program,
- Diagnosis,
- Prescription for services,
- Course of treatment, and
- Documentation supporting medical necessity for additional physical and occupational therapy.
- Current assessment or progress notes made within the last 60 days

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

Occupational Therapy and Physical Therapy modifiers

When billing CPT codes for therapy services rendered by physical therapists providers must use modifier GP (i.e., 97001-GP).

When billing CPT codes for therapy services rendered by occupational therapists providers must use modifier GO (i.e., 97003-GO). These modifiers should also be on the PARs.

The following table shows how Occupational Therapy (OT) and Physical Therapy (PT) procedures should be billed using the new modifiers.

Rendering Provider Type	Procedure Code		*Only* Valid Modifier
Physical Therapist	CPT code	+	**GP**
Occupational Therapist	CPT code	+	**GO**

2004 Physical Therapy & Occupational Therapy Procedure Codes and Rates

2004CPT* Codes	2004 Reimbursement per Unit	One Unit Equals	Max Units	Modifier Required
97001	$ 33.60	One evaluation session	1	GP
97002	$ 22.68	One re-evaluation session	1	GP
97003	$ 33.60	One evaluation session	1	GO
97004	$ 22.68	One re-evaluation session	1	GO

2004CPT* Codes	2004 Reimbursement per Unit	One Unit Equals	Max Units	Modifier Required
97010	$ 4.20	One treatment session	1	GP / GO
97012	$ 9.46	One treatment session	1	GP / GO
97014	$ 7.36	One treatment session	1	GP / GO
97016	$ 9.46	One treatment session	1	GP / GO
97018	$ 6.30	One treatment session	1	GP / GO
97020	$ 6.30	One treatment session	1	GP / GO
97022	$ 9.46	One treatment session	1	GP / GO
97024	$ 6.30	One treatment session	1	GP / GO
97026	$ 4.20	One treatment session	1	GP / GO
97028	$ 8.40	One treatment session	1	GP / GO
97032	$ 9.46	15 minutes	2	GP / GO
97033	$ 10.50	15 minutes	4	GP / GO
97034	$ 8.40	15 minutes	4	GP / GO
97035	$ 8.40	15 minutes	4	GP / GO
97036	$ 11.56	15 minutes	4	GP / GO
* 97039	By Report	One treatment session	4	GP / GO
97110	$ 10.50	15 minutes	4	GP / GO
97112	$ 10.50	15 minutes	4	GP / GO
97113	$ 9.46	15 minutes	4	GP / GO
97116	$ 8.40	15 minutes	4	GP / GO
97124	$ 11.56	15 minutes	4	GP / GO
* 97139	By Report	One treatment session	4	GP / GO
97140	$ 12.60	15 minutes	4	GP / GO
97150	$ 10.50	One Treatment Session	2	GP / GO
97504	$ 10.08	15 minutes	4	GP / GO
97520	$ 10.08	15 minutes	4	GP / GO
97530	$ 10.50	15 minutes	4	GP / GO
97532	$ 19.74	15 minutes	2	GP / GO
97533	$ 20.83	15 minutes	2	GP / GO
97535	$ 15.76	15 minutes	4	GP / GO
97537	$ 15.76	15 minutes	4	GP / GO
97542	$ 15.76	15 minutes	2	GP / GO
97545	$ 50.40	Initial 2 Hour treatment session	1	GP / GO
97546	$ 25.20	One Hour treatment session	4	GP / GO

2004CPT* Codes	2004 Reimbursement per Unit	One Unit Equals	Max Units	Modifier Required
97601	$ 46.20	One treatment session	1	GP / GO
* 97602	By Report	One treatment session	1	GP / GO
97703	$ 15.76	15 minutes	2	GP / GO
97750	$ 19.96	15 minutes	2	GP / GO
* 97799	By Report	One treatment session	4	GP / GO

The client's first 24 units of therapy do not require a prior authorization. Please refer to the September 2002 Medical Assistance Program Bulletin, Reference #B0200139 for Prior Authorization Requirements (PAR) and appropriate forms. The 24 units accumulate from paid units for a specific client regardless of the provider of services. A unit equals a 15-minute increment or one treatment session as described in the specific CPT procedure codes.

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.

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.

* "By Report" procedures require that the claim be billed on paper with a report/description of the provided service attached to the claim. The report should also include the time spent with the client performing the documented service.

Supply/DME Providers

Nursing Facility Reminder

Nursing facilities are responsible for providing medically necessary supplies and durable medical equipment for their residents. Do not bill the Medical Assistance Program for supplies or durable medical equipment for clients residing in nursing facilities. If the supply provider bills the Medical Assistance Program and receives reimbursement, the payment will be recovered. Exceptions to this rule include:

- Oxygen and certain oxygen related services
- Certain types of DME provided during the month in which the client is discharged from the facility
- Repairs to wheelchairs owned by the client prior to admission to the nursing facility

Policy Clarification and Coding Change for the Haberman Feeder – No PAR Required

Haberman Feeders are an alternative to naso-gastric feeding for children who have serious sucking and/or swallowing limitations. The Haberman Feeders are a benefit of the Colorado Medical Assistance Program and ***do not*** require prior authorization. Bill for the Haberman Feeder using procedure code S8265 and the "by invoice" claim methodology.

Replacement nipples, discs, valves, collars etc. are also a benefit of the Medical Assistance Program and ***do not*** require prior authorization. Bill using procedure code S8265 with modifier 52 (S8265-52). The maximum reimbursement is $15.00 per allowed unit. Providers are reminded to bill their usual and customary charge for each item. Bill one line with S8265-52 and the total number of units for the procedure code.

Providers should bill using the instructions above. Procedure codes B9999 and A9900 are no longer valid for billing Haberman Feeders and replacement parts.

Hearing Aids

When a hearing aid provider bills for a hearing aid dispensing fee, procedure code V5090, the provider must first have an approved Prior Authorization Request (PAR) for the code.

Code V5090 is manually priced by the PAR reviewer as follows:

- Digital and digitally programmable hearing aid dispensing fee is $150.00 per hearing aid.
- Conventional hearing aid dispensing fee is $75.00 per hearing aid.

Reminder: The service provider number on the Prior Authorization request form must be the same number that will be used for claim submission.

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

******* Attention Pharmacy Providers ********

The new Colorado Benefits Management System (CBMS)

Client Eligibility Issues

If a pharmacy claim denies for edit 52, "Participant not on File" and the client presents a letter from a county authorizing Medical Assistance Program eligibility:

1. Please fax the letter to the attention of the Pharmacy Section at 303-866-2803 and
2. Proceed with dispensing the medications to the client.

The State will work with the fiscal agent (ACS), to have the client's eligibility entered into the pharmacy point of sale system as quickly as possible. Since the volume of clients who may receive letters is unknown at this time, we are requesting that providers wait 48 hours before resubmitting the claim. Provider may experience a delay in payment during this transition period.

Presumptive Eligibility (PE) Issue

Presumptive Eligibility (PE) determination ends August 31, 2004. Those clients who were determined to be PE eligible between August 25 through 31, 2004 will be presumptive eligible through September 30, 2004.

If a pharmacy claim denies for edit 52, "Participant not on File", and the client presents a PE card, please submit the claim on a UCF (Universal Claim Form) with a copy of the PE card attached.