Provider Bulletin

Reference: B1100298 **March 2011**

colorado.gov/hcpf

In this issue:

All Providers 1
Update on Payment Delay 1
CLIA Update 1
Lower of Pricing 1
Web Portal News 2
W-9 Process 2
Medicaid Adjustments 3
Refunds and Returned Warrants 3
New Electronic Prior Authorization Request (PAR) Form 3
Dual Eligibles 3
Record Retention 3
November 2010 Enrollment Application 4
Dental Providers 4
Unsolicited Diagnostic Casts 4
Dental PARs 4
2011 Dental Program Policy and Billing Bulletin 4
FQHC Providers 4
New Value for 837 Institutional Facility Type Code Field 4
Pharmacy Providers 5
Next P&T Committee Meeting 5
PDL Update 5
Benefits Collaborative Meetings 5
DUR Board Updates 5
Appropriate use of PPIs 6
March & April Workshops 6
Refund to Medicaid or Return Warrant Form .... Attachment A

ACS A xerox Company

Denver Club Building
518 17th Street, 4th floor
Denver, Colorado 80202

ACS Contacts

Billing and Bulletin Questions
1-800-237-0757 or 1-800-237-0044

Claims and PARs Submission
P.O. Box 30
Denver, CO 80201

Correspondence, Inquiries, and Adjustments
P.O. Box 90
Denver, CO 80201

Enrollment, Changes, Signature authorization and Claim Requisitions
P.O. Box 1100
Denver, CO 80201

Did you know...?

An updated 837P Companion Guide has been posted in the Provider Services Specifications section of the Web site. The updated Companion Guide provides CLIA specifications for your billing system.
Detailed information about CLIA and answers to many provider questions can be found at http://www.cms.gov/clia/

All Providers

Update on Payment Delay

The proposed provider payment delay noted in the November 2010 provider bulletin (B1000290) is moving through the legislative process. The Department of Health Care Policy and Financing (the Department) expects a decision is to be made soon after the March 21, 2011 economic forecast. We will let providers know the decision as soon as the information becomes available. Please click here for a fact sheet and the proposed payment schedule.

Clinical Laboratory Improvement Amendments (CLIA) Update

Hospitals

Providers billing for CLIA services via the 837 Institutional (837I) electronic format or the UB-04 paper claim form must provide updated CLIA certification information to the fiscal agent prior to March 31, 2011. On or about that date, current CLIA information will be purged from the Medicaid Management Information System (MMIS) and updated information will be entered. Beginning on or about May 1, 2011, CLIA claims from providers billing via the 837I or UB-04 (hospitals) will be **denied** unless updated CLIA information has been received by the fiscal agent, ACS. See the CLIA Update Form under Update Forms in the Provider Services Forms section of the Department's Web site at colorado.gov/hcpf.

Laboratories, Clinics and Other Providers that Bill for CLIA Services

Beginning on or about May 1, 2011, providers billing for CLIA services via the 837 Professional (837P) electronic format or the Colorado 1500 paper claim form will need to provide their CLIA number on the claim or claim line. Providers billing via the 837P format should note that an updated 837P Companion Guide has been posted in the Provider Services Specifications section of the Department's Web site. This guide documents the specifications for electronic submission of claims containing CLIA numbers (see pages 30 and 37). Providers and billing agents should consider updating their billing systems for 837P transactions as soon as possible. Providers using the Colorado Medical Assistance Program Web Portal (Web Portal) to submit CLIA claims should refer to the February 2011 provider bulletin (B1100296) for instructions on submitting CLIA numbers via the Web Portal.

Lower of Pricing Logic (LOPL)

In the past, procedure codes for some medical tests and supplies on Medicare crossover claims were exempted by the Colorado Medicaid Program from Medicare LOPL. If exempted from LOPL, Medicaid may have paid for Medicare co-insurance or deductible, as described in the General Provider Information manual in the Provider Services Billing Manuals section of the Department's Web site.

Beginning on January 15, 2011, providers may have noticed that all procedure codes on Medicare crossover claims were processed as non-exempt from LOPL.

This change was implemented after the Department was informed that exemption of procedure codes may not comply with state and federal regulations. Within the next few weeks, the Department will complete an analysis to temporarily reinstate LOPL processing for some procedure codes. Claims will be reprocessed after the required analysis.

In the future, changes in rates and processing as part of the implementation of the National Correct Coding Initiative (NCCI) will likely eliminate the need for exemption from Medicare LOPL. Please contact ACS Provider Services with any questions at 1-800-237-0757 or 1-800-237-0044 Monday through Friday, 8:00 A.M. to 5:00 P.M. Mountain Time.

Web Portal News

Training Material Updates

The training presentations on claims submission via the Web Portal have been updated. These presentations are given by the fiscal agent for the MMIS in conjunction with the provider billing classes. Some of the revisions to these presentations include updating information on the Trading Partner Administrator (TPA), and adding screen shots to clarify the roles available to the TPA and the regular users.

In addition, an *Understanding User Names & Roles* job aid was created to clarify the differences between the TPA user and the regular user. It also has information on what each role will allow the user to access in the Web Portal.

The three claims presentations (837 Institutional, Dental, and Professional) and the *Understanding User Names & Roles* job aid are all available for download from the Provider Services Training & Workshops section of the Department's Web site.

In the near future, all of the Web-Based Trainings (WBTs) that are available through the Web Portal will also be updated to reflect new content and provide more detail to users. These WBTs can be accessed by any user with an active login User Name and Password for the Web Portal. These WBTs provide users with the functionality available in the Web Portal, but do not provide information on proper billing procedures.

Users with questions regarding Web Portal functionality should contact the CGI Help Desk at 1-888-538-4275, option 1 or HelpDesk.HCG.Central.us@cgi.com. Users with questions regarding claims processing and proper billing procedures should contact ACS Provider Services at 1-800-237-0757 or 1-800-237-0044 with questions.

Billing Agencies/Agent Requesting Provider Password Resets

Billing agencies/agents do not have the authority to request password resets for User Names assigned to providers for accessing the Web Portal. Billing agencies/agents are issued their own Trading Partner ID for purposes of billing on behalf of the provider, and should be prepared to identify themselves as individuals who are submitting claims on behalf of a provider when they call the help desk for a password reset.

W-9 Process

In order to better serve our providers, the Department is making a few changes to the way we process W-9 updates for address changes and Automatic Clearing House (ACH)/Electronic Funds Transfer (EFT) requests. Effective immediately, any changes for W-9 address changes or ACH/EFT requests are to be emailed to hcpfar@state.co.us or faxed to 303-866-3669. Please note this only affects changes to existing accounts. This change will allow us to send you updates in a timely manner.

If you are submitting a new enrollment package, the Authorization Agreement for Automatic Deposits (ACH Credits) form must be included in the documentation you submit to ACS Provider Enrollment.

If you have any questions or concerns, feel free to send inquiries to the email address noted above.

Medicaid Adjustments

Effective April 1, 2011, all adjustments must be submitted on the most current Adjustment Transmittal form indicating a revision date of 12/10 and include a replacement claim. The fiscal agent will not process adjustments submitted on older versions of the Adjustment Transmittal form, adjustments submitted without the Adjustment Transmittal form, or adjustments submitted without a replacement claim. These will be returned to the providers. To download the current Adjustment Transmittal form, go to Other Forms in the Provider Services Forms section and click on Adjustment Transmittal Form with Instructions.

Medicaid Refunds and Returned Warrants

Effective immediately, refund to Medicaid checks and returned warrants will be returned to the provider if the Medicaid Client ID, Billing Provider Medicaid ID number, and date of service are not submitted with the check or returned warrant. Checks or warrants will also be returned to the provider if any of the required information submitted is invalid or incomplete.

Effective May 1, 2011, all refund to Medicaid checks and returned warrants must be submitted on the Refund to Medicaid or Returned Warrant form with a revision date of 02/2011. The fiscal agent will not process refund to Medicaid checks or returned warrants without the completed Refund to Medicaid or Returned Warrant form. The Refund to Medicaid or Returned Warrant form must include a valid Transaction Control Number (TCN) or Medicaid Client ID, Billing Provider Medicaid ID number, and date of service. Refund to Medicaid checks or returned warrants will be returned to providers who do not submit the required Refund to Medicaid or Returned Warrant form or if the Refund to Medicaid or Returned Warrant form is missing required information or is illegible.

The new Refund to Medicaid or Returned Warrant Form is available as Attachment A to this bulletin and under Other Forms in the Provider Services Forms section of the Department's Web site.

Please contact ACS Provider Services at 1-800-237-0757 or 1-800-237-0044 with questions.

New Electronic Prior Authorization Request (PAR) Form

The Department is pleased to announce a new electronic interactive PAR form is now available. The interactive PAR form can be completed online. The Electronic PAR Form is located under Prior Authorization Request Forms in the Provider Services Forms section of the Department's Web site. Once completed, the form can be printed and mailed to ACS at P.O. Box 30, Denver, CO 80201. Please note that the use of this form does not alter paper PAR submission criteria. Please contact ACS Provider Services at 1-800-237-0757 or 1-800-237-0044 with questions.

Dual Eligibles

Providers are reminded that Medicaid is always the payer of last resort, therefore, services for dual-eligible clients - those with coverage from Medicare and Medicaid - must be billed first to Medicare.
Please refer to the December 2008 provider bulletin (B0800255) for an example of exceptions for Home Health services.

Providers must be able to show evidence that claims for dual eligible clients, where appropriate, have been denied by Medicare prior to submission to the Colorado Medical Assistance Program.
Per the Provider Participation Agreement, this evidence must be retained for six years following the Medicare denial.

The Colorado Medical Assistance Program requires that the Medicare Standard Paper Remit (SPR) accompany any paper claims for dual-eligible clients which are submitted for reimbursement.
Please contact ACS Provider Services at 1-800-237-0757 or 1-800-237-0044 with questions.

Record Retention

Providers must maintain records that fully disclose the nature and extent of services provided. Upon request, providers must furnish information about payments claimed for Colorado Medical Assistance Program services. Records must substantiate submitted claim information. Such records include but are not limited to:

- Treatment plans
- Prior authorization requests
- Medical records and service reports
- Records and original invoices for items, including drugs that are prescribed, ordered, or furnished

- Claims, billings, and records of Colorado Medical Assistance Program payments and amounts received from other payers

Each medical record entry must be signed and dated by the person ordering and providing the service. Computerized signatures and dates may be applied if the electronic record keeping system meets Colorado Medical Assistance Program security requirements.

Records must be retained for at least six years or longer if required by regulation or a specific contract between the provider and the Colorado Medical Assistance Program.

Only the November 2010 Version of the Provider Enrollment Application is Now Accepted

Beginning March 1, 2011, the fiscal agent will only accept the November 2010 version of the Provider Enrollment Application. The revision date is located in the bottom left corner of the application pages. Please refer to the February 2011 provider bulletin (B1100296) for more information.

Dental Providers

Unsolicited Diagnostic Casts

Please note this reminder: no dental provider, including orthodontists, should send diagnostic casts or study models to ACS unless requested to do so by the ACS dental consultant. All unsolicited diagnostic casts will not be returned to the provider and will be disposed of by ACS. If you have questions, please contact Marcy Bonnett at Marcy.Bonnett@state.co.us or 303-866-3604.

Dental Prior Authorization Requests (PARs)

Dental providers submitting dental PARs must submit PARs on the American Dental Association (ADA) 2006 form using their **billing** provider number in field 52A, *Billing Dentist Provider ID Number*. Check dental PARs carefully prior to submitting for approval. Verify that all tooth numbers and procedure codes are accurate and that the **billing** provider number is entered in field 52A. This may prevent the submitted PAR from being denied due to administrative errors. It is extremely important that providers review the most current dental provider bulletins listing the PAR requirements for each dental procedure.

2011 Dental Program Policy and Billing Bulletin

The February 2011 Dental Program Policy and Billing provider bulletin (B1100297) is posted in the Provider Services Provider Bulletins section of the Department's Web site. 2011 HCPCS/Procedure Codes bulletins are posted on the Web site as they are completed. Continue to check the Provider Services Provider Bulletins section of the Department's Web site for updated 2011 HCPCS/Procedure Codes bulletins.

Federally Qualified Health Center (FQHC) Providers

New Value for 837 Institutional Facility Type Code Field

On February 15, 2011, a new valid value option was added to the Facility Type Code drop-down field on the Client's Info tab for all 837I claims. This new value is **77-FQHC ASC**, and it is for a new Type of Bill (TOB) 77X. Users will select this field value for Institutional claims when the Facility is a Federally Qualified Health Center (FQHC).

Please recall that the numbers of the Facility Type Code make up the first two digits of the TOB, and that the last digit of the TOB is pulled from the number for the Frequency Type Code.

The new 77X TOB will be activated for FQHC claims that are billed with the Provider Type of 32-Federally Qualified Health Center. The claim will be assigned a Claim Type of O-Medicare Part B of A Crossover.

Questions regarding the proper use of the new value for the Facility Type Code field, or on the new 77X TOB should be directed to ACS Provider Services at 1-800-237-0757 or 1-800-237-0044.

Billing Information for FQHC Providers

Claims submitted on the UB04 claim form and by electronic batch can also use the TOB range 771-774 and 777-778. The claim will be assigned a Claim Type of O-Medicare Part B of A Crossover. Claims that are automatically sent to the MMIS from Medicare will process correctly and no longer require separate billing by the provider.

Pharmacy Providers

Next P&T Committee Meeting

Tuesday, April 5, 2011
1:00 P.M. - 5:00 P.M.
This meeting will be held at 225 E. 16th Avenue, Denver, CO 80203
1st Floor Conference Room

Preferred Drug List (PDL) Update

Effective April 1, 2011, the following medications will be preferred agents on the Medicaid PDL and will be covered without a prior authorization:

Alzheimer's Agents
Aricept tabs and ODT, donepezil tabs and ODT, galantamine IR and ER
****Namenda is non-preferred, but will be available without prior authorization for clients with the diagnosis of dementia of Alzheimer's type. The diagnosis code should be documented on the prescription so that it can be submitted on the pharmacy claim.*

Atypical Antipsychotics
Abilify, clozapine, Clozaril, Geodon, risperidone, Risperdal, Saphris, Seroquel (IR only) and Zyprexa tabs (Zydis will be non-preferred)
****Grand fathering will be approved for up to two years for clients currently stabilized on a non-preferred atypical antipsychotic if medically necessary. Please see PDL for individual drug criteria.*

Growth Hormones
Norditropin, Omnitrope and Saizen

Intranasal Corticosteroids
Fluticasone (generic Flonase) and Nasacort AQ

Leukotriene Modifiers
Singulair

Multiple Sclerosis Agents
Avonex, Betaseron, Copaxone and Rebif

Ophthalmic Allergy Agents
cromolyn, Patanol, Pataday and Zaditor

Sedative/Hypnotic Agents
Lunesta, zaleplon and zolpidem tablets (zolpidem CR is non-preferred)

Statins and Statin Combinations
Crestor, Lipitor, pravastatin and simvastatin

The complete PDL and prior authorization criteria for non-preferred drugs are posted in the Pharmacy Preferred Drug List (PDL) section of the Department's Web site.

For questions or comments regarding the PDL contact Jim Leonard at Jim.Leonard@state.co.us.

March 2011 Benefits Collaborative Meetings

- March 2 – Radiology Services
- March 11 – Transportation Services
- March 16 – Power Mobility Devices & Seat Lifts, Patient Lifts, and Standing Devices
- March 25 – Physical Therapy and Occupational Therapy

For more information about the Benefits Collaborative, go to: colorado.gov/hcpf, click "Boards & Committees," and then click "Benefits Collaborative." Should you have any questions or would like additional information, please feel free to contact Sheeba Ibidunni at sheeba.ibidunni@state.co.us or 303-866-3510.

Drug Utilization Review (DUR) Board Updates

The DUR Board would like to welcome Dr. Karen Weber, D.O., FACP, as our newest Board member. She comes to us from Exempla St. Joseph Hospital, and we are confident that her background will provide an asset to our Board.

Due to terms expiring in April 2011, we are currently looking for qualified applicants to serve on our DUR Board. We are seeking a representative from the pharmaceutical industry and there may be openings for physicians or pharmacists that wish to serve.

The members of the DUR Board shall have recognized knowledge and expertise in one or more of the following:

1. The clinically appropriate prescribing of covered outpatient drugs;
2. The clinically appropriate dispensing of covered outpatient drugs;
3. Drug use review, evaluation, and intervention;
4. Medical quality assurance.

To submit a CV or for additional information, please contact Jim.Leonard@state.co.us or visit the Pharmacy Drug Utilization Review (DUR) Board section of the Department's Web site.

Appropriate use of Proton Pump Inhibitors (PPI)

PPI Quantity Limits

Prior authorization will be required for proton pump inhibitor therapy beyond 100 days. Prior authorization will be approved for clients with Barrett's Esophagus, Erosive Esophagitis, GI Bleed, Hypersecretory Conditions (Zollinger Ellison), or Spinal Cord Injury clients with any acid reflux diagnosis.

In addition, clients with documented continuation of symptomatic GERD or recurrent peptic ulcer disease who have documented failure on step down therapy to an H2-receptor antagonist (of at least two weeks duration) will be approved for up to one year of daily PPI therapy.

March and April 2011 Provider Billing Workshops

Denver Provider Billing Workshops

Provider billing workshops include both Colorado Medical Assistance Program billing instructions and a review of Colorado Medical Assistance Program billing procedures.

The March and April 2011 workshop calendars are included in this bulletin and are also posted in the Provider Services Training & Workshops section of the Department's Web site.

Who Should Attend?

New and experienced receptionists, front desk personnel, admission personnel, office managers, billing services, and other billers should consider attending the appropriate workshops.

Reservations are required

Reservations are necessary for ***all workshops***.
Email reservations to:
workshop.reservations@acs-inc.com

Or

Call Provider Services to make reservations:
1-800-237-0757 or 1-800-237-0044

Press "**5**" to make your workshop reservation. You must leave the following information:

- Colorado 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

All this information is necessary to process your reservation successfully. Look for your confirmation by mail within one week of making your reservation.

Reservations will only be accepted until the Friday before the training workshop. This will assure that there is space available and enough training materials.

If you have not received a confirmation within at least two business days prior to the workshop, please contact Provider Services and talk to a Provider Relations Representative.

All Workshops held in Denver are located at:

ACS
Denver Club Building
518 17th Street, 4th floor
Denver, Colorado 80202

Beginning Billing Class Description

These classes are for new billers, billers who would like a refresher, and billers who would like to network with other billers about the Colorado Medical Assistance Program. Currently the class covers in-depth information on resources, eligibility, timely filing, reconciling remittance statements, and completion of the UB-04 and the Colorado 1500 paper claim forms.

*The Beginning Billing classes do **not** cover any specialty billing information.*

The fiscal agent provides specialty training throughout the year in their Denver office.

Classes do not include any hands-on computer training.

Provider Enrollment Application Workshop

This workshop focuses on the importance of correctly completing the Colorado Medical Assistance Program Provider Enrollment Application. Newly enrolling providers, persons with the responsibility for enrolling providers within their groups, association representatives, and anyone who wants to better understand the Colorado Medical Assistance Program enrollment requirements should attend.

March and April 2011 Specialty Workshop Class Descriptions

Dental

The class is for billers using the 2006 ADA/837D claim format. The class covers billing procedures, claim formats, common billing issues and guidelines specifically for the following provider types: Dentists, Dental Hygienists

FQHC/RHC

This class is for billers using the UB-04/837I and Colorado 1500/837P formats. The class covers billing procedures, Encounter Payments, common billing issues, and guidelines specifically for FQHC/RHC providers.

HCBS-BI

This class is for billers using the Colorado 1500/837P claim format for the following services: adult day care, non-medical transportation, home electronics, home modifications and personal care. The class covers billing procedures, common billing issues, and guidelines specifically for HCBS-BI providers.

HCBS-EBD

This class is for billers using the Colorado 1500/837P claim format for the following services: adult day care, non-medical transportation, home electronics, home modifications and personal care. The class covers billing procedures, common billing issues, and guidelines specifically for the following provider types:
HCBS-EBD HCBS-PLWA HCBS-MI

HCBS-DD

This class is for billers who bill on the Colorado 1500/837P claim format for the following: Comprehensive Services (HCBS-DD), Supported Living Services (SLS), Children's Extensive Support (CES), Children's Residential Habilitation Program (CHRP) and Targeted Case Management (TCM). The class covers billing procedures, common billing issues, and guidelines for HCBS-DD providers.

IP/OP Hospital

This class is for billers using the UB-04/837I format. The class covers billing procedures, common billing issues, and guidelines specifically for In-patient Hospital and Out-patient Hospital providers.

Occupational, Physical and Speech Therapy

This class is for billers using the Colorado 1500/837P claim format for therapies. The class covers billing procedures, common billing issues and guidelines specifically for Occupational, Physical and Speech Therapists providers.

Transportation

This class is for emergency transportation providers billing on the Colorado 1500/837P and/or UB-04/837I formats. The class covers billing procedures, common billing issues, and guidelines specifically for Transportation providers.

Vision

This class is for ophthalmologists, optometrists, and opticians billing on the Colorado 1500/837P claim format. The class covers billing procedures, common billing issues, and guidelines specifically for practitioners providing vision services.

Driving directions to ACS, Denver Club Building, 518 17th Street, 4th floor, Denver, CO:

Take I-25 toward **Denver**.
Take exit **210A** to merge onto **W. Colfax Ave. (40 E),** 1.1 miles.
Turn **left** at **Welton St.,** 0.5 miles.
Turn **right** at **17th St.,** 0.2 miles.
The Denver Club Building will be on the right.

ACS is located in the Denver Club Building on the west side of Glenarm Place at 17th Street (Glenarm is a two-way street).

Parking: Parking is not provided by ACS and is limited in the downtown Denver area.

Providers attending workshops are urged to carpool and arrive early to secure parking or use public transportation.

= **Light Rail Station -** A Light Rail map is available at: http://www.rtd-denver.com/LightRail_Map.shtml.

= **Free MallRide -** The MallRide stops are located at every intersection between Civic Center Station and Union Station.

= **Commercial Parking Lots** - Lots are available throughout the downtown area. The daily rates are between $5 and $20.

Please note: Email all WebEx training reservations to workshop.reservations@acs-inc.com.

A meeting notification containing the Web site, phone number, meeting number, and password will be emailed or mailed to providers who sign up for WebEx.

March 2011

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		1	2	3	4	5
6	7	8 Beginning Billing – CO -1500 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM OT/PT/ST 1:00 PM-3:00 PM	9 Beginning Billing – UB-04 9:00 AM-11:30 AM Web Portal 837I 11:45 AM-12:30 PM IP/OP Hospital 1:00 PM-3:00 PM	10 Provider Enrollment 9:00 AM-11:00 AM Dental (WebEx) 1:00 PM-4:00 PM	11 Vision 9:00 AM-11:00 AM HCBS-DD (WebEx) 1:00 PM-4:00 PM	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

April 2011

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
					1	2
3	4	5	6	7	8	9
10	11	12 Beginning Billing – CO -1500 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM Transportation 1:00 PM-3:00 PM	13 Beginning Billing – UB-04 9:00 AM-11:30 AM Web Portal 837I 11:45 AM-12:30 PM FQHC/RHC 1:00 PM-3:00 PM	14	15 Beginning Billing – CO -1500 9:00 AM-11:00 AM HCBS-EBD 11:00 AM-1:00 PM HCBS-BI 1:00 PM-2:30 PM HCBS-DD 3:00 PM-4:30 PM	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

Please direct questions about Colorado Medical Assistance Program billing or the information in this bulletin to
ACS Provider Services at 1-800-237-0757 or 1-800-237-0044.
Please remember to check the Provider Services section of the Department's Web site at colorado.gov/hcpf.

FISCAL AGENT FOR
The Colorado Medical Assistance Program

ACS
A xerox Company

P.O. BOX 30
DENVER, CO 80202

Refund to Medicaid or Returned Warrant

Complete a form for each claim or client ID and include the following:
1) A copy of the Provider Claim Report (PCR) showing payment or
2) Medicare/TPL - A copy of the SPR
Note: **Transaction Control Number (TCN) is required; if TCN is not available the following must be submitted with form;
*Medicaid Client ID, *Billing Provider Medicaid ID Number and *Date of Service. If Claim is older than 3 years provide paid date if available.
Do not use to adjust denied claims

Provider Name	
Street Address (Address used to Return to Provider)	
City, State, Zip Code	
Telephone Number	
Return to Provider: Checks or Returned Warrants and all associated documents will be returned if all <u>required information</u> is not supplied for processing. No Exceptions.	
REQUIRED INFORMATION:	
Transaction Control Number (TCN) 17 or 14 digits. Do not use to adjust denied or already voided claims.**	
***If TCN is not available the following must be submitted with form:**	
*Medicaid Client ID	*Billing Provider Medicaid ID Number
*Date of Service	Provider Claim Report Date if available
Paid Date: If Claim is older than 3 years provide claim paid date if available.	
Three-digit reason code indicating the reason for the Adjustment (required):	
☐ 406 billing error – Payment adjustment. Must include amount to be taken back: **$**_____	
☐ 412 claim credit (recovery) – This will void the entire claim and produce a take back for the entire amount.	
Date	By (Provider Signature)
FISCAL AGENT USE ONLY	
Reply (notes) and RTP reason	
Unarchive required ☐ Yes ☐ No	

Form #201101 (02/2011)

Directions for Completing the Form

The form must be completed correctly and legibly. **Do not use the form to adjust denied or already voided claims. This form is used to adjust paid claims only.** Read the information on the face of the form to assure proper completion. Each requires all of the following:

- A copy of the PCR showing the incorrect payment. Please highlight the claim to be adjusted on the PCR.
- A separate form for each claim or Medicaid client ID must be submitted unless there are more than 10 claims to be adjusted or voided. If there are more than 10 claims to be adjusted or voided see next bullet for processing requirements.
- If more than 10 claims need to be adjusted or voided please phone **303-534-8303** and leave contact information. An electronic document will be required with the following information: 1) TCN with refund amount for each claim or 2) Medicaid client ID, billing provider Medicaid ID number, date of service and paid date if available.

Form Instructions:

FIELD LABEL	INSTRUCTIONS
PROVIDER NAME, ADDRESS, AND TELEPHONE NUMBER	Enter the name, address, and telephone number of the provider requesting the adjustment.
TRANSACTION CONTROL NUMBER (TCN)	Enter the 17-digit or 14 digit (Pharmacies only) TCN for the claim being adjusted exactly as it appears on the PCR.
MEDICAID CLIENT ID	Enter the client's state identification number as it appears on the Provider Claim Report (PCR).
BILLING PROVIDER MEDICAID ID NUMBER	Enter the eight-digit Medical Assistance Program provider number assigned to the billing provider.
DATE OF SERVICE	Enter the date of service as shown on the PCR.
PROVIDER CLAIM REPORT DATE	Enter the run date of the PCR if available.
PAID DATE	If claim is older than 3 years provide claim paid date if available.
THREE-DIGIT REASON CODE	Check the appropriate three-digit reason code for the adjustment.
DATE/BY	Enter the authorized signature and date signed. An adjustment represents a claim amendment and is subject to the same signature and date requirements as any claim. If the form is not signed and dated, the form and all associated documents will be returned to the provider.
FISCAL AGENT USE ONLY	DO NOT mark or write in this space. This area is used by the fiscal agent for a reply to the provider.