All Providers

Delayed Eligibility Notification

Medical Assistance Program Providers who have rendered services to potentially eligible Medical Assistance Program clients are to use Provider Billing manual Appendix H for delayed notification of eligibility. The *Certification & Request for Timely Filing Extension* form certifies the first date a provider learned of a patient's Medical Assistance Program eligibility. The form is to be completed when notification is past the 120 day timely filing limit for the client's dates of service.

Timely filing explanations and proper use of this form can be found in the General Provider Information Manual under the General Claim Requirements section at:
http://www.chcpf.state.co.us/ACS/Pdf_Bin/General_Info_0205.pdf. Delayed/Retroactive Client Eligibility is explained on page 84. Providers are encouraged to use the 270 transaction to routinely check on client eligibility in order to bill claims timely.

When the eligibility inquiry response states that the client is not found, the claims processing system is unable to process any paper or electronic claims submitted for payment. Providers are not to bill for services rendered until the client is assigned a State identification number.

Provider Bulletin Board

The BBS, where providers are able to retrieve reports and HIPAA transactions, will be totally eliminated March 31, 2005. Providers will be required to obtain these documents through the File Report Service (FRS) on the web portal. If you have not yet enrolled for web portal access or received your user name and password from the Department, please contact provider services at 303-534-0109 or access the enrollment forms at http://www.chcpf.state.co.us/ACS/Pdf_Bin/EDI_Provider_Enroll_112004.pdf.

Web Portal Update

During March, watch for web portal announcements regarding the 837 Professional and Dental Claim web activation on your provider claims reports and on the Provider Services web site. These claims will be submitted interactively through the portal, and will replace that functionality in WINASAP. This spring the 837 institutional claim and 278 PAR transaction will be implemented after thorough functionality testing. NECS and WINASAP submissions will be eliminated 30 days after the last of the transactions are implemented in the portal.

Coming Soon to Your Office PC!

Electronic Bulletin Notification

The Department is working with the fiscal agent to develop a provider email notification system for new bulletins and website updates. The email will provide a link to the new or updated document. Watch for updates on this new process in future bulletins.

Change in Ownership (CHOW)

Change in owners or any change in a Medical Assistance Program provider's Federal Tax Identification Number terminates a Provider's Participation Agreement. New provider IDs and tax ID numbers must be applied for prior to the date of sale to be effective on the date of the change of ownership. New owners with their new tax ID numbers and existing owners with a new tax ID number must re-apply and complete new Medical Assistance Program Participation and Electronic Submission Agreements in order to participate in the Colorado Medical Assistance Program. The selling provider must stop billing once the CHOW has occurred. The new owner may NOT bill using the old provider ID.

When a new application is completed and approved, a new provider ID number is assigned to the provider. The old provider ID number (on the application) and all affiliations are terminated on the date the new ID number is activated. New affiliations must be listed on the Provider Application or by notifying Provider Enrollment in writing on the provider's letterhead. When there is a Change of Ownership (or Tax ID change) the provider must complete a new Provider Application, Provider Enrollment Agreement, Electronic Submission Application, any provider type specific documentation and an Electronic Funds Transfer form.

Sellers must also submit a statement on their letterhead stating the name of selling provider, selling provider number, change of ownership effective date or change of tax id number, and the seller's forwarding address.

To locate provider type specific documentation and Enrollment Requirements, enrolling providers should use the Provider Services Enrollment Section of the State's web site http://www.chcpf.state.co.us/ACS/Enrollment/new_providers.asp.

In order to submit electronic claims, providers must complete and submit an Electronic Data Interchange Provider Enrollment Agreement and an Interim Solutions Form. These forms are also available in the Enrollment section of the web site: http://www.chcpf.state.co.us/ACS/Enrollment/new_providers.asp under Provider Services, Forms, Enrollment Forms (Providers Not Yet Enrolled).

Provider Frequently Asked Questions

Q & A
Do certain types of providers need Medicare Certification before they can be enrolled and bill the Colorado Medical Assistance Program?
Yes. Ambulatory Surgery Centers, Hospitals, Rural Health Centers, Home Health Agencies, Dialysis Centers, and Hospice Agencies all require Medicare Certifications before a provider can enroll as a Colorado Medical Assistance Program provider. During a CHOW Medicare issues a new Medicare Provider ID to the organization. A provider's Medicare effective date may be used as their Colorado Medical Assistance Program application date. To expedite processing, the provider should submit the Colorado Medical Assistance Program application to the as soon as the provider is enrolled with Medicare.

Do certain types of providers need State Certification before they can be enrolled and bill the Colorado Medical Assistance Program?
Yes. Certain provider types must receive State approval to finalize the CHOW application process. (An example is State reimbursement rate setting). Provider numbers for these providers will be issued when this is completed. Please see the Department's website www.chcpf.state.co.us for more specific information on provider types.

Do Colorado Medical Assistance Program timely filing policies apply?
Yes. Medical Assistance Program timely filing policies apply. Special cases or situations can be analyzed and reviewed by the State.

Home Health Providers

Beginning in March, home health claims containing acute revenue codes *AND* long term revenue codes will be denied. Home health providers may not bill revenue codes from both programs on the same claim. The entire claim will be denied with edit 1436—Acute/Long Term Conflict. Providers must submit separate claims for acute home health services and long term home health services. The new edit will set on any claims submitted after March 9, 2005.

Hospital Providers

Head Injury and Neonatal DRG Billing Instructions Reminder

Head injury rehabilitation claims submitted on paper will continue to regroup to DRGs 860, 861 and 862 based on the Rancho Coma score on the claim.

DRG	Description	Diagnosis Codes
860	Rehab, Head Injury, Mild	Use Rancho Coma Score and Value Code Y4 Mild is 07, 08, 09, or 10
861	Rehab, Head Injury, Moderate	Use Rancho Coma Score and Value Code Y4 Moderate is 04, 05, or 06
862	Rehab, Head Injury, Severe	Use Rancho Coma Score and Value Code Y4 Severe is 01, 02, or 03

For HIPAA compliance, head injury rehabilitation claims submitted electronically may not include a Rancho Coma score and will all regroup to DRG 861. Electronic head injury claims are identified by a head injury diagnosis code on the claim. Attachment A lists the head injury diagnosis codes.

Neonatal Billing

Neonatal DRGs 385 through 391 continue to be evaluated and regrouped to DRGs 385, 389, 390, 391, 801, 802, 803, 804, 805, and 810 according to the logic illustrated in Attachment B.

PCP PROGRAM

New PCP Program Feature

In an effort to recruit more physicians to the Primary Care Physician Program (PCPP), the Colorado Medical Assistance Program will soon be able to accommodate physicians who focus their practice on specific client populations. Currently PCPs must take any client who chooses to enroll with them. For example, a family medicine physician who only sees geriatric patients would be reluctant to participate in the PCP Program because the practice would have to accept children and younger adults. The Department is removing this barrier effective March 1.

Beginning March 1, physicians enrolled in the PCP Program can inform the Department that their practice is focused in the following areas:

Physician Specialty	Areas of Focus Possible
Family Medicine, General Practice and Internal Medicine	Adults only (age 21 and older)
	Obstetrics only
	Geriatrics only
	Children only (under 21)
	Women and children under 21

Pediatrics	Infants and children only
	Adolescents and young adults only

Obstetrics and Gynecology	Obstetrics only
	Gynecology only

The practice focus information will be added to the computer system every month. Once added to the system, the practice focus will be taken into account when clients call to enroll with a PCP.

Calls to inform the Department of practice focus should be directed to 303.866.2385 or Diane.Stayton@state.co.us. Questions regarding this new feature should be directed to 303.866.4092 or Gloria.Johnson@state.co.us.

PHARMACY PROVIDERS

DAW-5 and Prior-Authorization Type Code 1, 2, 4 Clarification

Some providers have had questions about the use and function of different pharmacy codes. The following provides definitions.

DAW 5 – Dispense As Written - A DAW 5 substitution allowed-brand as generic will be allowed **only** if the product being billed is a brand that is less expensive than the generic. Also, if a generic product is indicated with a brand name indicator (by First Data Bank) a provider may use a DAW 5. All claims using DAW 5 will be reviewed for brand pricing of less than generic and manufacturer product indicator.

Prior Authorization Type Code 1 – Use for emergency only. An emergency situation is defined as any condition that is life threatening or requires immediate medical intervention. In an emergency, pharmacies may dispense a 72-hour supply of covered outpatient prescription drugs if a prior authorization cannot be obtained. A 3-day supply shall be dispensed to the client and the client's physician must contact the PA Help Desk and request a PA the next business day.

Prior Authorization Type Code 2 - The pharmacy must request this authorization from the Pharmacy Help Desk: 1-800-365-4944. Use this code only when there is a dosage change from the physician or when a client is going into or out of a nursing home and is in need of medication.

Prior Authorization Type Code 4 – Use this code **only** to indicate pregnancy and 90 days postpartum. All providers must use this code to indicate pregnancy in order to exempt the client from *co-pay*. Prior Authorization Type Code **4** *will* override the PA requirement for *prenatal vitamins only*, and only for those vitamins that are eligible for rebate. All other medications requiring a PA will require the physician to contact the PA Help Desk.

March, April and May 2005 Denver & Statewide Provider Billing Workshop Schedule

General Information

Provider billing workshops include both Medical Assistance Program billing instructions and a review of Medical Assistance Program billing procedures. There are specific classes for new billers to the Medical Assistance Program and for specialty training for different provider types. The schedule for Spring 2005 workshops follows.

Who Should Attend?
New and experienced receptionists, front desk personnel, admission personnel, office managers, billing services, and other billers should attend the appropriate workshops.

Do I need Reservations?
Yes, reservations are necessary for *all workshops*. We are currently requesting reservations for both Statewide and Denver workshops to be able to provide adequate space in all workshops.

> **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 "**5**" 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 one (1) week of making your reservation. If you do not receive a confirmation within one (1) week, please contact Provider Services and talk to a Provider Relations Representative.

Class Descriptions
Please see bulletin B0500191, January 2005 for complete class descriptions.

Denver Location

All Denver workshops are located at:

ACS
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, 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.
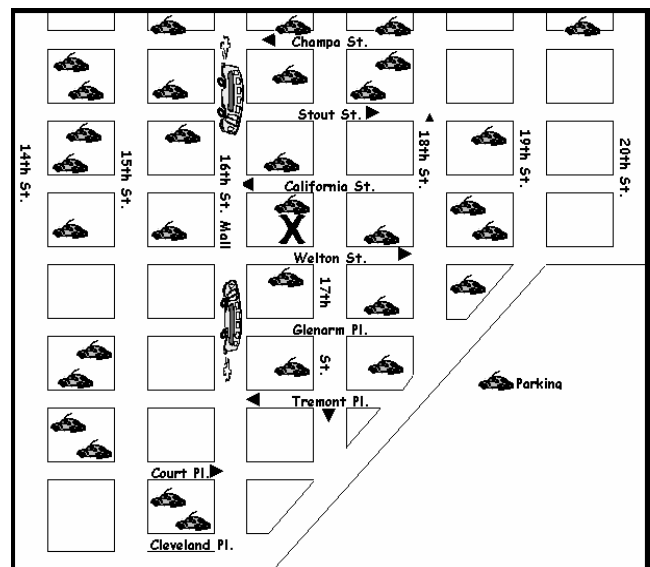
Denver Beginning Billing Schedule
9:00 – 3:00
(Unless Otherwise Noted)

Beginning Training CO-1500/837P
04/05/05 - Tuesday

Beginning Training UB-92/ 837I
04/07/05 – Thursday

Beginning Training CO-1500, UB-92, ADA Format (837D, 837I & 837P)
03/09/05 - Wednesday

Denver Specialty Training Schedule

Reminder:
You must attend a Beginning Billing session for your claim type prior to attending a Specialty class. Beginning Billing provides the basic information on which the Specialty classes are based.

Practitioners
03/15/05 – Tuesday, 8:30-11:30

Dental
03/17/05 – Thursday, 10:00-11:00

EPSDT
03/15/05 – Tuesday, 12:30-1:30

FQHC/RHC
03/18/05 – Friday, 2:00-4:00

HCBS
03/16/05 – Wednesday, 1:30-2:30

Home Health
03/14/05 – Monday, 11:45-12:45

Hospice
03/14/05 – Monday, 10:30-11:30

Hospital
03/16/05 – Wednesday, 11:00-12:00

Nurse Home Visitor Program
03/17/05 – Thursday, 8:30-9:30

Nursing Facility
03/14/05 – Monday, 8:30-10:00

Physical/ Occupational and Speech Therapy
03/18/05 – Friday, 11:00-1:00

Pharmacy
03/17/05 – Thursday, 1:00-2:00

RTC
03/15/05 – Tuesday, 2:00- 4:00

Supply/DME
03/16/05 – Wednesday, 8:30-10:30

Transportation
03/18/05 – Friday, 8:30-10:30

Statewide Locations

Alamosa
Clarion of the Rio Grande Hotel
333 Santa Fe
Alamosa, CO 81101
719-589-5833

Durango
Mercy Medical Center
1800 East 3rd Avenue
Durango, CO 81301
970-247-4311

Fort Collins
University Park Holiday Inn
425 West Prospect Road
Fort Collins, CO 80526
970-482-2626

Greeley
Best Western Regency
701 8th Street
Greeley, CO 80631
970-353-8444

Pueblo
Ramada Inn and Conference Center
4001 North Elizabeth
Pueblo, CO 81008
719-543-8050

Colorado Springs
Embassy Suites Hotel
7290 Commerce Center Dr
Colorado Springs, CO 80919
719-599-9100

Grand Junction
Holiday Inn
755 Horizon Drive
Grand Junction, CO 81502
970-243-6790

Statewide Beginning Billing
8:30-1:00
(Unless Otherwise Noted)
Beginning Training CO-1500/UB-92

05/12/05— Alamosa-- Thursday
05/16/05 – Ft. Collins Monday, 9:00 am-1:30
05/24/05 – Greeley – Tuesday, 9:00 am-1:30

05/10/05 – Grand Junction – Tuesday
05/17/05 – Pueblo – Tuesday
05/18/05 – Colorado Springs – Wednesday

Statewide Specialty Training

Reminder:
You must attend a Beginning Billing session for your claim type prior to attending a Specialty class.
Beginning Billing provides the basic information on which the Specialty classes are based.

Home Health/ Private Duty Nursing
05/12/05 – Alamosa – Thursday, 2:00-4:00

Supply
05/12/05 – Alamosa – Thursday, 2:00-4:00

Occupational Physical and Speech Therapies
05/16/05 - Fort Collins – Monday, 2:00-4:00

RTC
05/16/05 - Fort Collins – Monday, 2:00-4:00

HCBS
05/24/05 – Greeley – Tuesday, 2:00-3:30

Hospital
05/10/05 – Grand Junction – Tuesday, 2:00-4:00

Practitioner
05/10/05 - Grand Junction – Tuesday, 2:00-4:00

RHC/FQHC
05/17/05 – Pueblo– Tuesday, 2:00-3:30

Occupational Physical and Speech Therapies
05/18/05 – Colorado Springs – Wednesday, 2:00-4:00

Hospital
05/18/05 – Colorado Springs – Wednesday, 2:00-4:00

**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 Provider Services section of the Department's website at: http://www.chcpf.state.co.us
For Provider Updates and News*

Attachment A

Head Injury Diagnosis Codes

Begin Span	End Span	Begin Span	End Span	Begin Span	End Span	Begin Span	End Span
310.2	310.2	801.7	801.76	804.49	804.49	851.5	851.56
800.0	800.06	801.79	801.79	804.5	804.56	851.59	851.59
800.09	800.09	801.8	801.86	804.59	804.59	851.6	851.66
800.1	800.16	801.89	801.89	804.6	804.66	851.69	851.69
800.19	800.19	801.9	801.96	804.69	804.69	851.7	851.76
800.2	800.26	801.99	801.99	804.7	804.76	851.79	851.79
800.29	800.29	803.0	803.06	804.79	804.79	851.8	851.86
800.3	800.36	803.09	803.09	804.8	804.86	851.89	851.89
800.39	800.39	803.1	803.16	804.89	804.89	851.9	851.96
800.4	800.46	803.19	803.19	804.9	804.96	851.99	851.99
800.49	800.49	803.2	803.26	804.99	804.99	852.0	852.06
800.5	800.56	803.29	803.29	850.0	850.06	852.09	852.09
800.59	800.59	803.3	803.36	850.09	850.09	852.1	852.16
800.6	800.66	803.39	803.39	850.1	850.16	852.19	852.19
800.69	800.69	803.4	803.46	850.19	850.19	852.2	852.26
800.7	800.76	803.49	803.49	850.2	850.26	852.29	852.29
800.79	800.79	803.5	803.56	850.29	850.29	852.3	852.36
800.8	800.86	803.59	803.59	850.3	850.36	852.39	852.39
800.89	800.89	803.6	803.66	850.39	850.39	852.4	852.46
800.9	800.96	803.69	803.69	850.4	850.46	852.49	852.49
800.99	800.99	803.7	803.76	850.49	850.49	852.5	852.56
801.0	801.06	803.79	803.79	850.5	850.56	852.59	852.59
801.09	801.09	803.8	803.86	850.59	850.59	853.0	853.06
801.1	801.16	803.89	803.89	850.9	850.96	853.09	853.09
801.19	801.19	803.9	803.96	850.99	850.99	853.1	853.16
801.2	801.26	803.99	803.99	851.0	851.06	853.19	853.19
801.29	801.29	804.0	804.06	851.09	851.09	854.0	854.06
801.3	801.36	804.09	804.09	851.1	851.16	854.09	854.09
801.39	801.39	804.1	804.16	851.19	851.19	854.1	854.16
801.4	801.46	804.19	804.19	851.2	851.26	854.19	854.19
801.49	801.49	804.2	804.26	851.29	851.29	905.0	905.0
801.5	801.56	804.29	804.29	851.3	851.36	907.0	907.0
801.59	801.59	804.3	804.36	851.39	851.39	959.01	959.01
801.6	801.66	804.39	804.39	851.4	851.46	995.55	995.55
801.69	801.69	804.4	804.46	851.49	851.49		

Attachment B

Assignment of Neonatal DRGs

```
         ┌──────────┐
         │ DRG 385  │ ────── No ──────►  ┌─────────────────────┐
         │ tthru 391│                    │ Keep DRG Assigned   │
         └──────────┘                    │ by Grouper          │
              │                          └─────────────────────┘
             Yes
              ▼
         ┌──────────┐              ┌──────────┐
         │   DRG    │ ─── Yes ───► │ LOS >=   │ ── No ──►  ┌──────────────────┐
         │   385    │              │ 3 Days   │            │ Assign DRG 385   │
         └──────────┘              └──────────┘            └──────────────────┘
              │                          │
             No                         Yes
              │                          ▼
              │                    ┌─────────────────────┐
              │ ◄───────────────── │ Move "01" to Patient│
              │                    │ Status and regroup  │
              ▼                    └─────────────────────┘
         ┌────────────────┐
         │ Wgt* < 2000g & │
         │ Age > 28 Days at│ ── Yes ──►  ┌──────────────────┐
         │ Admission      │             │ Assign DRG 810   │
         └────────────────┘             └──────────────────┘
              │
             No
              ▼
         ┌──────────┐
         │ Wgt <    │ ── Yes ──►  ┌──────────────────┐
         │ 1000g    │            │ Assign DRG 801   │
         └──────────┘            └──────────────────┘
              │
             No
              ▼
         ┌──────────┐
         │ Go to    │
         │ pg 2     │
         └──────────┘
```

*Birth weight is determined from the fifth digit of the diagnosis code in the range 764.00 through 765.19. An unspecified birth weight is assumed to be greater than 2,500g.

From
pg 1

Wgt is
1000 to
1499g
→ Yes → Assign DRG 802

No ↓

Wgt is
1500 to
1999g
→ Yes → Assign DRG 803

No ↓

Diag Code 1
thru 10 is
769
→ Yes → Assign DRG 804

No ↓

Assigned
DRG is 387
→ Yes → Assign DRG 805

No ↓

Assigned
DRG is 388
or 390
→ Yes → Assign DRG 390

No ↓

Keep Assigned DRG
(389 or 391)