Medical Assistance Program Bulletin

Colorado Title XIX

Fiscal Agent

A C S

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 Retain all bulletins until published notification advises that the information is obsolete or reproduced in subsequent bulletins or provider manual updates.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

Reference: B0400183

All Providers

Medicare Crossover Claims

The Medical Assistance Program claims processing system did not receive many automatic crossover claims in September due to an internal system problem. Most of the affected claims were for practitioner services. If a crossover claim does not appear on the Medical Assistance Program Provider Claim Report within 30 days after the Medicare processing date, you must submit the crossover either electronically or on paper. Please submit these crossover claims electronically through WINASAP. For additional electronic billing information or billing instructions please go to:
http://www.chcpf.state.co.us/ACS/Provider_Services/provider_services.asp

Provider Web Portal File and Report Service is now available!

The File and Report Service (FRS) is replacing the BBS/MEVSNET. After December 8, 2004, BBS/MEVSNET will not be available.

The reports available on the FRS include:

Report	Report Name	Description
X12N 271	Eligibility Response	Response to an eligibility and benefit request (270)
X12N 277	Claim Status Response	Response to a health care claim status request (276)
X12N 820	Client Capitation	Provides information about premium payments to Prepaid Health Plans (PHP), including the Program for All Inclusive Care for the Elderly (PACE) Program, and Mental Health Assessment and Service Agencies (MHASAs).
X12N 824	Error Report	Response to 837 transactions to report payor specific front-end edits
X12N 834	PCP Roster	Provides enrollment information to health care providers (Prepaid Health Plans (PHPs), Mental Health Assessment and Service Agencies (MHASAs), and Primary Care Physicians (PCPs)
X12N 835	Claim Payment/Claim Report	Reports paid and denied claims for one pay-to provider per transaction
X12N 997	Functional acknowledgement of a sent transaction	Provides information on whether the transaction was accepted and if not, sends error information
	Provider Claim Report	Lists claims paid, claims denied and claims in process for the week
	Accept/Reject (A/R) Report	Lists claims received, accepted & rejected. If rejected claims are listed, you can correct & resubmit them.

If you are not able to retrieve your reports, please send an email with your Trading Partner number, Provider ID number, contact information and a list of the reports you need to: comedicaidweb@hcpf.state.co.us.

Providers who have not completed the Provider Web Portal enrollment should complete this process as soon as possible. Please go to the Department's web site at: www.chcpf.state.co.us. Click on the Provider Services button on the upper left-hand side of the gray menu bar. Then click on the blue Enrollment button on the menu on the left and follow the instructions for completing the Provider EDI Enrollment form

Providers who have completed and submitted the required enrollment form and have not received a letter with your trading partner ID, should 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 letter with a Web Portal log on and password from the Department. If you have not received this document, please email the Department at comedicaidweb@hcpf.state.co.us. Submitters who do not have access to email 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 email or voice mail so that your request can be researched.

See attachment A for a copy of the FRS letter sent to providers.

Old Age Pension Health and Medical Care Program

At their October 8, 2004 meeting, the Medical Services Board approved changes to the medical benefits and provider payments for the Old Age Pension (OAP) 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.

Because the OAP Health and Medical Care Program is a state-funded program and not an entitlement, the authorized spending amount cannot be exceeded. The approved changes were established to allow the program to remain within the authorized funding through the current State fiscal year.

The following medical benefits for OAP Health and Medical Care Program clients were restored on October 15, 2004:

- Inpatient hospital benefit only at hospitals participating in the Colorado Indigent Care Program (CICP). Services to clients covered under the OAP Health and Medical Care Program are limited to those inpatient services available under the CICP.

The following provider payment rates are effective for dates of service on and after October 15, 2004 and will remain in effect until further notice:

- Inpatient hospital services reimbursed at 10% of the Medical Assistance Program Rate
- Practitioner services reimbursed at 82% of the Medical Assistance Program Rate
- Emergency transportation services reimbursed at 82% of the Medical Assistance Program Rate
- Home health services (including hospice services) and supplies reimbursed at 82% of the Medical Assistance Program Rate
- 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 (including services received in outpatient hospital settings, federal qualified health centers, rural health centers and dialysis centers) 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 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 the Web Portal, CMERS, FaxBack or WINASAP. Clients covered by the OAP Health and Medical Care Program are identified by the following message: "CLIENT HAS MODIFIED MEDICAL PLAN. NO NURSING MEDICAL FACILITY, HCBS OR INPATIENT PSYCH".

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
- If a hospital facility does not participate in the CICP and receives reimbursement through the OAP Health and Medical Care Program for an inpatient hospital services, recoveries will be made retroactively.
- 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.

More information concerning this program can be found on the Department's website: www.chcpf.state.co.us

For questions regarding these changes, please contact:
Chris Underwood, Manager, Safety Net Financing at 303-866-5177

Nursing Facility Providers

PAR Procedures and Forms from Dual Diagnosis Management

Dual Diagnosis Management (DDM) has documented procedures and developed new forms for the Prior Authorization Request (PAR) submission process. The information is located on the DDM website, www.dd-management.com (select user tools/Colorado/PAR). This website can also be accessed through the Medical Assistance Program website, www.chcpf.state.co.us (select provider services/related links). Major procedural points include:

1. Before submitting the PAR to DDM, providers should review both the 5615 and the certification page of the ULTC 100.2 for accuracy. A new certification page is required for admissions, including transfers, even when a new ULTC 100.2 is not required. The review must include provider number, start date, end date, birth date, social security number and name. The provider cannot change the ULTC 100.2 start date, but can request the Single Entry Point (SEP) to change or backdate the start date.

   The provider may submit a backdate request to the Department Health Care Policy and Financing, Nursing Facilities Section if:

   - If the SEP denies backdating *and*
   - The backdate criteria listed in the *July 24, 2003 Dear Administrator Letter* are met
2. Providers must verify that the 5615 is signed and dated. Note that the effective date on the 5615 is the start date of the PAR. The eligibility technician assigns the most recent date of the following criteria:

   - Admission date
   - ULTC 100.2 date
   - Financial eligibility date and
   - Disability effective date for clients under age 65

   If the effective date is not correct, providers must notify the eligibility technician of the correction before submitting the PAR to DDM.
3. The 5615 and the ULTC 100.2 certification page must be submitted together. If sent separately, DDM will not process the PAR and will fax the provider an error notification.
4. If there are errors or omissions on the PAR, DDM will not process the PAR and will fax a Notice of PAR Submission Error form to the provider. The provider must correct and re-submit both the 5615 and ULTC 100.2 certification page to DDM.
5. If there are no errors, DDM will fax a Notice of PAR Certification form with attached Certification Page to the provider. If the provider finds errors on the Certification Page, the provider must note them on the Certification Page and fax it back to DDM immediately.
6. Providers must notify DDM, the SEP and the eligibility technician of discharges and deaths as soon as possible. Providers must report discharge or death on the discharge form or in section IV on a copy of the 5615.

Claims with Medical Leave

When a client is discharged to the hospital and expected to return, the claim should be coded for medical leave (HIPAA-compliant revenue code 185 which replaced value code Y1). Do not code the claim as a final bill (type of bill 224 or 624). Facilities should code a claim as a final bill only for clients who are discharged to another facility, to home or who die. See attachment B for examples of a medical leave and non-medical leave claims. Examples are also located in the Nursing Facility section of the Specialty Manuals. Billing Manuals are located in the Provider Services section of the Department's website: www.chcpf.state.co.us.

If the claim is billed as a final bill, the next claim for that client may be rejected with error code 605 on the provider claim report. This is caused by some batch billing vendors' and clearing houses' software that automatically enters occurrence code 42 on a final bill claim. Occurrence code 42 end dates the PAR.

Physical Therapy and Occupational Therapy Providers

Reminder

An estimated 10% of Colorado Medical Assistance Program clients have other health insurance known as third party resources available to pay for medical expenses. Federal regulations require that all available health insurance resources be used before the Medical Assistance Program considers payment. Commercial health insurance coverage often offers greater benefits than the Medical Assistance Program, so it is to the provider's advantage to pursue commercial health insurance payments. If the commercial health insurance benefit is the same or more than the Medical Assistance Program benefit allowance, the Medical Assistance Program makes no additional payment.

With few exceptions, Medical Assistance Program claims for clients with third party health insurance are denied or rejected when the claim does not show health insurance payment or denial information.

If the client is enrolled in a commercial health plan, the Physical Therapist or Occupational Therapist (PT/OT) must submit the denial for PT/OT services from the commercial health plan with the claim. The provider must indicate that all the commercial health plan's PT/OT benefits have been exhausted, and it is appropriate to bill the Medical Assistance Program for these services.

Pharmacy Providers

Pharmacy Changes

Effective January 1, 2005, the Department will no longer pay for Actiq unless it is prescribed for the alleviation of breakthrough cancer pain. This is in accordance with the rules that were implemented on March 4, 2004. The criteria for Actiq are as follows:

1. All prescriptions for Actiq require a PA.
2. Approval will be granted if the client is diagnosed with cancer and has already received and is tolerant to opioid drugs for the cancer pain.
3. The PA may be granted for up to 4 lozenges per day.
4. If the patient is a hospice patient, the PA will be automatically granted regardless of the number of doses prescribed.

Practitioners

Adult Preventative Care Exam

Effective November 1, 2004, the Colorado Medical Assistance Program will reimburse charges for Adult Preventative Care Exams. Adult Preventive Exams are limited to one exam per client per fiscal year and limited to the office setting. An Evaluation and Management visit cannot be billed for the same patient on the same day. Bill Adult Preventive Care Exams using the following CPT codes for clients 21 years of age and older:

CPT Codes	Description	Age Requirement
New Patient		
99385	Initial comprehensive preventive medicine*	21-39
99386	Initial comprehensive preventive medicine	40-64
99387	Initial comprehensive preventive medicine	65 years and over
Established Patient		
99395	Periodic comprehensive preventive medicine**	21-39
99396	Periodic comprehensive preventive medicine	40-64
99397	Periodic comprehensive preventive medicine	65 years and over

* For new patients, the adult preventive exam includes the evaluation and management of an individual including an age and gender appropriate history, examination, counseling/risk factor reduction interventions and the ordering of appropriate immunizations and laboratory/diagnostic procedures.

** For an established patient, the adult preventive exam includes the reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/risk factor reduction interventions and the ordering of appropriate immunizations and laboratory/diagnostic procedures.

CPT codes **not** included in the adult preventive medicine exam include, but are not limited to:

CPT Codes	Description
99401-99404	Preventive Medicine, Individual Counseling
99411, 99412	Preventive Medicine, Group Counseling
99429	Other Preventive Medicine Services – Administration and interpretation of health risk assessment instrument (ie health hazard appraisal).

Periodic and Interperiodic screening exams for children and adolescents, birth through 20 years old are not affected by this benefit.

Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs) and Indian Health Services (IHSs)

When reporting encounters on the 837 I or UB92, bill adult preventive exam using the diagnosis code, V72.9, unspecified examination. Using the V72.9 diagnosis code allows the Department and the agency to track utilization of this service to determine health outcomes and cost-effectiveness.

Influenza Vaccine Update[1]

Almost half of the nation's flu vaccine will not be delivered this year. Chiron, a major manufacturer of flu vaccine, was to make 46-48 million doses of vaccine for the United States. Chiron will not be distributing any influenza vaccine this flu season. Due to the vaccine shortage, the Center for Disease Control (CDC) is changing its vaccine guidelines this season.

Priority: Who should be vaccinated?

The Colorado Medical Assistance Program recommends following CDC influenza vaccine guidelines. Existing flu vaccine supplies should be given to protect people who are at greatest risk from serious complications from influenza disease. Persons in the groups listed below should receive the influenza vaccination:

- People 65 years of age and older
- Children ages 6 months to 23 months
- Adults and children 2 years of age and older with chronic lung for heart disorders including heat disease and asthma
- Pregnant women

- Adults and children 2 years of age and older with chronic metabolic diseases (including diabetes), kidney disease, blood disorders (such as sickle cell anemia), or weakened immune systems, including person with HIV/AIDS
- Children and teenagers, 6 months to 18 years of age, who take aspirin daily
- Residents of nursing homes and other chronic care facilities
- Household members and out-of-home caregivers of infants under the age of 6 months (Children under the age of 6 months cannot be vaccinated)
- Healthcare workers who provide direct, hands on care to patients

Who Should Go Without the Inactivated Vaccination?

- Healthy people ages 2-64 years are asked not to get vaccinated or to wait until persons in the priority groups in their area have had a chance to be vaccinated. This allows the available inactivated vaccine to go to protect those at highest risk for flu complications.
- CDC also recommends intranasally administered, live, attenuated influenza vaccine, if available, should be encouraged for healthy persons ages 5–49 years and are not pregnant, including health care workers (except those who care for severely immunocompromised patients in special care units) and persons caring for children aged <6 months. Colorado Medical Assistance Program does not pay for the intranasal influenza vaccine at this time.

Billing Information

For Medical Assistance Program clients age 0-20, reimbursement is limited to an Administration, Recordkeeping and Tracking (ART) fee of $6.50 for private practitioners and $2.00 for public health clinics. Influenza vaccine is available at no cost through the Vaccines For Children (VFC) and Infant Immunization programs. Providers who elect to obtain vaccine from other suppliers may not request or receive reimbursement in addition to the ART payment level. Influenza vaccines for Medical Assistance Program clients age 21 and older are reimbursed by the Medical Assistance Program.

Vaccine Code	Description	Vaccine Code	Description
90657	Flu Vaccine, 6-35 months, IM/INJ	90658	Flu Vaccine, 3+ years, IM/INJ

For Medical Assistance Program client billing questions, please contact Gina Robinson, Immunization Program Manager at 303.866.6167 or Gina.Robinson@state.co.us

Please Note: Medical Assistance Program clients cannot be billed for additional cost associated with injectable influenza vaccination. Office co-pays are allowable.

Information for VFC Providers

According to the VFC Program, the VFC vaccine has been distributed to federally Qualified Health Centers/Rural Health Clinics and Public Health Agencies. VFC has stated that all VFC vaccine ordered should be supplied, including those requests from private practitioner offices. The recommendations for VFC providers differ slightly from CDC recommendations. The VFC program recommends *priority to children and adolescents aged 2-18 years who are household contacts of children less than 6 months of age.*

The Colorado Medical Assistance Program requests that you contact Rosemary Spence, VFC Program Administrator, at 303.692.2798 for more information about influenza vaccine immunizations for VFC-eligible children.

[1] Reference: CDC Fact Sheet, October 5, 2004, Accessed October 15, 2004 http://www.cdc.gov/flu/protect/whoshouldget.htm

Prenatal Presumptive Eligibility

Update

All prenatal Presumptive Eligibility (PE) spans ended September 30, 2004. Providers who treat pregnant women with little or no health insurance coverage may refer those patients to their county social/human services office to apply for the Medical Assistance Program benefits. Clients should call their local office and ask about the documentation needed to apply on sight and learn about their eligibility status.

As a reminder, once a Presumptive Eligibility time span ends, providers should not assume a client is Medical Assistance Program eligible. Always verify eligibility to assure Medical Assistance Program coverage. If your patient does not know the status of their application, encourage them to call their county and inquire.

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

FISCAL AGENT FOR

The Colorado Medical Assistance Program

Medical Assistance Program Provider Services
P.O. Box 1100
Denver, CO 80201-1100

303-534-0146
1-800-237-0757
Fax: 303-534-0439

October 7, 2004

Dear Colorado Medical Assistance Provider,

Beginning **October 8, 2004**, providers may retrieve all electronic reports and/or transactions through the Department's web portal. The **File and Report Service (FRS)** is replacing 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 will remain functional for 60 days. It will be discontinued at that time and the web portal will be the only source for electronic reports and/or transactions.

Please disregard this notice if you have received both of the following items:

1. Your Trading Partner (TP) ID and logon information from ACS EDI Gateway **and**
2. Your Web Portal Logon ID and Password from the Colorado Department of Health Care Policy and Financing,

If you have not submitted your EDI enrollment form yet, please download either the EDI **Submitter** Enrollment Packet for X12N Transactions or the EDI **Provider** Enrollment Packet for X12N Transactions from http://www.chcpf.state.co.us/ACS/Enrollment/enrollment.asp. Complete the appropriate EDI enrollment form and mail the completed packet to:

ACS State Healthcare
Colorado Medical Assistance Program Provider Services
P.O. Box 1100
Denver, CO 80201-1100

If you have your TP ID and logon information from ACS EDI Gateway but do not have your Web Portal logon ID and password from the Department of Health Care Policy and Financing,

1. Please call 303-866-2363 or
2. Send an email to COMEDICAIDWEB@hcpf.state.co.us.

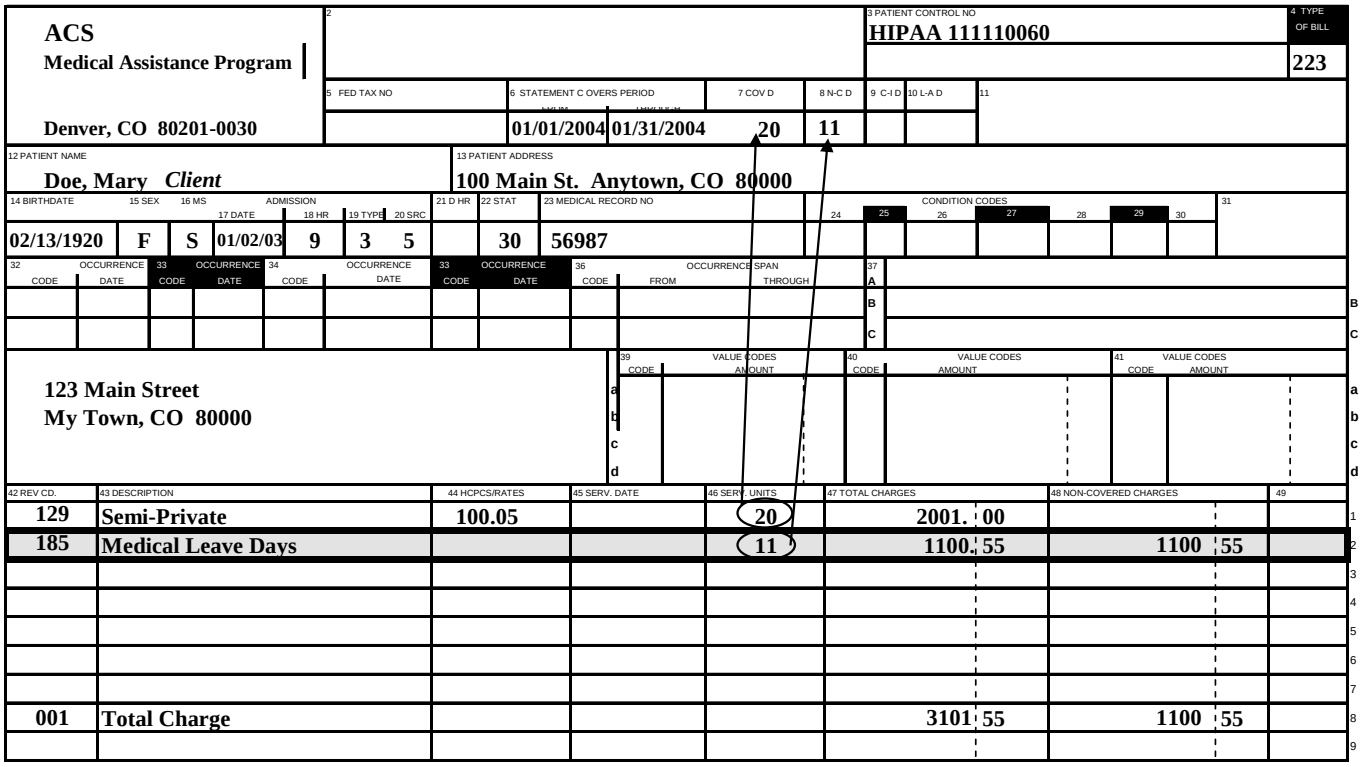
Please provide your TP ID number and your Provider ID in the voice mail or email so that your request can be researched.

If you have submitted your EDI enrollment forms and have not received your TP ID and Logon information from ACS EDI Gateway, please contact ACS EDI Gateway at 1-800-987-6721.

Sincerely,

The Colorado Medical Assistance Program

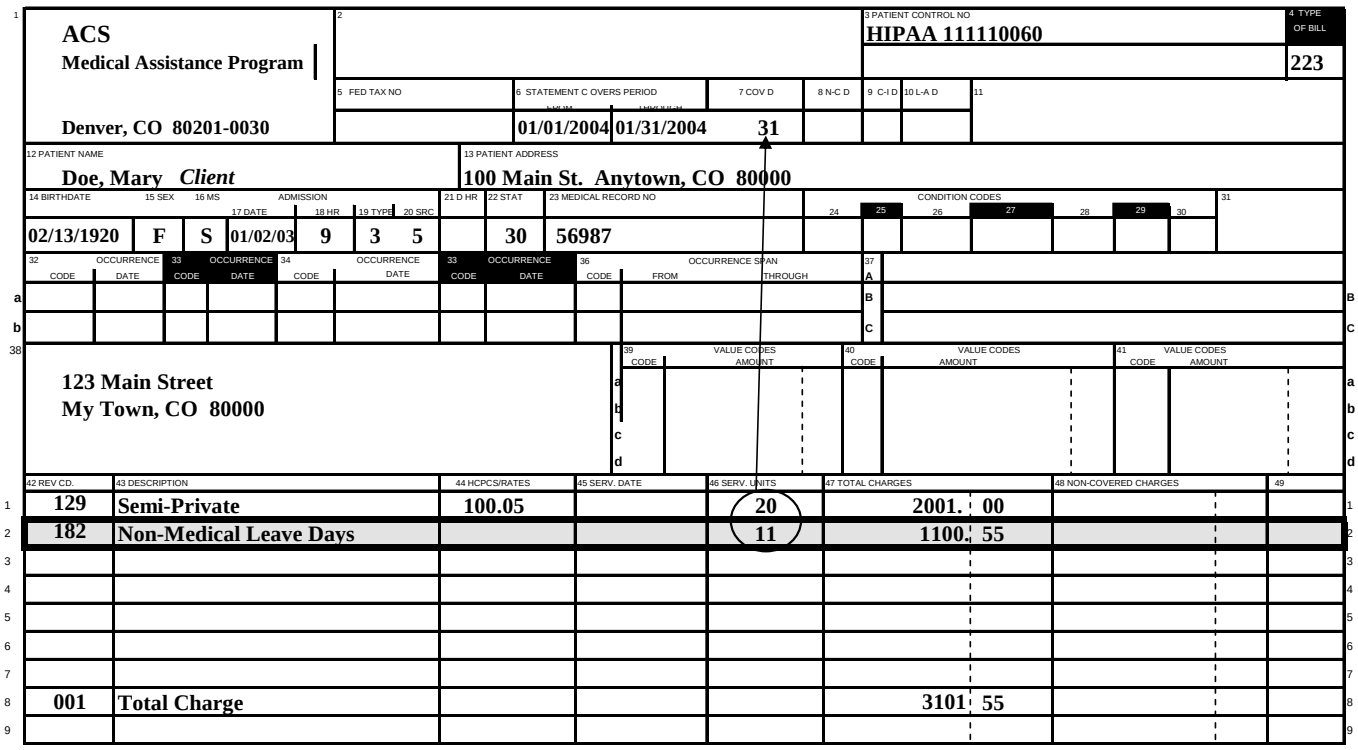
Nursing Facility Claim with Medical Leave Days Example



ACS Medical Assistance Program Denver, CO 80201-0030	3 PATIENT CONTROL NO: HIPAA 111110060 4 TYPE OF BILL: 223
5 FED TAX NO	
6 STATEMENT C OVERS PERIOD	01/01/2004 01/31/2004
7 COV D	20
8 N-C D	11
12 PATIENT NAME	Doe, Mary *Client*
13 PATIENT ADDRESS	100 Main St. Anytown, CO 80000
14 BIRTHDATE / 15 SEX / 16 MS / ADMISSION 17 DATE / 18 HR / 19 TYPE / 20 SRC	02/13/1920 / F / S / 01/02/03 / 9 / 3 / 5
22 STAT	30
23 MEDICAL RECORD NO	56987
123 Main Street My Town, CO 80000	

42 REV CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
129	Semi-Private	100.05		20	2001. 00	
185	Medical Leave Days			11	1100. 55	1100 55
001	Total Charge				3101 55	1100 55

Nursing Facility Claim with Non-Medical Leave Days Example



ACS Medical Assistance Program Denver, CO 80201-0030	3 PATIENT CONTROL NO: HIPAA 111110060 4 TYPE OF BILL: 223
5 FED TAX NO	
6 STATEMENT C OVERS PERIOD	01/01/2004 01/31/2004
7 COV D	31
8 N-C D	
12 PATIENT NAME	Doe, Mary *Client*
13 PATIENT ADDRESS	100 Main St. Anytown, CO 80000
14 BIRTHDATE / 15 SEX / 16 MS / ADMISSION 17 DATE / 18 HR / 19 TYPE / 20 SRC	02/13/1920 / F / S / 01/02/03 / 9 / 3 / 5
22 STAT	30
23 MEDICAL RECORD NO	56987
123 Main Street My Town, CO 80000	

42 REV CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
129	Semi-Private	100.05		20	2001. 00	
182	Non-Medical Leave Days			11	1100. 55	
001	Total Charge				3101 55	