STATE OF COLORADO

DEPARTMENT OF HEALTH CARE POLICY & FINANCING

1570 Grant Street
Denver, CO 80203-1818
(303) 866-2993
(303) 866-4411 FAX
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Bill Owens
Governor

Stephen C. Tool
Executive Director

June 1, 2006

The Honorable Bernie Buescher, Chairman
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Representative Buescher:

This letter is in response to footnotes 37a, 40a and 42a of H.B. 06-1369, "Concerning a supplemental appropriation to the Department of Health Care Policy and Financing," which was approved in part and disapproved in part on March 31, 2006 by the Governor. As you are aware, footnotes 37a, 40a and 42a were vetoed by the Governor, because the footnotes interfere with the ability of the executive branch to administer the appropriation and may constitute substantive legislation that cannot be included in the general appropriations bill. The Governor did instruct the Department to comply to the extent feasible for footnotes 37a and 42a.

Footnote 37a of H.B. 06-1369, states:

> *Department of Health Care Policy and Financing, Medical Services Premiums -- The calculations for this line item include $831,000 total funds for a 1.0 percent rate increase for inpatient hospital services provided to Medicaid clients. It is the intent of the General Assembly that the Medical Services Board adopt rules that increase each individual hospital's Medicaid reimbursement rate by 1.0 percent for inpatient hospital services provided to Medicaid clients. The Department is also requested to provide a report to the Joint Budget Committee by June 1, 2006, on the status of the rules adopted by the Medical Services Board regarding this rate increase."*

In response, effective April 1, 2006, a 1.0 percent reimbursement rate increase for inpatient hospital services provided to Medicaid clients has been implemented for the fourth quarter of FY 05-06. The 1.0 percent increase, which was applied to every hospitals' inpatient rate, is estimated to increase FY 05-06 expenditures by approximately $773,254. Implementation of this rate increase did not require rules to be adopted by the Medical Services Board, but does require

the approval of the Centers for Medicare and Medicaid Services (CMS) through a State Plan Amendment. The Department will submit the necessary State Plan Amendment timely (prior to June 30, 2006) and expects that CMS will approve the rate increase. The Department will notify the Joint Budget Committee if the State Plan Amendment is not approved by CMS. The Department notified all hospitals of this rate increase through a reimbursement letter sent on April 7, 2006, which is attached for your reference.

Footnote 40a of H.B. 06-1369, states:

> *Footnote 40a, page 7, "Department of Health Care Policy and Financing, Medical Services Premiums -- The calculations for this line item include $5,100,000 total funds for rate increases for long-term care community providers. It is the intent of the General Assembly that the Department increase rates as follows:*

Provider Class	*Rate Increase*	*Estimated Funding*
Assisted Living Facilities 1	*15.07%*	*$1,142,490*
Day Care Services	*3.57%*	*$46,367*
Skilled Nursing	*7.20%*	*$567,960*
Home Health Aides	*4.20%*	*$586,690*
Physical Therapy	*36.30%*	*$286,990*
Speech Therapy	*35.90%*	*$146,664*
Occupational Therapy	*29.20%*	*$173,356*
Private Duty Registered Nursing	*3.80%*	*$90,220*
Private Duty Licensed Nursing	*8.00%*	*$90,218*
Personal Care Homemaker	*10.00%*	*$1,846,514*
All Other	*2.57%*	*$122,531*
Total		*$5,100,000*

> *The Department is requested to report to the Joint Budget Committee by June 1, 2006 the rate plan that has been adopted by the Medical Services Board."*

In response, effective April 1, 2006, the percent reimbursement rate increases recommended by the Senate Committee on Appropriations report of March 17, 2006 were implemented for the long term care community providers for the fourth quarter of FY 05-06. The increase to the providers is estimated to increase FY 05-06 expenditures by approximately $5,100,000. Implementation of this rate increase did not require rules to be adopted by the Medical Services Board nor a State Plan Amendment to be submitted to CMS. The providers were notified through the May 2006 Medical Assistance Program Provider Bulletin.

Footnote 42a of H.B. 06-1369, states

> *"Department of Health Care Policy and Financing, Medical Service Premiums -- The calculations for this line item includes $309,000 total funds for a 2.0 percent rate increase for durable medical equipment rates. It is the intent of the General Assembly that the Medical Services Board adopt rules that increase each durable medical equipment rates by 2.0 percent. The Department is also requested to provide a report to the Joint Budget Committee by June 1, 2006, on the status of the rules adopted by the Medical Services Board regarding this rate increase."*

In response, the funds indicated ($309,000) were applied to all Medicaid fee-for-service durable medical equipment (DME) billing codes. DME services that are paid by invoice plus 19% were excluded from this rate increase. This allowed the remaining DME rates to actually be increased by 2.25% as of April 1, 2006. Providers were notified of the rate increase in the Medical Assistance Program Bulletin issued in May 2006. Implementation of this rate increase did not require rules to be adopted by the Medical Services Board and did not require the approval of the CMS through a State Plan Amendment.

Questions regarding this response to footnotes 37a, 40a and 42a of H.B. 06-1369 can be addressed to John Bartholomew, Director, Budget Division at (303) 866-2854.

Sincerely,

Stephen C. Tool
Executive Director

SCT:jjb

Enclosure: Medical Assistance Program Bulletin issued May 2006

Cc: Senator Abel Tapia, Vice-Chairman, Joint Budget Committee
Senator Moe Keller, Joint Budget Committee
Senator Dave Owen, Joint Budget Committee
Representative Jack Pommer, Joint Budget Committee
Representative Dale Hall, Joint Budget Committee
Senator Joan Fitz-Gerald, President of the Senate
Senator Ken Gordon, Senate Majority Leader
Senator Andy McElhany, Senate Minority Leader
Representative Andrew Romanoff, Speaker of the House
Representative Alice Madden, House Majority Leader
Representative Mike May, House Minority Leader
John Ziegler, JBC Staff Director
Melodie Beck, JBC Analyst
Henry Sobanet, Director, Office of State Planning and Budgeting
Luke Huwar, Budget Analyst, OSPB
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John Bartholomew, Budget Director
Lisa Esgar, Operations and Finance Office
Barbara Prehmus, Medical Assistance Office
Hollie Stevenson, Acting Legislative Liaison/Public Information Officer
HCPF Budget Data Library, HCPF Division

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 **May 2006**

Reference: B0600212

Table of Contents

** * * RTC Workshop Cancellation * * **

Due to changes currently taking place in the RTC programs, the workshop scheduled in Fort Collins on Tuesday, May 9, 2006 from 2:00 PM to 4:00 PM has been cancelled. Once the new programs are in place, the fiscal agent (ACS) will schedule a special training workshop. Please watch for the new workshop announcement in future bulletins and in the Provider Services Training & Workshops section of the Department's website.

All Providers

National Provider Identifiers (NPIs)

The National Provider Identifier will replace the traditional healthcare provider numbers commonly used today. All health care providers who are HIPAA (Health Insurance Portability and Accountability Act of 1996) compliant providers must obtain an NPI to identify themselves for HIPAA Standard transactions.

The National Provider Identifier (NPI) must be obtained in one of three ways:

- A web-based National Plan and Provider Enumeration (NPPES) where an online application can be obtained and completed;
- Completing a paper NPI application form and mailing it to either the Enumerator, the Centers for Medicare & Medicaid Services (CMS); or

- Utilizing an Electronic File Interchange (EFI) that allows CMS approved organizations (on behalf of the health care providers) to submit their application information for hundreds or even thousands of associated providers. The application information may be submitted all at one time in a single electronic file or series of files. This process is also known as bulk enumeration.
  Web sites for further information and tips will be found at:
  https://nppes.cms.hhs.gov/NPPES/Welcome.do or at
  http://www.cms.hhs.gov/NationalProvIdentStand/

Web Portal Update

New functionalities planned for May

Improved Eligibility Responses- The interactive responses will be modified to reduce the redundancies in the Third Party Payer information. Batch Eligibility responses will be converted to user friendly formats similar to the interactive responses.

Postponed to June

Purge Functionality - The Purge functionality will allow trading partners to delete large number of claims and PARs. For more information please review last month's bulletin (B0600211).

Portal Tips for the Month

New Trading Partner Administrators (TPA) – Use the Trading Partner Administrator training found in the menu or the User Guide at the top of the page to help you to understand the responsibilities of your role and to set up additional users. Initial logins for new Trading Partner Administrators and users display limited functionality in the menu until roles are set up for the user.

PAR Submitters – For assistance in the transition from paper or WINASAP PARs please review the 278 crosswalk located on the "What's New" page of Provider Services website at: http://www.chcpf.state.co.us/ACS/What_s_new/what_s_new.asp

Use Claim Status Inquiry to get the current status on the claim. Claims are updated on a nightly basis to the current status. When a suspended claim is not getting a status update, use the Claim Status Inquiry to get the current status. To submit a claim status inquiry click (highlight) a claim on the grid and click on the Claim Status button below the grid.

Assign the Restricted Admin Role to a user to assist the Trading Partner Administrator in managing user passwords, timeouts, and suspended sessions. Trading Partner Administrators can assign this role to a user by clicking User Maintenance on the Main Menu, selecting the appropriate user in the User Lookup, moving the Restricted Admin Role to the assigned box, and saving the record.

Eligibility Verification Information and Response Examples

Links to examples of the Web Portal and FaxBack responses are located in the Provider Services FAQ section under Frequently Asked Billing Questions. Please see **"Q: How do I check to see if a client is eligible for the Medical Assistance Program?".**

Provider Enrollment FAQs

A link to frequently asked provider enrollment questions is now available on the Provider Services Enrollment page of the Department's website. Please go to: http://www.chcpf.state.co.us/ACS/Pdf_Bin/PE_QA_0424.pdf for the list of enrollment questions and answers.

Electronic Bulletin Notification!

Are you receiving your Colorado Medical Assistance Program by email notification? Email notifications contain a link to the new or updated website document allowing providers to receive bulletin information up to a week sooner than 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 the attached Publication Preferences form (Attachment D). *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 fax or mail the completed form to the fiscal agent at the fax number/address on the form. Thank you for your prompt completion and submission of the form.

Important Email Information: *Providers can 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.*

Dental Providers Reminder – Originally published in April 2006 bulletin (B0600211)

Treatment of Oral Cavity Conditions for Adult Clients

The Medical Services Board recently approved rules regarding the treatment of oral cavity conditions for adult clients. These services for clients age 21 and older are limited to emergency treatment for oral cavity conditions **or** treatment for clients with allowable concurrent medical conditions. **The prior authorization and billing requirements are effective May 1, 2006.**

Emergency Services to Treat Adult Client Oral Cavity Conditions

Adult clients, age 21 and older, are eligible for emergency treatment if the client presents an acute oral cavity condition that requires hospitalization and/or immediate surgical care.

Emergency Oral Medical Conditions

Emergency treatment provided to an adult client includes, but is not limited to:

- Immediate treatment or surgery to repair trauma to the jaw.
- Reduction of any fracture of the jaw or any facial bone, including splints or other appliances used for this purpose.
- Extraction of tooth or tooth structures associated with the emergency treatment of a condition of the oral cavity.
- Repair of traumatic oral cavity wounds.
- Anesthesia services ancillary to the provision of emergency treatment.

Please refer to the coding reference guide in the April bulletin (B0600211) for the only codes available for billing **treatment of emergency oral cavity conditions for adults.**

- Only the most limited service(s) needed to correct the emergency oral cavity condition(s) are allowed.
- Emergency treatment of oral cavity conditions do not require a prior authorization (PAR).

Non-Emergency Treatment of the Oral Cavity for Adult Clients with Concurrent Medical Condition(s)

Treatment of the oral cavity is limited to adult clients with allowable concurrent medical condition(s) as listed in the April bulletin (B0600211). Providers must document the presence of the concurrent medical condition(s) in the dental record.

IMPORTANT –

1. The allowable concurrent medical conditions listed in the April bulletin (B0600211) or chronic medical conditions that are exacerbated by a condition of the oral cavity as documented by the dentist are the only ones that qualify an adult client for services.
2. Prior Authorization Requests (PAR)

   Approval must be obtained prior to rendering services. Approval is not a guarantee of payment.

   Please refer to the coding reference guide in the April bulletin (B0600211) for codes and prior authorization request (PAR) requirements for billing Treatment of the oral cavity condition(s) of adult clients with concurrent or chronic medical conditions.

   Effective May 1, 2006, the fiscal agent (ACS) will no longer return the paper PAR or attachments with procedure approvals and/or denials to the providers. ACS will return original radiographs and photographs to provider. Providers must wait to submit claims until they receive the system generated PAR letter. Do not submit radiographs with a PAR unless requested by the dental consultant.

Exclusions: Not a benefit for adult clients under any circumstance.

- Preventive services: prophylaxis, fluoride treatment and oral hygiene instruction.
- Treatment for dental caries, gingivitis and tooth fractures.
- Restorative and cosmetic procedures.
- Inlay or onlay restorations.
- Crowns, bridges, and implants.
- Full and partial dentures. This includes assessment or preparation of the oral cavity for delivery of dentures/partials and bridges or subsequent adjustments to dentures/partials and bridges including treatment of pain or soreness from the wearing of dentures or any other fixed or removable prosthetic appliance.
- Alveoloplasty, vestibuloplasty, and excision of bone tissue.
- Full mouth extractions.

Non-Citizen Services

Dental services for non-citizens are limited to emergency treatment of the oral cavity. Other dental services are not a benefit for non-citizens under any circumstances.

Reminder

Providers enrolled as "Dentists" must bill all treatment of oral cavity conditions using the current ADA allowed codes. Only providers enrolled as "Physicians" may use the CPT medical and surgical codes for billing oral cavity treatments.

All ADA **paper** claims received by the fiscal agent on and after **November 1, 2005** without a signed Dental Provider Certification form attached will deny for "no signature on file" regardless of the dates of service. Providers are reminded that the Certification requires the ***original signature*** of the provider.

Note: Certification need not be submitted with the Dental Prior Authorization Request.

The certification form is available in the Provider Services Forms section of the Department's website at:
http://www.chcpf.state.co.us/ACS/Pdf_Bin/Dental_Cert_1005.pdf

Billing Updates

Effective May 1, 2006, the American Dental Association 2002 claim form will be the only form accepted by the Colorado Medical Assistance Program when submitting all dental claims and PARs. **All other versions will be returned for resubmission.**

The ADA 2002 form is available from the: American Dental Association
211 East Chicago Avenue
Chicago, IL 60611-2678
www.ADA.org

Please watch the Provider Services Billing Manuals section of the Department's website for upcoming revisions to the Dental and General Billing Manuals.

Durable Medical Equipment and Supply Providers

Wheelchair Repair

Providers are reminded that any wheelchair repairs up to $150 in a six month period do not require a PAR. Please refer to the Supplies and Durable Medical Equipment section of the Specialty Billing Information in the Provider Services Billing Manuals section of the Department's website: http://www.chcpf.state.co.us/ACS/Pdf_Bin/Specialty_Manuals_0406.pdf.

Reimbursement Changes

Effective April 1, 2006, the maximum allowable reimbursement for durable medical equipment and supply CMS codes will be updated as follows:

Codes Paid on a Fee for Service Basis

All covered procedure codes currently paid on a fee for service basis will receive a 2.25% rate increase for services rendered on or after April 1, 2006. For services rendered on or before March 31, 2006, the maximum allowable reimbursement will reflect the lower of billed charges or the fee schedule rates listed in Provider Bulletin B0500206. For services rendered on or after April 1, 2006, the maximum allowable reimbursement will reflect the lower of billed charges or the fee schedule rates listed in Provider Bulletin B0500206 plus an additional 2.25%

Some claims for services rendered on or after April 1, 2006 may have already been processed and paid at the old reimbursement amount. For providers who billed their usual and customary charges, these claims will automatically be adjusted to reflect the 2.25% rate increase. Providers who billed the fee schedule amount listed in Provider Bulletin B0500206 should contact Medical Assistance Program Provider Services for information on reprocessing your claims and receiving the appropriate reimbursement. No claims for services rendered on or before March 31, 2006 will be reprocessed.

Codes Paid by Invoice

The Medical Assistance Program allowed handling fees listed on page 4 of Provider Bulletin B0500206 will be increased to 20%. All covered procedure codes currently paid on a "by invoice" basis will be reimbursed as described on pages 3 and 4 of Provider Bulletin B0500206 for services rendered on or before March 31, 2006. For services rendered on or after April 1, 2006, the Medical Assistance Program allowed handling fee will be increased to 20%.

Some claims for services rendered on or after April 1, 2006 may have already been processed and paid using the 19% handling fee. These claims will automatically be adjusted to reflect the 20% handling fee. No claims for services rendered on or before March 31, 2006 will be reprocessed.

EPSDT Providers

New EPSDT Provider Web-Based Toolkit

Effective May 1, 2006, the Medical Assistance Program will introduce a web-based toolkit about the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program. The toolkit can be found on the HCPF web page at: http://www.chcpf.state.co.us/HCPF/EPSDT/EPSDT_Final_page.asp

The toolkit includes a list of all required EPSDT benefits and a toolbar with forms or links to assist in obtaining EPSDT services. The printable forms include health maintenance exams for multiple ages, parent information sheets, a parent reminder letter template and immunization permission forms. There are several links in the toolkit to provide a full-service approach to the care of children. An important inclusion is the link to the Colorado Immunization Information System (CIIS), the immunization registry for the State of Colorado.

The toolkit is adapted from successful web pages in other states. The content was developed by a subcommittee that included health plan and provider office experts. It is designed to be used from the initial point of service through the entire visit. We encourage your office to bookmark

http://www.chcpf.state.co.us/HCPF/EPSDT/EPSDT_Final_page.asp

Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD) Providers

Community Transition Services

On March 10, 2006, The Medical Services Board approved a new rule establishing regulations for implementation and maintenance of the Community Transition Services (CTS). CTS is effective May 1, 2006 and is a benefit under the Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD) waiver. .

CTS assists Medical Assistance Program clients in transitioning from nursing facilities to community-based residences. CTS will be administered by a new provider specialty, Transition Coordination Agency (TCA). TCAs have to provide at least two Independent Living Core Services and will be certified by the Department to provide CTS. Agencies interested in becoming TCAs may call 303-866-3674 for more information.

Home and Community Based Services Waivers (BI, EBD, MI, PLWA, and CHCBS) Home Health & Private Duty Nursing Providers

Rate Increase for Providers

Effective April 1, 2006, the following services provided under Home and Community Based Services (HCBS) Waivers, as well as Home Health and Private Duty Nursing, received rate increases. The rate increases are a result of action taken by the General Assembly which specified the percentage of increase according to provider types. The chart below lists the rates according to percentage of increase specified by Colorado legislature.

Rate Increases					
Services/ Provider Type	**Code**	**Current**	**Increased by HB06-1369**	**% increased**	**Unit of Reimbursement**
Day Care Services	S5105	$21.47	$22.24	3.57%	Half Day-3 to 5 hrs per day
	S5105	$27.44	$28.42	3.57%	Half Day-3 to 5 hrs per day
	S5102	$45.23	$46.84	3.57%	Day
	H2018	$71.75	$74.31	3.57%	Day
Personal Care	T1019	$3.20	$3.52	10.00%	Quarter hour
	T1019-HR	$3.20	$3.52	10.00%	Quarter hour
	U6-T1019	$3.25	$3.58	10.00%	Quarter hour
	U6-T1019-HR	$3.25	$3.58	10.00%	Quarter hour
	T1019-KX-HR	$3.20	$3.52	10.00%	Quarter hour
	T1019-KX	$3.20	$3.52	10.00%	Quarter hour
Homemaker	S5130&S5130KX	$3.20	$3.52	10.00%	Quarter hour
Skilled Nursing	550+551	$72.85	$78.10	7.20%	up to 2 1/2 hrs
	590	$51.00	$54.67	7.20%	per visit
	599	$35.70	$38.27	7.20%	per visit
Home Health Aides	570+571	$32.29	$33.65	4.20%	per first hour of visit
	572+579	$9.65	$10.06	4.20%	30 mins.each after 1st hr.
Physical Therapy	420+421+424	$62.66	$85.41	36.30%	up to 2 1/2 hrs
Occupational Therapy	430+431+434	$66.54	$85.97	29.20%	up to 2 1/2 hrs
Speech Therapy	440+441	$68.29	$92.81	35.90%	up to 2 1/2 hrs
Private Duty Registered Nursing	552	$29.78	$30.91	3.80%	per hour
	580	$22.30	$23.15	3.80%	per hour-per client
Private Duty Licensed Nursing	559	$21.44	$23.16	8.00%	per hour
	581	$16.43	$17.74	8.00%	per hour-per client
	582	$21.39	$23.10	8.00%	per hour-per client
Alternative Care Facilities	T2031	$36.75	$42.29	15.07%	Day
All Other					
IHSS Health Maintenance	H0038	$6.45	$6.62	2.57%	Quarter hour

Please remember that the Colorado Medical Assistance Program claims processing system utilizes "lower of" pricing. Providers are responsible for submitting the correct charges and any adjustments to claims already submitted with dates of service on or after April 1, 2006. The Medical Assistance Program claims processing system will not adjust claims automatically. Revised rate schedules for specific programs are located on Attachments A, B, and C of this bulletin.

Alternative Care Facility (ACF) Providers

The new daily rate for the ACF benefit is $42.29. All PARs for ACF clients must be modified to reflect the new rate.

The PARs for "standard" Medical Assistance Program clients will be systematically updated for dates of service starting April 1, 2006, with the new rate and the remaining units. The PARs for 300% clients need to be updated by the SEP Agency case manager because the Colorado Medical Assistance Program claims processing system does not calculate PETI (Form- LTC 106) for clients. The PETI amount determines the client's portion of the payment for care in an ACF. SEP Agencies have been notified about new PETI calculations and will send providers an updated PAR with the new daily rate for 300% clients.

Home Health Providers

Long Term Home Health Documentation Requirements for Continued Stay Review

- Submit a new Prior Authorization Request (PAR) form
- Submit a current CMS-485 Plan of Treatment
- Submit additional documentation as necessary for PRN or CNA extended units

Home Health agencies are required to provide a complete picture of the client's need for LTHH to assist the Single Entry Point (SEP) case managers in the review. The CMS-485 form must be newly completed and not be a duplicate of the original document even if there has been no change in client condition. The CMS-485 form must be used to provide a current picture of the client.

LTHH Medication Administration, Medication Set-Up, and Wound Care

SEP agencies determine eligibility for LTHH using the ULTC 100.2 functional assessment tool. The area of Supervision on the ULTC 100.2 includes Behavioral or Cognitive needs for LTHH clients. Should a client require medication administration, medication set-up, and wound care services, and he/she is found eligible for long term care under the heading of Supervision, the SEP case manager assessment is critical in determining medical necessity. The assessment includes a mini-mental status examination. Often the SEP case manager evaluates the client's cognitive ability differently from what the home health agency has documented about the client. Documentation of medical necessity is the key to appropriate home health visits and prior authorization approvals. A statement that the client is forgetful is not adequate documentation of medical necessity in the absence of a supporting diagnosis. There are alternatives to nursing visits for medication administration or medication box set-up that accommodate forgetfulness. Alarm watches, calendar hints and cues, and electronic medication minders may be utilized. Home health agency nurses should train clients and/or families in the use of alternatives that prevent dependence upon the nurse for the medication regime.

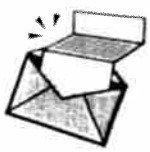
P.R.N. in Latin means *pro re nata* translated as "according to circumstances, as necessary".

PRN nursing or CNA visits cannot stand alone on the PAR for LTHH. A client that requires home health care requires a regularly scheduled visit on the CMS-485. A client receiving regularly scheduled visits may need PRN visits as well for a justifiable circumstance. Examples of specific circumstances that may necessitate a request for PRN visits:

1. Catheter irrigation or changes when a client has a catheter between normally scheduled visits.
2. Involuntary bladder or bowel evacuation between normally scheduled visits requiring skilled assistance.
3. Certain blood draws.
4. History of periodic UTI requiring nursing assessment and laboratory testing.

Home Health is not ordered "just in case" something unforeseen occurs. Acute Home Health visits may provide training and instruction to clients about what to do "in case" something occurs, but LTHH visits are designed for chronic, continuing, medically necessary care only.

PAR Letter Changes



The information contained in provider Prior Authorization Request (PAR) letters has been changed. In the past, the header title on the letter was either "approved," "denied," or "pended." You will soon be receiving letters with a header title of "partially approved." This will occur when more units are requested than are approved for the line item by the authorizing agent or when one line item is approved and another line item is denied. PAR letters will have line item units listed as "requested" and "approved." "APP COND" means partially approved when more units are requested than are approved. The notation will be corrected in the future to state "partially approved." Reading from left to right in the line item section of the PAR letter you will see the number of units requested and the associated dollar amount then the number of units approved and the dollar amount associated with that number. The line item status will state either "approved," or "APP COND" when units are approved. If all of the units are denied the line status will state "denied."

Nursing Facility Providers

Notification of Discharge or Death

A study by the Department's Medical Assistance Program Eligibility Quality Control staff found that nursing facilities are not always adhering to the notification requirements when a Medical Assistance Program client is discharged or dies. As a reminder, nursing facilities shall notify the county, the statewide utilization review contractor (SURC) and the single entry point agency (SEP) of the discharge or death of a Medical Assistance Program client. According to 10 C.C.R. 2505-10, Section 8.482.34.A the notification to the county shall be on the Colorado Department of Health Care Policy and Financing Status of Nursing Facility Care (AP 5615) form which shall be mailed within five working days of the discharge or death. Notification to the SURC and the SEP shall be by the end of the month of discharge.

May and June 2006 - Denver & Statewide 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 specialty training for different provider types. The schedule for May and June 2006 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 B0500202, December 2005 or the 2006 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

for a complete list of class descriptions.

All Denver workshops are located at:

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

Denver Beginning Billing Schedule

9:00 – 3:00

Beginning Training CO-1500/837P
06/13/06 – Tuesday

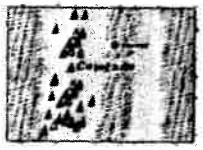
Beginning Training UB-92/ 837I
06/15/06 – Thursday

May 2006 Statewide Locations

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

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



Grand Junction ***(New location for 2006)***
Hilton Hampton Inn Grand Junction
205 Main Street
Grand Junction, CO 81501
970-243-3222

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

Pueblo ***(New location for 2006)***
The Pueblo Convention Center
320 Central Main Street
Pueblo, CO 81003
719-542-1100

Please note: ***There is a correction to the day for the Grand Junction Workshops – The date of 05/15/06 is correct but that date is a Monday not a Thursday as originally published.***
We apologize for any inconvenience this may have caused.

Statewide Beginning Billing CO-1500/UB-92

05/22/06— Durango – Monday - 9:00am-1:30pm
05/09/06 – Ft. Collins – Tuesday - 9:00am-1:30pm
05/17/06 – Greeley – *Wednesday* - 9:00am-1:30pm
05/15/06 – Grand Junction – ***Monday*** - 8:30am-1:00pm
05/24/06 – Pueblo – Wednesday - 8:30am-1:00pm
05/25/06 – Colorado Springs – Thursday - 8:30am-1:00pm

Statewide Specialty Training

Hospital
05/22/06 – Durango – Monday – 2:00pm-3:30pm

Indian Health Service
05/22/06 – Durango – Monday – 3:30pm-5:00pm

Practitioner
05/09/06 – Fort Collins – Tuesday – 2:00pm-4:00pm

Supply
05/17/06 – Greeley – *Wednesday* – 2:00pm-4:00pm

Nursing Facility
05/15/06 – Grand Junction – ***Monday*** – 2:00pm-4:00pm

Practitioner
05/15/06 – Grand Junction – ***Monday*** – 2:00pm-4:00pm

RHC/FQHC
05/24/06 – Pueblo – Wednesday – 2:00pm-3:30pm

Practitioner
05/25/06 – Colorado Springs – Thursday – 2:00pm-4:00pm

Nursing Facility
05/25/06 – Colorado Springs – Thursday – 2:00pm-4:00pm

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/ACS/Provider_Services/provider_services.asp
For Provider Updates and News

HCBS-BI Rates - FY 05-06					
Service Type	Sub-Type	Current Rate 7/1/2006	New Rate 4/1/2006	Unit Value	Comments
Adult Day Services		$ 45.23	$ 46.84	Day	At least 2 or more hours of attendance 1 or more days per week
S5102					
Day Treatment		$ 71.75	$ 74.31	Day	At least 2 or more hours of attendance 1 or more days per week
H2018					
Personal Care		$ 3.25	$ 3.58	Quarter Hour	Not to exceed 10 hours per day
T1019					
Relative Personal Care		$ 3.25	$ 3.58	Quarter Hour	Maximum reimbursement not to exceed 1776 units per year
T1019 HR					
Respite Care	In Home	$ 3.03	$ 3.03	Quarter Hour	
S5150					
Respite Care	NF	$ 111.77	$ 111.77	Day	All inclusive of client's needs
H0045					
Independent Living Skills Training		$ 24.28	$ 24.28	Hour	
T2013					
Behavioral Programming		$ 13.34	$ 13.34	Half Hour	
H0025					
Individual Mental Health Counseling*		$ 13.80	$ 13.80	Quarter Hour	Must pre-authorize over 30 cumulative visits of counseling
H0004					
Family Mental Health Counseling		$ 13.80	$ 13.80	Quarter Hour	
H0004 HR					
Group Mental Health Counseling		$ 7.73	$ 7.73	Quarter Hour	
H0004 HQ					
Individual Substance Abuse Counseling		$ 55.19	$ 55.19	Hour	
H0047 HF					
Group Substance Abuse Counseling		$ 30.91	$ 30.91	Hour	
H0047 HQ					

HCBS-BI Rates - FY 05-06					
Service Type	**Sub-Type**	**Current Rate 7/1/2006**	**New Rate 4/1/2006**	**Unit Value**	**Comments**
Family Substance Abuse Counseling		$ 55.19	$ 55.19	Hour	
T1006					
Assistive Technology					Negotiated by SEP through prior authorization
T2029					
Non-Medical Transportation	Med Trans. Rate			1 Way Trip	Negotiated by CM; varies by client. Not to exceed Med. Transport Rate.
T2001	Taxi	$ 48.45	$ 48.45		Taxi: up to $48.45 per trip, not to exceed the rate with the Public Utilities Commission.
	Mobility Van	$ 12.44	$ 12.44		Mobility Van: $12.44 per trip.
	Wheelchair Van	$ 15.49	$ 15.49		Wheelchair Van: $15.49 per trip. Wheelchair Van Mileage Add-On: 62 cents per mile.
Home Modifications		$ 10,000.00	$ 10,000.00	Lifetime Max	
S5165					
Transitional Living		$ 130.56	$ 130.56	Day	
T2016					
Supported Living Program				Day	Per diem rate set by HCPF using acuity levels of client population
T2033					

HCBS-EBD, MI and PLWA Rates - FY 05-06					
Service Type	Sub-Type	Current Rate 7/1/2006	New Rate 4/1/2006	Unit Value	Comments
Adult Day Services	Basic Rate	$ 21.47	$ 22.24	Half Day	Maximum number of units is 2 per day.
S5105	Specialized Rate	$ 27.44	$ 28.42	Half Day	An individual unit is 3-5 hours per day.
Alternative Care Facility		$ 36.75	$ 42.29	Day	May be less for clients with 300% income.
T2031					
Electronic Monitoring	Installation S5160				Negotiated by CM; varies by client..
	Service S5161				Negotiated by CM; varies by client..
Homemaker		$ 3.20	$ 3.52	Quarter Hour	
S5130					
Home Modification		$ 10,000.00	$ 10,000.00	Lifetime Max	
S5165					
Personal Care		$ 3.20	$ 3.52	Quarter Hour	
T1019					
Relative Personal Care		$ 3.20	$ 3.52	Quarter Hour	Relative Personal Care cannot be combined with HCA.
T1019 HR					Maximum reimbursement not to exceed 1776 units per year.
Respite Care	ACF	$ 52.98	$ 52.98	Day	Limit of 30 days per calendar year.
S5151					
Respite Care	NF	$ 118.13	$ 118.13	Day	Limit of 30 days per calendar year.
H0045					
Respite Care	In Home	$ 3.03	$ 3.03	Quarter Hour	Limit of 30 days per calendar year. Not to exceed the ACF per diem for respite care.
S5150					
Non-Med. Transportation	Med. Transp. Rate			1 Way Trip	Negotiated by CM; varies by client. Not to exceed Med. Transport Rates.
T2001	Taxi	$ 48.45	$ 48.45		Taxi: up to $48.45 per trip, not to exceed the rate with the Public Utilities Commission.
	Mobility Van	$ 12.44	$ 12.44		Mobility Van: $12.44 per trip. .
	Wheelchair Van	$ 15.49	$ 15.49		Wheelchair Van: $15.49 per trip. Wheelchair Van Mileage Add-On: 62 cents per mile.

HCBS-EBD, MI and PLWA Rates - FY 05-06					
Service Type	Sub-Type	Current Rate 7/1/2006	New Rate 4/1/2006	Unit Value	Comments
IHHS Personal Care		$ 3.20	$ 3.52	Quarter Hour	
T1019 KX					
IHSS Relative Personal Care		$ 3.20	$ 3.52	Quarter 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 .
T1019 HR KX					
IHSS Homemaker		$ 3.20	$ 3.52	Quarter Hour	
S5130 KX					
IHSS Health Maintenance Act		$ 6.45	$ 6.62	Quarter Hour	
H0038					

Private Duty Nursing and Home Health Rates

Private Duty Nursing Rates				
Service	**FY 05-06 Rate July 1, 2006**	**4th Qtr. FY 05-06**	**Revenue Code**	**Unit**
PDN-RN	$29.78	$30.91	552	Hour
PDN-LPN	$21.44	$23.16	559	Hour
PDN-RN (group-per client)	$22/30	$23.15	580	Hour
PDN-LPN (group-per client)	$16.43	$17.74	581	Hour
"Blended"* group rate / client*	$21.39	$23.10	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				

Home Health					
Service	**Acute HH Revenue Code**	**Long Term HH Revenue Code**	**Unit Rate FY 05-06**	**Unit Rate 4th Qtr. FY 05-06**	**Duration**
RN Assess and Teach	589	None	$72.85	$78.10	Acute only- up to 2 ½ hours
RN/LPN	550	551	$72.85	$78.10	Up to 2 ½ hours
RN Brief 1st of Day	n/a	590	$51.00	$54.67	
RN Brief 2nd or >	Na	599	$35.70	$38.27	
HHA BASIC	570	571	$32.29	$33.65	One hour
HHA Extended	572	579	$9.65	$10.06	15-30 minutes each after 1st hour
PT	420	421 (for 0-17 years LTHH)	$62.66	$85.41	Up to 2 ½ hours
PT for HCBS Home Mod Evaluation	424	424	$62.66	$85.41	1-2 units
OT	430	431 (for 0-17 years LTHH)	$66.54	$85.97	Up to 2 ½ hours
OT for HCBS Home Mod Evaluation	434	434	$66.54	$85.97	1-2 units
S/LT	440	441 (for 0-17 years LTHH)	$68.29	$92.81	Up to 2 ½ hours
Maximum Daily Amount Acute Home Health			297.00	$364.00	24 hours, MN to MN
Maximum Daily Amount Long Term Home Health			$232.00	$284.00	24 hours, MN to MN

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:

Medical Assistance Program Provider Enrollment
303-534-0439

or

Mail to:

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

Revised 04/26/05