



COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

1570 Grant Street, Denver, CO 80203-1818 • (303) 866-2993 • (303) 866-4411 Fax • (303) 866-883 TTY

January 1, 2012 Colorado Medicaid Fee Schedule Instructions

The reimbursement rates listed in this fee schedule are valid for services rendered on or after January 1, 2012.

Current Procedural Terminology (CPT) or Healthcare Common Procedural Coding System (HCPCS) Procedure Code

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

Code descriptions are not contained in this file because they are copyrighted by the American Medical Association (AMA). We are legally prohibited from providing a list of procedure code descriptions.

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.)

Base Value

The base value of a procedure is the first part of the formula used to determine the maximum allowable reimbursement. The base values are specific to Colorado Medicaid and do not correspond to the Resource Based Relative Value Scale (RBRVS).

Conversion Factor

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

Description	Amount Effective 1/1/2012
Anesthesia	20.17
Medical	2.68
Surgery	32.47
Anatomical Lab	7.70
Radiology	7.41
Fee Schedule	1.00



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Total Colorado Medicaid Allowable

The total Colorado Medicaid allowable reimbursement amount is listed in this column. (Total allowable equals the Base Value x the Conversion Factor.)

Codes that are manually priced by invoice, by Manufacturer's Suggested Retail Price (MSRP), or on a claim-by-claim basis by the Department of Health Care Policy and Financing's fiscal agent, Xerox State Healthcare, are marked "code is manually priced".

Codes that are not benefits of the Colorado Medical Assistance Program are marked "not a benefit".

Codes that are available at no cost to providers through the Colorado Department of Public Health (CDPHE) and Environment Vaccines for Children (VFC) or Colorado Immunization programs are marked "Available through VFC" and "Available through Colorado Immunization Program".

Minimum (Min) Age / Maximum (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.