COLORADO INDIGENT CARE PROGRAM

FISCAL YEAR 2008

MANUAL

SECTION II:

DATA COLLECTION

EFFECTIVE: JULY 1, 2007

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ARTICLE I. PROGRAM OVERVIEW

Section 1.01 Program Definition

The Colorado Indigent Care Program (CICP) is a state program that partially reimburses health care providers for services rendered to qualifying Colorado residents, migrant workers, and legal immigrants with limited financial resources. The CICP primarily serves non-Medicaid and non-CHP+ eligible individuals who are uninsured or underinsured. The Colorado Department of Health Care Policy and Financing (The Department) administers the CICP.

Section 1.02 Contract Requirements for Participating CICP Providers

Providers eligible for participation in the CICP must meet all of the following minimum criteria:

1. Licensed or certified as a general hospital, community health clinic, or maternity hospital (birth center) by the Department of Public Health and Environment

2. Assures that emergency care is available to all CICP clients throughout the contract year

3. If the provider is a hospital, the hospital must have at least two obstetricians with hospital staff privileges who agree to provide obstetric services to Medicaid clients. In the case where a hospital is located in a rural area, the term "obstetrician" includes any physician with hospital staff privileges to perform non-emergency obstetric procedures. This obstetrics requirement does not apply to a hospital in which the patients are predominantly under 18 years of age; or which did not offer non-emergency obstetric services as of December 21, 1987.

Only facilities with contracts to provide CICP services for the Department can receive reimbursement for care provided to CICP eligible clients.

Section 1.03 Client Eligibility

Please see Section I: Eligibility of this manual for details regarding client eligibility**.**

Section 1.04 Prior Authorization Requirements

There are no prior authorization requirements associated with CICP services. Health care services provided to CICP clients must be medically necessary, as determined by the CICP provider. All health care services normally provided at the hospital and/or clinic are regularly available at a discount to CICP clients unless the provider sets a standardized policy that limits available services. Providers must provide emergency services at a discount. The CICP Administration has granted waivers to limit medical services to a specific area or county. Waivers do not exclude the provider from supplying required emergency care at a discount to any CICP client, even if that client resides outside the provider's service area.

ARTICLE II. BILLING INFORMATION

Section 2.01 Definitions

The **CICP Data Collection System** includes the specifications on how providers must submit inpatient and outpatient billing information to the CICP Administration. There is no electronic submission of claims, nor are paper claims accepted.

Indigent Patient (client) - A person who meets the guidelines outlined in the Colorado Indigent Care Program Manual – Eligibility Section, which stipulates that the individual must have income and assets combined at or below 250% of the current Federal Poverty Level (FPL).

Emergency (Urgent) Care - Treatment for conditions of an acute, severe nature which are life, limb, or disability threats requiring immediate attention, where any delay in treatment would, in the judgment of the responsible physician, threaten life or loss of function of a patient or viable fetus.

Non-Emergency (Non-Urgent) Care - Treatment for any conditions not included in the emergency care definition and any additional medical care for those conditions the Department determines to be the most serious threat to the health of medically indigent persons.

Patient Liability - Client copayments are required for the CICP. Enter the amount due as a CICP copayment or copayment due from third party insurance, whichever is lower. Enter the required copayment even if the provider did not receive full payment.

Total Charges Total amount billed. The total charges billed to the CICP must be equal to the total charges billed to payers for equal medical services. Bill only one charge value, which is the sum of the detailed charge lines on a claim. Do not subtract Medicare or third party payments from line charge amounts. This field cannot be negative.

Third Party Liability - Payments due from third party insurance, including Medicare. These are not payments received, but the amount owed by the client's primary insurance. Do not include contractual adjustments as a payment due or as a liability. CICP will reimburse for contractual adjustments.

Section 2.02 History

Effective December 2000, the Colorado Indigent Care Program (CICP) no longer accepts the submission of claims in electronic format. The state's fiscal agent, Consultec (now ACS), processed a number of FY 2001 claims, but providers were required to resubmit that information in the CICP Data Collection System – Detail Format. After requests from providers, the CICP Data Collection System was modified to include the CICP Data Collection System – Summary Format.

Effective July 2003, the CICP eliminated the CICP Data Collection System – Detail Format as an acceptable method of submitting FY 2003 billing information. All providers now are required to use the CICP Data Collection System – Summary Format. Providers who receive data from their electronic vendor in the Detail Format can use an Access Database created by the CICP Administration to convert the billing information into the Summary Format standard.

Section 2.03 Provider Billing Information

There are three different types of billing information required by the Program.

Inpatient & Outpatient Service: All inpatient admissions and outpatient visits are billed using the CICP Data Collection System - Summary Format.

Outpatient Pharmaceutical: Providers shall separate Outpatient Pharmacy visits from regular inpatient and outpatient charges. If a client has an Outpatient Pharmacy visit (prescription only) that information will be reported separately from the regular billing information. If a client receives a pharmaceutical during an outpatient visit or inpatient admission, the pharmacy charge can be included on the regular claim information and it does not need to be separated out. Your facility must notify the CICP Administration of the intent to bill for Outpatient Pharmaceuticals on the Provider Application prior to the start of the fiscal year.

Physician Charges: Hospital providers have an option to bill CICP for physician charges. Physician charges associated with clinic visits are considered part of the outpatient service and are included in the CICP Data Collection System.

Hospital physician charges are associated with care provided at the facility for CICP clients. The physician charges must not be included in the charges submitted under the CICP Data Collection System and must not be reimbursed by another source. Prior to billing, physicians must have an appropriate contract with the facility stating that the physician will follow the statutes and rules governing the Program. An example of this contract is provided in Section VII, Sample Participating Physician Contract of the CICP Manual. Physicians cannot bill the Program directly. The provider must handle all the billing for physician charges. No provider is obligated to bill for physician charges. Prior to the start of the fiscal year, your facility must notify the CICP Administration on the Provider Application of the intent to bill for physician charges.

Section 2.04 Summary Format vs. Detail Format

The CICP Data Collection System – Summary Format includes the specifications on how providers must submit billing information to the CICP Administration. There is no electronic submission of claims. The information is requested so that the CICP Administration can identify funding available to specific providers and write the CICP Annual Report for the Colorado General Assembly.

Providers must submit billing information under the Summary Format and follow the guidelines set forth in Article III Data Collection System – Summary Format. By using the Summary Format the CICP Administration does not receive claim level details, but rather summary totals for clients served at each provider. The summary information is submitted quarterly, in a year-

to-date format. The summary information can be e-mailed as an attachment to the CICP Administration.

Effective July 2002, providers could not submit FY 2003 billing information under the Detail Format as set forth in Article IV Data Collection System – Detail Format.

Section 2.05 Timely Filing Requirement

The State fiscal year starts July 1st and ends the following June 30th. All billing information with an inpatient discharge date or an outpatient date-of-service within the fiscal year must be received by the CICP Administration prior to October 31st following the fiscal year end. In other words, for billing information with an inpatient discharge date or an outpatient date-of-service contained in Fiscal Year 2007-08 (July 1, 2007 - June 30, 2008) all billing information must be received by the CICP Administration by October 31, 2007. It is imperative that final billing data is submitted by October 31, 2007, to allow the Department adequate time for completion of the CICP Annual Report due to the Colorado General Assembly each year.

Section 2.06 Retention of Billing Records

All billing records related to the Contractor's or subcontractor's participation in the CICP must be maintained in a central location by the providers for a period of five State fiscal years after the expiration of each State fiscal year. This includes all the detailed information used to support the summary information submitted to the CICP. The Provider Compliance Audit mandated by the CICP requires that providers be able to identify all claims used to create the summary format submitted to the program. Providers must keep the claim detail for a period of five State fiscal years to justify the information submitted to the CICP.

Section 2.07 Third Party Insurance

If the client has a third party insurance, including Medicare, the provider will bill the commercial health insurance policy first for all medical expenses incurred. Remaining amounts not paid by the third party insurance can be billed to the CICP. Providers can report contractual adjustments negotiated under commercial health insurance contracts and Medicare contractual adjustments in Total Charges. The CICP will reimburse providers for contractual adjustments. Do not include contractual adjustment under Third Party Liability.

Health Insurance Billing Examples:

Example #1: Simple Third Party Payment with CICP as Secondary Payer

$150.00	Medical bill (Total Charges Billed to Client's Commercial Health Plan)
-$100.00	Minus Payment Due from Client's Commercial Health Plan
$50.00	Equals Hospital Charges Remaining
$50.00	Hospital Charges Remaining
-$25.00	Minus Client CICP Copay
$ 25.00	***Allowable Write-Off Charges Reported to CICP***

Charges Reported to CICP

Total Charges	Patient Liability	3rd Party Liability	Write-Off Charges
$150.00	$25.00	$100.00	$25.00

Example #2: Medicare Third Party Payment with CICP as Secondary Payer

$150.00	Medical bill –(Total Charges Billed to Medicare)
-$100.00	Minus Payment Due from Medicare
$50.00	Equals Hospital Charges Remaining
$50.00	Hospital Charges Remaining
-$25.00	Minus Client CICP Copay
$25.00	***Allowable Write-Off Charges Reported to CICP***

Charges Reported to CICP

Total Charges	Patient Liability	3rd Party Liability	Write-Off Charges
$150.00	$25.00	$100.00	$25.00

ARTICLE III. DATA COLLECTION SYSTEM - SUMMARY FORMAT

Section 3.01 Definition

Providers submitting billing information under the Summary Format must follow the guidelines set forth in this Article. In the Summary Format the CICP Administration receives totals for clients served at each provider rather than claim-level detail. The summary information is submitted quarterly, in a year-to-date format. The summary information may be e-mailed to the CICP Administration.

Section 3.02 Field Description

Provide the following summary information:

Field	Instructions
Provider Name	CICP Contracting Provider's Name
Date of Service	From and To Dates of Reporting Period
Total Charges	Sum of the detail charge lines. Do not subtract Medicare or third party payments from line charge amounts. This field should be gross charges and cannot be a negative figure.
Third Party Liability	Payments due from 3rd Party Insurance, including Medicare. Do not include contractual adjustments.
Patient Liability	Client copayments are required for the CICP. Enter the amount due as a CICP copayment or as a copayment due from 3rd Party Insurance, whichever is lower. Enter the required copayment even if the provider did not receive full payment.
Outpatient Urgent & Emergency Charges	Bill Type* is Outpatient 131, 134 721, 724 711, 714 731, 734 AND Admit Type is Emergency Claims 1 – Emergency 2 – Urgent

Outpatient Non-Urgent & Non-Emergency Charges	Bill Type* is Outpatient 131, 134 721, 724 711, 714 731, 734 AND Admit Type is Non-Emergency Claims 3 – Elective 4 – Newborn
Inpatient Urgent & Emergency Charges	**Hospitals Only** Bill Type* is Inpatient 111, 114 121, 124 AND Admit Type is Emergency Claims 1 – Emergency 2 – Urgent
Inpatient Non-Urgent & Non-Emergency Charges	**Hospitals Only** Bill Type* is Inpatient 111, 114 121, 124 AND Admit Type is Non-Emergency Claims 3 – Elective 4 – Newborn
Total Number of Inpatient Admissions	**Hospitals Only** Bill Type* is Inpatient 111, 114 121, 124
Total Number of Inpatient Days	**Hospitals Only** Bill Type* is Inpatient 111, 114 121, 124
Number of Inpatient Admissions by CICP Rating	**Hospitals Only** Bill Type* is Inpatient 111, 114 121, 124 Client's CICP Rating Codes N, A, B, C, D, E, F, G, H, I, or Z

Number of Inpatient Days by CICP Rating	**Hospitals Only** Bill Type* is Inpatient 111, 114 121, 124 Client's CICP Rating Codes N, A, B, C, D, E, F, G, H, I,or Z
Number of Inpatient Admissions by Age & Sex	**Hospitals Only** Bill Type* is Inpatient 111, 114 121, 124 Client's Sex M or F Age Groups 0-5, 6-17, 18-24, 25-54, 55-64, 65+
Inpatient Charges by Age & Sex	**Hospitals Only** Bill Type* is Inpatient 111, 114 121, 124 Client's Sex M or F Age Groups 0-5, 6-17, 18-24, 25-54, 55-64, 65+
Total Number of Outpatient Visits	Bill Type* is Outpatient 131, 711, 731
Number of Outpatient Visits by CICP Rating	Bill Type* is Outpatient 131, 134 721, 724 711, 714 731, 734 Client's CICP Rating Codes N, A, B, C, D, E, F, G, H, I or Z
Number of Outpatient Visits by Age & Sex	Bill Type* is Outpatient 131, 134 721, 724 711, 714 731, 734 Client's Sex M or F Age Groups 0-5, 6-17, 18-24, 25-54, 55-64, 65+

Outpatient Charges by Age & Sex	Bill Type* is Outpatient 131, 134 721, 724 711, 714 731, 734 Client's Sex M or F Age Groups 0-5, 6-17, 18-24, 25-54, 55-64, 65+
Total Number of Clients (not claims) by Age	Number of distinct clients served. Age Groups 0-5, 6-18, 19+
Total Number of Inpatient Clients (not claims) by Age	**Hospitals Only** Bill Type* is Inpatient 111, 114 121, 124 Number of distinct clients served. Age Groups 0-5, 6-18, 19+
Total Number of Inpatient Clients (not claims) by Age	Bill Type* is Outpatient 131, 134 721, 724 711, 714 731, 734 Number of distinct Clients served Age Groups 0-5, 6-18, 19+
Number of Admits & Visits by County (County code)	Two-digit county code. (See Article X - county codes).

*Listed bill types are only examples. CICP accepts all bill types accepted by Colorado Medicaid, except interim claims. CICP accepts only final claims.

Section 3.03 Outpatient Visits

Providers are requested not to use a span date when billing for outpatient services because a bill using a span date could be mistaken as one visit under the CICP Data Collection System, whereas the client might have actually received services several times in the month. Claims with a span bill date will still be accepted.

However, when counting the number of outpatient visits, providers are requested not to count claims, since many providers use a span billing. Instead, providers should count the actual number of visits by all CICP clients. If a client had four visits on one claim, four visits should be reported.

Section 3.04 Unduplicated Client Count

The unduplicated client count is the number of clients served by the provider. The Total Number of Clients (not claims) by Age is the unduplicated client count of all clients served by the provider. The Total Number of Inpatient Clients (not claims) by Age is the unduplicated client count for all clients served on an inpatient basis. The Total Number of Outpatient Clients (not claims) by Age is the unduplicated client count for all clients served on an outpatient basis. For example:

- A single client could have 2 inpatient admissions and 6 outpatient visits at the provider over the fiscal year. This client is counted once in the total unduplicated client count, only once in the unduplicated inpatient client count and only once in the unduplicated outpatient client count.
- A single client could have four outpatient visits at the provider over the fiscal year, and is counted only once in the unduplicated client count for outpatient and only once in the total unduplicated client count.

For a provider with no inpatient clients, the total number of unduplicated clients should equal the unduplicated outpatient client count. Usually, the sum of the unduplicated inpatient clients and unduplicated outpatient clients will not equal the total number of unduplicated clients. The only time this sum should equal the total number of unduplicated clients is when clients receive either inpatient or outpatient services, but not both, over the course of a year. This scenario is very unlikely.

To ensure accurate data, it is advisable that the total number of unduplicated inpatient clients should not exceed the total number of inpatient admissions. Also, the total number of unduplicated outpatient clients should not exceed the total number of outpatient visits. Therefore, the total number of unique clients served should not exceed the total number of unique inpatient plus outpatient clients.

Section 3.05 Verify Accuracy of Subset Data

In the interest of providing accurate data, providers should make a reasonable effort to ensure the subset data pulled for inpatient admits (i.e., gender and age) corresponds to the same data group submitted for inpatient charges by age and sex. As well, the outpatient visits information pulled by age and gender should reasonably correspond to the same data group submitted for outpatient charges by age and sex. For example: a provider submits summary data information listing no inpatient admits for females between the ages of 6-17 years old. However, there is a specific dollar amount reported for inpatient charges for females between the ages of 6-17 years old. This situation indicates an error in the data.

Section 3.06 Summary Information Format

Providers can download the Excel template for transmitting summary information to the CICP Administration. The template is available on the CICP Website (see Article VIII – CICP Information). Summary information can be e-mailed or mailed on disc directly to the CICP Administration.

An example template is as follows (pages 13-19):

Total Charges	
Total Charges	$0.00
3rd Party Liability	$0.00
Patient Liability	$0.00
Write-Off Amount	$0.00

Charges	
Outpatient Urgent & Emergency	$0.00
Outpatient Non-Urgent & Non-Emergency	$0.00
Inpatient Urgent & Emergency	$0.00
Inpatient Non-Urgent & Non-Emergency	$0.00
Total Charges	$0.00

Inpatient Admits	
Total Number of Admissions	#
Total Number of Days	#
Number of Admissions by CICP Rating	
A	#
B	#
C	#
D	#
E	#
F	#
G	#
N	#
H	#
I	#
Z	#
Unknown	#
Total	#

Number of Days by CICP Rating

A	#
B	#
C	#
D	#
E	#
F	#
G	#
N	#
H	#
I	#
Z	#
Unknown	#
Total	#

Number of Admits by Age & Sex

Male

0-5	#
6-17	#
18-24	#
25-54	#
55-64	#
65+	#
Total	#

Female

0-5	#
6-17	#
18-24	#
25-54	#
55-64	#
65+	#
Total	#

Total

Inpatient Charges by Age & Sex

Male

0-5	#
6-17	#
18-24	#
25-54	#
55-64	#
65+	#
Total	#
Female	
0-5	#
6-17	#
18-24	#
25-54	#
55-64	#
65+	#
Total	#
Total	#

Outpatient Visits

Total Number of Visits	#
Number of Visits by CICP Rating	
A	#
B	#
C	#
D	#
E	#
F	#
G	#
N	#
H	#
I	#
Z	#
Unknown	#
Total	#

Number of Visits by Age & Sex

Male

0-5	#
6-17	#
18-24	#
25-54	#
55-64	#
65+	#
Total	#

Female

0-5	#
6-17	#
18-24	#
25-54	#
55-64	#
65+	#
Total	#

Total

Outpatient Charges by Age & Sex

Male

0-5	#
6-17	#
18-24	#
25-54	#
55-64	#
65+	#
Total	#

Female

0-5	#
6-17	#
18-24	#
25-54	#
55-64	#
65+	#

Total	#
Total	#

Unduplicated Patient Count

Total Number of Unique Clients Served (not claims) by Age	
0-5	#
6-18	#
19+	#
Total	#

Total Number of Unique Inpatient Clients Served (not claims) by Age	
0-5	#
6-18	#
19+	#
Total	#

Total Number of Unique Outpatient Clients Served (not claims) by Age	
0-5	#
6-18	#
19+	#
Total	#

County Utilization

Admits & Visits by County (County code)	
01 Adams	#
02 Alamosa	#
03 Arapahoe	#
04 Archuleta	#
05 Baca	#
06 Bent	#
07 Boulder	#
08 Chaffee	#
09 Cheyenne	#
10 Clear Creek	#
11 Conejos	#
12 Costilla	#
13 Crowley	#
14 Custer	#

15	Delta	#
16	Denver	#
17	Dolores	#
18	Douglas	#
19	Eagle	#
20	Elbert	#
21	El Paso	#
22	Fremont	#
23	Garfield	#
24	Gilpin	#
25	Grand	#
26	Gunnison	#
27	Hinsdale	#
28	Huerfano	#
29	Jackson	#
30	Jefferson	#
31	Kiowa	#
32	Kit Carson	#
33	Lake	#
34	La Plata	#
35	Larimer	#
36	Las Animas	#
37	Lincoln	#
38	Logan	#
39	Mesa	#
40	Mineral	#
41	Moffat	#
42	Montezuma	#
43	Montrose	#
44	Morgan	#
45	Otero	#
46	Ouray	#
47	Park	#
48	Phillips	#
49	Pitkin	#
50	Prowers	#
51	Pueblo	#
52	Rio Blanco	#
53	Rio Grande	#

54	Routt	#
55	Saguache	#
56	San Juan	#
57	San Miguel	#
58	Sedgwick	#
59	Summit	#
60	Teller	#
61	Washington	#
62	Weld	#
63	Yuma	#
64	Broomfield	#
	Unknown	#
Total		#

Section 3.07 File Description

Excel Spreadsheet: A Microsoft Excel Spreadsheet is provided by the CICP Administration. Providers can download this spreadsheet from the CICP Website (see Article VIII – CICP Information) and can input data directly.

Section 3.08 Filing Requirements

Effective July 1, 2002, this summary information is to be submitted quarterly. Providers will submit year-to-date information to the CICP Administration on the following time-line:

Quarter	Dates of Service	Due to CICP Administration
1st	July 1 - September 30	October 31
2nd	July 1 - December 31	January 31
3rd	July 1 -March 31	April 30
4th	July 1 - June 30	July 31
Final Yearly Report	July 1 - June 30	October 31

For FY 2008 (July 1, 2007 - June 30, 2008) providers will submit their 1st Quarter Report on October 31, 2007, covering the dates of service July 1, 2007 – September 30, 2007.

On October 31, 2008, providers will submit two reports: the Final Yearly Summary Report for FY 2008 covering the dates of service July 1, 2007 - June 30, 2008, and the 1st Quarter Report for FY 2009 covering the dates of service July 1, 2008 - September 30, 2008.

Section 3.09 E-Mail or Cover Letter Requirements

All Quarterly Summary data must be submitted by e-mail with the following information at the top of the spreadsheet:

- Provider Name
- Reporting Period
- Name, Phone Number and E-Mail address as a contact regarding the data submission

ARTICLE IV. DATA COLLECTION SYSTEM – DETAIL FORMAT

Section 4.01 Definition

Effective July 2002, providers will no longer submit billing information under the Detail Format as set forth in Article IV. The Detail Format allowed the provider to submit claim level information from their billing system or electronic vendor. The CICP Administration will not process this information, but will provide an Access database for providers to input the Detail Format and convert the information to meet the needs of the Summary Format.

Providers are strongly requested not to use a span date when billing for outpatient services. A bill using a span date will be counted as one visit under the CICP Data Collection System, whereas the client might have actually received services several times in the month.

Section 4.02 Mapping

The fields of the Detail Format are directly correlated with the UB-92 claim format (Uniform Bill-1992 version). The mapping from each field on the National Standard Format (NSF) is shown below:

UB-92 File Description/Reference Table					CICP Data Collection System Fields - Detail Format				
NSF Record	Beginning Position	Field Length	Form Locator	Field Name	New Field Name	Field Type	Start Position	Field Length	Special Instructions
30-24	160-172	13	51	Provider Number	Provider Number	X(10)	1	10	Required
10-12	97-121	25	1	Provider Name	Provider Name	X(25)	11	25	Required
20-03	5-24	20	3	Patient Control Number	Patient Control Number	X(12)	36	12	Optional
30-10	80-96	17	62	Insurance Group Number	Patient County Code	9(2)	48	2	Required
20-19	133-140	8	6	First day of service	First day of service	9(8)	50	8	Required
20-20	141-148	8	6	Last day of service	Last day of service	9(8)	58	8	Required
10-02	03-05	3	4	Type of Bill	Type of Bill	9(3)	66	3	Required
20-25	173-189	17	23	Medical Record Number	CICP Control Number	X(17)	69	17	Required for Adjustment Claims
30-20	147-149	3	7	Covered Days	Covered Days	9(3)	86	3	Required for Inpatient
30-21	150-153	4	8	Non-Covered Days	Non-Covered Days	9(4)	89	4	Required for Inpatient, when applicable
30-07	35-53	19	60	Certificate/SSN/HIC	Patient SSN	9(9)	93	9	Required
20-04	25-44	20	12	Patient Last Name	Patient Last Name	X(20)	102	20	Required
20-05	45-53	9	12	Patient First Name	Patient First Name	X(9)	122	9	Required
20-06	54-54	1	12	Patient Middle Initial	Patient Middle Initial	X(1)	131	1	Required
20-08	56-63	8	14	Birth date	Birth date	9(8)	132	8	Required
20-07	55-55	1	15	Sex	Sex	X(1)	140	1	Required
20-10	65-65	1	19	Admission Type	Admission Type	9(1)	141	1	Required
50-07	42-51	10	47	Accommodation Total Chg	Total Charge	9(8)v99	142	10	Required (submitted charge)
60-09	45-54	10	47	Inpatient Ancillary Tot Chg	Total Charge	9(8)v99	142	10	Required (submitted charge)
61-10	51-60	10	47	Outpatient Total Charge	Total Charge	9(8)v99	142	10	Required (submitted charge)
30-25	173-182	10	54	Payments Received - A,B,C	Payments Received - A,B,C	9(8)v99	152	10	Conditional
20-23	153-162	10	54	Due from Patient - D	Due from Patient - D	9(8)v99	162	10	Required
30-26	183-192	10	55	Estimated Amount Due	Estimated Amount Due	9(8)v99	172	10	Required
30-10	80-96	17	62	Insurance Group Number	CICP Rating Code	X(1)	182	1	Required
70-04	25-30	6	67	Principal Diag Code	Principal Diag Code	X(6)	183	6	Required

Section 4.03 Field Description

New Field Name	Field Type	Start Position	Field Length	Instructions	Special Instructions
Provider Number	X(10)	1	10	Enter the eight-digit unique provider number the same as assigned by Medicaid Administration.	Required
Provider Name	X(25)	11	25	Enter a provider name, 25 characters only.	Required
Patient Control Number	X(12)	36	12	This field is for the provider's use. Enter the client's unique account number, either a medical record number or patient account number.	Optional
Patient County Code	9(2)	48	2	The two-digit county code. (See Appendix A for Colorado County Codes.)	Required
First Day of Service	9(8)	50	8	"From" date is the first date covered by the bill.	Required
Last Day of Service	9(8)	58	8	"Through" date is the last date covered by the bill.	Required
Type of Bill	9(3)	66	3	Enter the three-digit code indicating the specific type of bill. Valid CICP type of bill codes are: Inpatient 111, 114, 117*, 118* 121, 124, 127*, 128* Outpatient 131, 134, 137*, 138* 721, 724, 727*, 728* 711, 714, 717*, 718* 731, 734, 737*, 738* *Conditional Note: For claims with the third-digit type of bill equal to 7 (replacement/adjustment) or 8 (void/credit), the original CICP Control Number must always be entered in the CICP Control Number field. Listed bill types are only examples. CICP accepts all bill types accepted by Colorado Medicaid, except interim claims. CICP accepts only final claims. The three-digit code requires one digit each in the following	Required

				sequences: Digit 1 – Type of Facility 1 – Hospital 7 – Clinic Digit 2 – Bill Classification (Hospitals) 1 – Inpatient (including Medicare Part A) 2 – Inpatient (Medicare Part B only) 3 – Outpatient Digit 2 – Bill Classification (Clinics) 1 - Rural Health/FQHC 2 – Freestanding Renal Dialysis Center 3 – Freestanding 4 – Outpatient Rehabilitation Facility (ORF) 5 – Comprehensive Outpatient Rehab facilities (CORFs) Digit 3 – Frequency 1 – Admit through discharge claim 4 – Interim – final claim 7 – Replacement of prior claim (replacement/adjustment)* 8 – Void/cancel of prior claim (void/credit)*	
CICP Control Number	X(17)	69	17	For claims with the third-digit type of bill equal to 7 (replacement/adjustment) or 8 (void/credit), the original CICP Control Number must always be entered in the CICP Control Number field. CICP Administration assigns this 17-digit number upon acceptance of each individual CICP claim. It is printed on the electronic accepted claims report. Keep a copy of the accepted claims report for all CICP claims submissions as a claim verification tool.	Required for Adjustment Claims
Covered Days	9(3)	86	3	Enter the number of days covered by CICP.	Required for Inpatient

Non-Covered Days	9(4)	89	4	Enter the number of days not covered by CICP.	Required for Inpatient, when applicable
Patient SSN	9(9)	93	9	Client's Social Security Number	Required
Patient Last Name	X(20)	102	20	Client's Last Name (20 digit max)	Required
Patient First Name	X(9)	122	9	Client's First Name (9 digit max)	Required
Patient Middle Initial	X(1)	131	1	Client's Middle Initial (1 digit max)	Required
Birth date	9(8)	132	8	Client's date of birth	Required
Sex	X(1)	140	1	Client's Sex (M or F)	Required
Admission Type	9(1)	141	1	Enter a one-digit code indicating the priority of inpatient admission or Outpatient/Clinic visit. Emergency Claims 1 – Emergency 2 – Urgent Non-Emergency Claims 3 – Elective 4 – Newborn	Required
Total Charge	9(8)v99	142	10	Enter the sum of the detail charge lines. Do not subtract Medicare or third party payments from line charge amounts. This field cannot be negative.	Required (submitted charge)
Payments Received	9(8)v99	152	10	Third party payments due, including Medicare. Do not include contractual adjustments as a payment due or liability. CICP will reimburse for contractual adjustments.	Conditional
Due from Patient	9(8)v99	162	10	Client copayments are required for the CICP. Enter the amount due as a CICP copayment. Enter the required copayment even if provider did not receive full payment.	Required
Estimated Amount Due	9(8)v99	172	10	Net Charge/Write-off Amount submitted to the CICP. This field must equal total gross charges, minus all other insurance reimbursements, minus Medicare reimbursements, minus patient copayment.	Required

CICP Rating Code	X(1)	182	1	CICP Client's Rating Codes N, A, B, C, D, E, F, G, P or Z	Required
Principal Diag Code	X(6)	183	6	Enter the exact ICD-9-CM diagnosis code describing the principal diagnosis.	Required
Record Status Code	X(1)	189	1	CICP Administration assigns this 1-digit number upon acceptance of each individual CICP claim.	Not Used Field reserved for CICP Administration use.

Notes:

Field Type = X is alphanumeric left justified, blank fill.
Field Type = 9 is numeric, right justified, zero fill.
Field Type = 9(8)v99, is a number field 10 digit length, with an assumed decimal point and two decimal places.

As an example, X(12) in an alphanumeric field 12 character length.

1 record (claims information) is transmitted as a row.

The decimal place is assumed. Key in the numeric digits after the assumed decimal point even if zeroes. Maintain positional uniformity and do not use decimal point.

No negative values. All numeric fields are positive.

All fields are required to be programmed and transmitted by specified start position. Not all fields will be populated, but they must be programmed to maintain position.

Record Status Code is returned to providers on Accept/Reject report from CICP. Code will inform providers if the claim was accepted or rejected, due to duplicate claim already in system or if required field was not populated correctly. Code will also relate information if claim was sent as an adjustment or void.

Section 4.04 File Description

Providers cannot transmit the CICP Data Collection System - Detail Format information to the CICP Administration. The recommended file format when working with data in the Detail format is a fixed width delimited text file. The length of each field is provided in Section 4.03. Providers can export the required information directly from their billing systems into the text file and then transfer the data into the Access database available from the CICP Administration.

ARTICLE V. OUTPATIENT PHARMACEUTICAL

Section 5.01 Definition

Outpatient Pharmaceuticals: Providers are required to separate Outpatient Pharmacy visits from regular inpatient and outpatient claims (charges). If a client has an Outpatient Pharmacy visit (prescription only) that information will be reported separately from the regular claim information. If a client receives a pharmaceutical during an outpatient visit or inpatient admission, the pharmacy charge is included on the regular claim information as it does not need to be separated out. Your facility must notify the CICP Administration prior to the start of the fiscal year of the intent to bill for Outpatient Pharmaceuticals on the Provider Application.

Section 5.02 Declaring Pharmaceutical Charges

Providers will send a letter or e-mail, to the CICP Administration stating the following summary information:

- Total Number of Visits (or prescription claims)
- Total Charges
- 3rd Party Liability
- Patient Liability

Section 5.03 Filing Requirements

This summary information is submitted quarterly. Providers will submit year-to-date information to the CICP Administration on the following timeline:

Quarter	Dates of Service	Due to CICP Administration
1st	July 1 - September 30	October 31
2nd	July 1 - December 31	January 31
3rd	July 1 -March 31	April 30
4th	July 1 - June 30	July 31
Final Yearly Report	July 1 - June 30	October 31

For FY 2008 (July 1, 2007 - June 30, 2008) providers will submit their 1st Quarter Report on October 31, 2007, covering the dates of service July 1, 2007 – September 30, 2007.

On October 31, 2008, providers will submit two reports: the Final Yearly Summary Report for FY 2008 covering the dates of service July 1, 2007 - June 30, 2008, and the 1st Quarter Report for FY 2009 covering the dates of service July 1, 2008 - September 30, 2008.

ARTICLE VI. PHYSICIAN CHARGES

Section 6.01 Definition

Physician Charges: CICP hospital providers have the option to bill CICP for hospital-based physician charges. These are charges associated with care provided at the hospital facility for CICP clients. The physician charges must not be included in the charges submitted under the CICP Data Collection System or be completely reimbursed by another source. Prior to billing, physicians must have an appropriate contract with the facility stating the physician will follow the statutes and rules governing the Program. An example of this contract is provided in Section VII, Sample Participating Physician Contract, of the CICP Manual. Providers are not obligated to bill for physician charges, but if these charges are to be billed to CICP, they must be submitted by the provider, not the physician. Your facility must notify the CICP Administration prior to the start of the fiscal year of the intent to bill for Physician Charges on the Provider Application.

Section 6.02 File Description

Excel Spreadsheet: A Microsoft Excel Spreadsheet will be provided by the Program. Providers can download this spreadsheet from the CICP website (see Article VIII. – CICP Information). This spreadsheet will allow providers to directly input data as necessary. Please provide the following summary information:

INPATIENT	Service Dates:	(From Date)	(Through Date)

Claim Information:	**CHARGES**	**Number of ADMISSIONS**	**Number of DAYS**	**Number of CLIENTS**
Urgent Care	$0.00	0	0	0
Non-Urgent Care	$0.00	0	0	0
Totals:	$0.00	0	0	0
Third Party Liability:	$0.00			
Patient Liability:	$0.00			
Medical Indigency Write-Offs	$0.00			

OUTPATIENT	Service Dates:	(From Date) (Through Date)

Claim Information:	**CHARGES**	**Number of VISITS**	**Number of CLIENTS**
Urgent Care	$0.00	0	0
Non-Urgent Care	$0.00	0	0
Totals:	$0.00	0	0
Third Party Liability:	$0.00		
Patient Liability:	$0.00		
Medical Indigency Write-Offs	$0.00		

Section 6.03 Filing Requirements

This summary information will be submitted quarterly. Providers will submit year-to-date information to the CICP Administration:

Quarter	**Date of Service**	**Due to CICP Administration**
1st	July 1 – September 30	October 31
2nd	July 1 – December 31	January 31
3rd	July 1 -March 31	April 30
4th	July 1 - June 30	July 31
Final Yearly Report	July 1 - June 30	October 31

For FY 2008 (July 1, 2007 - June 30, 2008), providers will submit their 1st Quarter Report on October 31, 2007, covering the dates of service July 1, 2007 – September 30, 2007.

On October 31, 2008, providers will submit two reports: the Final Yearly Summary Report for FY 2008 covering the dates of service July 1, 2007 - June 30, 2008, and the 1st Quarter Report for FY 2009 covering the dates of service July 1, 2008 - September 30, 2008.

ARTICLE VII. PREVIOUSLY CHARGED CLAIM ADJUSTMENTS

Section 7.01 General Information

Providers who receive payment for claims that have already been reimbursed by the Program are required to report these payments. These payments can be made under the following circumstances:

- Client became enrolled in Medicaid or CHP+
- Settlement of lawsuits or other court ordered action in which the client or other 3rd party was required to pay the medical bill
- Client was incorrectly included on the CICP data submission

Previously charged claim adjustments are charges that the provider submitted to the CICP in a previous fiscal year. If a charge for the current fiscal year needs to be adjusted, the provider should make that adjustment to the data prior to the October 31, 2007, data submission deadline. For example:

- The provider submitted a $100 charge to CICP Administration on its first quarterly report for FY 2007. Six months later the provider learns that the client was enrolled on Medicaid during that period. The provider will then submit the bill to Medicaid for proper reimbursement and will not include the charge on the third quarterly report for FY 2007 submitted to the CICP. This is allowable, since the CICP reporting is always year-to-date and providers can make adjustments to the totals submitted up to the October 31, 2007, deadline.
- The provider submitted a $100 charge to the CICP Administration on its final quarterly report. Six months later the provider learns that the client was enrolled on Medicaid during that period. The provider then submits the bill to Medicaid for proper reimbursement, but is unable to adjust its quarterly reporting to the CICP since the October 31, 2007, deadline has passed. The provider will submit the required information in Section 7.02 by October 31 to correct the charge that was incorrectly submitted to CICP.

Section 7.02 Reporting Requirements

The following information is required for charges submitted to the CICP that need to be adjusted after the close of the fiscal year in which the service was provided. Adjustments for different fiscal years must not be combined into one report and must be reported separately. The following information must be included in the report:

- Provider name
- Fiscal year that the claim was incorrectly reported
- Number of visits incorrectly reported
- Number of admissions incorrectly reported

- Total charges incorrectly reported
- Third party liability incorrectly reported
- Patient liability incorrectly reported

Section 7.03 Filing Requirements

Providers are required to notify CICP of any charges that need to be adjusted. This notification should be made in a letter to be included with the Final yearly report which is due October 31 for the previous state fiscal year. The facility's Chief Financial Officer (CFO) or Administrator should sign this letter.

ARTICLE VIII. CICP INFORMATION

Section 8.01 CICP Website

The CICP Website, www.chcpf.state.co.us, is for public use and contains general program information. This is the main website for the Department of Health Care Policy & Financing. Click on the CICP link at the top menu bar. At this website, providers can find the templates for the billing files and CICP Provider Directory.

Section 8.02 CICP Mailing Information

Discs should be mailed to:

Shirley Jones
C/O Daniel Nunez
CICP
Department of Health Care Policy & Financing
1570 Grant St.
Denver, Co 80203-1818

Summary Data files should be sent by e-mail to:

Shirley Jones and Daniel Nunez
Shirley.Jones@state.co.us and Daniel. Nunez@state.co.us

Section 8.03 CICP Administration Contact Information

Greg Tanner, Manager
Greg.Tanner@state.co.us, 303-866-5177

Daniel Nunez, Accountant
Daniel.Nunez@state.co.us, 303-866-6198

Shirley Jones, Systems Analyst
Shirley.Jones@state.co.us, 303-866-5506

Corinne Lamberson, Eligibility Specialist
Corinne.Lamberson@state.co.us, 303-866-2580

ARTICLE IX. COUNTY CODES

01	**Adams**	**33**	**Lake**
02	**Alamosa**	**34**	**La Plata**
03	**Arapahoe**	**35**	**Larimer**
04	**Archuleta**	**36**	**Las Animas**
05	**Baca**	**37**	**Lincoln**
06	**Bent**	**38**	**Logan**
07	**Boulder**	**39**	**Mesa**
08	**Chaffee**	**40**	**Mineral**
09	**Cheyenne**	**41**	**Moffat**
10	**Clear Creek**	**42**	**Montezuma**
11	**Conejos**	**43**	**Montrose**
12	**Costilla**	**44**	**Morgan**
13	**Crowley**	**45**	**Otero**
14	**Custer**	**46**	**Ouray**
15	**Delta**	**47**	**Park**
16	**Denver**	**48**	**Phillips**
17	**Dolores**	**49**	**Pitkin**
18	**Douglas**	**50**	**Prowers**
19	**Eagle**	**51**	**Pueblo**
20	**Elbert**	**52**	**Rio Blanco**
21	**El Paso**	**53**	**Rio Grande**
22	**Fremont**	**54**	**Routt**
23	**Garfield**	**55**	**Saguache**
24	**Gilpin**	**56**	**San Juan**
25	**Grand**	**57**	**San Miguel**
26	**Gunnison**	**58**	**Sedgwick**
27	**Hinsdale**	**59**	**Summit**
28	**Huerfano**	**60**	**Teller**
29	**Jackson**	**61**	**Washington**
30	**Jefferson**	**62**	**Weld**
31	**Kiowa**	**63**	**Yuma**
32	**Kit Carson**	**64**	**Broomfield**