Phone Numbers and Addresses

Colorado Medical Assistance Program Fiscal Agent

Provider Services
- Provider assistance
- Provider training
- Provider enrollment

Monday thru Friday 8:00 am to 5:00 pm Mountain Time
Toll Free 1-800-237-0757
Fax 303-534-0439

Fiscal Agent Prior Authorization Assistance
Monday thru Friday 8:00 am to 5:00 pm Mountain Time
Toll Free 1-800-237-0757

Electronic Data Interchange (EDI) Support
Monday thru Friday
8:00 am to 5:00 pm Mountain Time
Toll Free 1-800-237-0757

Prescription Drug Card System (PDCS) - Pharmacy Support
24 hours a day – Seven days a week
Toll Free 1-800-365-4944
Fax 1-888-772-9696

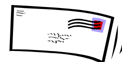
Colorado Medical Assistance Program Eligibility Response System (CMERS)
Eligibility verification by touch tone telephone
Seven days a week, 24 hours a day
Toll Free 1-800-237-0044

Fax-Back Eligibility
Requires a touch tone telephone
Seven days a week, 24 hours a day
1-800-493-0920

Paper Submissions Claims & Prior Authorization Requests
PO Box 30
Denver, CO 80201-0030

Correspondence & Adjustment Requests
PO Box 90
Denver, CO 80201-0090

Provider Form Requests & Provider Enrollment
PO Box 1100
Denver, CO 80201-1100



Colorado Medical Assistance Program
Fiscal Agent Information on the Internet
- Billing Manuals
- Bulletins
- EDI Support
- Enrollment
- FAQs
- Forms
- Manuals
- Specifications
- Training/Workshops
- News/Updates
- Web Portal News

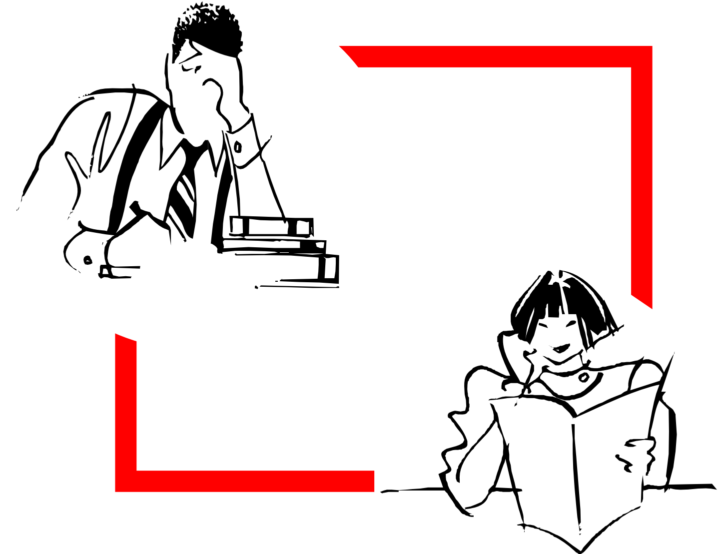
Provider Services Home page is located on the Department's Web site at

colorado.gov/hcpf ➡Provider Services ➡Provider Quick Links ➡Provider Services

Colorado Medical Assistance Program

The Little Billing Book

A Quick Reference for Medical Assistance Program Billers



The Essentials for successful participation in the Colorado Medical Assistance Program

Revised August 2010

Using the reference

The Basics

This reference summarizes basic requirements for serving Medical Assistance Program clients and preparing claims. It is not a substitute for the detailed instructions in the Medical Assistance Program provider-specific manuals.

Instructions in this reference are general and are meant to direct the user to the comprehensive instructions in the provider-specific manual and electronic specifications. Providers are responsible for compliance with all Medical Assistance Program regulations and requirements as referenced in the Medical Assistance Program provider agreement.

Speaking the same language Common terms

Web Portal

The Medical Assistance Program's electronic approach to rapid, efficient information exchange with providers includes eligibility verification, claim & PAR submission/ inquiries and electronic report retrieval.

Fee-For-Service (FFS) Reimbursement

Claims processed by the Medical Assistance Program's fiscal agent and paid based on the services that are billed.

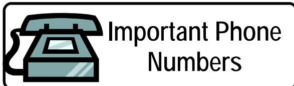
Managed Care Organizations (MCOs)

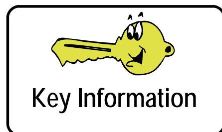
Medical Assistance Program managed care contractors, often HMOs, that offer services through a provider network and receive a monthly capitation fee for each enrolled client. MCOs pay the costs of MCO benefit services provided to MCO-enrolled clients.

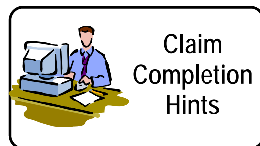
Third Party Resources

Financial resources - usually commercial health insurance - that may pay for medical services provided to Medical Assistance Program clients.

Watch for...


Important Phone Numbers


Key Information


Claim Completion Hints

Getting Help

15 Get help when you need it!

Web Portal interactive claim submission help screens

Help is available for the fields on every transaction record.

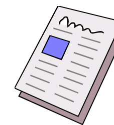
Medical Assistance Program Companion Guides

Specifications for all Web Portal transactions provide important information for programmers and software vendors.

The Medical Assistance Program Provider Manuals

Provider-specific billing instructions and answers to many questions about Medical Assistance benefit services and policies.

Medical Assistance Program bulletins and publications



Publications offer billing tips and describe changes in benefits and billing information.

Talk to your mail handling department or person. Be sure that all Medical Assistance Program publications are promptly routed to the people who need the information or go to

colorado.gov/hcpf ➡Provider Services ➡Provider Quick Links ➡Provider Services

to download publications.

Read Provider Claim Report messages. They contain timely information about Medical Assistance Program updates, processing schedule changes, business office closures, and current processing issues.

The Fiscal Agent

The fiscal agent helps providers through:

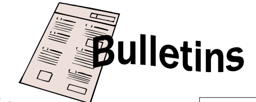
- Provider Services telephone support
- Individualized training by telephone
- Scheduled workshops at the fiscal agent's Denver offices and by WebEx.
  - Billing workshops schedules are published in Provider bulletins

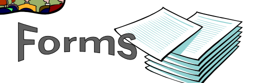
The Colorado Medical Assistance Program on the Internet

colorado.gov/hcpf

Click on Providers at the top of the web page.

Then click on the Provider Services tab on the left side of the Providers page for access to:





Provider Claim Reports

14 Reconcile Provider Claim Reports promptly and thoroughly

The Provider Claim Report (PCR) is official notification of the action taken on accepted claims.

Medical Assistance Program PCRs are created weekly for providers who have claims processed during the week.

Electronic claims transmitted and accepted before 6:00 PM Friday are included in the weekly payment processing cycle.

State holidays may cause payment processing to be moved up one or two days. Watch for notices that identify changed processing dates on the PCR and at colorado.gov/hcpf ➡Providers ➡Provider Services.

You may retrieve your PCR electronically** through the Web Portal File and Report Service.

Reconcile the PCR promptly.

Confirm that the claims you sent were received or accepted for processing.

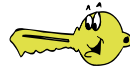
Paper claims may take from 10 days to 2 weeks to appear on the PCR.

Promptly post payments and adjust balances that cannot be billed to clients.

Review every denied claim to determine the denial reason. Correct the claim (if appropriate) and quickly resubmit the bill (if appropriate).

The PCR also contains important updates and messages for providers. Be sure to read the messages at the front of the PCR.

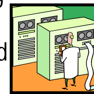
** *Requires Security: Assigned user name and password.*



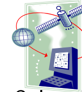
Claim Processing and Payment

Friday night - Saturday-Sunday

The claim processing system processes weekly payments and creates Provider Claim Reports.



Monday



Payment information is transmitted to the Colorado Financial Reporting System (COFRS).

Tuesday

COFRS processes Electronic Funds Transfers (EFTs) and warrants (checks).

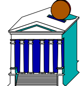
Wednesday

The Department of Health Care Policy and Financing reviews payment information.

Thursday & Friday

The fiscal agent mails paper remittance statements and warrants.

Friday - 12:00 am



EFT payments are deposited in provider accounts.

Getting Started...

1 Always verify eligibility before providing services

Ask new patients who will pay for services

1. Ask to see the client's Medical Identification Card (MIC) containing the State Identification number
2. Process an eligibility transaction by touch-tone telephone or electronically through the Web Portal

To verify eligibility, you must provide

The client's birth date - *and* Medical Assistance Program State ID number or Social Security Number

2 Respond to Eligibility Information

Is the client enrolled in the Primary Care Physician (PCP) Program?

Yes ➡ Go to 3

Is the client enrolled in a Medical Assistance Managed Care Organization (MCO)?

Yes ➡ Go to 4

Does the client have commercial health insurance resources?

Yes ➡ Go to 5

Does the client have Medicare coverage?

Yes ➡ Go to 6

Does the eligibility response show benefit limitations?

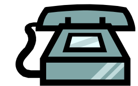
Yes ➡ Go to 7

None of the above? ➡➡➡ Go to 8

Verify Eligibility

Successful Medical Assistance Program provider participation depends upon establishing and conducting effective procedures for verifying Medical Assistance Program eligibility before services are rendered.

- Ask patients how they will pay for services each time they are seen.
- Identifying Medical Assistance Program coverage after services are rendered may be too late to comply with program requirements.



Colorado Medical Assistance Program Eligibility Response System (CMERS)

Toll Free 1-800-237-0044

Fax-Back Eligibility 1-800-493-0920

Web Portal colorado.gov/hcpf Secured Site

Primary Care Physician Program (PCPP)

3 Understand the referral requirements of the Primary Care Physician Program

If the client is enrolled in the Primary Care Physician (PCP) Program and you are not the primary care provider you must have a PCP referral unless the services are PCP referral exempt.

PCP referrals may be made verbally.

PCP referrals are for treatment of a specific condition or for a specific time period.

The following services do not require PCP referral:

- Emergency services
- Psychiatric services
- Vision care services
- Family planning services
- Laboratory & x-ray services
- Obstetrical care
- Prescription drugs
- Services to child abuse victims
- Community-Based services

The Client Overutilization Program

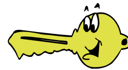
Restricts Medical Assistance Program clients to one designated pharmacy, Primary Care Physician (PCP) or Man Care Organization (MCO)

Referrals must be written

The PCP must write all prescriptions

The client is restricted to the use of a single pharmacy

Psychiatric services require PCP referral



Primary Care Physician Program

The Primary Care Physician Program is a Fee-For-Service (FFS) managed care program.

Most services require PCP referral.

The PCP is identified by name and telephone number on the eligibility response.

Claims for clients enrolled in the PCP program are processed by the Medicall Assistance Program fiscal agent.

Claim completion

On FFS claims, record the PCP referral by entering the PCP provider number as the referring provider, attending physician or other physician.

Unauthorized use of PCP provider numbers is strictly prohibited.

Identify emergencies by completing the emergency indicator for each billed service. For institutional format (UB-04) claims, complete the type of admission as "1."

Getting Paid

13 Electronic Funds Transfer

Enrolled providers are required to receive Colorado Medical Assistance Program payments through Electronic Funds Transfer (EFT).

EFT is efficient and cost effective.

EFT reduces payment turn-around time.

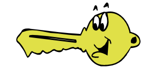
EFT authorizes the Colorado Medical Assistance Program to deposit payments directly into the provider's designated bank account.

EFT authorization does not allow the Colorado Medical Assistance Program to remove funds from the provider's bank account. Erroneous transactions (e.g., duplicate deposits) are electronically reversed.

Participating EFT providers are responsible for furnishing accurate banking information. If EFT information (e.g., bank account numbers, institutional identification numbers, etc.) changes, EFT may be interrupted until the provider submits corrected information.

All Colorado Medical Assistance Program payments are made to the enrolled provider (i.e., an individual or organization that meets the licensure and/or certification requirements for program participation).

No payments are made to a collection agencies, accounting firms, legal firms, business managers, billing services, or similar organizations.



Payment Processing

The fiscal agent processes claims for payment each Friday evening.

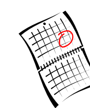
The fiscal agent mails paper remittance statements and warrants (paper checks) on Thursday & Friday of the following week

EFT payments are deposited in provider's account on the following Friday at 12:00 am.

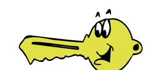
For some State and Federal holidays payment processing dates are changed to avoid payment delays.

When the holiday falls on a Monday or Friday, claim payments are processed on Thursday instead of Friday.

The processing cycle includes electronic claims accepted before 6:00 P.M. on Thursday.



When the holiday falls during the week, the receipt of warrants or EFT will be delayed.



Billing Tip

When you submit claims electronically and receive payment by EFT, your claims are processed faster and you receive payment faster!

More Timely Filing

Timely filing extensions for extenuating circumstances

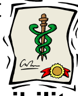
Use the numeric delay reason code with the Late Bill Override Date (LBOD).

Valid Delay Reason Codes

1 Proof of Eligibility Unknown or Unavailable
3 Authorization Delays
7 Third Party Processing Delay
8 Delay in Eligibility Determination
9 Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules
11 Other

Other insurance

If pursuing commercial insurance resources extends beyond the initial timely filing period, claims may be filed within 60 days of the insurance payment or denial notice up to 365 days from the date of service.



Pending, delayed, or retroactive eligibility

If eligibility is backdated, claims may be filed within 120 days of the date that eligibility appears on the State eligibility file. Special billing requirements apply - see the General Provider Information manual at colorado.gov/hcpf ➡Providers ➡Provider Services ➡Billing Manuals.

Use the notes section on the electronic claim to provide the date eligibility first appeared on the State eligibility file.

Delayed notification of Medical Assistance Program eligibility

Providers are responsible for taking necessary action to identify Medical Assistance Program eligibility. If initial timely filing expires because you don't know that the client has Medical Assistance Program coverage, claims may be filed within 60 days of the date you are notified that the individual is Medical Assistance Program covered - up to a maximum of 365 days from the date of service. Special billing requirements apply - see the General Provider Information manual.

Use the notes section on the electronic claim to enter the date you were first notified that the individual was Medical Assistance Program eligible.

Delay Reason Codes

The delay reason code documents compliance with timely filing requirements when the initial timely filing period expires.

You must use the notes section on the electronic claim to provide information on the reason regarding the exception to the timely filing requirement.

You must maintain documentation for the exception and – if requested – furnish documentation that proves timely filing compliance.

Inaccurate delay reason code completion may subject the provider and the individual who prepared the claim to civil penalties.

Billing Tip

A client's failure to notify you about Medical Assistance Program coverage may be caused by delayed or retroactive eligibility determination.

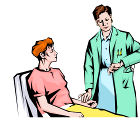
Always ask these clients when their eligibility was approved. Different timely filing rules apply to retroactive eligibility.

Managed Care organization

4 If you are not a MCO network provider and the services you provide are MCO-covered through an MCO – get authorization and billing instructions from the MCO before you provide care.

- In emergencies, non-network providers must contact the MCO within 48 hours to coordinate care and obtain billing instructions.
- MCOs deny claims if providers fail to get treatment authorization or do not follow MCO referral policies.
- If the MCO denies your claim because you have not followed MCO policy, the fiscal agent will not make payment for the claim and you cannot bill the Medical Assistance Program client.

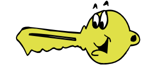
The following services may be provided by non-network FFS providers:



- Family planning
- Long-term care
- Dental care - Full benefits for children (Age 20 and under)
- Dental care - Limited adult benefits
- Transportation
- Hospice services
- Personal care (Health aide)

The following benefit services are shared between MCOs and Medical Assistance Program Fee-For-Service:

- Physical therapy
- Skilled Nursing Facility care
- Home Health



Managed Care Organizations

MCO-enrolled clients must obtain benefit services through the MCO.

Get MCO approval before providing services to a MCO enrolled client.

The MCO is identified by name & telephone number on the eligibility response.

Claim completion

Submit claims for MCO benefit services to the MCO.

1. Contact the MCO to determine if benefits are available through the MCO.
2. If the MCO doesn't offer the service, render care and submit claims to the Medical Assistance Program fiscal agent for FFS reimbursement.

For shared benefits, after the MCO benefit is exhausted, FFS claims must be submitted to the fiscal agent on paper with an attached copy of the MCO contractual denial.

Other Health Insurance

5 If the client has commercial health insurance, bill the commercial carrier before billing the Medical Assistance Program

If the commercial insurer denies payment for contractual reasons, submit the claim for Medical Assistance Program reimbursement. The claim can be submitted electronically.

The Medical Assistance Program doesn't pay coinsurance or deductible amounts if the commercial insurance payment equals or exceeds the Medical Assistance Program benefit.

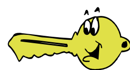
Example: Your charge = $100
Insurance payment = $80
Medical Assistance Program benefit = $60
No additional Medical Assistance Program payment.

Clients are not financially responsible for balances remaining after the Medical Assistance Program's maximum benefit has been paid.

Don't delay filing claims for potential third party liability related to accidents.

Bill the Medical Assistance Program. C.R.S. 26-4-403(3) (2003) gives the Department an enforceable right to recover Medical Assistance Program payments on behalf of a client for which a third party is liable.

This also applies to clients covered by Workers' Compensation as a third party liability.



Third Party Resources

With the exception of victim assistance programs, the Medical Assistance Program is always the payer of last resort.

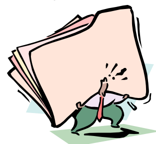
The Medical Assistance Program denies or rejects claims for clients with other health resources unless the claims show insurance payment or contractual denial information.

Always ask Medical Assistance Program clients if they also have commercial health insurance.

Commercial health insurance benefits are often greater than the Medical Assistance Program so it is always worthwhile to identify and pursue commercial insurance benefits.

Claim completion

Claims with commercial insurance payments and denials can be submitted electronically. Maintain audit records in your office.



Timely Filing

12 File claims within the timely filing period

Initial timely filing

Claims must be received by the fiscal agent within 120 days from the date of service.

Inpatient and Nursing Facility claims: Timely filing is calculated from the Statement Covers through date of service.

Community-based services claims: Timely filing is calculated from the through date of service on each billed line.

All other claims: Timely filing is calculated for each date of service.

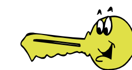
Initial timely filing for Medicare crossover claims is 120 days from the Medicare processing date.

The sixty day rule

If the initial timely filing period expires, claims must be received within 60 days of the last adverse action.

Adverse action may include a claim denial, an electronic claim rejection, a rejected eligibility verification, a returned paper claim with the fiscal agent's date stamp, or dated correspondence about a specific claim.

Always retain documents or copies of documents that show compliance with timely filing requirements for six years.



Timely Filing

The timely filing period is not extended for holidays or weekends.

Electronic claims can be submitted seven days a week, 24 hours a day.

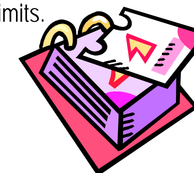
A claim is filed when it is received by the fiscal agent. Postmarks & mail receipts are not proof of fiscal agent receipt.

Timely filing compliance must be an unbroken chain:

Filing within the initial timely filing period and – when the initial filing period is exhausted - continuous filing within sixty days after every adverse action.

Any single broken link in the filing chain makes the claim non-payable.

If any sixty day filing period is missed, the timely filing chain is broken. The claim cannot be paid even if subsequent filings are received within the sixty day limits.

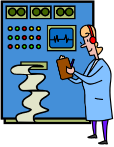


Electronic batch claims

Batch claim submission eliminates the need to create claims one at a time.

The Medical Assistance Program does not furnish batch submission software. You must purchase or develop batch submission software. These systems usually communicate with or obtain information from your patient accounting system.

Batch claim processing



Batch systems submit claims through the Web Portal. When processing has been completed, results are reported on batch accept and reject reports - also called batch response reports.

Batch response reports are available through the Web Portal File and Report Service (FRS).

The rejection report identifies errors that cause the claim to be unacceptable for processing. The rejection report is your official notice that the claim has not been accepted for processing.

Retrieve and reconcile batch response reports promptly

You must reconcile the rejection report, correct errors, and resubmit rejected claims.

If you don't retrieve and reconcile batch response reports, you won't know when a claim has been rejected. Rejected claims don't appear on the Provider Claim Report.

Electronic Billing Myths and Facts

Myth

Batch billing is better than interactive billing.

Fact

Both have advantages and disadvantages. You have to re-enter claim information in interactive systems, but the interactive feedback makes error correction and rebilling easier and more reliable.

You don't have to re-enter information in a batch billing system, but failure to retrieve and reconcile batch response reports may result in lost claim payments.

Myth

I have a batch billing system so I don't need the Web Portal.

Fact

Even if you have a batch billing system, you may, at times, want to submit transactions or retrieve certain reports through the Web Portal.

All providers and their agents should be able to access the Web Portal to submit transactions and retrieve certain reports.

6 If the client has Medicare – and the services are Medicare benefits – bill Medicare first

After Medicare completes processing, most claims are transferred to the Medical Assistance Program for automatic crossover.

If automatic crossover does not occur within 30 days of the Medicare payment, you must submit the crossover claim. Crossover claims can be submitted electronically. Paper claims must include a copy of the Standard Paper Remit (SPR).

If services are not covered by Medicare, you may submit the claim directly to the Medical Assistance Program. Complete the required claim information to identify the service as Medicare non-covered.

The Medical Assistance Program does not pay Medicare coinsurance or deductible if the Medicare payment is more than the Medical Assistance Program benefit.

Example: Your charge = $100
Medicare payment = $80
Medical Assistance Program benefit = $60

No additional Medical Assistance Program payment.

Types of Medicare Coverage

Medicare + Medical Assistance Program
Medicare benefits + Medical Assistance Program benefits

Medicare QMB + Medical Assistance Program
Medicare benefits + Medical Assistance Program benefits coinsurance and deductible for Medicare covered services even if the services aren't Medical Assistance Program benefits.

Medicare QMB only
Coinsurance and deductible for Medicare covered services including services that aren't Medical Assistance Program benefits. No Medical Assistance Program benefits, such as prescriptions.

Medicare/Medical Assistance ProgramBenefits

"Dually eligible" clients have Medical Assistance Program and Medicare benefits.

Claims for payment of Medicare residuals - coinsurance & deductible - are called Medicare crossover claims.

Medicare resources must be pursued before the Medical Assistance Program will consider payment.

Medical Assistance Program clients are not responsible for balances remaining after Medical Assistance Program crossover processing.

Allow 30 days for automatic crossover between Medicare & the Medical Assistance Program. If the crossover does not appear on the Medical Assistance Program Provider Claim Report, submit a crossover claim by completing the Medicare payment information on the claims.

Crossover claims may be submitted electronically. Maintain audit records in your office.

Benefit Limits

7 If eligibility shows a benefit limit, don't provide services until you fully understand the limitation

Presumptive Eligibility for pregnant women

Ambulatory service benefits only. There are no inpatient benefits.

If the woman is later determined to be fully Medical Assistance Program eligible, eligibility may be backdated to cover inpatient care.

Modified Medical Program

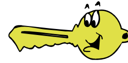
No benefit for inpatient psychiatric care, Nursing Facility care, or Home and Community Based Services.

Undocumented aliens

Benefits are limited to emergency services and obstetrical delivery. Identification of the emergency must appear on the claim. There is no benefit for treatment of chronic illness or postpartum care.

QMB - Only - Benefits

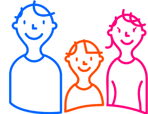
Client has Medicare crossover benefits for Medicare covered services; does not have Medical Assistance Program benefits. The client is financially responsible for services that are not covered by Medicare but is not responsible for balances remaining after Medical Assistance Program benefits are paid for Medicare covered services.



Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

EPSDT offers comprehensive preventive care and follow-up to Medical Assistance Program children.

Clients must be age 20 or under when services are rendered.



EPSDT Benefits

Periodic medical screening examinations and immunizations – Submit paper claims on the EPSDT claim form. Submit electronic claims as an 837P transaction.

Periodic dental screening examinations and treatment claims are submitted on the dental claim format.

Vision screening and necessary eyewear claims are submitted on the Colorado 1500 or as an 837P transaction.

Outreach and assistance in accessing EPSDT benefits and health resources provided through local county health agencies.

Submitting Claims

11 File all claims electronically unless specifically required to file paper

Submit the following claims on paper:

- Claims from providers who consistently submit 5 claims or fewer per month (requires prior approval)
- Claims that, by policy, require attachments
- Reconsideration claims

Interactive electronic claims are created and transmitted one-at-a-time. Claims are edited for completeness and accuracy as information is entered and transmitted.

Providers can access the Web Portal through *Secured Site* on the Department's Web site:

colorado.gov/hcpf

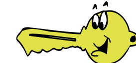
Submitted claim information is edited to assure that required fields are properly completed.

Transmitted claims are reviewed for client eligibility and compliance with timely filing, prior authorization requirements, PCP referral requirements, and coding errors.

Claims with completion errors are rejected. Errors are identified on the interactive rejection notice.

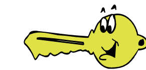
Rejected claims do not appear on the Medical Assistance Program Provider Claim Report (PCR).

You must correct the identified errors and resubmit the claim.



Providers do **not** need any additional software or equipment to use the Web Portal.

Providers do need internet access plus their State-assigned user names and passwords.



Web Portal Features

- Interactive eligibility verification through: 270 / 271 eligibility request and response transactions
- Interactive electronic claim submission and inquiry
- Electronic batch eligibility inquiry
- Electronic PCRs and batch response reports retrieval
- Electronic claim adjustments
- Electronic prior authorization submission and inquiry.
- Provider specialty lookup
- Dashboard on the Main Menu page
- A Claim Activity Tracing Report
- Purge Service

National Provider Identifier

If required, remember to register your NPI through the Web Portal or on paper with the fiscal agent.

Successful Billing

C Read coding information carefully and use the correct Medical Assistance Program coding reference.

Many coding references change every year.

Read coding information carefully. You must submit the code that most accurately describes the rendered service.

Be sure that you understand what the billing unit represents. If the description says daily care, the billing unit represents all of the care provided on a single day.

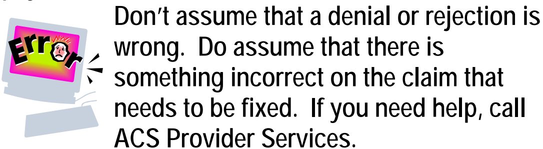
Combine multiple services rendered on a single day (same procedure code, same date) on a single claim line with multiple units of service and charges that represent the sum of the fees for the billed services.

D Don't Delay. File early and maintain timely filing compliance.

Timely filing for Colorado Medical Assistance Program claim submission is 120 days from the date of service.

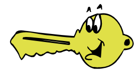
File claims early. Filing late in the timely filing period increases the risk of not being paid.

Promptly reconcile claim rejection reports and Provider Claim Reports. Responding to claim rejections and denials is as important as posting payments.



Don't assume that a denial or rejection is wrong. Do assume that there is something incorrect on the claim that needs to be fixed. If you need help, call ACS Provider Services.

Correct errors that cause claim rejection or denial and re-file quickly.



Collection Procedures

Medical Assistance Program clients are not financially responsible for the costs of Medical Assistance Program benefit services (except for Medical Assistance Program copay).

Providers cannot bill Medical Assistance Program clients for unpaid balances after the Medical Assistance Program reimbursement (except for Medical Assistance Program copay).

Providers cannot bill Medical Assistance Program clients if the Medical Assistance Program denies payment because program or billing requirements are not met.

Don't send Medical Assistance Program accounts to collection agencies.✱

Collection agencies cannot obtain payment from Medical Assistance Program clients or from the Medical Assistance Program fiscal agent.

Collection agencies cannot resolve claim filing errors.

✱Except for Medical Assistance Program copay, you may treat delinquent accounts for Medical Assistance Program copay in the same manner as accounts for non-Medical Assistance Program patients.

Medical Assistance Program Copayment

8 Collect Medical Assistance Program copay for services and clients that require copayment

You may not deny services if the client cannot pay the copay but you may bill the client for the copay and collect it later.

Copayment automatically is deducted from claim payments.

If you collect copayment and it is not deducted from your claim payment, you must return the copay to the client.

Copayment-Exempt Clients and Services

Clients who are ages 18 and under

Clients who are in the maternity cycle ★ — pregnancy and up to 6 weeks postpartum – services don't have to be pregnancy related

Clients in a nursing facility ★

OAP SO clients who have met their copay maximum of $300.00

Clients age 20 and under or 65 and older in mental institutions ★

Family planning services ★

Emergency services ★

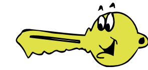
★ Submitted claims must properly be completed to claim these exemptions.

There is no longer a copayment maximum for Medical Assistance Program eligible clients.

Do's & Don'ts

Do...correctly complete claim information to identify copay-exempt family planning services, women in the maternity cycle, emergency services, nursing facility residents, and clients in mental institutions.

Don't...deduct copay from billed charges and don't show Medical Assistance Program copayment as a third party payment on the claim.



Copayment Requirements

Outpatient Hospital Services — $3.00 per visit

Physician (MD or DO) Home or Office visit — $2.00 per visit

Rural Health Clinic Visit – $2.00 per visit

Brief, individual, group, visit and partial care community mental health care visits (except services which fall under Home and Community Based Service Programs) — $2.00 per visit

Pharmacy Services (each prescription or refill)

Generic drugs — $1.00

Brand name and single-source drugs — $3.00

Optometrist visit — $2.00 per visit

Podiatrist visit — $2.00 per visit

Inpatient Hospital Services— $10.00 per covered day or 50% of the averaged allowable daily rate whichever is less. The average allowable daily rate can be calculated using the 'total allowed charge' for the entire stay divided by the 'calculated covered days'.

Psychiatric Services — $ .50 per unit of service (1 unit =15 minutes)

DME/Disposable Supply Services — $1.00 per date of service

Laboratory Services — $1.00 per claim

Radiology Services — $1.00 per claim

Answers to common Eligibility Questions

9 Answers to common questions about eligibility

Q How do I submit claims for individuals who say that their Medical Assistance Program eligibility is pending?

A Claims can't be paid until the individual has a Medical Assistance Program ID number.

Claims without a Medical Assistance Program ID number are rejected or denied. If you are waiting for assignment of the Medical Assistance Program number, check eligibility frequently using the individual's social security number. Bill quickly once eligibility is determined.

Q If a client consistently is unable to pay copay, do I have to continue to see the individual?

A You cannot refuse services if the individual is unable to pay copayment. You may apply the same collection procedures to collect copay from a Medical Assistance Program client that you apply to any individual who is delinquent on payments.

Q What if the client doesn't tell me about Medical Assistance Program eligibility until after the Medical Assistance Program timely filing period has expired?

A Be proactive. Be direct. Don't rely solely on the client to respond to billing notices. Always ask patients who will pay for services. Employ good reception and referral procedures and share information with referral sources. Remember to ask about backdated eligibility.

You may file the claim within 60 days of the date that you were first notified of Medical Assistance Program eligibility. The claim must be filed (received by the fiscal agent) within 365 days of the date of service. After 365 days, there is no allowance for late billing. Refer to the General Provider Information manual for special eligibility billing instructions. The General Provider Information manual is located at colorado.gov/hcpf ➡Providers ➡Provider Services ➡Billing Manuals.

Client Education

Who educates clients about Medical Assistance Program benefits and their responsibilities?

Medical Assistance Program clients receive information that describes their benefits and responsibilities from the county technician.

Medical Assistance Program clients who enroll in a managed care organization receive benefit information from the plan.

Clients may not always understand or remember the information explained to them and described in the eligibility brochure.

The special relationship between providers and their patients often places the provider in the best position to help clients understand Medical Assistance Program benefits and programs.

Successful Billing

10 The ABCs of successful billing

A Always verify eligibility before you provide services

The basic key to success is to obtain Medical Assistance Program eligibility information before services are rendered.

Be sure you understand the eligibility and benefit delivery programs that apply to the services you render.

Managed care requirements: If you find out about managed care enrollment after services are provided, you probably won't be paid for rendered services.

Benefit limits: Protect yourself by understanding eligibility benefit limits. Clients may not always understand benefits or referral requirements.

Bill other payers first. The Medical Assistance Program is the payer of last resort. Always pursue commercial health insurance benefits first.

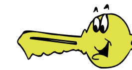
B Understand benefit information for the services you provide.

Understand prior authorization requirements. If prior authorization is required, get approval before you provide services.

Understand special consent requirements. Sterilizations and hysterectomies require special consent forms. Understand the forms and the signature requirements.

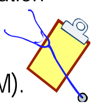
Sterilization Consent forms are located on the Department's Web site at colorado.gov/hcpf ➡Providers ➡Provider Services ➡Forms.

The Acknowledgment/Certification Statement for a Hysterectomy is located at colorado.gov/hcpf ➡Providers ➡Provider Services ➡Billing Manuals ➡Appendices.



Coding References

All providers use the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD9-CM).

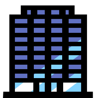


Coding

Used for practitioner, dental (ADA codes), community-based services, supply, durable medical equipment, laboratory, radiology, and transportation services.

The Centers for Medicare and Medicaid Services (CMS, Common Procedural Coding System (HCPCS) includes:

- Codes in *Physicians' Current Procedural Terminology* (CPT), revised annually
- CMS developed codes
- The Medical Assistance Program publishes HCPCS codes in bulletins annually



Institutional Coding

Use UB-04 revenue codes, ICD-9 surgical codes, and HCPCS codes published in Medical Assistance Program HCPCS bulletins, UB-04 specialty billing manuals and in the Billing Manual Appendices