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 Retain all bulletins until published notification advises that the information is obsolete or reproduced in subsequent bulletins or provider manual updates.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 2007**

Reference: B0700235

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ALL PROVIDERS

National Provider Identifier Update
Claim Payments on or after June 24, 2007

On June 24, 2007, the Colorado Medical Assistance Program claims processing system was modified to accept 837 electronic claim transactions submitted with only the provider's NPI number. Providers are encouraged to get an NPI, register the NPI with the fiscal agent, and begin to use the NPI on electronic claim submissions. Please refer to the Companion Guides on the website.

(http://www.chcpf.state.co.us/ACS/Provider_Services/provider_services.asp; Select Manuals or Specifications for instructions on X12 transactions).

If the claims processing system does not accept your NPI, please make sure you registered your NPI with the MMIS. Once your NPI is registered you may submit claims using the NPI number. You may still submit electronic claims using only your Medicaid provider number.

To match an NPI number to a unique Medicaid provider number and pay claims one of the following scenarios must be true.

1. The provider has one NPI number to match each Medicaid provider number.
2. The provider has one NPI number to match many Medicaid numbers and each Medicaid provider number has a different location and a unique zip+4 code (available at: http://zip4.usps.com/zip4/welcome.jsp) and taxonomy information registered in the MMIS. This information must be submitted to ACS on the provider's letterhead.

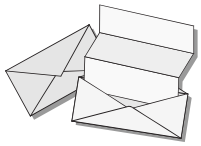
Providers who have more than one Medicaid provider number at the same address need a separate NPI for each Medicaid provider number to ensure efficient claims processing and payment.

Each NPI number must be registered in the MMIS to the corresponding Medicaid provider number before claims can be submitted using the NPI numbers.

Continue to bill claims using the 8-digit Medicaid provider number if you do not have an NPI for each Medicaid number without a unique zip+4 code. Claims billed with an NPI number that cannot be matched to one Medicaid provider number will be denied. Claims billed with the NPI that is not registered in the MMIS will be denied.

Paper Claim Forms and the NPI

At the present time, Colorado is not accepting the UB-04 claim form or any new claim form. Until further notice, providers must continue to submit paper claims on the paper claim form currently accepted by the Colorado Medical Assistance program (UB-92). There are several agencies that are still producing this form. Providers must also continue to use their eight-digit Colorado Medical Assistance provider number NOT their NPI on PAPER claims. The NPI is for electronic claims submission only. Please watch for NPI and claim form updates in future bulletins and in the Provider Services section of the Department's website at:



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

Register your NPI with the Medicaid Fiscal Agent Now

Only 50% of Medicaid-enrolled providers have registered their NPI with the fiscal agent. Health care providers, including pharmacies, who have received their NPIs, must register their National Provider Identifier (NPI) with the fiscal agent as soon as possible. Doing so may avoid a denied claim.

Registering through the Web Portal updates the Medicaid Management Information System (MMIS). In addition, as part of the submission process, the provider's record in the Web Portal Provider Maintenance will be updated with the NPI. To access this functionality, a Trading Partner Administrator (TPA) can assign a user the role "Provider (MMIS)". The user will then have the authority to register the NPI using the "Inquiry/Update Provider Data" link located under "(MMIS) Provider Data Maintenance" in the Web Portal menu.

If the provider has multiple NPIs assigned to their Medicaid provider number, they will need to notify the fiscal agent by submitting NPI information on the provider's letterhead with the corresponding Medicaid provider number and a signature of the person whose NPI number is listed (e.g., the doctor).

Information on how to send your NPI will be displayed on the main Web Portal page. Update information is also available on the following web page:

http://www.chcpf.state.co.us/ACS/Pdf_Bin/Revised_provider_update_form0207.pdf

It is each provider's responsibility to obtain an NPI(s), to match them with their current provider number(s) where appropriate and then share this information with their payers. It is also the provider's responsibility to send their NPI to each and every payer.

Due to the high volume of NPI calls to the fiscal agent's call center, it is recommended that providers verify NPI registration through the Web Portal for faster results.

Web Portal Update

New Feature planned for July

- **Providers can submit Medicare Coinsurance and Deductible in fields located on the "Other Insurance" page.** Due to the ruling of The National Uniform Billing Committee (NUBC) to restrict the use of value codes A1, A2, A7, B1, B2, B7, C1, C2, and C7 to paper claims, providers will now submit Medicare coinsurance and deductible amounts in fields located on the "Other Insurance" page. Please look for updates on the main Web Portal page for the effective dates. For more specific information click "Help" located on the gray bar located at the top of the screen.

Web Portal Frequently Asked Questions

Q. Why did my eligibility inquiry reject for reason code 51?

A. The provider is not valid in the Medicaid Management Information System (MMIS). If you submitted the eligibility with the legacy provider number, check the ID and resubmit the inquiry. If you submitted the inquiry with the National Provider ID (NPI) please check to see if the NPI is registered in the MMIS. Review the FAQs located in the Web Portal menu for instructions on checking and registering the NPI.

Q. Why did my claim reject indicating that there is "no provider match for the Billing National Provider Identifier"?

A. The NPI submitted for the billing provider on the claim is not registered in the MMIS. Review the FAQs located in the Web Portal menu for instructions on checking and registering the NPI. Billing and Rendering provider NPI fields in the professional and dental claims are disabled for text entry. These fields can only be populated by selecting the provider from the dropdown in the legacy Provider ID field.

The reason for this is additional data in the Provider Maintenance records that is sent with the transaction. In order to change or remove the NPI for the billing and rendering provider in the claim a user must modify the Provider Identifier field in the Provider Maintenance record for that provider.

Q. Why can't I find our Provider Claim Report (PCR) in the FRS?

A. Only one trading partner can receive the PCR. Either the provider or the clearinghouse can receive the PCR, but not both. If you have problems finding your PCR please contact ACS EDI services at 1-800-237-0757.

Holiday Claims Payment Schedule

Independence Day Claims Payment Schedule

Due to the Independence Day holiday on Wednesday, July 4, 2007, both EFT and paper warrants will be delayed by one day. Providers should receive claim payments a day later than usual.

Colorado Medical Assistance Program Eligibility Response System (CMERS)

CMERS now includes the ability to use an NPI number when making inquiries. CMERS is an automated voice response system that furnishes providers with:

Eligibility Verification – Press 1
Provider Warrant Information – Press 2
Claim Status – Press 3
Instructions on using the system – Press 4

The telephone numbers for CMERS are: 303-534-3500 Denver Metro or 1-800-237-0044 Toll free Colorado.
The General Provider Information (06/07) in the Provider Services Billing Manuals section of the Department's website http://www.chcpf.state.co.us/ACS/Provider_Services/Billing_Manuals/Billing_Manuals.asp has been updated to include the new CMERS information.

Provider Billing Manual Revision

Appendices N – Prior Authorization Request Denial Reasons and R – Provider Claim Report Messages have been updated to include NPI denial reasons. The Appendices section of the Billing Manual is located at:

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

Fee for Service Rate Increases

Effective July 1, 2007, the following fee for service rate updates will be implemented as mandated by Senate Bill 07-239:

Anesthesia

The current anesthesia conversion factor of 14.33 will be increased to 21.49.

Surgical Procedures

The current surgical conversion factor of 33.43 will be increased to 34.58.

Physical Therapy, Occupational Therapy, and Speech Therapy

Rates for outpatient physical therapy, occupational therapy, and speech therapy procedure codes will be increased by 9.05%. Please see the August 2007 provider bulletin for specific procedure code and rate information.

Immunizations for Adults

The total appropriation for medically necessary immunizations provided to clients age 21 and older will be increased by $600,000. Please see the August 2007 provider bulletin for specific procedure code and rate information.

Durable Medical Equipment Repair

The current rate of $16.21 for procedure code E1340 (repair or non-routine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes) will be increased to $35.48 per 15 minutes.

Paragard Intrauterine Copper Contraceptive

The current rate of $301.64 for procedure code J7300 (Paragard intrauterine copper contraceptive) will be increased to $398.37.

Updates for All PARs Processed by the Fiscal Agent (ACS)

Due to an usually high number of shortened PARs, effective July 1, 2007, PARs must be for a length of one year. If you submit a PAR for a length of time less than one year, you must also provide a written reason for the shortened date span. PARs submitted for less than a period of one year without an explanation will be denied.

PAR Revisions

Please print "REVISION" in bold letters at the top and enter the PAR number being revised in box #7. Do not enter the PAR number being revised anywhere else on the PAR.

PAR Reminders

1. Enter the complete dates of service in month/day/year format (e.g., 07/15/2007) for both the "From" and "To" dates.
2. Enter both the Requesting and Billing Provider numbers – Verify that they have been entered correctly
3. Submit PARs to the correct reviewing entity. Please refer Appendix D in the Appendices section of the Billing Manuals (http://www.chcpf.state.co.us/ACS/Provider_Services/Billing_Manuals/Billing_Manuals.asp) for a list of Authorizing Agencies.
4. Submit a "change of provider letter" signed by the client or their legal guardian when the client changes providers. The "change of provider letter" is required by the State.
5. Submit requested documentation with all previous documentation as well as a copy of the pending or denial letter. Without the previous documentation and the pending/denial letter, the fiscal agent is unable to match the requested documentation to the correct client's PAR and the PAR cannot be processed.

Failure to follow the above instructions may result in PAR delays or denials.

New Hours for the Fiscal Agent Provider Services Call Center

Beginning July 2, 2007, Provider Services Call Center agents will be available to answer your calls Monday through Friday from 7AM - 6PM, Mountain Time.

Updated Provider Enrollment Applications

Effective September 1, 2007, providers must submit enrollment applications with a revision date of July 2007. Several changes have been made to both the standard and rendering provider applications that should help alleviate confusion and ensure your applications are processed smoothly. There is now only one application for all provider types; rendering providers must complete the rendering provider application to ensure proper enrollment.

Beginning July 1, 2007, the new applications can be downloaded from the Provider Services Enrollment web page. Click the "Providers not yet enrolled", and click on the appropriate provider type. The following link will take you directly to the "Providers not yet enrolled" page: http://www.chcpf.state.co.us/ACS/Enrollment/new_providers.asp

Please contact ACS Provider Services at 303-534-0146 or 800-237-0757 (Colorado toll-free) with any questions on completing the application.

Change to EDI Services Telephone Number

On June 1, 2007, the 1-800-987-6721 for EDI Services was disabled. Providers with EDI inquiries should now call 1-800-237-0757, and select option 4.

Billing the Client for Medical Assistance Program Services

(Originally published in May 2004, Bulletin B0400175)

The Colorado Medical Assistance Program and fiscal agent representatives frequently address questions as to what can be billed to Medical Assistance Program clients. Please share this information with your billing offices and use the following questions (Q) and answers (A) as a guide for determining whether Medical Assistance Program clients can be billed for services rendered.

Q: Can Medical Assistance Program clients be charged for services covered by the Medical Assistance Program?

A: *No.*

Participating providers agree to accept the Medical Assistance Program payment as payment in full for benefit services rendered. Required Medical Assistance Program deductibles, co-insurance or copayments and those specific to specialty areas of practice are described in the Billing Information section of the Billing Manual.

Q: What if the Medical Assistance Program payment does not cover all of my costs. Can I charge the difference to the client?

A: *No.*

All providers submitting medical services claims to the Medical Assistance Program certify that, "I accept as payment in full, payment made under the Medical Assistance Program, and certify that no supplemental charges have been, or will be billed to the patient, except for those non-covered items or services, if any, which are not reimbursable under the Medical Assistance Act."

Q: What if I no longer want to be a Medical Assistance Program provider. Can I bill the Medical Assistance Program clients for my services?

A: *No.*

Clients may not be billed if the failure to obtain Colorado Medical Assistance Program payment is caused by the provider's failure to comply with Colorado Medical Assistance Program billing procedures.

Constraints against billing Colorado Medical Assistance Program clients for benefit services apply whether or not Colorado Medical Assistance Program makes or has made payment and whether or not the provider participates in the Colorado Medical Assistance Program.

Q: Can I use a collection agency or execute a lien against assets to get payment from Medical Assistance Program clients?

A: *No.*

Collection agencies cannot submit Colorado Medical Assistance Program claims for payment and cannot collect payment from Colorado Medical Assistance Program-eligible clients. Providers may not assert a lien – including a hospital lien – on any money, settlement, recovery, or judgment paid to the client or to the client's estate as the result of a personal injury lawsuit. Colorado law prohibits providers from billing Medical Assistance Program clients or the estates of deceased Medical Assistance Program clients for Medical Assistance Program benefit services.

Q: Can I bill Medical Assistance Program clients for missed appointments?

A: *No.*

Providers may not bill the Colorado Medical Assistance Program clients for missed appointments, telephone calls, completion of claim submission forms, or medication refill approvals.

Primary care physicians participating in a managed care program may dismiss an enrolled client from their practice for cause at any time.

The primary care physician shall give no less than 45 days notice to both the Department and the client. Cause shall be defined as any of the following:

- *The client misses multiple scheduled appointments*

- *The client fails to follow the recommended treatment plan or medical instructions.*
- *The primary care physician cannot provide the level of care necessary to meet the client's needs.*
- *The client and /or client's family is abusive to provider and/or staff in compliance with 42 CFR 438.56(a)(2).*
- *The physician moves out of the service area.*
- *Other reasons satisfactory to the Department.*

Q: Can I bill Medical Assistance Program clients for services not covered by the Medical Assistance Program?

A: *Yes.*

Before providing services that will not be covered by the Colorado Medical Assistance Program, providers shall have the client sign an acknowledgment of financial responsibility. Only if a written agreement is developed do clients have the following responsibilities:

- *If the service is not a covered benefit of the Colorado Medical Assistance Program, clients may be billed for the service.*
- *Clients are responsible for Colorado Medical Assistance Program co-p ayment. By federal law, providers may not refuse services if the client cannot pay co-payment when services are rendered. Clients may be billed for unpaid co-payment. Providers may apply standard collection policies if the client fails to satisfy co-payment obligations.*
- *Clients in nursing facilities are responsible for patient payment when under Medicare A (skilled nursing) coverage. If the patient payment amount exceeds the Medicare A co-insurance due, the difference is refunded to the client.*
- *Colorado Medical Assistance Program clients enrolled in a Colorado Medical Assistance Program Managed Care Program must follow the rules of the Prepaid Health Plan (PHP). Clients who insist upon obtaining care outside of the PHP network may be charged for non-covered services.*
- *Colorado Medical Assistance Program clients enrolled in the Primary Care Physician (PCP) Program are required to follow PCP Program rules. Non-emergency care in a setting that is not authorized by the primary care physician is not a benefit of the Colorado Medical Assistance Program. Clients who insist upon obtaining non-emergency care in an emergency or urgent care setting without PCP authorization may be charged for the cost of those services.*
- *Colorado Medical Assistance Program clients who have commercial insurance coverage that requires them to obtain services through a provider network must obtain all available services through the network.*
- *Clients who insist upon obtaining non-managed-care covered services outside the network may be charged for such services.*

Refer to the following sites for questions concerning charging Medical Assistance Program clients for services rendered.

1. Code of Federal Regulations:
Title 42 Section 447.15 - Acceptance of State payment as payment in full.
http://www.gpoaccess.gov/cfr/index.html

2. Colorado Revised Statutes:
26-4-403 - Recoveries–overpayments–penalties–interest–adjustments–liens.
http://198.187.128.12/colorado/lpext.dll?f=templates&fn=fs-main.htm&2.0.com
26-4-518 - Payments by third parties–co-payments by clients–review–appeal.
http://198.187.128.12/colorado/lpext.dll?f=templates&fn=fs-main.htm&2.0.com

3. Colorado Code of Regulations (State Rules Concerning the Medical Assistance Program):
10 CCR 2505-10, 8.000 et seq.
10 CCR 2505-10, section 8.012
10 CCR 2505-10, section 8.205.4.I
http://www.chcpf.state.co.us/HCPF/StateRules/index.asp

4. Colorado Medical Assistance Program Provider Participation Agreement, Page 2 Item G.
http://www.chcpf.state.co.us/HCPF/Pdf_Bin/Enrollmentapp.pdf

5. Colorado Medical Assistance Program General Information and Requirements Manual, Pages 19-20
http://www.chcpf.state.co.us/HCPF/Pdf_Bin/MasterGenFinalrev.pdf

6. Medical Assistance Program Bulletin #B9900020, July 1999
http://www.chcpf.state.co.us/HCPF/Pdf_Bin/provrespons.PDF

Title VI, Civil Rights Act – Reminder

(Originally published in September 2006, Bulletin B0600217)

Providers who receive *any* federal funds through programs such as the Medical Assistance Program, Medicare, CHAMPUS, etc., must provide oral interpretation services (excluding a patient's family members) to *all* limited English proficient patients in their practice, including those for whom you do not receive federal funds. Limited English proficient patients are patients who do not speak English as their primary language. Examples of oral interpretation services include oral interpretation services, bilingual staff, telephone interpreter lines, written language services and community volunteers.

Written materials must be translated and provided to limited English proficient patients if the practice comprises of 10% or 3,000 limited English proficient patients, whichever is less. If you have questions, contact the Office of Civil Rights at 1-888-848-5306.

HCBS Waiver, Home Health and PDN Providers

Rate Increases

Effective July 1, 2007, Home and Community Based Services (HCBS) Waiver providers, Home Health agencies, and Private Duty Nursing providers will receive a 1.5% rate increase. Please see Attachment A for the adjusted rates for each procedure or revenue code.

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, 2007. The Medical Assistance Program claims processing system will not adjust claims automatically. Any claim adjustments are the responsibility of the provider.

Alternative Care Facility (ACF) Providers

The new daily rate for the ACF benefit is $48.29. All PARs for 300% ACF clients will be systematically modified to reflect the new rate. This will affect the provider's daily rate, but will not affect the client's payment amount.

The PARs for "standard" Medicaid clients will be systematically updated for dates of service starting July 1, 2007, with the new rate and the remaining units. The modified PARs for 300% clients will be sent to the SEP Agency and will be forwarded to the provider as quickly as possible.

Hospital Providers

DRG Education and Review Project Provider Questions and Answers

On April 27, 2007, the Department of Health Care Policy and Financing (HCPF) and the contractor Health Management Systems (HMS) held an informational meeting at the Colorado Hospital Association. The questions and answers resulting from the meeting are now available in the Provider Services News and Updates section of the Department's website at:

http://www.chcpf.state.co.us/ACS/Pdf_Bin/DRG_Education_and_Review_Project.pdf

Providers are encouraged to direct any further questions to:

Susan Parks, R.N.
Project Manager, HMS
Metro: 303-837-8293 x205
Toll Free: 1-800-293-3973 x205
E-Mail: sparks@hmsy.com

Practitioners

Implanon Contraceptive

Implanon became a covered benefit of the Medical Assistance Program on May 1, 2007.

Use the following codes when billing on the electronic Colorado 1500/837P format:

Code	Description
11975-FP	Insertion, implantable contraceptive capsule
11976-FP	Removal, Implantable contraceptive capsule
11977-FP	Removal with insertion, implantable contraceptive capsule
S0180-FP	Etonogestrel (contraceptive) implant system, including implants and supplies

Please always use the 'FP' (family planning) modifier when billing the above codes for Implanon. Please refer any questions to Jenny Nickerson at 303-866-3936 or email at jenny.nickerson@state.co.us.

Pharmacy Providers

News and Updates

The State will soon be updating Appendix P (Colorado Medical Assistance Program Prior Authorization Procedures and Criteria for Physicians and Pharmacists). When the update is complete, it will be posted on the Medicaid Pharmacy Site at: http://www.chcpf.state.co.us/HCPF/Pharmacy/phmindex.asp.

Since there is currently no Growth Hormone PA form, Pharmacies and Practitioners (Prescribers) must use the **General PA form** when requesting a PA for Growth Hormones. The **General PA form** is located at:

http://www.chcpf.state.co.us/HCPF/Pharmacy/General_PA_Request.PDF.

24 Hour Helpdesk

Starting 07/01/2007, the Pharmacy Prior Authorization Helpdesk will be available twenty-four hours a day seven days a week.

Prior Authorization Type Code 1

Because the PA Helpdesk will be available to take prior authorization requests twenty-four hours a day seven days a week, the Department will no longer accept PA Type Code 1 overrides from pharmacies starting July 1, 2007. PA Type Code 1 is used to supply a client with a three- day emergency supply of a medication while the prescriber processes the prior authorization request. Pharmacies will still be able to process an emergency three-day supply through the POS system by calling the PA Helpdesk to receive authorization. Pharmacies should call 1-800-365-4944 to request an emergency three-day supply.

Compound Claim Processing Changes

Effective July 1, 2007, single-line compound claims submitted POS will no longer be accepted. Multi-line compound claim submission will be required. POS single-line compounds will continue to be required on all claims submitted through June 30, 2007.

ICD-9 Codes

In an attempt to decrease the number of prior authorization requests that are based solely on diagnosis, the Department will allow the use of ICD-9 codes to override some prior authorization denials. Staring July 1, 2007, ICD-9 codes can be submitted on pharmacy point-of-sale claims in NCPDP Version 5.1 Field 424-DO (Diagnosis Code) to override prior authorization requirements for the following medications/diagnosis.

Medication	Diagnosis	ICD-9 Codes
Tretinoin & Isotretinoin	Cystic Acne	706.1
	Keratinization	370.9
	Psoriasis	696.1
	Neoplasms	199.1, 234.9, 229.9, 238.9, 239.9
Bactroban Cream	Secondarily infected traumatic skin lesions	709.9
	Impetigo	684
	Infected Eczema	692.9, 686.8, 706.8, 691.8, 692.9, 705.81, 380.22, 274.89, 054.0, 692.72, 454.1, 454.2, 999.0, 698.3, 701.8, 684, 690.12, 110.3, 690.18
	Folliculitis	704.8
Revatio	Pulmonary Hypertension	416.8, 415, 416, 747.83, 416.8
Bactroban Nasal Ointment	MSRA	V09.0
Blood Products	Shock due to burns, trauma and surgery	only shock- 785.50
	Adult Respiratory Distress Syndrome	769, 515.5, 518.82, 768.5
	Cardiopulmonary bypass	39.61, 39.66
	Liver failure	572.8, 570
	Renal dialysis	V56.0, 361.04, V56.0, V45.1, V56.8
	Hemophilia	286.0, V83.01, V83.02, 286.5, 286.1, 286.2, 286.7, 286.0, 286.4
Cranberry Tablets	UTI	599
OTC and Rx Cough and Cold Products	Asthma, COPD and Chronic Bronchitis	496, 493.2, 491.20, 491.21, 493.9, 493.2, 493.0, 428.1, 404.90, 504, 505, 502, 316, 495.8, 428.1, 495.8, 500, 493.81, 502,254.8, 506.9, 478.75, 493.82, 507.8, 506.3, 493.1, 518.3
OTC and Rx Antihistamine/Decongestant	Seasonal or Perennial Allergic Rhinitis	477.9
	Chronic Sinusitis	473.9
Oxsoralen	Myosis	379.2, 236.0
	Fungoides	111.9, 110.4, 110.2
	Psoriasis	696.1
	Vitiligo	709.01
Sandostatin	Acromegaly	253
Sodium Chloride 3%	Cystic Fibrosis	277.0-277.03, 996.0-996.5, 277.09
Folic Acid Rx	Folic Acid Deficiency	266.2, 281.2, 281.9, 281.3, 281.2, 648.2, 429.2, 746.9, 402.90, 402.10 402.00, 404.90, 093.9, 270.4, 361.04 V56.0, V45.1, V56.8, 633.10, 633.11 761.4, 633.10, 633.1
	Macrocytic Anemia	
	Megaloblastic Anemia	
	Prevention of miscarriages	
	Neural Tube Defect Pregnancy	

If you have any questions regarding these updates, please call the Colorado Medicaid Pharmacy Services Help Desk at 1-800-365-4944.

Supply/DME Providers

Pulse Oximeters

Effective August 1, 2007 Pulse Oximeters will have a maximum allowable rental cap of $750.00 per year. Once the total rental payment reaches $750.00 the equipment will convert to a purchase. This change is in accordance with the following Rule: 8.590.2.R. Rental Policy.

1. The Department may set a financial cap on certain rental items. The monetary price for those items shall be determined by the Department and noted in the Medicaid bulletin. The provider is responsible for all maintenance and repairs as described at 8.590.4.P-Q, until the cap is reached.
2. Upon reaching the capped amount, the equipment shall be considered purchased and shall become the property of the client. The provider shall give the client and/or caregiver all applicable information regarding the equipment as described at 8.590.4.C.4. The equipment shall not be under warranty after the rental period ends.
3. The rental period may be interrupted, for a maximum of sixty consecutive days.
4. If the rental period is interrupted for a period greater than sixty consecutive days, the rental period must begin again. The interruption must be justified, documented by a physician, and maintained in the provider file.
5. If the client changes providers, the current rental cap remains in force.

For questions regarding this policy, please contact:
Renee Robinson at 303-866-5622

Are you enrolled for EFT?

Don't let inclement weather or postal service delay your paper checks (warrants)! To avoid mail delays, sign up for Electronic Funds Transfer (EFT). EFT is the safest, best, fastest and easiest way to receive Medical Assistance Program payments. The EFT form is located in the Provider Services Forms section of the Department's website at:
http://www.chcpf.state.co.us/ACS/Provider_Services/Forms/Forms.asp

EFT permanently solves paper check (warrant) problems!

Allow 30 days for processing your EFT request.

1. After 30 days, check with your bank to verify that EFT has been set up.
2. You will receive paper checks until EFT has started or until the update is active.

Please Note: *The fiscal agent (ACS) does* ***not*** *have EFT information*

Sign-up for Electronic Bulletin Notification!

Did you know you can stop receiving paper bulletins and start receiving your Colorado Medical Assistance Program bulletins by email notification? Email notifications contain a link to the latest bulletin and allow providers to receive program information up to a week sooner than through bulletins sent by mail.

Medical Assistance Program enrolled providers who do not have their email on file with the fiscal agent should complete and submit their information through the Inquiry/Update Provider Data option located at the main menu within the Web Portal.

Providers may also complete and submit the Publication Preferences form in the Provider Services Forms section of the Department's website at: http://www.chcpf.state.co.us/ACS/Provider_Services/Forms/Forms.asp.

Please fax or mail the completed form to the fiscal agent at the fax number/address on the form. Thank you for promptly completing and submitting the Publication Preferences form.

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.

Please Remember: *Providers may have* ***only one*** *email address on file with the fiscal agent. The person receiving the email notification should forward the email to all additional people needing the updated information.*

Fall 2007 Specialty Workshops

Based on feedback from Spring Workshop attendees, the State and fiscal agent are re-evaluating the Specialty Workshops scheduled for Fall 2007. Changes may include adding some specialties and canceling others, based on provider needs and requests. Any changes to the current schedule will be published in the August 2007 bulletin and posted in the Provider Services Training and Workshops section of the Department's website at:
http://www.chcpf.state.co.us/ACS/Provider_Services/Train_Workshops/train_workshops.asp

July and August 2007 Denver Provider Billing Workshops

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 types of providers. The schedule for July and August 2007 Denver 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 in order 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:

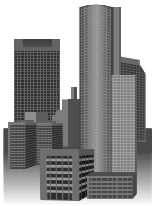
➢ Medical Assistance Program provider billing number	➢ The number of people attending and their names
➢ The date and time of the workshop	➢ Contact name, address and phone number

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

For a complete list of class descriptions, please see bulletin B0700227 (January 2007) or the 2007 Denver and Statewide Workshop Schedule in the Provider Services Training and Workshops section of the Department's website at:
http://www.chcpf.state.co.us/ACS/Provider_Services/Train_Workshops/train_workshops.asp.

Denver Location



All Denver workshops are located at:
ACS
600 Seventeenth Street, Suite 600 N
(6th Floor, North Tower)
Denver, CO 80202

Denver Beginning Billing Schedule
9:00am – 3:00pm

This class is for new billers, billers who would like a refresher and would like to network with other billers about the Colorado Medical Assistance Program. The class covers in-depth information on resources, eligibility, timely filing, reconciling your remittance statements and paper claim completion for the UB-92 and the CO1500. *This class does **not** cover any specialty billing information.* The fiscal agent provides specialty training in their Denver office during March and October each year.

Please refer to the 2007 Denver and Statewide Workshop Schedule in the Provider Services Training & Workshops section of the Department's website at:
http://www.chcpf.state.co.us/ACS/Provider_Services/Train_Workshops/train_workshops.asp for a complete listing and descriptions of Denver workshops.

Beginning Training CO-1500/837P
07/10/07 – Tuesday
08/14/07 – Tuesday

Beginning Training UB-92/ 837I
07/12/07 – Tuesday
08/16/07 – Thursday

Denver Specialty Schedule

Dental
07/20/07 – Friday, 9:00am-11:00am

Colorado Medical Assistance Program Enrollment Application Workshop

The fiscal agent will conduct the second of four 2007 Provider Enrollment Application workshops on Wednesday, July 25, 2007 (9:00am-1:00pm). The workshop focuses on the importance of correctly completing the Colorado Medical Assistance Provider Application. The workshop is located at:

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

Seating for these workshops is limited and reservations are required.
Please 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

Please go to http://www.chcpf.state.co.us/ACS/Enrollment/new_providers.asp and click on your provider type. Please download and print your enrollment documents and bring them with you to the workshop.

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)
For updates check: *http://www.chcpf.state.co.us/ACS/Provider_Services/provider_services.asp*

HCBS-EBD, MI AND PLWA RATES
FY 06-07

SERVICE TYPE	PROCEDURE CODE	CURRENT RATE	NEW RATE 7/1/2007	UNIT VALUE	COMMENTS
Adult Day Services					
Basic Rate	S5105	$ 22.46	$ 22.80	Half Day	Maximum number of units is 2 per day
Specialized Rate	S5105	$ 28.70	$ 29.13	Half Day	An individual unit is 3-5 hours per day
Alternative Care Facility	T2031	$ 47.58	$ 48.29	Day	May be different for clients with 300% income
Electronic Monitoring					
Installation	S5160				Negotiated by CM; varies by client
Service	S5161				Negotiated by CM; varies by client
Homemaker	S5130	$ 3.52	$ 3.57	15 minutes	
Home Modification	S5165	$ 10,000.00	$ 10,000.00	Lifetime Max	
IHSS Health Maintenance Activities	H0038	$ 6.62	$ 6.72	15 minutes	
IHHS Personal Care	T1019 KX	$ 3.52	$ 3.57	15 minutes	
IHSS Relative Personal Care	T1019 HR KX	$ 3.52	$ 3.57	15 minutes	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	$ 3.52	$ 3.57	15 minutes	
Non-Med. Transportation					
Med. Transp. Rate	T2001			1 Way Trip	Negotiated by CM; varies by client. Not to exceed Med. Transport Rates
Taxi	T2001	$ 48.45	$ 49.18	1 Way Trip	Taxi: up to $48.45 per trip, not to exceed the rate with the Public Utilities Commission
Mobility Van	T2001	$ 12.44	$ 12.63	1 Way Trip	Mobility Van: $12.44 per trip
Wheelchair Van	T2001	$ 15.49	$ 15.72	1 Way Trip	Wheelchair Van: $15.49 per trip Wheelchair Van Mileage Add-On: 62 cents per mile
Personal Care	T1019	$ 3.52	$ 3.57	15 minutes	
Relative Personal Care	T1019 HR	$ 3.52	$ 3.57	15 minutes	Relative Personal Care cannot be combined with HCA. Maximum reimbursement not to exceed 1776 units per year
Respite Care					
ACF	S5151	$ 52.98	$ 53.77	Day	Limit of 30 days per calendar year
NF	H0045	$ 118.13	$ 119.90	Day	Limit of 30 days per calendar year.
In Home	S5150	$ 3.03	$ 3.08	15 minutes	Limit of 30 days per calendar year Not to exceed the ACF per diem for respite care

HCBS-BI RATES
FY 06-07

SERVICE TYPE	PROCEDURE CODE	CURRENT RATE	NEW RATE 7/1/2007	UNIT VALUE	COMMENTS
Adult Day Services	S5102	$ 47.31	$ 48.02	Day	At least 2 or more hours of attendance 1 or more days per week
Assistive Technology	T2029				Negotiated by SEP through prior authorization
Behavioral Programming	H0025	$ 13.34	$ 13.54	Half Hour	
Day Treatment	H2018	$ 75.05	$ 76.18	Day	At least 2 or more hours of attendance 1 or more days per week
Home Modifications	S5165	$ 10,000.00	$ 10,000.00	Lifetime Max	
Independent Living Skills Training	T2013	$ 24.28	$ 24.64	Hour	
Mental Health Counseling					
Family	H0004 HR	$ 13.80	$ 14.01	15 minutes	
Group	H0004 HQ	$ 7.73	$ 7.85	15 minutes	
Individual	H0004	$ 13.80	$ 14.01	15 minutes	Must prior-authorize over 30 cumulative visits of counseling
Non-Medical Transportation					
Med Trans. Rate	T2001			1 Way Trip	Negotiated by CM; varies by client. Not to exceed Med. Transport Rate.
Taxi	T2001	$ 48.45	$ 49.18	1 Way Trip	Taxi: Up to $48.45 per trip, not to exceed the rate with the Public Utilities Commission.
Mobility Van	T2001	$ 12.44	$ 12.63	1 Way Trip	Mobility Van: $12.44 per trip.
Wheelchair Van	T2001	$ 15.49	$ 15.72	1 Way Trip	Wheelchair Van: $15.49 per trip. Wheelchair Van Mileage Add-On: 62 cents per mile.
Personal Care	T1019	$ 3.58	$ 3.63	15 minutes	Not to exceed 10 hours per day
Relative Personal Care	T1019 HR	$ 3.58	$ 3.63	15 minutes	Maximum reimbursement not to exceed 1776 units per year
Respite Care			$ -		
NF	H0045	$ 111.77	$ 113.45	15 minutes	
In Home	S5150	$ 3.03	$ 3.08	Day	All inclusive of client's needs
Individual Substance Abuse Counseling			$ -		
Family	T1006	$ 55.19	$ 56.02	Hour	
Group	H0047 HQ	$ 30.91	$ 31.37	Hour	
Individual	H0047 HF	$ 55.19	$ 56.02	Hour	
Transitional Living	T2016	$ 130.56	$ 132.52	Day	
Supported Living Program	T2033			Day	Per diem rate set by HCPF using acuity levels of client population

HCBS CWA Rates and Children's HCBS Rate
FY 07-08

SERVICE TYPE - CWA	PROCEDURE CODE	CURRENT RATE	NEW RATE 7/1/2007	UNIT VALUE
Behavior Therapies - Lead Therapist	H0004	$ 21.75	$ 22.08	15 minutes
Behavior Therapies - Senior Therapist	H0004 52	$ 11.32	$ 11.49	15 minutes
Behavior Therapies - Line Staff	H2019	$ 3.58	$ 3.63	15 minutes
SERVICE TYPE - Children's HCBS				
Case Management	T1016	$ 8.03	$ 8.15	15 minutes

HOME HEALTH RATES
FY 07-08

SERVICE TYPE	REVENUE CODE		CURRENT RATE	NEW RATE 7/1/2007	UNIT VALUE
	Acute Home Health	Long Term Home Health			
RN Assess and Teach	589	None	$ 96.53	$ 97.98	Acute only- one visit up to 2 ½ hours
RN/LPN	550	551	$ 96.53	$ 97.98	One visit up to 2 ½ hours
RN Brief 1st of Day	n/a	590	$ 67.57	$ 68.58	One Visit
RN Brief 2nd or >	Na	599	$ 47.30	$ 48.01	One Visit
HHA BASIC	570	571	$ 33.65	$ 34.15	One hour
HHA EXTENDED	572	579	$ 10.06	$ 10.21	For visits lasting more than one hour, extended units of 15-30 minutes
PT	420	421 (for 0-17 years LTHH)	$ 105.57	$ 107.15	One Visit up to 2 ½ hours
PT for HCBS Home Mod Evaluation	424	424	$ 105.57	$ 107.15	1-2 visits
OT	430	431 (for 0-17 years LTHH)	$ 106.26	$ 107.85	One visit up to 2 ½ hours
OT for HCBS Home Mod Evaluation	434	434	$ 106.26	$ 107.85	1-2 visits
S/LT	440	441 (for 0-17 years LTHH)	$ 114.71	$ 116.43	One visit up to 2 ½ hours
Maximum Daily Amount Acute Home Health			$ 449.79	$ 456.54	24 hours, MN to MN
Maximum Daily Amount Long Term Home Health			$ 350.94	$ 356.20	24 hours, MN to MN

PRIVATE DUTY NURSING RATES
FY 07-08

SERVICE TYPE	REVENUE CODE	CURRENT RATE	NEW RATE 7/1/2007	UNIT VALUE
PDN-RN	552	$ 38.14	$ 38.71	Hour
PDN-LPN	559	$ 28.63	$ 29.06	Hour
PDN-RN (group-per client)	580	$ 28.57	$ 29.00	Hour
PDN-LPN (group-per client)	581	$ 21.93	$ 22.26	Hour
"Blended"* group rate / client*	582	$ 28.55	$ 28.98	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.