COLORADO INDIGENT CARE PROGRAM

FISCAL YEAR 2013-14 MANUAL

SECTION II:

DATA COLLECTION

EFFECTIVE: JULY 1, 2013

TABLE OF CONTENTS

ARTICLE I.	PROGRAM OVERVIEW	1	
Section 1.01	Program Definition	1	
Section 1.02	Requirements for Participating CICP Providers	1	
Section 1.03	Client Eligibility	1	
Section 1.04	Prior Authorization Requirements		
ARTICLE II.	BILLING INFORMATION	3	
Section 2.01	Definitions	3	
Section 2.02	Provider Billing Information	3	
Section 2.03	Summary Format	4	
Section 2.04	Timely Filing Requirement	4	
Section 2.05	Retention of Billing Records	5	
Section 2.06	Third-party Insurance	5	
ARTICLE III.	DATA COLLECTION SYSTEM - SUMMARY FORMAT	6	
Section 3.01	Definition	6	
Section 3.02	Field Description	6	
Section 3.03	Outpatient Visits	9	
Section 3.04	Unduplicated Client Count	10	
Section 3.05	Verify Accuracy of Subset Data	10	
Section 3.06	Summary Information Format	10	
Section 3.07	File Description	17	
Section 3.08	Filing Requirements	17	
Section 3.09	Provider Summary Data Submission Extension or Waiver Request	18	
Section 3.10	E-Mail Submission Requirements	18	
ARTICLE IV.	OUTPATIENT PHARMACEUTICAL	19	
Section 4.01	Definition	19	
Section 4.02	Declaring Pharmaceutical Charges	19	
Section 4.03	Filing Requirements	19	
ARTICLE V.	PHYSICIAN CHARGES	21	
Section 5.01	Definition	21	
Section 5.02	File Description	21	
Section 5.03	Filing Requirements	22	
ARTICLE VI.	PREVIOUSLY CHARGED CLAIM ADJUSTMENTS	23	
Section 6.01	General Information	23	
Section 6.02	Reporting Requirements	23	
Section 6.03	Filing Requirements	24	
ARTICLE VII	CICP INFORMATION	25	
Section 7.01	CICP Website	25	
Section 7.02	Department Contact Information:	25	
	COUNTY CODES	26	

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-Child Health Plan *plus* (CHP+) eligible individuals who are uninsured or underinsured. The Colorado Department of Health Care Policy and Financing (Department) administers the CICP.

Section 1.02 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 (DPHE).
- 2. A federally qualified health center, as defined in section 1861 (as) (4) of the federal "Social Security Act", 42 U.S.C sec. 1395x (as) (4);
- 3. A rural health clinic, as defined in section 1861 (aa) (2) of the federal "Social Security Act", 42 U.S.C sec. 1395x (aa) (2);
- 4. Assures that emergency care is available to all CICP clients throughout the contract year;
- 5. 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. has granted waiver exclude the provide even if that client re	s to limit medical s or from supplying re-	services to a spec quired emergency	ific area or county care at a discount t	. Waivers do not

ARTICLE II. BILLING INFORMATION

Section 2.01 Definitions

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

County Codes: County codes are used to track patient visits. Providers should include the patient's county code on the CICP discount card.

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. The CICP will reimburse for contractual adjustments.

Section 2.02 Provider Billing Information

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

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 Department 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 the 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 CICP. An example of this contract is provided in Section VII, Sample Participating Physician Contract, of this CICP Manual. Physicians cannot bill the CICP 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 Department on the Provider Application of the intent to bill for physician charges.

Section 2.03 Summary Format

The CICP Data Collection System – Summary Format includes the specifications on how providers must submit billing information to the Department. There is no electronic or paper submission of claims. The information is requested so that the Department 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 Department 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 sent to the Department as an e-mailed attachment.

Section 2.04 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 Department 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 202-13 (July 1, 2012 - June 30, 2013) all billing information must be received by the Department by October 31, 2013 It is imperative that final billing data be submitted annually by October 31st, to allow the Department adequate time for completion of the CICP Annual Report due to the Colorado General Assembly each year.

CICP FY 2013-14 Manual – Data Collection Rev. 6/30/13

Section 2.05 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 six 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 Department. Providers must keep the claim detail for a period of six State fiscal years to justify the information submitted to the Department.

Section 2.06 Third-party Insurance

If the client has third-party insurance, including Medicare, the provider will bill the commercial health insurance policy first for all medical expenses incurred. 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: Sin	mple Third-party Payment with CICP as Secondary Payer	
<u>-\$100.00</u>	Medical bill (Total Charges Billed to Client's Commercial Health Plan) Minus Payment Due from Client's Commercial Health Plan Equals Hospital Charges Remaining	
	Minus Client's CICP Copayment	
Charges Reporte	ed to CICP	
Total Charges Pa \$150.00	\$25.00 \$\frac{3^{rd} Party Liability}{\$100.00}\$ \$\frac{\text{Write-Off Charges}}{\$25.00}\$	

Example #2: Mo	edicare Third-party Payment with CICP as Secondary Payer
\$150.00 -\$100.00	Medical bill –(Total Charges Billed to Medicare) Minus Payment Due from Medicare
\$50.00	Equals Hospital Charges Remaining
\$50.00	Hospital Charges Remaining
\$25.00	Minus Client's CICP Copayment
\$25.00	Allowable Write-Off Charges Reported to CICP

Rev. 6/30/13

Charges Reported to CICP

Total Charges Patient Liability \$3^{rd}\$ 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 Department shall receive 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 Department.

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 3 rd 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 3 rd 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	

CICP FY 2013-14 Manual – Data Collection

Rev. 6/30/13

Outpatient Non-Urgent & Non-Emergency	Bill Type* is Outpatient
Charges	131, 134
Charges	
	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	Hospitals Only
Charges	Bill Type* is Inpatient
Charges	111, 114
	121, 124
	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	Hospitals Only
Rating	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
	11, 11, D, C, D, L, 1, O, 11, 1 Of L

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

^{*}Listed bill types are only examples. The CICP accepts all bill types accepted by Colorado Medicaid, except interim claims. The 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 two inpatient admissions and six 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 <u>no</u> 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 Department. The template is available on the CICP Website (see Article VIII – CICP Information). Summary information must be e-mailed directly to: cicpcorrespondence@state.co.us

CICP FY 2013-14 Manual – Data Collection

An example template is as follows:

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	#
Total Number of Days	"
Number of Admissions by CICP Rating	"
·	#
Number of Admissions by CICP Rating	
Number of Admissions by CICP Rating A	#
Number of Admissions by CICP Rating A B	#
Number of Admissions by CICP Rating A B C	# # #
Number of Admissions by CICP Rating A B C D	# # #
Number of Admissions by CICP Rating A B C D E	# # # #
Number of Admissions by CICP Rating A B C D E	# # # #
Number of Admissions by CICP Rating A B C D E F	# # # # #
Number of Admissions by CICP Rating A B C D E F G	# # # # #

#

#

Unknown

Total

Number of Days	s by CICP Rating	
A		#
В		#
C		#
D		#
Е		#
F		#
G		#
N		#
Н		#
I		#
Z		#
Unkr	nown	#
Total		#
Number of Adm	nits by Age & Sex	
Male	nts by Age & Sex	
iviaic	0-5	#
	6-17	#
	18-24	#
	25-54	#
	55-64	#
	65+	#
To		#
10		"
Female		
	0-5	#
	6-17	#
	18-24	#
	25-54	#
	55-64	#
	65+	#
To	tal	#

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	#
В	#
C	#
D	#
E	#
F	#
G	#
N	#
Н	#
I	#
Z	#

CICP FY 2013-14 Manual – Data Collection Rev. 6/30/13

Unknov	vn	#
Total		
Number of Visit	s by Age & Sex	
Male		
	0-5	#
	6-17	#
	18-24	#
	25-54	#
	55-64	#
	65+	#
Tot	cal	#
Female	0.5	11
	0-5	#
	6-17	#
	18-24	#
	25-54	#
	55-64	#
	65+	#
Tot	al	#
Total		
Outpatient Char	ges by Age & Sex	
Male		
	0-5	#
	6-17	#
	18-24	#
	25-54	#
	55-64	#
	65+	#
Tot	al	#
Female		
	0-5	#
	6-17	#

18-24	#
25-54	#
55-64	#
65+	#
Total	#
Total	#

Unduplicated Patient Count

claims) by Age	
0-5	#
6-18	#
19+	#
Total	#

Total Number of Unique Clients Served (not

Total	Number	of	Unique	Inpatient	Clients
Serve	d (not cla	ims) 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	2 Alamosa	#
03	3 Arapahoe	#
04	Archuleta	#
05	5 Baca	#
06	6 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	#
	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	#
U	nknown	#
Total		#

Section 3.07 File Description

Excel Spreadsheet: A Microsoft Excel Spreadsheet is provided by the Department. 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 <u>year-to-date</u> information to the Department on the following time-line:

Quarter	Dates of Service	Due to Department
1^{st}	July 1 - September 30	October 31
2 nd	July 1 - December 31	January 31
3 rd	July 1 -March 31	April 30

CICP FY 2013-14 Manual – Data Collection

Rev. 6/30/13

4 th	July 1 - June 30	July 31
Final Yearly Report	July 1 - June 30	October 31

For FY 2013-14 (July 1, 2013 - June 30, 2014) providers will submit their 1st Quarter Report on October 31, 2013, covering the dates of service July 1, 2013 – September 30, 2013.

On October 31, 2013, providers will submit two reports: the Final Yearly Summary Report for FY 2012-13 covering the dates of service July 1, 2012 - June 30, 2013, and the 1st Quarter Report for FY 2013-14 covering the dates of service July 1, 2013 - September 30, 2013.

Section 3.09 **Provider Summary Data Submission Extension or Waiver Request**

Providers must seek an extension of the quarterly data submission's due date by written request. The request must include a reason for the request and the date the summary data will be completed. The request for an extension must be received by the Department within 30 days before the provider's quarterly summary data submission's due date.

Providers may submit a request to provide only the Final Yearly Summary Report (due October 31st). A waiver request must be submitted in writing to the Department explaining the reasons for not being able to maintain the quarterly reporting schedule. The waiver request will be reviewed by the Department and approved if proper justification is provided.

It is the responsibility of the provider to submit the request for extension or waiver to the Department at:

> **Department of Health Care Policy and Financing** Colorado Indigent Care Program - Summary Data 1570 Grant St. Denver, CO 80203-1818 or Ryan.Chrzan@state.co.us

Providers that fail to submit the quarterly summary data within the due dates specified in Section 3.08 while also failing to request an extension or waiver shall be considered out of compliance. Providers that are found out of compliance in the submission of the required summary data may be subject to penalty.

It is mandatory that final billing data be submitted annually by October 31st, to allow the Department adequate time for completion of the CICP Annual Report due to the Colorado General Assembly each year.

Section 3.10 **E-Mail Submission Requirements**

All quarterly and yearly summary data must be submitted by e-mail with the following information at the top of the spreadsheet:

18

- Provider Name
- Reporting Period

CICP FY 2013-14 Manual – Data Collection

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

ARTICLE IV. OUTPATIENT PHARMACEUTICAL

Section 4.01 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 Department prior to the start of the fiscal year of the intent to bill for Outpatient Pharmaceuticals on the Provider Application.

Section 4.02 Declaring Pharmaceutical Charges

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

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

Section 4.03 Filing Requirements

This summary information is submitted quarterly. Providers will submit <u>year-to-date</u> information to the Department on the following timeline:

Quarter	Dates of Service	Due to The
Q	2 4000 01 2 01 1100	Department
1 st	July 1 - September 30	October 31
2 nd	July 1 - December 31	January 31
3 rd	July 1 -March 31	April 30
4 th	July 1 - June 30	July 31
Final Yearly Report	July 1 - June 30	October 31

For FY 2013-14 (July 1, 2013 - June 30, 2014) providers will submit their 1st Quarter Report on October 31, 2013, covering the dates of service July 1, 2013 – September 30, 2013.

On October 31, 2013, providers will submit two reports: the Final Yearly Summary Report for FY 2012-13 covering the dates of service July 1, 2012 - June 30, 2013, and the 1st Quarter Report for FY 2012-13 covering the dates of service July 1, 2013 - September 30, 2013.

See Section 3.09 for requests to extend due dates or for a waiver to submit final summary data only.

ARTICLE V. PHYSICIAN CHARGES

Section 5.01 Definition

Physician Charges: CICP hospital providers have the option to bill the 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 CICP. 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 the CICP, they must be submitted by the provider, not the physician. Your facility must notify the Department prior to the start of the fiscal year of the intent to bill for physician charges on the Provider Application.

Section 5.02 File Description

Excel Spreadsheet: A Microsoft Excel Spreadsheet will be provided by the CICP. 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:			
		Nameh ou of	Normals on of	Nhow of
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			

(From Date)

(Through Date)

Medical Indigent Write-Offs:

\$0.00

OUTPATIENT

	(From Date)	(Through Date)
Service Dates:		

Claim Information:	CHARGES	Number of VISITS	Number of CLIENTS
Urgent Care:			0
Non-Urgent Care:	·		0
			0
Totals:	\$0.00	I	U
Third-party Liability:			
Patient Liability:	\$0.00		
Medical Indigent Write-Offs:	\$0.00		

Section 5.03 Filing Requirements

This summary information will be submitted quarterly. Providers will submit <u>year-to-date</u> information to the Department:

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

For FY 2013-14 (July 1, 2013 - June 30, 2014), providers will submit their 1st Quarter Report on October 31, 2013, covering the dates of service July 1, 2013 – September 30, 2013.

On October 31, 2013, providers will submit two reports: the Final Yearly Summary Report for FY 2012-13 covering the dates of service July 1, 2012 - June 30, 2013, and the 1st Quarter Report for FY 2013-14 covering the dates of service July 1, 2013 - September 30, 2013.

See Section 3.09 for requests to extend due dates or for a waiver to submit final summary data only.

ARTICLE VI. PREVIOUSLY CHARGED CLAIM ADJUSTMENTS

Section 6.01 General Information

Providers who receive payment for claims that have already been reimbursed by the CICP 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, 2012, data submission deadline. For example:

- The provider submits a \$100 charge to the Department on its first quarterly report for FY 2013-14. Six (6) 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 2013-14 submitted to the Department. 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, 2014, deadline.
- The provider submits a \$100 charge to the Department 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 Department since the October 31, 2013, deadline has passed. The provider will submit the required information in Section 7.02 by October 31st to correct the charge that was incorrectly submitted to the Department.

Section 6.02 Reporting Requirements

The following information is required for charges submitted to the Department 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 6.03 Filing Requirements

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

ARTICLE VII. CICP INFORMATION

Section 7.01 CICP Website

The CICP Web site, <u>Colorado.gov/hcpf</u>, is for public use and contains general CICP information. This is the main website for the Department of Health Care Policy and Financing. Click on the "Providers" link at the top menu bar and then click on the CICP link on the left menu bar. At this Web site, providers can find the templates for the billing files and the CICP Provider Directory.

Section 7.02 Department Contact Information:

For questions or comments, please contact:

Ryan Chrzan, Financing Specialist
Ryan.Chrzan@state.co.us – (303) 866-6636,

Karen Talley, Safety Net Programs and Grant Administrator Karen. Talley@state.co.us - (303) 866-3170, and

Chandra Vital, Safety Net Operations Specialist Chandra.Vital@state.co.us – (303) 866-5506

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

Ryan Chrzan, Financing Specialist Ryan.Chrzan@state.co.us

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