COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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January 2010 Colorado Medicaid Fee Schedule Instructions

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CPT or HCPCS Procedure Code

The CPT or HCPCS procedure code is listed in this column, and the table is sorted in procedure code order beginning with HCPCS codes.

Code descriptions are not contained in this file. CPT codes, descriptions and other data only are copyright 2010 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.

Procedure Code Modifier

CPT and HCPCS procedure code modifiers are listed in this column. For example, radiology services may be billed using a modifier for the technical component of the procedure (modifier TC), the professional component of the procedure (modifier 26), or the total procedure (modifier field left blank.)

Relative Value

The relative value of a procedure is the first part of the formula used to determine the maximum allowable reimbursement. It also represents the relative value of the procedure when compared to other similar procedures.

Conversion Factor

The conversion factor is the second part of the formula used to determine the maximum allowable reimbursement. Colorado Medicaid uses 6 conversion factors as listed below:

Description	Amount Effective 1/1/10
Anesthesia	20.53
Medical	2.73
Surgery	33.05
Anatomical Lab	7.84
Radiology	7.55
Fee Schedule	1.00

Total CO Medicaid Allowable

The total Colorado Medicaid allowable reimbursement amount is listed in this column. (Total allowable equals the Relative Value x the Conversion Factor.) Codes that are manually priced by invoice, by MSRP, or on a claim-by-claim basis by the Colorado Medicaid fiscal agent (ACS) are marked “code is manually priced”. Codes that are not benefits of the Colorado Medicaid program are marked “not a benefit”. Codes that are available at no cost to providers through the Colorado Department of Public Health and Environment Vaccines for Children or Colorado Immunization programs are marked “available through VFC”.

Min Age / Max Age

The two columns -- one headed "Min Age" and one headed "Max Age" --- indicate the ages during which the procedure is considered a benefit for Medicaid clients. “000-999” means the procedure code is a benefit for clients of any age.

Post Op Days

The column headed “Post Op Days” indicates the number of days, including and following the date of service, during which care provided for the same diagnosis indicated for the rendered surgical procedure, must be provided as inclusive in the reimbursement for that surgical procedure.

Prior Authorization Needed

The column headed “Prior Authorization Needed” indicates whether or not a given procedure or service must be prior authorized. “Sometimes” means that under some circumstances a service may not require prior authorization while, under other circumstances, it does. For example, many wheelchair component parts do not require prior authorization when they are being used as part of a repair, but when requested with a new wheelchair, they must be authorized in advance.