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 Retain all bulletins until published notification advises that the information is obsolete or reproduced in subsequent bulletins or provider manual updates.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 **July 2005**

Reference: B0500196

Table of Contents

All Providers

The Web Portal

Trading Partner Administrator (TPA)

The TPA is the person responsible for the use and administration of the Web Portal within the provider's office. The TPA assigns user accounts to staff members. The TPA account user name follows this formula:

COTP + Your facility's trading Partner Number + A

An example of the username is COTP000000A (COTP stands for Colorado Trading Partner, 000000 is the Trading Partner ID, and the username ends with the letter "A").

After logging on as the TPA, please review the TPA training and User Guide. The training and User Guide will assist you in adding users to the portal for your trading partner. For TPA passwords, please contact the State Security Administrator (SSA) at 303-866-2363.

The TPA establishes users under the trading partner ID. A user is set up with a log on and password, and roles within the portal. Each user has applications they are allowed access to within the trading partner. Roles include: FRS, 270/271 eligibility verification, 837 claim submission, 278 PAR submission, claim inquiry PAR inquiry etc. Until the user has an established role, they are unable to access the listed applications.

It is vital that each user have their own log on and password because you ***cannot*** have more than ***one open session*** per *user* name. ***Do Not*** share log on information with other users.

Web Portal Update

Currently providers can submit Eligibility Inquiries, Claim Status Inquiries, and Professional and Dental Claims through the portal. In July, the ability to submit Prior Authorization Requests and Responses (PAR 278), PAR Inquiries, and Batch Eligibility should be available. Also, several enhancement services will be available including:

1. Provider Specialty Lookup for searching Medical Assistance Program Providers for referral purposes,
2. Dashboard on the Main Menu page for system and transaction status information, and

3. Provider Inquiry and Update for updating provider data in the MMIS.

Sometime in July the Institutional claims will be available.

Please note: EPSDT and Waiver claims can be submitted using the professional claim through the portal. For Waiver claims select "Waiver" in the Special Program Indicator field on the Claim Info tab and use the appropriate modifiers in the detailed line. For EPSDT claims select "EPSDT" in the Special Program Indicator field on the Claim Info tab. The EPSDT Referral Given field and EPSDT Condition Ind. are required fields for EPSDT claims.

If EPSDT Referral Given = "N" (No), then the Condition Ind. = "Not Used". An incorrect selection will cause a validation error and you will not be able to submit the claim. In addition, for EPSDT claims, in the Detail Line tab select "N" (No) for the field: *"Are these services a follow-up to an EPSDT screening?"*.

Provider Payment to Clients

It has come to the attention of the Colorado Department of Health Care Policy & Financing (the Department) that there may be Medical Assistance Program providers who are soliciting clients. Some providers may be offering payments to clients in an effort to have a client change his or her provider. This practice is prohibited by federal regulations and in no way is endorsed by the Department. Providers who fail to abide by federal or state laws or regulations governing the Medical Assistance Program may be subject to investigation and legal action. The Department wants to ensure that all Medical Assistance Program providers are aware that there are federal prohibitions against and penalties for conducting such acts.

Providers who participate in the Colorado Medical Assistance Program agree to comply with federal and state laws and regulations applicable to the Colorado Medical Assistance Program. The federal and state laws and regulation may be found at 42 U.S.C. Section 1936a-7b, 42 C.F.R. Section 438.6, Section 26-4-101, C.R.S. (2004) and 10 C.C.R. 2505-10, 8.000 et seq. Federal penalties for fraudulent acts and false reporting are detailed in 42 U.S.C. Section 1320a-7b and Section 26-4-410.5(c)(I), C.R.S. (2004).

This is a reminder that payment to clients by providers is considered to be an act of illegal remuneration. Federal statute, 42 U.S.C. Section 1320a-7b states, "Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person… to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service or item for which payment may be may in whole or in part under a Federal health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both."

WINASAP Update

As of May 2, 2005, providers have been able to bill the 837 Professional and Dental claims through the web portal. The 278 (PAR), PAR Inquiry, and 837 Institutional transactions should be available in July.

WINASAP software will be inactivated 30 days after these transactions are implemented. We anticipate that the WINASAP software will no longer be available for any transactions during August 2005.

Provider Applications

Effective August 1, 2005, all providers enrolling in the Colorado Medical Assistance Program must use the current Colorado Medical Assistance Program Provider Application (Revision Date: April 2005). Please discard all previous versions of the Enrollment Application as they are no longer valid. The current application is available in the Provider Services Enrollment section of the Department's website. We appreciate your cooperation in this matter.

Ambulatory Surgery Centers (ASCs)

For payment purposes, ASC surgical procedures are grouped into reimbursement categories. The Colorado Medical Assistance program recognizes nine categories defined by the Centers for Medicare and Medicaid Services (CMS) and published by Medicare.

CMS has recently updated the list of approved ASC procedure codes. The following information is a supplement to the existing list of approved codes for the Colorado Medical Assistance Program. These updates are effective July 5, 2005.

ASC Group 1

Codes added: 15001, 19298, 31603, 31637, 44397, 45327, 45341, 45342, 45345, 45387, 46230, 46706, 49419, 62264, 65820

Codes deleted:23600, 23620

ASC Group 2

Codes added: 28108, 31636, 31638, 33233, 43237, 43238, 45391, 45392, 57155, 58346, 64517, 64681, 66711

Codes deleted: 42820 (already covered under group 3), 42825 (already covered under group 4), 42830 (already covered under group 4), 42835 (already covered under group 4)

ASC Group 3
Codes added: 15836, 15839, 29873, 30220, 33212, 33213, 36475, 36476, 36478, 36479, 36834, 37500, 46947, 52301, 52402, 67912
Codes deleted:21440

ASC Group 4
Codes added: 31545, 31546, 58565, 67570
Codes deleted:none

ASC Group 5
Codes added: 51992, 57288, 67445
Codes deleted:69725

ASC Group 6
No changes

ASC Group 7
Codes added: 21120, 21125, 42665, 67343
Codes deleted:none

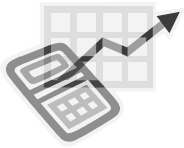
ASC Group 8
No changes

ASC Group 9
Codes added: 19296
Codes deleted:53850

In addition to the codes listed above, several procedure codes included in the CMS update are not covered benefits under the Colorado Medical Assistance Program. No payment will be made for the following procedure codes: 58970, 58974, 58976, 65780, 65781, 65782, and 68371.

HOME AND COMMUNITY BASED SERVICES WAIVERS, HOME HEALTH AND PRIVATE DUTY NURSING

Provider Rate Increases



Effective July 1, 2005, services provided by Home and Community Based Services (HCBS) Waivers, Home Health, and Private Duty Nursing will receive a 2% rate increase. Please remember that the Medical Assistance Program claims processing system utilizes "lower of" pricing meaning that providers are responsible for submitting the correct charges for dates of service on or after July 1, 2005. Any claim adjustments are the responsibility of the provider. The Medical Assistance Program claims processing system will not adjust claims automatically. Please see the schedules included with this bulletin for the adjusted rates.

Alternative Care Facilities

The individual client-based rates in Alternative Care Facilities (ACFs) will receive their increase as follows: The client's PAR will be updated in the Medical Assistance Program claims processing system. A notification letter to the client's Single Entry Point (SEP) Agency indicating the increased amount will be generated. The SEP Agency will notify the appropriate ACF provider of the client's new rate.

Adult Day Services

Providers of Adult Day Services have an individual rate based on their annual cost report submission. Adult Day Service providers will be notified of their new rate.

Home Health and Private Duty Nursing

Rate increases will also be implemented for Home Health and Private Duty Nursing revenue codes effective July 1, 2005. Please see the table comparing the FY04-05 rates to the new FY05-06 rates included with this bulletin.

HCBS PROVIDERS

Changes to Respite Care

New HCBS Service in HCBS-EBD

The HCBS-EBD Waiver has a new benefit service, in-home respite care. The new service is billed using procedure code S5150. Effective May 20, 2005, clients can receive respite care in the home at a rate of $2.97 per 15-minute unit, not to exceed the rate for ACF respite care at $51.94 per diem. For dates of service after July 1, 2005, submit claims using the new rates included in this bulletin.

New HCBS Waiver Prior Authorization Request Form

The HCBS Waiver Prior Authorization Request (PAR) Form has been revised to accommodate new codes for respite care. The previous code of T1005 used for respite care in an Alternative Care Facility for EBD and MI clients and in-home respite care for BI clients will be end-dated as of July 31, 2006. If you have an existing PAR with T1005, you can continue billing under that code until it is end-dated. All PARs for services after July 31, 2005, requesting in-home respite care for either EBD or BI clients must be billed using procedure code S5150. Respite care provided in an Alternative Care Facility must be billed using procedure code S5151 after July 31, 2005.

The new PAR Form and instructions are located in the Provider Services Forms section of the Department's website. Please download and print the form from the website. Copies of the revised form and instructions are included in this bulletin. Effective October 1, 2005, the HCBS PAR Form with revision date 07/2005 is required. All previous forms including Revision 04/2005 will not be accepted.

LONG TERM CARE SERVICE PROVIDERS

Dear Administrator Letters Available Online

All Dear Administrator Letters (DALs) issued since December 8, 2004, by the Long Term Benefits Division of the Department of Health Care Policy and Financing (the Department) are now available on the Department's web site. The DALs can be accessed through the Medical Assistance Program website, www.chcpf.state.co.us (select Reference Material/Dear Administrator Letters).

NURSING FACILITY PROVIDERS

Medical Leave Day Billing for Nursing Facility Claims

When a client is in a nursing facility and has a hospital inpatient stay during the same month, only one of the providers may be reimbursed by the Medical Assistance Program for a given calendar day. The billing provider will be paid for the date of admission but will not be paid for the client's date of discharge. This allows the admitting provider to receive payment for services provided on the date of admission without overlapping the discharging provider's billing dates.

Medical Assistance Program claims for clients on medical leave from a nursing facility during any portion of a month must be coded according to the Nursing Facility billing instructions in the Specialty Billing Manual. The nursing facility is not paid for the client's medical leave days. Correct coding allows the Medical Assistance Program payment system to distinguish for which days the nursing facility should be paid, and for which days the hospital should be paid. If the nursing facility does not code claims with medical leave days, the claims will be denied.

For example: A nursing facility submits a claim to the Medical Assistance Program for the time period July 1, 2005 through July 15, 2005, but fails to enter July 15 as a medical leave day for the client. The client is admitted to a hospital and the hospital submits a claim for July 15. The payment system detects the overlapping day and allows payment for the inpatient claim, but denies the nursing facility's entire claim. If the nursing facility claim had entered July 15 as a medical leave day, the nursing facility would be paid for the first 14 days of July, and the hospital would be paid for July 15.

PHARMACY AND PHYSICIAN PROVIDERS

Beginning July 1, 2005 pharmacies will no longer be able to bill diaphragms as a pharmaceutical item. Pharmacies billing for diaphragms must submit electronic claims on the electronic Colorado 1500/837P format and paper claims must be submitted on the Colorado 1500 claim form. Claims submitted for diaphragms must use CMS procedure code A4266 with modifier FP.

Erectile Dysfunction Drugs

Please note: The Centers for Medicare and Medicaid Services has established guidelines concerning the inappropriate use of Erectile Dysfunction drugs for sex offenders. As of June 2005 prior authorization requests for all Erectile Dysfunction drugs will be cross checked with the Colorado's Sexual Offenders list. If a client is on the Sexual Offenders list, no prior authorization will be approved for that client for any diagnosis.

Drugs used for Erectile Dysfunction are not emergency drugs, except in the diagnosis of Pulmonary Hypertension. If a pharmacy provider forces a claim to go through as an emergency drug, except for a diagnosis of Pulmonary Hypertension, the Department will reverse the claim.

Policy Clarification for Injectable Drugs

Practitioners and/or Clinics

- Injectable drugs given in a practitioner's office or clinic must be billed by the practitioner using CMS codes on the CO-1500 claim format.
- According to State policy (Volume 8, 8.831), pharmacies cannot bill for injectable drugs given in a practitioner's office.
- By State policy, practitioners may not send clients to pharmacies to get injectable drugs for use in the practitioner's office.

Pharmacies

- Injectable drugs, intended for self-administration or use in the client's home, must be billed by the pharmacy through PDCS.

With few exceptions, Colorado Medical Assistance Program claims must be submitted electronically.
For help submitting electronic pharmacy claims, call PDCS, toll free, at: **1-800-365-4944**

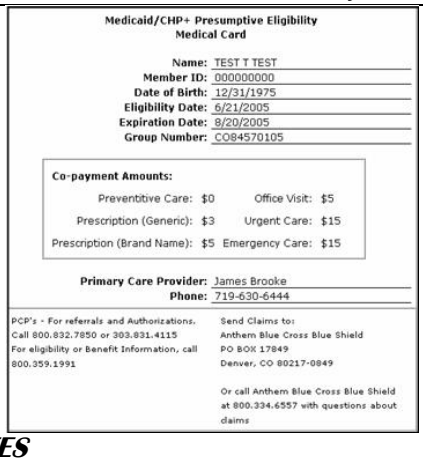
Practitioners

Presumptive Eligibility for Pregnant Women Update

Medical Assistance Program Presumptive Eligibility (PE) will be reinstated as of July 1, 2005. Presumptive Eligibility is temporary coverage of outpatient Medical Assistance Program services until eligibility is determined.

Providers must be a Medical Assistance Program/CHP+ PE site in order to offer Medical Assistance Program/CHP+ PE services. This enables the provider to bill for services rendered before a full Medical Assistance Program or CHP+ determination is made. Providers will be able to verify Medical Assistance Program/CHP+ PE client eligibility through Anthem. Questions regarding this program are to be directed to the Special Account Customer Service numbers: 720-330-6106 for members in the Denver metro area or toll free at 1-877-523-8171.

A client eligible for Medical Assistance Program Presumptive Eligibility may be determined fully Medical Assistance Program eligible or CHP Prenatal eligible, or not eligible at all for any full benefits. If Medical Assistance Program eligibility is later established, the provider may verify eligibility through the Web Portal, CMERS, or Faxback and begin billing claims for services to the Medical Assistance Program Fiscal Agent (ACS).



Medicaid/CHP+ Presumptive Eligibility
Medical Card

Name: TEST T TEST
Member ID: 000000000
Date of Birth: 12/31/1975
Eligibility Date: 6/21/2005
Expiration Date: 8/20/2005
Group Number: CO84570105

Co-payment Amounts:

Preventitive Care:	$0	Office Visit:	$5
Prescription (Generic):	$3	Urgent Care:	$15
Prescription (Brand Name):	$5	Emergency Care:	$15

Primary Care Provider: James Brooke
Phone: 719-630-6444

PCP's - For referrals and Authorizations, Call 800.832.7850 or 303.831.4115
For eligibility or Benefit Information, call 800.359.1991

Send Claims to:
Anthem Blue Cross Blue Shield
PO BOX 17849
Denver, CO 80217-0849

Or call Anthem Blue Cross Blue Shield at 800.334.6557 with questions about claims

SUPPLY PROVIDERS - CMS CODE UPDATES

The supply codes in the table below have been updated. All updates are in bold.

CODE	NARRATIVE	PAR	MAXIMUM PURCHASE ($)	MAXIMUM RENTAL ($)	COMMENTS
B4102	Enteral formula, for adults, used to replace fluids and electrolytes (e.g. clear liquids), 500 ml = 1 unit	Yes	BI	n/a	**Effective 06/01/05** Bill one unit = one can, regardless of the size of the can or number of calories in the can. If attaching a paper invoice for pricing purposes and billing unit on the invoice indicates 'cases' as units, enter the number of cans per case on the acquisition cost invoice.
B4103	Enteral formula, for pediatrics, used to replace fluids and electrolytes (e.g. clear liquids), 500 ml = 1 unit	Yes	BI	n/a	**Effective 06/01/05**. Pedialyte Bill one unit = one can, regardless of the size of the can or number of calories in the can. If attaching a paper invoice for pricing purposes and billing unit on the invoice indicates 'cases' as units, enter the number of cans per case on the acquisition cost invoice.
K0092	Rear wheel assembly for power wheelchair, complete each	Yes	**29.70**	n/a	For repair only.
T4534	Youth sized disposable incontinence product, protective underwear/pull-on, each	Conditional	**.99**	n/a	**Effective 06/01/05**. Pull-up.

AMENDED SUMMER/FALL 2005 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 Summer and Fall 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 ensure that adequate space is available for 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.

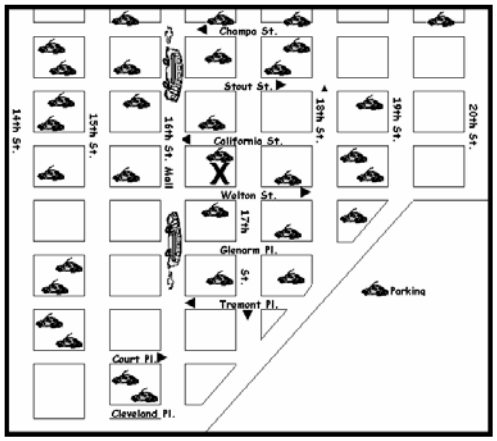
Class Descriptions

Please see bulletin B0500191, January 2005 for a complete list of class descriptions.

Locations - *Denver*

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 Billing CO-1500/837P
08/02/05 – Tuesday
11/08/05 – Tuesday

Beginning Billing UB-92/ 837I
08/04/05 – Thursday
11/10/05 – Thursday

Beginning Billing CO-1500, UB-92, ADA Format (837D, 837I & 837P)
07/06/05 – Wednesday, 8:30 am-2:30 pm
10/13/05 - Thursday

Denver Specialty Training Schedule

Practitioners
10/18/05 – Tuesday, 8:30-11:30

Dental
10/20/05 – Thursday, 10:00-11:00

EPSDT
10/18/05 – Tuesday, 12:30-1:30

FQHC/RHC
10/21/05 – Friday, 2:00-4:00

HCBS
10/19/05 – Wednesday, 1:30-2:30

Home Health
07/06/05 – Wednesday, 2:30-3:30
(Providers with questions about the recent HH, PDN & EPSDT PDN changes should attend)
10/17/05 – Monday, 11:45-12:45

Hospice
10/17/05 – Monday, 10:30-11:30

Hospital
10/17/05 – Monday, 11:00-12:00

Nursing Facility
10/17/05 – Monday, 8:30-10:30

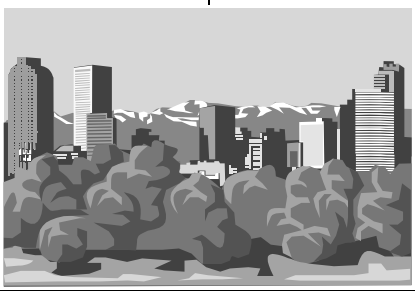
Physical/ Occupational and Speech Therapy
10/21/05 – Friday, 11:00-1:00

Pharmacy
10/20/05 – Thursday, 1:00-2:00

RTC
10/18/05 – Tuesday, 2:00- 4:00

Supply/DME
10/19/05 – Wednesday, 8:30-10:30

Transportation
10/21/05 – Friday, 8:30-10:30



Statewide

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

Fort Collins
Hilton Fort Collins
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 Billing CO-1500/UB-92

Grand Junction – 09/15/05 – Thursday
Durango – 09/19/05 - Monday, 9:00 am-1:30
Fort Collins - 09/26/05 - Monday, 9:00 am-1:30
Pueblo – 09/21/05 – Wednesday
Colorado Springs – 09/22/05 – Thursday
Greeley – 09/27/05 – Tuesday, 9:00 am-1:30

Statewide Specialty Training Schedule

Corrections to Days are Bolded

Beginning Billing CO-1500 and UB-92
Grand Junction – 09/15/05 – Thursday, 8:30-1:00

Practitioner
Grand Junction – 09/15/05 – Thursday, 2:00-4:00

Beginning Billing CO-1500 and UB-92
Durango – 09/19/05 – Monday, 9:00-1:30

Hospital
Durango – 09/19/05 – Monday, 2:00-4:00

Beginning Billing CO-1500 and UB-92
Pueblo – 09/21/05 – **Wednesday**, 8:30-1:00

RHC/FQHC
Pueblo – 09/21/05 – Wednesday, 2:00-3:30

Beginning Billing CO-1500 and UB-92
Colorado Springs – 09/22/05 – **Thursday**, 8:30-1:00

Occupational Physical and Speech Therapies
Colorado Springs – 09/22/05 – Thursday, 2:00-4:00

Beginning Billing CO-1500 and UB-92
Fort Collins – 09/26/05 – Monday, 9:00-1:30

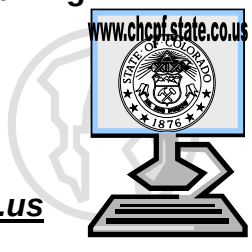
Occupational Physical and Speech Therapies
Fort Collins – 09/26/05 – Monday, 2:00-4:00

Beginning Billing CO-1500 and UB-92
Greeley – 09/27/05 – Tuesday, 9:00-1:30

Practitioner
Greeley – 09/27/05 – Tuesday, 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-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



Private Duty Nursing Rates

Service	FY 04-05 Rate	FY 05-06 Rate	Revenue Code	Unit
PDN-RN	$29.20	$29.78	552	Hour
PDN-LPN	$21.02	$21.44	559	Hour
PDN-RN (group-per client)	$21.95	$22.30	580	Hour
PDN-LPN (group-per client)	$16.11	$16.43	581	Hour
"Blended"* group rate / client*	$20.97	$21.39	582	Hour

* The "blended" rate is available on request for a Home Health Agency that provides Private Duty Nursing to multiple clients at group care settings. All Private Duty Nursing provided in those settings is billed at the same rate and revenue code for an RN or LPN. Any other Home Health Agency interested in billing this blended rate in a group setting may request it on the PAR.

Home Health					
Service	**Acute HH Revenue Code**	**Long Term HH Revenue Code**	**Unit Rate FY 04-05**	**Unit Rate FY 05-06**	**Duration**
RN assess and teach	589	None	$71.42	$72.85	Acute only- up to 2 ½ hours
RN/LPN	550	551	$71.42	$72.85	Up to 2 ½ hours
RN Brief 1st of day	n/a	590	$50.00	$51.00	
RN Brief 2nd or >	n/a	599	$35.00	$35.70	
HHA BASIC	570	571	$31.66	$32.29	One hour
HHA Extended	572	579	$9.46	$9.65	15-30 minutes each after 1st hour
Maximum Daily Amount Acute Home Health			$291	296.82	24 hours, MN to MN
Maximum Daily Amount Long Term Home Health			$227	$231.54	24 hours, MN to MN

HCBS-BI Rates FY 05-06					
Service Type	**Sub-Type**	**Previous Rate**	**New Rate 07/01/2005**	**Unit Value**	**Comments**
Adult Day Services S5102		$ 44.34	$ 45.23	Day	At least 2 or more hours of attendance 1 or more days per week
Day Treatment H2018		$ 70.34	$ 71.75	Day	At least 2 or more hours of attendance 1 or more days per week
Personal Care T1019		$ 3.19	$ 3.25	¼ Hour	Not to exceed 10 hours per day
Relative Personal Care T1019 HR		$ 3.19	$ 3.25	¼ Hour	Maximum reimbursement not to exceed 1776 units per year
Respite Care S5150	In Home	$ 2.97	$ 3.03	¼ Hour	
Respite Care H0045	NF	$ 109.58	$ 111.77	Day	All inclusive of client's needs
Independent Living Skills Training T2013		$ 23.80	$ 24.28	Hour	
Behavioral Programming H0025		$ 13.08	$ 13.34	½ Hour	
Individual Mental Health Counseling H0004		$ 13.53	$ 13.80	¼ Hour	Must pre-authorize over 30 cumulative visits of counseling
Family Mental Health Counseling H0004 HR		$ 13.53	$ 13.80	¼ Hour	
Group Mental Health Counseling H0004 HQ		$ 7.58	$ 7.73	¼ Hour	
Individual Substance Abuse Counseling H0047 HF		$ 54.11	$ 55.19	Hour	
Group Substance Abuse Counseling H0047 HQ		$ 30.30	$ 30.91	Hour	
Family Substance Abuse Counseling T1006		$ 54.11	$ 55.19	Hour	
Assistive Technology T2029					Negotiated by SEP through prior authorization
Non-Medical Transportation T2001	Med Trans. Rate Taxi	 $ 47.50	 $ 48.45	1-Way Trip	Negotiated by CM; varies by client. Not to exceed Med. Transport Rate. Taxi: up to $48.45 per trip, not to exceed the rate with the Public Utilities Commission.

HCBS-BI Rates FY 05-06					
Service Type	**Sub-Type**	**Previous Rate**	**New Rate 07/01/2005**	**Unit Value**	**Comments**
	Mobility Van	$ 12.20	$ 12.44		Mobility Van: $12.44 per trip.
	Wheelchair Van	$ 15.19	$ 15.49		Wheelchair Van: $15.49 per trip. Wheelchair Van Mileage Add-On: 62 cents per mile.
Home Modifications S5165		$10,000.00	$10,000.00	Lifetime Max	
Transitional Living T2016		$ 128.00	$ 130.56	Day	
Supported Living Program T2033		HCPF		Day	Per diem rate set by HCPF using acuity levels of client population

HCBS-EBD, MI AND PLWA Rates FY 05-06					
Service Type	**Sub-Type**	**Previous Rate**	**New Rate 07/01/2005**	**Unit Value**	**Comments**
Adult Day Services S5105	Basic Rate Specialized Rate	$ 21.05 $ 26.90	$ 21.47 $ 27.44	½ Day ½ Day	Maximum number of units is 2 per day. An individual unit is 3-5 hours per day.
Alternative Care Facility T2031		$ 36.03	$ 36.75	Day	May be less for clients with 300% income.
Electronic Monitoring	Installation S5160 Service S5161	N/A N/A			Negotiated by CM; varies by client.. Negotiated by CM; varies by client..
Homemaker S5130		$ 3.14	$ 3.20	¼ Hour	
Home Modification S5165		$10,000.00	$10,000.00	Lifetime Max	
Personal Care T1019		$ 3.14	$ 3.20	¼ Hour	
Relative Personal Care T1019 HR		$ 3.14	$ 3.20	¼ Hour	Relative Personal Care cannot be combined with HCA. Maximum reimbursement not to exceed 1776 units per year.
Respite Care S5151	ACF	$ 51.94	$ 52.98	Day	Limit of 30 days per calendar year.
Respite Care H0045	NF	$ 115.81	$ 118.13	Day	Limit of 30 days per calendar year.
Respite Care S5150	In Home	$ 2.97	$ 3.03	¼ Hour	Limit of 30 days per calendar year. Not to exceed the ACF per diem for respite care.
Non-Med. Transportation T2001	Med. Transportation Rate Taxi Mobility Van Wheelchair Van	 $ 47.50 $ 12.20 $ 15.19	 $ 48.45 $ 12.44 $ 15.49	1-Way Trip	Negotiated by CM; varies by client. Not to exceed Med. Transport Rates. Taxi: up to $48.45 per trip, not to exceed the rate with the Public Utilities Commission. Mobility Van: $12.44 per trip. . Wheelchair Van: $15.49 per trip. Wheelchair Van Mileage Add-On: 62 cents per mile.
IHHS Personal Care T1019 KX		$ 3.14	$ 3.20	¼ Hour	
IHSS Relative Personal Care T1019 HR KX		$ 3.14	$ 3.20	¼ Hour	No limits on IHSS benefits provided by parents of adult children. For all other relatives, the limitations on payment to family applies as set forth in 10 C.C.R. 2505-10, Section 8.485.200 .
IHSS Homemaker S5130 KX		$ 3.14	$ 3.20	¼ Hour	
IHSS Health Maintenance Act H0038		$ 6.32	$ 6.45	¼ Hour	

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

REQUEST FOR HCBS PRIOR APPROVAL AND COST CONTAINMENT

Check the appropriate waiver program with modifier:

☐ **BI**-U6, ☐ **EBD**-U1, ☐ **CHCBS**-U5, ☐ **CDCE**-UC, ☐ **MI**-UA, ☐ **PLWA**-U2

REVISION? Yes ☐ No ☐

PA Number being revised

1. CLIENT NAME	2. CLIENT ID NUMBER	3. SEX ☐ M ☐ F	4. BIRTH DATE

5. REQUESTING PROVIDER #	6. CLIENT'S COUNTY	7. CASE NUMBER (AGENCY USE)	8. DATES COVERED FROM	THROUGH

STATEMENT OF REQUESTED SERVICES

9. Description	10. Modifier	11. Max # Units	12. Cost Per Unit	13. Total $ Authorized	14. Comments
A S5105 Adult Day Care					
B T2001 Non-medical Transportation					
C S5130 Homemaker					
D T1019 Personal Care					
E T1019 Relative Personal Care	HR				
F S5165 Home Modifications					
G S5161 Electronic Monitoring					
H S5160 Electronic Monitor Install/Purchase					
I T2031 Alternative Care Facility					
J H0045 Respite Care NF					
K S5151Respite Care (ACF -U1, UA)					
L T2016 Transitional Living, per day, U6					
M T2029 Assistive Technology, per service, U6					
N H0004 Mental Health Counseling, U6					
O T1006 Substance Abuse Counseling – Family, U6					
P H0047 Substance Abuse Counseling– Group/Indiv, U6					
Q T2013 Independent Living Skills Training, U6					
R H2018 Day Treatment, U6					
S H0025 Behavioral Management, U6					
T T2025 Personal Support Services (PSS), UC					
U T2025 Personal Support Services Administration, 52					
V T2038 Community Transitions, U1					
W T2033 Supported Living Program, U6					
X H0038 Health Maintenance Activities, U1					
Y S5150 In-Home Respite Care (U1, U6)					

15. TOTAL AUTHORIZED HCBS EXPENDITURES (SUM OF AMOUNTS IN COLUMN 13 ABOVE) $

16. PLUS TOTAL AUTHORIZED HOME HEALTH EXPENDITURES (SUM OF AUTHORIZED HOME HEALTH SERVICES DURING THE HCBS CARE PLAN PERIOD) – Excludes In-Home Support Services amounts $

17. EQUALS CLIENT'S MAXIMUM AUTHORIZED COST (HCBS EXPENDITURES + HOME HEALTH EXPENDITURES) $

18. NUMBER OF DAYS COVERED (FROM FIELD 8 ABOVE) $

19. AVERAGE COST PER DAY (Client's maximum authorized cost divided by number of days in the care plan period) $

A. Monthly State Cost Containment Amount $

B. Minus Client's Monthly Income $

C. Minus Client's Monthly HCA Warrant Amount $

D. Equals Client's Monthly Cost Containment $

E. Divided by 30.42 days = Daily Cost Containment Ceiling $

20. Immediately prior to HCBS enrollment, this client lived in a Nursing Facility ☐ YES ☐ NO

21. CASE MANAGER SIGNATURE	22. AGENCY	23. DATE

DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY

24. CASE PLAN: ☐ Approved - Date _____ ☐ Denied - Date _____ ☐ Returned for Correction - Date _____

25. REGULATION(S) upon which Denial or Return is based:

26. AUTHORIZING AGENT SIGNATURE	27. DATE

PAR Completion Instructions

FORM MUST BE COMPLETED IN BLACK BALLPOINT OR TYPEWRITER - PLEASE PRINT

Complete this form for Prior Authorization Requests for **BI**, **EBD**, **CHCBS, CDCE, MI**, **and PLWA**. Submit the PAR to the HCBS program's authorizing agent listed at the bottom of the instructions.

Complete the Revision section at the top of the form ***only*** if you are revising a current approved PAR.

For PAR revisions you must add the number of units being requested to the original number of units approved and include all services that were approved on the original PAR.

Complete the following fields

Check the type of program (☐ **BI**-U6, ☐ **EBD**-U1, ☐ **CHCBS**-U5, ☐ **CDCE**-UC, ☐ **MI**-UA, ☐ **PLWA**-U2) at the top of the PAR form for which you are requesting services - **Required**

1. **Client Name – Required**: Enter the client's name.
2. **Client ID number – Required**: Enter the client's Medical Assistance Program ID number.
3. **Sex**: Check M or F.
4. **Birth Date – Required**: Enter the client's date of birth.
5. **Requesting Provider # - Required**: Enter the requesting provider's Medical Assistance Program provider number.
6. **Client's County – Required**: Enter the client's county of residence.
7. **Case Number**: Enter the agency's case number for this PAR.
8. **Dates Covered (From and Through) – Required**: Enter the PAR start date and PAR end date.
9. **Description**: List of approved procedure codes.
10. **Modifier**: Enter all applicable modifiers.
    For PCP and Homemaker services provided under IHSS, please use modifier KX. Example: T1019 U1 KX or S5130 U1 KX.
    When the CDCE waiver authorizes Personal Care Administration, use UC and 52. For PSS services, use UC.
    Modifiers for BI Mental Health and Substance Abuse Counseling (N, O and P) are listed below:

Brain Injury Mental Health Counseling Codes and Modifiers		Brain Injury Substance Abuse Counseling Codes and Modifiers	
H0004, U6, HR	Mental Health Counseling, Family	T1006	Substance Abuse Counseling, Family
H0004, U6, HQ	Mental Health Counseling, Group	H0047, HQ	Substance Abuse Counseling, Group
H0004, U6	Mental Health Counseling, Individual	H0047, HF	Substance Abuse Counseling, Individual

11. **Max # Units**: Enter the number of units next to the services for which you are requesting reimbursement.
12. **Cost Per Unit**: Enter the cost per unit of service.
13. **Total # Authorized**: Enter the total amount authorized for the service.
14. **Comments**: Enter any additional useful information.
15. **Total Authorized HCBS Expenditures** (Sum of Amounts in Column 13): Enter the total of all amounts listed in column 13.
16. **Plus Total Authorized Home Health Expenditures** (Sum of Authorized Home Health Services during the HCBS Care Plan Period): Enter the total Authorized Home Health expenditures.
17. **Equals Client's Maximum Authorized Cost**: Enter the sum of the HCBS Expenditures + Home Health Expenditures.
18. **Number of Days Covered:** Enter the number of days covered from Field 8.
19. **Average Cost Per Day:** Enter the client's maximum authorized cost divided by number of days in the care plan period.
20. **Immediately prior to HCBS enrollment, this client lived in a Nursing Facility**: Check Yes or No.
21. **Case Manager Signature**: Enter the signature of the Case Manager.
22. **Agency**: Enter the name of the agency.
23. **Date**: Enter the date signed.

Do ***not*** enter anything below the shaded area "**DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY"**. This is for the authorizing agency use only.

Send only *New*, CSRs and Required PARs to:

BI PARs	**EBD, CHCBS, CDCE, MI, PLWA PARs**
Send to:	**Send to:**
The Department of Health Care Policy and Financing	ACS
Waiver Coordinator	PARs
1570 Grant Street	PO Box 30
Denver CO 80203-1714	Denver, CO 80201-0030

Publication Preferences

Publication and Notification Preference

Medical Assistance Program updates and billing instructions are communicated through Medical Assistance Program publications. *An email notification with a link to the publication will be sent to providers when new bulletins, publication revisions and program updates are posted on the Provider Services Section of the Department's website. Providers are responsible for ensuring that the fiscal agent has their current publications email address on file. The Colorado Medical Assistance Program is not responsible for undeliverable notifications due to incorrect email addresses.*

All publications are available in the Provider Services section of the Department's website:

http://www.chcpf.state.co.us/ACS/Provider_Services/provider_services.asp

Please complete the following information:

Provider Name: _____ Medical Assistance Program Provider Number: _____

Contact Name: _____ Telephone Number: ( ) _____

Address: _____ (Street/PO Box) _____ (State) _____ (Zip Code)

Provider Publications Email Address: _____

Publications Media:
(Please check one)

- ☐ *Email notification with link to publication*
- ☐ *Another provider will receive email notification on my behalf. I understand that I am responsible for obtaining the notification from this provider and that I will **not** receive an email notification from the Colorado Medical Assistance Program.*
- ☐ *None (I understand that I am responsible for retrieving publications from the website and that I will **not** receive an email notification from the Colorado Medical Assistance Program).*

_____ (Authorized Signature) _____ (Date)

Please complete all of the above information and

Fax to: or **Mail to:**

Medical Assistance Program Provider Enrolment
303-534-0439

Medical Assistance Program Provider Enrolment
PO Box 1100
Denver, CO 80201-1100

Revised 04/26/05