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Privacy Statement

The Colorado Department of Health Care Policy and Financing (the Department) is committed to ensuring the privacy and security of Colorado Medical Assistance Program member protected health information. To support this commitment, the Department has implemented and will continue to maintain appropriate policies and procedures and mechanisms to protect the privacy and security of Protected Health Information that is used or disclosed by the Department.

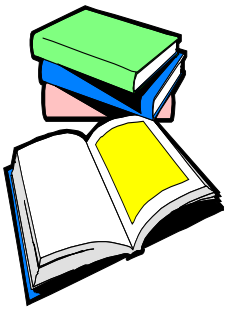
As the single state agency responsible for the administration of the Colorado Medical Assistance Program pursuant to Title XIX of the Social Security Act, the Department of Health Care Policy and Financing is specifically considered a Health Plan under the Privacy Regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As such, the Department is a Covered Entity that must adhere to the HIPAA Privacy Regulations as promulgated by the U.S. Department of Health and Human Services.

As part of its HIPAA compliance efforts, the Department has enacted several policies and procedures detailing the rights of Colorado Medical Assistance Program members, the Department's permitted uses and disclosures of member protected health information, and the Department's administrative duties under HIPAA.

How to Use the Manual

This manual provides general information about the Colorado Medical Assistance Program to assist enrolled providers with submitting claims for services rendered to Colorado Medical Assistance Program members. Manuals address specific claim and service types. The manuals are instructional guides and are not Colorado Medical Assistance Program policy manuals. The rules and regulations governing Colorado Medical Assistance Program policy may be found in *Volume VIII, the Medical Assistance Manual of the Colorado Department of Health Care Policy and Financing (Program Rules and Regulations)*. These rules also are available in the *Colorado Code of Regulations (10 CCR 2505-10)* available at most libraries.

The Colorado Medical Assistance Program Provider Billing Manuals contain basic billing and benefit information about the Colorado Medical Assistance Program. The Provider Billing Manuals are the only authorized billing procedure manuals for the Colorado Medical Assistance Program. The fiscal agent provides a CD containing billing information to each Colorado Medical Assistance Program enrolled provider when requested. Providers may download copies of manuals as needed. The manuals are designed to help providers correctly file Colorado Medical Assistance Program claims.



The Billing Manuals are designed to be used by both electronic and paper claim billers as a Colorado Medical Assistance Program policy reference. Providers should file electronic claims whenever possible. Although providers are required to bill electronically, the manual does not provide electronic billing instructions. Electronic billers can use the explanations of the paper claim fields located in individual manuals to clarify field descriptions on electronic claims. Electronic billers should utilize electronic specifications and on-line help screens. In cases where electronic filing is not possible, the manuals provide detailed paper claim filing instructions.

The Colorado Medical Assistance Program Provider Manuals consist of:

- The General Provider Information section
  - This section contains Colorado Medical Assistance Program information common to all provider types, including eligibility, covered services, and provider enrollment and participation guidelines.
- The Appendices section
  - This section includes contact addresses and phone numbers, prior authorization information, a glossary/acronym list, and additional reference information.
- The Specialty Billing Information manuals
  - These manuals contain Colorado Medical Assistance Program information specific to provider types, including paper claims, electronic claims, and the Late Bill Override Date (LBOD).

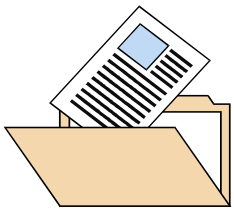
- The Dental Billing Manual
  - This manual provides Dental specific billing instructions.

- Pharmacy Billing Instructions
  - This provides a link to the Pharmacy billing instructions.
- CMS 1500 Specialty Billing Information
  - This section contains program specific benefit, procedural, and billing information for providers billing on the CMS 1500 paper claim form (this manual is soon to be replaced with individual manuals).
- Individual CMS 1500 Specialty Billing Manuals (in progress)
  - These manuals contain provider specific benefit, procedural, and billing information for providers billing on the CMS 1500 paper claim form.
- The Home and Community Based Services (HCBS) Specialty Billing Information section
  - This section contains program specific benefit, procedural, and billing information for Home and Community Based Services and should be used with the Billing Information section for detailed CMS 1500 claim field completion instructions.
- Individual UB-04 Specialty Billing Manuals
  - These manuals contain provider specific benefit, procedural, and billing information for providers billing on the UB-04 paper claim form.

Keep the current Healthcare Common Procedure Coding System (HCPCS) procedure code bulletin for your program with your program specific manual. Replace procedure code bulletins as new bulletins are published. If you need a hard copy of a manual, please download it from the Provider Services Billing Manuals section of the Department's Web site at colorado.gov/hcpf.

Providers and their staff should familiarize themselves with the manual and refer to it to answer program and billing questions. Provider manuals and bulletins help clarify covered services, member eligibility, and billing procedures. Using the information in manuals and bulletins helps eliminate program and billing misunderstandings which can result in payment delays, incorrect payments, and payment denials.

Manual Maintenance



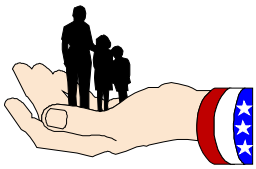
To have an accurate, working hardcopy manual, providers are responsible for keeping information current. **Updated Colorado Medical Assistance Program information is published in Colorado Medical Assistance Program Bulletins.** A link to the most recent bulletin is sent in an email to providers who have a valid email address on file with the Department's fiscal agent, Xerox State Healthcare. All billing and program information contained in Provider Bulletins should be kept with hardcopy manuals for easy reference. Bulletins regarding topics covered in manuals should be filed in that manual. Bulletins containing new information should also be kept with the manuals.

Occasionally, it may be necessary to replace manual pages or sections. All manual page and section revisions are made to manuals posted in the Provider Services Billing Manuals section of the Department's Web site. Update notifications are published in Provider Bulletins. Each page of the manual has the issue/revision date and the page number noted in the footer. All updates/changes are listed in the Revisions Log at the end of each manual.

Provider manuals or any sections of a manual may be copied and distributed to staff or a billing service as needed.

Administration

The Social Security Act provides entitlement to medical services for individuals who meet eligibility requirements. Title XVIII governs the Medicare Program, and Title XIX establishes the State Option Medical Assistance Program, also known as the Colorado Medical Assistance Program. The Colorado Medical Assistance Act provides the legal authority for the Colorado Medical Assistance Program.



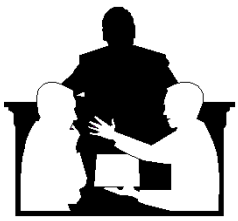
The Colorado Medical Assistance Program is a state and federal partnership funded by the State of Colorado and federal matching dollars. State funds are appropriated through the Colorado Legislature. Federal funding is dependent upon compliance with federal guidelines.

By statute, the Colorado Medical Assistance Program pays for covered health care benefits for eligible members after all other health care resources have been exhausted. The Colorado Medical Assistance Program is an entitlement program, which means that any person who meets the eligibility criteria is entitled to receive any medically necessary service covered by the program. Covered benefits include most medical services and limited related support services required in the diagnosis and treatment of disease, disability, infirmity, or impairment. In general, Colorado Medical Assistance Program benefits are comprehensive and provide care in most medical disciplines. Detailed benefit information is discussed in the Benefits and Benefit Delivery Programs section.

Department of Health Care Policy and Financing (the Department) Responsibilities

The Department of Health Care Policy and Financing (the Department):

Establishes the policies, rules, and regulations that govern the Colorado Medical Assistance Program.



Administers the Colorado Medical Assistance Program to assure compliance with state and federal rules, guidelines and regulations.

Administers a Modified Medical Program providing limited medical benefits for needy citizens age sixty and older who are not eligible for Colorado Medical Assistance Program coverage. Benefits for these individuals are similar but not identical to Colorado Medical Assistance Program coverage.

Administers other medical assistance programs such as Child Health Plan Plus (CHP+) and the Colorado Indigent Care Program (CICP).

Establishes Colorado Medical Assistance Program policy.

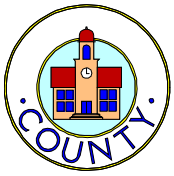
Determines benefit and reimbursement levels for all medical assistance programs according to state and federal legislative intent.

Directs and monitors the activities of the fiscal agent, Xerox State Healthcare.

Reviews and monitors program utilization.

County Departments of Human/Social Services Responsibilities

The County Departments of Human/ Social Services:



- Determines Colorado Medical Assistance Program member eligibility.
- Issues Medical Identification Cards (MIC Card) to eligible members.
- Advises Colorado Medical Assistance Program members of Colorado Medical Assistance Program benefits.

Fiscal Agent (FA) Responsibilities

The Fiscal Agent (FA):

- Enrolls Colorado Medical Assistance Program providers.
- Provides education and billing assistance to enrolled providers.
- Receives, controls, and processes Colorado Medical Assistance Program claims according to department policy.
- Responds to provider inquiries.
- Prepares department's required financial and utilization reports.
- Prepares and mails Provider Claim Reports (PCRs).
- Adjusts claims as required.
- Accepts and reviews Reconsideration requests.
- Produces the Colorado Medical Assistance Program Provider Manuals in cooperation with the Department.

Provider Responsibilities

Providers are responsible for:

- Maintaining the manual in a current, updated manner (provider manual updates and revisions are made to manuals posted in the Provider Services Billing Manuals section of the Department's Web site. Update notifications are published in Colorado Medical Assistance Program bulletins).

- Keeping provider enrollment information current with the fiscal agent.
- Submitting claims correctly to the fiscal agent.
- Following the procedures and guidelines for program participation established by the Department.

Member Responsibilities

Members are responsible for:

- Providing complete and accurate information to establish eligibility.
- Providing information about all health insurance.
- Paying co-pay amounts at the time of services.

- Working with the primary care provider or health maintenance organization (HMO) to receive services.

Provider Participation

To perform Colorado Medical Assistance Program benefit services and to receive Colorado Medical Assistance Program payments, providers must enroll in the Colorado Medical Assistance Program. Enrolled providers must have and maintain licensure and certification required by Colorado Medical Assistance Program regulations.

Provider Numbers

- Each enrolled provider is assigned an eight-digit provider number.
- The Colorado Medical Assistance Program provider number must be used to submit claims and to communicate with the Colorado Medical Assistance Program.
- Unauthorized use or publication of provider numbers is not allowed.

Special Participation Conditions

Limited Participation Providers

Providers enrolled solely for the purpose of receiving Colorado Medical Assistance Program payments for services provided to Colorado Medical Assistance Program members also enrolled in the Medicare Program (dually eligible members) must have and maintain Medicare enrollment. Services by these providers (e.g., chiropractors, free-standing physical therapy facilities) usually are not Colorado Medical Assistance Program benefits, or these services are provided under circumstances that do not meet Colorado Medical Assistance Program requirements. Payment is limited to consideration of Medicare deductibles and coinsurance.

Locum Tenens

Practitioners who provide services under a locum tenens agreement must enroll in the Colorado Medical Assistance Program. Claims for services by a locum tenens practitioner must identify the enrolled locum tenens physician as the rendering provider.

Hospitals may enter the member's regular physician's Medical Assistance Program provider ID in the Attending Physician ID field if the locum tenens physician is not enrolled in the Colorado Medical Assistance Program.

Out-of-State Providers

Out-of-State providers enroll in the Colorado Medical Assistance Program under the same rules and regulations applied to Colorado providers. The following benefit services are provided outside Colorado:

- Services to residents of Colorado border localities where the use of medical resources in the adjacent state is common (a listing of recognized Colorado border towns is in Appendix F in the Provider Services Billing Manual section).

- Services to Colorado Medical Assistance Program members who live in other states under special circumstances, such as foster care.
- Emergency services provided to Colorado Medical Assistance Program members who are traveling or visiting outside Colorado (documentation of the emergency must be submitted with the claim).
- Services needed because the individual's health would be endangered if he or she were required to return to Colorado for medical care (services must be prior authorized).
- Services that are unavailable in Colorado (services must be prior authorized).

Non-Physician Practitioners

Except as listed, benefit services provided by non-physician practitioners must comply with the following requirements:

- Services must be ordered by a licensed physician.
- Services must be performed under the direct and personal supervision of an on-premise physician who is immediately available when services are provided.
- Claims must be submitted by an enrolled physician or clinic.
- The supervising physician's Colorado Medical Assistance Program provider number must appear on the claim form as the supervising physician, the referring physician, or the billing provider.
- Claims must be billed using procedure codes specifically designated for non-physician billing.
- Claims must identify the non-physician practitioner by provider number as the rendering provider.
- The non-physician practitioner must look to the billing provider for reimbursement.

On-premise supervision and non-direct reimbursement exemptions

Dentists	▪ Services do not require physician order or physician supervision ▪ Dentists receive direct reimbursement
Podiatrists	▪ Services do not require physician order or physician supervision ▪ Podiatrists receive direct reimbursement
Optometrists	▪ Services do not require physician order or physician supervision ▪ Optometrists receive direct reimbursement
Certified Nurse Midwives	▪ Within the definitions of the Nurse Practice Act, services do not require physician order or on-premise physician supervision ▪ Certified Nurse Midwives receive direct reimbursement ▪ For reimbursement purposes, nurse midwives may not serve as supervisors of lesser licensed practitioners

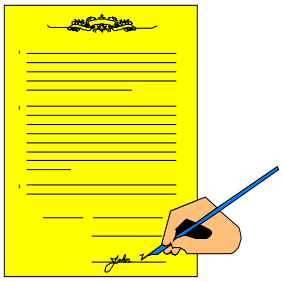
State Licensed Psychologists	▪ Services defined in Colorado Medical Assistance Program regulations do not require physician order or on-premise physician supervision ▪ State licensed psychologists receive direct reimbursement ▪ For reimbursement purposes, psychologists may not serve as supervisors of lesser licensed mental health practitioners
Certified Registered Nurse Anesthetists	▪ Services defined in Colorado Medical Assistance Program regulations do not require physician order or on-premise physician supervision ▪ If special enrollment qualifications are met, they may receive direct reimbursement
Certified Pediatric Nurse Practitioners	▪ Services defined in Colorado Medical Assistance Program regulations do not require physician order or on-premise physician supervision ▪ If special enrollment qualifications are met, may receive direct reimbursement
Certified Family Nurse Practitioners	▪ Services defined in Colorado Medical Assistance Program regulations do not require physician order or on-premise physician supervision ▪ If special enrollment qualifications are met, may receive direct reimbursement
Audiologists and Speech Pathologists	▪ If special enrollment requirements are met, qualified audiologists and speech pathologists do not require on-premise physician supervision and may receive direct reimbursement
Non-Physician Practitioners in a certified health agency	▪ Non-Physician Practitioner Must be enrolled ▪ On-premise physician supervision is not required ▪ Claims must be submitted by the center and the center's supervising physician must appear on the claim form ▪ Reimbursement is made directly to the center
Physical and Occupational Therapists	▪ Services defined in Colorado Medical Assistance Program regulations require a physician order or on-premise physician supervision

Participation Agreements and Responsibilities

A copy of the current Provider Participation Agreement can be found under each provider type in "Providers not yet enrolled in the Colorado Medical Assistance Program" within the Provider Services

Enrollment section of the Department's Web site. All Colorado Medical Assistance Program-enrolled providers must sign the agreement before being accepted as a participating provider.

- Enrolled providers are required to comply with federal and state laws and regulations applicable to the Colorado Medical Assistance Program.



Colorado rules and regulations applicable to the Colorado Medical Assistance Program are published in the Code of Colorado Regulations, 10 C.C.R. 2505-10, Department of Health Care Policy and Financing, Staff Manual Volume VIII, Medical Assistance.

Billing instructions and references to applicable Colorado Medical Assistance Program laws and regulations are published in Provider manuals and Bulletins.

Providers must comply with instructions and policies described in Colorado Medical Assistance Program publications.

Change of Ownership (CHOW) or Change in Tax Identification Number

- A change of ownership or a change of tax ID number terminates the Medical Assistance Program Provider participation agreement.
- A change of ownership requires the new owner(s) to submit an application and complete a new Medical Assistance Program Provider Participation Agreement in order to participate in the Colorado Medical Assistance Program.
- Providers with a change in tax ID number must re-apply and complete a new Medical Assistance Program Provider Participation Agreement in order to participate in the Colorado Medical Assistance Program.

Practice Capacity

Providers are not required to accept all Colorado Medical Assistance Program members. Providers may limit the number of Colorado Medical Assistance Program members associated with their practice agency or facility if the policies and methods of applying limitations are non-discriminatory.

Colorado Medical Assistance Program Member Billing

Providers agree to accept the Colorado Medical Assistance Program payment as payment in full for benefit services. Colorado law prohibits providers from billing Colorado Medical Assistance Program members or the estates of deceased Colorado Medical Assistance Program members for Colorado Medical Assistance Program benefit services.

Member Billing Prohibited

Members may not be billed for the difference between the provider's charges and Colorado Medical Assistance Program, Medicare, or commercial insurance payments (except for members requesting brand name pharmacy items).

Providers may not assert a lien - including a hospital lien - on any money, settlement, recovery, or judgment paid to the member or to the member's estate as the result of a personal injury lawsuit.

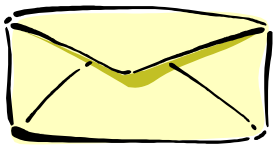
Constraints against billing Colorado Medical Assistance Program members for benefit services apply whether or not Colorado Medical Assistance Program makes or has made payment and whether or not the provider participates in the Colorado Medical Assistance Program.

Providers may not bill Colorado Medical Assistance Program members for missed appointments, telephone calls, completion of claim submission forms, or medication refill approvals.

Members may not be billed if the failure to obtain Colorado Medical Assistance Program payment is caused by the provider's failure to comply with Colorado Medical Assistance Program billing procedures.

Collection agencies cannot submit Colorado Medical Assistance Program claims for payment and cannot collect payment from Colorado Medical Assistance Program-eligible members.

Member Billing Permitted



Before providing services that will not be covered by the Colorado Medical Assistance Program, providers should have the member sign an acknowledgment of financial responsibility. Only if a written agreement is developed, members have the following responsibilities:

- If the service is not a covered benefit of the Colorado Medical Assistance Program, members may be billed for the service.
- Some members are responsible for Colorado Medical Assistance Program co-payment. By federal law, providers may not refuse services if the member cannot pay a co-payment when services are rendered. Members may be billed for unpaid co-payments. Providers may apply standard collection policies if the member fails to satisfy co-payment obligations.
- Members in nursing facilities are responsible for patient payment when under Medicare Part A (skilled nursing) coverage. If the patient payment amount exceeds the Medicare Part A coinsurance due, the difference is refunded to the member.
- Colorado Medical Assistance Program members enrolled in a Colorado Medical Assistance Program Managed Care Program must follow the rules of the Managed Care Organization (MCO). Members who insist upon obtaining care outside of the MCO network may be charged for non-covered services.

Colorado Medical Assistance Program members who have commercial insurance coverage that requires them to obtain services through a provider network must obtain all available services through the network. Members who insist upon obtaining managed care-covered services outside the network may be charged for such services.

Claim Certification Statements

All claims sent electronically must contain a certification field to indicate that the sender verifies that submitted information is true and correct. The enrolled provider is completely responsible for the claim information and the conditions under which claims are submitted.

Certification statements on Colorado Medical Assistance Program paper claim forms become effective when the provider signs the form. If the form is signed by an authorized agent, the provider remains completely responsible for the information on the claim and the conditions under which the claim is submitted.

According to Title VI of the Civil Rights Act, providers who receive *any* federal funds through programs such as the Medical Assistance Program, Medicare, CHAMPUS, etc., must provide oral interpretation services (excluding a patient's family members) to *all* limited English proficient patients in their practice, including those for whom you do not receive federal funds. Limited English proficient patients are patients who do not speak English as their primary language. Examples of oral interpretation services include oral interpretation services, bilingual staff, telephone interpreter lines, written language services and community volunteers. Written materials must be translated and provided to limited English proficient patients if the practice comprises of 10% or 3,000 limited English proficient patients, whichever is less. If you have questions, contact the Office of Civil Rights at 888-848-5306.

Authorized Signatures

An authorized signature is the signature that appears on the Colorado Medical Assistance Program application and the Colorado Medical Assistance Program Provider Agreement. Claims must be signed by the enrolled billing provider or by an authorized agent or representative designated by the enrolled billing provider.

The enrolled provider is solely responsible for submitted claim information.

To designate an authorized agent, providers must submit a signed letter of authorization to the fiscal agent. The letter of authorization must identify the agent by name and signature. An authorized agent signs his or her own name. There is no provision for an individual to sign the enrolled provider's name either with or without notation.

Enrolled providers may authorize the use of a holographic signature stamp (rubber stamp) for the purpose of submitting claims. To authorize the use of a rubber stamp, providers submit a letter of authorization to the fiscal agent, Provider Enrollment at P.O. Box 1100, Denver, CO 80201.

The letter must be signed by the enrolled provider and contain a sample of the rubber stamp signature as it will appear on the claim form. The enrolled provider is responsible for maintaining control of the stamp and is fully responsible for submitted claim information.

Reimbursement Policies

Payment for Services

All Colorado Medical Assistance Program payments are made in the name of the enrolled provider (i.e., an individual or organization that meets the licensure and/or certification requirements for program participation). Under no circumstance will payments be made to a collection agency, accounting firm, legal firm, business manager, billing service, or similar organization. Collection agencies, accounting firms, legal firms, and similar organizations cannot submit claims for direct reimbursement. Claims and claim inquiries must be submitted by the enrolled provider.

Electronic Funds Transfer

Enrolled providers are encouraged to receive their 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. When EFT is interrupted, payments are made by State warrant (paper check). Paper warrants and remittance statements may be mailed separately.

Federal Income Reporting

Colorado Medical Assistance Program payment information is reported each January on the Federal 1099 Income Report. Income is reported under billing provider's Tax Identification Number (TIN), which is the Social Security Number (SSN) or Employer Identification Number (EIN).

The name of the enrolled provider must match exactly the name associated with the TIN. The IRS requires that Colorado Medical Assistance Program payments made in the name of an individual practitioner be reported under the individual's SSN.

Payments for services by enrolled practitioners may be made in the name of an employer, professional corporation, health care organization, or health delivery agency if:

The health care employer or organization is a Colorado Medical Assistance Program-enrolled provider with a Colorado Medical Assistance Program group provider number.

There is an agreement between the enrolled practitioner and the employer or organization that requires the practitioner to turn over payments to the employer or organization.

The individual who actually renders the services is identified on the claim (by provider number) as the rendering provider.

The group provider number appears on the claim as the billing provider.

Civil Rights Anti-discrimination

Providers must comply with applicable civil rights laws and regulations including prohibitions against discrimination on the basis of race, color, sex, age, religion, or national origin, or discrimination on the basis of disability under the Americans with Disabilities Act.

Enrollment Information Accuracy

Providers are responsible for:

- Furnishing accurate enrollment information.
- Confirming the accuracy of the fiscal agent's enrollment information.
- Notifying the fiscal agent when enrollment information changes.
- Responding to requests from the fiscal agent for updated enrollment information.

Providers who are also enrolled in the Medicare Program should notify the Colorado Medical Assistance Program fiscal agent immediately when Medicare billing information is changed. All enrollment changes must be requested in writing on the provider's letterhead, or for most providers, through the Colorado Medical Assistance Program Secure Web Portal (Web Portal). Providers may also submit the Provider Enrollment Update form located in forms section of the Department's website. Telephoned requests cannot be accepted. An enrollment report is mailed to the provider after the enrollment application has been processed and when requested changes are made.

Re-certification

The fiscal agent periodically may require that enrolled providers update their enrollment information. Providers receive written notification of re-certification. Failure to respond to requests for re-certification information may result in provider suspension.

Record Keeping and Retention

Providers are required by the Provider Participation Agreement with the Colorado Medical Assistance Program and Colorado State Rule 8.130.1 (Program Rules and Regulations) to maintain records necessary to disclose the nature and extent of services provided to members.

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:

- Billing information
- Treatment plans
- Prior authorization requests
- Medical records and service reports, and orders prescribing treatment plans
- 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.

These records must fully substantiate or verify claims submitted for payment and must be furnished on request to the authorizing agency. 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.

Ownership Disclosure

Upon request, providers must disclose information about ownership and control, persons convicted of crime, business transactions, and subcontractor ownership.

The Federal Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) prohibits enrolled physicians from making referrals for certain health services to an entity where the physician or an immediate member of the physician's family has a financial relationship with the service entity. The health service entity may not submit a claim or bill to any individual, third party payer, or other entity for services provided as the result of a prohibited referral.

Advance Directives

Hospitals, nursing facilities, hospice programs, and health maintenance organizations must maintain written advance directive policies that include:

- A description of the procedures for giving Colorado Medical Assistance Program members written information about their legal right to accept or refuse medical treatment and the right to formulate advance directives.
- The provider's policies respecting implementation of such rights.

Termination of Enrollment

Colorado Medical Assistance Program provider enrollment may be terminated under the following circumstances:

- Demonstrated inability to perform under the terms of the provider agreement.
- Breaches of the provider agreement.
- Failure to abide by applicable Colorado and United States laws.
- Failure to abide by the rules and regulations of the U.S. Department of Health and Human Services and the Colorado Medical Assistance Program.
- Ineligibility or suspension from participation in other Federal or State medical programs.
- Inactivity: No claim activity for 24 months.

Inactivation of enrollment

Colorado Medical Assistance Program provider enrollment may be inactivated under the following circumstances:

- Returned mail: Failure to provide updated address information.
- Failure to furnish requested recertification information.

Providers whose enrollment has been inactivated may be re-activated by submitting a completed enrollment application and providing all required information. In some cases, proof of services rendered to a Medical Assistance Program member may be required.

Co - payment

The Colorado Medical Assistance Program requires members who receive Fee-For-Service (FFS) benefits to pay a small portion of their medical care costs to the provider.

Providers' bill usual and customary charges for all FFS services and co-payment is automatically deducted during claims processing.

FFS providers collect co-payments from members when services are rendered.

If a member is unable to pay the co-payment, providers may collect it later.

Federal regulations prohibit providers from refusing service because of a member's inability to pay.

If the co-payment is collected but not deducted from the FFS payment, the provider **must** refund the co-payment to the member.

There is no co-pay maximum per calendar year.

Co-payment Amounts

Service	Co-payment Amount
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	$2.00 per visit

Service	Co-payment Amount
services which fall under Home and Community Based Service Programs)	
Pharmacy Services (each prescription or refill) Generic drugs Brand name and single-source drugs	 $1.00 $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 and divide 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 date of service
Radiology Services	$1.00 per date of service

Co-payment-exempt Members and Services

Some co-payment exemptions are processed automatically and others require the provider to complete specific information on the claim transaction or form.

Exemptions Shown on Eligibility Verification

Members who are ages 18 and younger are automatically exempt from co-payments.

Exemptions Claimed through Claim Completion

The following co-payment exemptions are not displayed through Colorado Medical Assistance Program eligibility verification. Co-payment exemption is claimed through the FFS claims submission process. In some instances, providers should question members about their circumstances to determine the appropriateness for the following exemptions:

Institutionalized Members are Exempt from Co-Payment

Members under the age of 21 or over the age of 65 who reside in Skilled Nursing Facilities (SNF) or Intermediate Care Facilities (ICF) or reside in institutions for mental diseases.

Claims require completion of the following claim fields:**Claim Form**	**Required field completion for institutionalized members**	
CMS 1500	Field 12 ☑ Nursing Facility	
837P	Loop 2300 CLM05-1 = "21"	Skilled Nursing Inpatient

Claims require completion of the following claim fields:**Claim Form**	**Required field completion for institutionalized members**	
UB-04/837I	Loop 2300 CLM05-1 = "21"	
Pharmacy – NCPDP 5.1 Point Of Sale and Universal Claim Form (UCF)	Point of Sale: Use Patient Location "03"	UCF: Use Person Code: "03"

All services to women in the maternity cycle (including prenatal, delivery, and immediate postpartum period not to exceed six weeks) are exempt from co-payment.

Services do not have to be pregnancy related.

The member must inform the provider of her condition at the time of service.

Physicians should note the condition on prescriptions.

Claims require completion of the following claim fields.

Claim Form	**Required field completion for members in maternity cycle**	
CMS 1500	Field 12 ☑ Pregnancy	
837P	Loop 2000B PAT09 = "Y"	
UB-04/837I	Condition Code B3	
Pharmacy NCPDP 5.1 Point of Sale and Universal Claim Form (UCF)	Point of Sale: Use Pregnancy Indicator "2" and Prior Authorization Type Code: "4"	UCF: Use Prior Authorization Type Code: "4"

Emergency services delivered in any setting require indicated claim completion.

Claim Form	**Required field completion for emergency services**
CMS 1500	Field 19J: Enter "X" for each billed line
837P	Loop 2400 SV109 = "Y"
UB-04	Type of Admission 1 (Form Locator 19)
837I	Loop 2300 CL101 = 1

Family planning services require indicated claim completion.

Includes oral contraceptives, which should be dispensed in a 3-month supply after a 1-month trial period.

Claim Form	**Required field completion for family planning services**
CMS 1500	Field 19K: Enter "X" for each billed line
837P	Loop 2400 SV112 = "Y"
UB-04	Diagnosis Coding

Claim Form	Required field completion for family planning services
Pharmacy	NDC Codes for oral contraceptives

Co-pay exemptions processed automatically

- Dental services
- Home and community based services
- Home health care
- Behavioral Health Organizations (BHOs), formerly MHASA
- Transportation

Inquiries

The Department's Customer Contact Center serves Colorado Medical Assistance Program members. Representatives are available Monday through Friday between the hours of 7:30 A.M. and 5:30 P.M. through the following:

- Denver Metro: 303-866-3513
- Toll free: 800-221-3943
- TDD: 800-659-2656
- Email: customer.service@hcpf.state.co.us
- Fax: 303-866-4411

Members who have questions about the Colorado Medical Assistance Program co-payments should contact the Department's Customer Contact Center.

Providers with questions about co-payment deductions on processed claims should call Colorado Medical Assistance Program Provider Services.

Contact information for Colorado Medical Assistance Program Provider Services is listed in Appendices A and B in the Appendices of the Provider Services Billing Manuals section.

Colorado Medical Assistance Program Member Eligibility

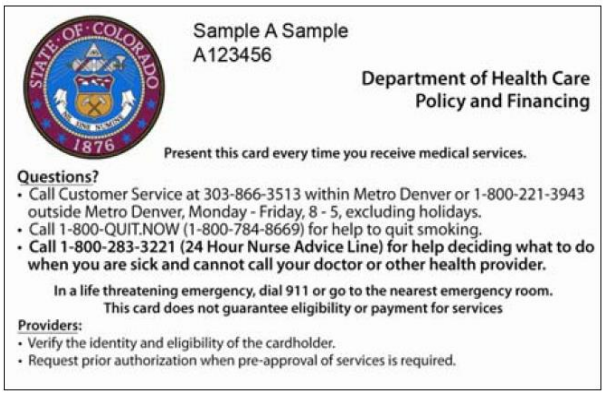
Before rendering services, the provider should verify the member's eligibility to ensure that the member is eligible for benefits. Providers should retain documentation of the verified eligibility for billing purposes.

Member Eligibility

The member's County Department of Human/Social Services establishes member eligibility for Colorado Medical Assistance Program benefits. Case managers advise potential members of proper application procedures and Colorado Medical Assistance Program benefits, and they also provide a brochure. Appendices D and E located in the Appendices of the Provider Services Billing Manuals section list the address, phone and fax number for obtaining information.

After member eligibility is established, the county issues a unique State Identification (State ID) number and a Medical Identification Card (MIC).

MIC


Sample A Sample
A123456

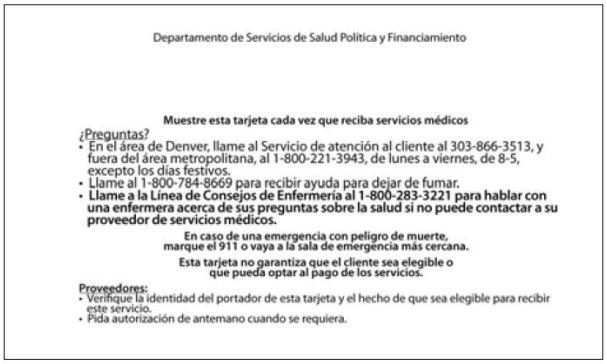
Department of Health Care Policy and Financing

Present this card every time you receive medical services.

Questions?
- Call Customer Service at 303-866-3513 within Metro Denver or 1-800-221-3943 outside Metro Denver, Monday - Friday, 8 - 5, excluding holidays.
- Call 1-800-QUIT.NOW (1-800-784-8669) for help to quit smoking.
- **Call 1-800-283-3221 (24 Hour Nurse Advice Line) for help deciding what to do when you are sick and cannot call your doctor or other health provider.**

In a life threatening emergency, dial 911 or go to the nearest emergency room.
This card does not guarantee eligibility or payment for services

Providers:
- Verify the identity and eligibility of the cardholder.
- Request prior authorization when pre-approval of services is required.


Departamento de Servicios de Salud Política y Financiamiento

Muestre esta tarjeta cada vez que reciba servicios médicos

¿Preguntas?
- En el área de Denver, llame al Servicio de atención al cliente al 303-866-3513, y fuera del área metropolitana, al 1-800-221-3943, de lunes a viernes, de 8-5, excepto los días festivos.
- Llame al 1-800-784-8669 para recibir ayuda para dejar de fumar.
- **Llame a la Línea de Consejos de Enfermería al 1-800-283-3221 para hablar con una enfermera acerca de sus preguntas sobre la salud si no puede contactar a su proveedor de servicios médicos.**

En caso de una emergencia con peligro de muerte, marque el 911 o vaya a la sala de emergencia más cercana.

Esta tarjeta no garantiza que el cliente sea elegible o que pueda optar al pago de los servicios.

Proveedores:
- Verifique la identidad del portador de esta tarjeta y el hecho de que sea elegible para recibir este servicio.
- Pida autorización de antemano cuando se requiera.

On June 1, 2010, the Department began issuing Medical Identification Cards (MICs) with a new look. The new MICs are bilingual (English and Spanish) and more informative. A sample of the front and back of the new card is shown above.

The new cards do not replace those issued before June 1, 2010. Please accept both versions.

Delayed/Retroactive Eligibility

A member's Colorado Medical Assistance Program eligibility may be made retroactive prior to the application date. Charges for services are the patient's responsibility until eligibility is established. (Example: A member is "pending" Colorado Medical Assistance Program eligibility.) Claims are denied if the member's eligibility status is not available through eligibility verification methods. See Timely Filing in the Claims Submission section for more information.

Newborn Eligibility

A Colorado Medical Assistance Program State ID number is assigned to a newborn when the case manager establishes and approves eligibility. The hospital or physician may initiate the assignment of a

newborn's Colorado Medical Assistance Program State ID number by contacting the mother's case manager at the time of delivery and providing the following information:

- Newborn's name, sex, and date of birth
- Mother's State ID number to verify eligibility at the time of delivery
- Indication that the newborn is in the home of the mother or that the newborn is still hospitalized but will be discharged to the mother's home.

Special Eligibility Programs

The Colorado Medical Assistance Program offers benefits through special programs. Members who qualify for special programs may not be eligible for regular Colorado Medical Assistance Program benefits. However, members may qualify for one of the following special programs:

- Presumptive Eligibility (PE)
- Pregnant Women
- Medicaid
- CHP+ Prenatal Program
- Breast and Cervical Cancer Program (BCCP)
- Modified Medical Program
- Qualified Medicare Beneficiaries (QMBs)
- Undocumented Non-citizen

Presumptive Eligibility (PE) for Pregnant Women

Presumptive Eligibility (PE) is temporary coverage of medical benefits until eligibility for either Medicaid or the CHP+ Prenatal Program is determined.

Pregnant women who are U.S. citizens or documented non-citizens and have self-declared incomes at or below 133% of the Federal Poverty Level may be eligible for Medicaid PE. Pregnant women who are U.S. citizens or documented non-citizens and have self-declared incomes between 134% and 200% of the Federal Poverty Level may be eligible for CHP+ Prenatal PE. Undocumented women are not eligible for PE. However, PE sites shall assist all members in filling out a Colorado Health Care Application regardless of citizenship, as undocumented members may be eligible for Emergency Medicaid for the delivery. All PE sites shall determine PE eligibility for both Medicaid and CHP+ Prenatal. Sites must verify pregnancy before enrolling a member in PE.

PE Period for Pregnant Women

The start date of Medicaid PE and CHP+ Prenatal PE is the date on which the PE card is issued and extends for 60 days. If the member does not have required documents at the time of application, she is given a fourteen day provisional PE span. If the member does not present the required documents within fourteen days, the PE period will terminate at the end of the provisional period. If the application has not been processed by the end of the PE period, the PE site may extend the PE period until the eligibility determination is made. If eligibility is denied, PE expires at the end of the 60 days. When a PE card is presented by a member after the expiration date, always verify eligibility.

A pregnant woman who is determined to be eligible for the Colorado Medical Assistance Program or CHP+ Prenatal remains eligible through her pregnancy and until the end of the month in which her 60th

day postpartum occurs. Income changes during pregnancy do not affect eligibility. The infant has continuous eligibility until his or her first birthday.

PE Benefits for Pregnant Women

A Medicaid presumptively eligible pregnant woman is entitled to all medically necessary outpatient services covered by the Colorado Medical Assistance Program. Inpatient hospital services are not a benefit during the Medicaid PE period. Labor and delivery are not covered during the PE period.

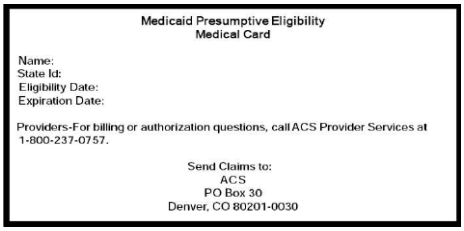
If determined to be eligible for Medicaid, after the PE period, the pregnant woman is entitled to all medically necessary covered benefits. Pregnant women age 20 and under are also eligible for Early and Periodic Screening Diagnosis and Treatment (EPSDT) services, including dental, vision care, and EPSDT health checkups. All Medicaid eligible pregnant women may receive EPSDT outreach and case management services.

CHP+ Prenatal PE benefits include outpatient and inpatient services as well as labor and delivery. Providers must be designated a CHP+ site in order to offer services. Providers must verify CHP+ Prenatal PE member eligibility through Colorado Access. CHP+ PE billing is processed through Colorado Access. Individual providers submit claims on the CMS 1500. Federally Qualified Health Centers submit claims on the UB-04. Questions regarding this program should be directed to CHP+ Customer Service at 800-359-1991.

Women in the maternity cycle are exempt from co-payment. The provider must mark the pregnancy indicator on the paper claim form or on the electronic format.

PE Card for Pregnant Women

A presumptively eligible pregnant member will receive a PE card that identifies her as eligible for medical services under either Medicaid PE or CHP+ Prenatal PE. However, inpatient hospital services are not a Medicaid PE benefit. After the full eligibility determination process, Colorado Medical Assistance Program eligible members receive a Medical Identification Card (MIC) and CHP+ Prenatal Program eligible members will receive a program card from the CHP+ Prenatal Program.


Medicaid Presumptive Eligibility
Medical Card

Name:
State Id:
Eligibility Date:
Expiration Date:

Providers-For billing or authorization questions, call ACS Provider Services at 1-800-237-0757.

Send Claims to:
ACS
PO Box 30
Denver, CO 80201-0030

Presumptive Eligibility for the Breast and Cervical Cancer Program (BCCP)

The Breast and Cervical Cancer Program (BCCP) provides full Colorado Medical Assistance Program benefits to women screened at a Colorado Women's Cancer Control Initiative (CWCCI) site, who meet the eligibility requirements, and who are found to have breast or cervical cancer treatment needs including pre-cancerous treatment needs.

This program provides immediate Colorado Medical Assistance Program coverage through the PE process initiated at the CWCCI sites throughout Colorado. For BCCP, the PE period begins on the date the diagnostic test is performed. The CWCCI site is responsible for calling the Colorado Benefits Management System (CBMS) Help Desk to enroll the member and obtain a State ID number. The PE form and Colorado Medical Assistance Program application are completed at the CWCCI site. A copy of the PE form and the original application are sent by the CWCCI site to the department of human/social services in the member's county of residence for processing. The PE form, the signature page of the application, and other CWCCI forms are faxed to the Colorado Department of Public Health and Environment at 303-691-7900.

PE Period for BCCP

PE for the BCCP begins on the date the diagnostic test is performed. The CWCCI site may not receive the results of the test for several days. A woman cannot be enrolled in PE until the results of the test are known.

When the results are received and the diagnosis confirms an eligible cancerous or pre-cancerous condition, the CWCCI site may then call the State CBMS Help Desk. It is important that the CWCCI site use the diagnostic test date as the PE start date. The PE period extends until the end of the month in which the 45th day from the PE start date occurs. The State CBMS Help Desk may extend PE for an additional month if the Colorado Medical Assistance Program application has not been processed by the PE end date.
After a Colorado Medical Assistance Program application has been processed and the member is determined to be eligible for BCCP, the member will receive a Medical Identification Card and will remain on this program until active treatment for breast or cervical cancer (or pre-cancerous condition) is complete, or until she no longer meets other eligibility criteria. If a BCCP member has not sought treatment within three months of the PE start date, the member's eligibility will end on the last day of the third month.

PE Benefits for BCCP

A presumptively eligible BCCP member is entitled to all Colorado Medical Assistance Program services determined to be medically necessary.

BCCP Presumptive Eligibility Card

The BCCP no longer requires that a CWCCI site complete a PE card application. The PE form, however, must always be completed and signed by the member.

Modified Medical Program

The Modified Medical Program provides care for Colorado old age pensioners with limited incomes who do not qualify for the Colorado Medical Assistance Program. Members in this program are not eligible for Home and Community Based Services (HCBS), inpatient psychiatric care, or nursing facility care.

Dual Eligibility

Providers are reminded that Medicaid is always the payer of last resort, therefore, services for dual-eligible members - those with coverage from Medicare and Medicaid - must be billed first to Medicare. Please refer to the July 2011 Provider Bulletin (B1100303) for an example of exceptions for Home Health services. Providers must be able to show evidence that claims for dual eligible members, 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 a copy of the Medicare Standard Paper Remit (SPR) accompany any paper claims for dual-eligible members which are submitted for reimbursement.

Please contact Provider Services at 800-237-0757 (toll free) Monday through Friday, 8:00 A.M. to 5:00 P.M. Mountain Time (MT) with questions.

Qualified Medicare Beneficiaries

Elderly and disabled Medicare beneficiaries with incomes below the Federal poverty level and resources at twice the Supplemental Security Income (SSI) level are eligible for Colorado Medical Assistance Program payment of Medicare deductibles and coinsurance. Individuals who qualify are called Qualified Medicare Beneficiaries (QMBs).

Benefits

Colorado Medical Assistance Program benefits for Medicare QMB-Only members are limited to the Medicare coinsurance and deductibles for all Medicare-covered services.

Benefits for Colorado Medical Assistance Program-Medicare/QMB Beneficiaries (dually eligible) are all Colorado Medical Assistance Program covered services and the coinsurance and deductibles for all Medicare-covered services.

Non-Citizens

Non-citizens are individuals who are in the United States for educational or visitation purposes; for employment purposes permitted with a visa; and for reasons unknown, characterized by non-citizens who lack status verification documents.

Application Procedures

Non-citizens must apply for assistance through the county where the individual currently lives and must meet the Colorado Medical Assistance Program eligibility requirements.

Because non-citizens may be reluctant to apply for governmental assistance, providers are encouraged to contact the appropriate County Department of Social/Human Services office when a potentially eligible individual receives emergency care services.

Non-citizens are limited to care and services necessary to treat immediate emergency conditions including labor and delivery.

Benefits

Benefits available to non-citizens are limited to care and services necessary to treat immediate emergency conditions including labor and delivery. Coverage does not include follow-up or postpartum care.

Important: Organ transplants are not a covered benefit for non-citizens.

Lab tests for non-citizens must be coded as "Emergency". Tests for non-citizens that are not marked as "Emergency" will not be paid.

Limitation Messages

The message "Good for emergency services only" appears on eligibility inquiries.

Accessing Eligibility Verification Information

After obtaining the birth date and State ID or SSN, providers are encouraged to conduct eligibility requests to determine eligibility.

Eligibility information is updated daily, except for weekends and State holidays, through the State's eligibility database known as the Colorado Benefits Management System (CBMS). Eligibility verification is available electronically 24 hours a day, 7 days a week.

Providers can verify eligibility through one of the following:

HIPAA 270/271 Health Care Eligibility Benefit Inquiry and Response

The HIPAA 270/271 Health Care Eligibility Benefit Inquiry and Response transaction is designed to allow providers to obtain member eligibility information using electronic data transfer. To use this method of eligibility verification, providers must have:

- The ability to send a HIPAA compliant 270/271 transaction from their office or through a clearinghouse or switch vendor.
- A signed Trading Partner Agreement with the clearinghouse, if used, or with the Colorado Medical Assistance Program if sending the transaction directly from your office.
- Characteristics of the interactive eligibility verification system are:
  - Date spans can be verified.
  - Eligibility and benefit limitations are provided.
  - Eligibility responses can be printed.

Specific directions on how to submit a 270 eligibility inquiry and what to expect in the 271 eligibility response is outlined in the 270/271 Companion Guide located in the Provider Services Specifications section.

Web Portal (Batch or Interactive):

X12N 270 – Eligibility Inquiry

FaxBack Eligibility Verification

800-493-0920 Toll-free

FaxBack provides fax responses to member eligibility requests for providers. To use this method of eligibility verification:

- A fax machine and touch tone phone are required.
- A provider must ensure that the fiscal agent has the correct fax number on file.

A fax is generated reporting eligibility, and benefit limitations for the date of service entered.

Characteristics of FaxBack are:

- The recorded voice prompts the caller for input and responds to the caller.
- One date of service can be verified at a time.
- If the memberis eligible, the voice verifies eligibility and a fax is generated reporting eligibility and benefit limitations and provides A guarantee number (audit number) for member eligibility
- If the member is ineligible, the voice informs the provider of the ineligibility and no fax is generated.

FaxBack information is included in this manual.

Colorado Medical Assistance Program Eligibility Response System (CMERS)/Interactive Voice Response System (IVRS)

800-237-0757 Toll free

CMERS/IVRS is an automated voice response system that furnishes providers with:

- Colorado Medical Assistance Program eligibility
- Provider warrant information
- Claim status information
- Unlimited eligibility inquiries
- Claim status check by Provider ID/National Provider Identifier (NPI) with Member ID and Date of Service, or by Transaction Control Number (TCN).

- A guarantee number (audit number) for member eligibility.
- Verbalize eligible service types to the caller (If using Faxback, eligible service types will be displayed).
- Include co-pay amounts and descriptions for applicable service types. (Faxback will also display co-pay amounts and descriptions for applicable service types.)
- Allow callers the ability to skip through the co-pay messages if the member is exempt from co-pay requirements or if the caller doesn't want to hear the information.

Please refer to CMERS/IVRS instructions included in this manual.

Response Information

Eligibility verification includes:

- Eligibility dates
- Co-payment status
- Third Party Resources
- Managed Care enrollment

Important eligibility information

Always verify eligibility **before** rendering services.

Why should you verify eligibility? The provider who checks a member's eligibility on the day of service and finds the member eligible receives an eligibility guarantee number. If eligibility has changed when the claim is submitted, the guarantee number exempts those claims from eligibility edits for that date of service. This simple process can save the provider a lot of paper work in the future.

Medical Identification Card (MIC)

MICs include the member's name and State ID. The card by itself will not verify eligibility; providers must still verify eligibility before services are rendered.

Notice of Proposed Action

The Notice of Proposed Action is a monthly status report from the county stating the member is approved to receive medical benefits. The Notice of Proposed Action provides key information to obtain eligibility verification, but **it is not a guarantee of eligibility.**

Billing Information

National Provider Identifier (NPI)

The Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities (i.e., health plans, health care clearinghouses, and those health care providers who transmit any health information electronically in connection with a transaction for which the Secretary of Health and Human Services has adopted a standard) use NPIs in standard transactions.

Paper Claims

Electronic claims format shall be required unless hard copy claims submittals are specifically prior authorized by the Department. Requests for paper claim submission may be sent to the Department's fiscal agent, Xerox State Healthcare, P.O. Box 30, Denver, CO 80201-0090. The following claims can be submitted on paper and processed for payment:

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

Paper claims do not require an NPI, but do require the Colorado Medical Assistance Program provider number. In addition, the UB-04 Certification document must be completed and attached to all claims submitted on the paper UB-04. Electronically mandated claims submitted on paper are processed, denied, and marked with the message "Electronic Filing Required".

Electronic Claims

Instructions for completing and submitting electronic claims are available through the following:

- X12N Technical Report 3 (TR3) for the 837P, 837I, or 837D (wpc-edi.com/)
- Companion Guides for the 837P, 837I, or 837D in the Provider Services Specifications section of the Department's Web site.
- Web Portal User Guide (via within the portal)

The Colorado Medical Assistance Program collects electronic claim information interactively through the Colorado Medical Assistance Program Secure Web Portal (Web Portal) or via batch submission through a host system.

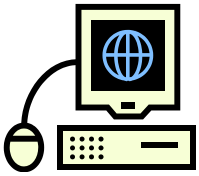
Interactive Claim Submission and Processing

Interactive claim submission through the Web Portal is a real-time exchange of information between the submitter and the Colorado Medicaid.Management Information System (MMIS). Colorado Medical Assistance Program providers may create and transmit HIPAA compliant 837Professional (837P), 837Institutional (837I), and 837Dental (837D) claims electronically one at a time. These claims are transmitted through the Colorado Medical Assistance Program OnLine Transaction Processor (OLTP).

The OLTP reviews the claim information for compliance with Colorado Medical Assistance Program billing policy and returns a response to the submitter's personal computer about that single transaction. If the claim is rejected, the OLTP sends a rejection response that identifies the rejection reason.

If the claim is accepted, the submitter receives an acceptance message and the OLTP passes accepted claim information to the Colorado MMIS for final adjudication and reporting on the Colorado Medical Assistance Program Provider Claim Report (PCR).

The Web Portal contains online training, user guides and help that describe claim completion requirements, a mechanisms that allows the user to create and maintain a data base of frequently used



information, edits that verify the format and validity of the entered information, and edits that assure that required fields are completed.

Because a claim submitter connects to the Web Portal through the Internet, there is no delay for "dialing up" when submitting claims. The Web Portal provides immediate feedback directly to the submitter. All claims are processed to provide a weekly Health Care Claim Payment/Advice (Accredited Standards Committee [ASC] X12N 835) transaction and/or a PCRt containing information related to submitted claims .

The Web Portal provides access to the following reports through the File and Report Service (FRS):

- Accept/Reject Report
- Provider Claim Report
- Health Care Claim Payment/Advice (ASC X12N 835)
- Managed Care Reports such as Primary Care Physician Rosters
- Prior Authorization Letters

Users may also inquire about information generated from claims submitted via paper and through electronic data submission methods other than the Web Portal. Other inquiry options include:

- Eligibility Inquiry (interactive and batch)
- Claim Status Inquiry
- PAR Status Inquiry

Claims may be adjusted, edited and resubmitted, and voided in real time through the Web Portal. Access the Web Portal at colorado.gov/hcpf/provider-services. For help with claim submission via the Web Portal, please choose the *User Guide* option available for each Web Portal transaction. For additional electronic billing information, please refer to the appropriate Companion Guide located in the Provider Services Specifications section of the Department's Web site.

Batch Electronic Claims Submission

Batch billing refers to the electronic creation and transmission of several claims in a group. Batch billing systems usually extract information from an automated accounting or patient billing system to create a group of claim transactions. Claims may be transmitted from the provider's office or sent through a billing vendor or clearinghouse.

All batch claim submission software must be tested and approved by the Department's fiscal agent. Any entity sending electronic transactions through the fiscal agent's Electronic Data Interchange (EDI) Gateway for processing where reports and responses will be delivered must complete an EDI enrollment package. This provides EDI Gateway the information necessary to assign a Logon Name, Logon ID, and Trading Partner ID, which are required to submit electronic transactions, including claims. An enrollment package may be obtained by contacting the Department's fiscal agent or by downloading it from the Provider Services EDI Support section of the Department's Web site.

The X12N 837P, 837I, or 837D transaction data will be submitted to the EDI Gateway, which validates submission of American National Standards Institute (ANSI) X12N format(s). The TA1 Interchange Acknowledgement reports the syntactical analysis of the interchange header and trailer. If the data is corrupt or the trading partner relationship does not exist within the MMIS, the interchange will reject and a TA1 along with the data will be forwarded to the State Healthcare Clearinghouse (SHCH) Technical Support for review and follow-up with the sender. An X12N 999 Functional Acknowledgement is generated when a file that has passed the header and trailer check passes through the SHCH.

If the file contains syntactical error(s), the segment(s) and element(s) where the error(s) occurred will be reported. After validation, the SHCH will then return the X12N 835 Remittance Advice containing information related to payees, payers, dollar amount, and payments. These X12N transactions will be returned to the Web Portal's FRS for retrieval by the trading partner, following the standard claims processing cycle.

Testing and Vendor Certification

Completion of the testing process must occur prior to submission of electronic batch claims to EDI Gateway. Assistance from EDI Gateway business analysts' is available throughout this process. Each test transmission is inspected thoroughly to ensure no formatting errors are present. Testing is conducted to verify the integrity of the format, not the integrity of the data; however, in order to simulate a production environment, EDI Gateway requests that providers send real transmission data.

The number of required test transmissions depends on the number of format errors on a transmission and the relative severity of these errors. Additional testing may be required in the future to verify any changes made to the MMIS system have not affected provider submissions. Also, changes to the ANSI formats may require additional testing.

In order to expedite testing, EDI Gateway requires providers to submit all X12N test transactions to Edifeds prior to submitting them to EDI Gateway. The Edifecs service is free to providers to certify X12N readiness. Edifecs offers submission and rapid result turnaround 24 hours a day, 7 days a week. For more information, go to edifecs.com.

Provider Reimbursement

The Colorado Medical Assistance Program only reimburses enrolled Colorado Medical Assistance Program providers. Claims for reimbursement must be submitted by the provider to the fiscal agent on the appropriate claim form or electronic claim format and properly completed according to Colorado Medical Assistance Program policy.

Colorado Medical Assistance Program reimbursement is based on Colorado legislative funding as well as Federal and State regulations. The Colorado Medical Assistance Program offers benefits through two reimbursement methods: Fee-For-Service (FFS) and Capitation.

Fee- For-Service Reimbursement

Fee-For-Service (FFS) reimbursement provides payment to enrolled providers for each service rendered to Colorado Medical Assistance Program members.

- The FFS reimbursement rates are determined through the Colorado legislative budgetary process.
- FFS claims are processed by the Colorado Medical Assistance Program fiscal agent.
- Providers are responsible for preparing and submitting FFS claims in compliance with Colorado Medical Assistance Program claim filing requirements.

Capitated Reimbursement

The Colorado Medical Assistance Program enters into contractual agreements with organizations to furnish services to Colorado Medical Assistance Program members under capitated reimbursement arrangements. Under capitation, contracted organizations receive a monthly fee for each Colorado Medical Assistance Program member enrolled in their program.

- Capitated contractors provide services through a network of service providers.
- Service providers are paid by the contracted organization.
- The contractor is financially responsible for all services described in the capitation contract.
- The Colorado Medical Assistance Program fiscal agent denies claims for covered benefit services provided to a member enrolled in a capitated program.
- Capitation reimbursement is common for Managed Care Organizations (MCOs).

Third Party Resources

By regulation, the Colorado Medical Assistance Program does not duplicate payments made by any other resource. With the exception of Victim Assistance Programs, for each of the reimbursement methods described in this manual, third party payments by other insurance carriers must be reported on the claim and are deducted from any applicable Colorado Medical Assistance Program payments. If the third party payment is equal to or greater than the Colorado Medical Assistance Program allowable benefit, the Colorado Medical Assistance Program will make no additional payment.

Colorado Medical Assistance Program Co-payment

Applicable Colorado Medical Assistance Program co-payment is automatically deducted from the provider's payment during claims processing. Providers can collect co-payment from the member at the time of service, but services cannot be withheld if the member is unable to pay the co-payment.

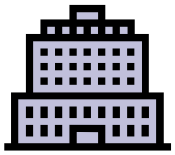
Lower of Pricing

The following services and benefits identify multiple reimbursements formulas to calculate the Colorado Medical Assistance Program reimbursement amount. This process is known as "Lower of Pricing". Each service identifies the specific criteria it uses to determine its Lower of Pricing amount.

Inpatient Hospital Services

Inpatient hospital services are reimbursed by applying **one** of the following three payment methods:

Hospitals designated as Prospective Payment System (PPS) hospitals are paid using the Diagnosis Related Group (DRG) methodology. Each hospital is assigned to a peer group, and a base reimbursement rate is calculated representing the average cost per discharge for Colorado Medical Assistance Program members. This base rate may be increased for disproportionate share based on the percentage of Colorado Medical Assistance Program patient days compared to total patient days. Each DRG is assigned a relative weight. Reimbursement is calculated as the base rate, including any applicable disproportionate share increase, multiplied by the DRG relative weight. If a hospital stay exceeds the DRG trim point, outlier days are calculated for additional payment at 80% of the established DRG per diem. If the patient is transferred from one hospital to another, both facilities are paid a DRG per diem rate up to the maximum reimbursement under the appropriate DRG, based on the length of stay. Both hospitals receive outlier day payments, if applicable.



Hospitals designated as Non-Prospective Payment System (NPPS) hospitals are reimbursed at an established per diem rate.

Urban or rural out-of-state hospitals are paid using DRG methodology. Reimbursement is made using a base rate of 90% of the Colorado urban and rural base rate.

- Medicare crossover claims are reimbursed by the Colorado Medical Assistance Program based on whichever of the following two formulas results in a **lesser amount**:
- The sum of the reported Medicare coinsurance and deductible
- The Colorado Medical Assistance Program-allowed benefit minus the Medicare payment

Outpatient Hospital Services

Reimbursement for outpatient hospital services is calculated by multiplying the submitted charges by the cost to charge ratio of the submitting hospital and then by the Medicare Part B cost ratio.

The Colorado Medical Assistance Program identifies clinical laboratory services using the Healthcare Common Procedure Coding System (HCPCS) codes. The maximum reimbursement amount for each procedure code is based on Federal and State regulations.

Medicare crossover claims are reimbursed by Colorado Medical Assistance Program based on whichever of the following two formulas results in a **lesser amount**:

- The sum of the reported Medicare coinsurance and deductible.

- The Colorado Medical Assistance Program allowed benefit minus the Medicare payment.

Family Practice

Practitioner Services

Practitioner services are billed on the CMS 1500 and EPSDT claim forms using the Centers for Medicare and Medicaid Services (CMS) HCPCS.

The Colorado Medical Assistance Program contracts with providers of specialized services, such as family planning clinics and community mental health centers, to render services at a specified reimbursement rate.

Payment for practitioner services is based on whichever of the following two calculations results in a **lesser amount**:

- The maximum allowable price for the submitted HCPCS code multiplied by the number of units of service.
- The provider's submitted charge.

Anesthesia payments are based on whichever of the following two calculations results in a **lesser amount**:

- The number of units multiplied by the established anesthesia base unit rate.
- The number of units multiplied by the provider's submitted charge.

Each 15 minute block of time or any fraction thereof equals one unit. Each anesthesia procedure has a base unit rate. Providers should bill units (i.e., time) only and not dollar amounts. The fiscal agent will calculate the dollar amount. Therefore, do not add in the actual base rate or additional units because of the patient's physical status.

Medicare crossover claims are based on whichever of the following two calculations results in a **lesser amount**:

- The sum of the reported Medicare coinsurance and deductible.
- The Colorado Medical Assistance Program allowed benefit minus the Medicare payment.

Home and Community Based Services (HCBS)

The Colorado Medical Assistance Program contracts with providers of Home and Community Based Services (HCBS) to render services at specified reimbursement rates. These services are identified by unique HCPCS codes and used by contracted providers to submit Colorado Medical Assistance Program claims. Home health services provided to HCBS members are reimbursed as described below under Home Health Services.

Payment for HCBS is based on whichever of the following three calculations results in a **lesser amount**:

- The Colorado Medical Assistance Program established price for the submitted HCPCS code multiplied by the number of units of service.
- The negotiated rate for the service for a particular member (selected services).
- The provider's submitted charge.

Supplies and Durable Medical Equipment (DME)

There are three ways to determine the price for supplies and DME: the Fee Schedule, the Manufacturer's Suggested Retail Price (MSRP), and By Invoice.

Fee Schedule

Supplies and DME that are on the Fee Schedule have a maximum allowable reimbursement. These items are reimbursed at the lesser of submitted charges or the Fee Schedule amount. If the cost of the supply or DME is less than the maximum allowable rate listed on the Fee Schedule, the provider must submit the claim for the actual cost.

Manufacturer Suggested Retail Price (MSRP)

If there is no maximum purchase price listed on the Fee Schedule, the provider is reimbursed the current MSRP less the current percentage outlined in section 8.590.7. The provider must keep a copy of the item invoice and documented MSRP. The documented MSRP must include the name of the provider's employee that received and documented the MSRP, and the date the MSRP was received.

Member must be contacted prior to shipping to ensure member information is correct.

- Providers may not submit for reimbursement either state sales tax collection or shipping costs.
- Providers must add the "SC" modifier when using the MSRP for pricing.
- Providers must attach a copy of the MSRP on all paper claims.
- Providers may not use MSRP pricing for procedure code A9901.

Billing for "By Invoice" Services

DME/Supply items that have no Fee Schedule rate and no Manufacture Suggested Retail Price (MSRP) are reimbursed at the actual acquisition invoice cost plus the percentage amount outlined in Colorado Code of Regulations, 10 Section 8.590.7. Providers must bill code A9901 to cover handling at 20% of the actual acquisition costs of the products. Eyewear reimbursement is based on whichever of the following two calculations results in a **lesser amount**:

- The maximum allowable price for materials and dispensing.
- The provider's submitted charge.

Medicare crossover claims are reimbursed based on whichever of the following two calculations results in a **lesser amount**:

- The sum of the reported Medicare coinsurance and deductible.
- The Colorado Medical Assistance Program allowed benefit minus the Medicare payment.

Nursing Facilities

Nursing facilities are reimbursed at a determined daily (per diem) rate multiplied by the number of covered days of service minus applicable patient payments.

Medicare Part A covered services are reimbursed based on whichever of the following two calculations results in a **lesser amount,** minus applicable patient payment:

- The Colorado Medical Assistance Program allowed per diem minus the Medicare payment.
- The Medicare-determined coinsurance.

For ancillary services covered under Medicare Part B, the Colorado Medical Assistance Program pays the determined coinsurance and deductible.

Managed Care Organizations (MCOs)

Colorado Medical Assistance Program-contracted Managed Care Organizations (MCOs), including Health Maintenance Organizations (HMOs) and Behavioral Health Organizations (BHOs), formerly MHASA, receive a single monthly Colorado Medical Assistance Program capitation payment for each MCO-enrolled Colorado Medical Assistance Program member.

Dental/Oral Surgery Services

Payment for dental/oral surgery services is based on whichever of the following two calculations results in a **lesser amount**:

- The maximum allowable based on the Colorado Medicaid fee schedule multiplied by the number of units of service.
- The provider's submitted charge.

The Colorado Medical Assistance Program identifies dental surgery services using HCPCS codes when provided by a dentist. Oral surgery codes are identified by Common Procedural Terminology (CPT) codes when provided by an oral surgeon.

Ambulatory Surgical Centers (ASCs)

The Colorado Medical Assistance Program identifies surgical procedures performed in an Ambulatory Surgical Center (ASC) using HCPCS codes that group surgical procedures together by scope and complexity. The codes are defined by CMS and published by Medicare and the Colorado Medical Assistance Program. There is no Colorado Medical Assistance Program reimbursement for procedures not listed in the surgical code grouping.

Colorado Medical Assistance Program reimbursement to ASCs is based on whichever of the following three calculations results in a **lesser amount**:

- An established percentage of the Medicare-allowed payment for the billed ASC group identified by the performed procedure.
- The average Colorado Medical Assistance Program rate for one hospital day.
- The provider's submitted charge.

Medicare crossover claims are reimbursed based on whichever of the following two calculations results in a **lesser amount**:

- The sum of the reported Medicare coinsurance and deductible.
- The Colorado Medical Assistance Program allowed benefit minus the Medicare payment.

Rural Health Clinics (RHCs)

Rural health clinics are paid an encounter fee based upon Medicare rates established for the clinic.

Medicare crossover claims are paid based on whichever of the following two calculations results in a **lesser amount**:

- The Colorado Medical Assistance Program pays the sum of the reported Medicare coinsurance and deductible.
- The Colorado Medical Assistance Program allowed benefit minus the Medicare payment.

Rehabilitation Services provided by a Freestanding Rehabilitation Clinic

Colorado Medical Assistance Program reimbursement for rehabilitation services provided by a freestanding rehabilitation clinic is limited to Medicare crossover payment. The payment is made by the Colorado Medical Assistance Program based on whichever of the following two calculations results in a **lesser amount**:

- The sum of the reported Medicare coinsurance and deductible.
- The Colorado Medical Assistance Program allowed benefit minus the Medicare payment.

Home Health and Private Duty Nursing Services

The Colorado Medical Assistance Program contracts with home health agencies to rende services at specified reimbursement rates. These services are identified by specific revenue codes used by the provider to submit Colorado Medical Assistance Program claims.

Payment for home health care is based on whichever of the following two calculations results in a **lesser amount**:

- The established price for the submitted revenue code multiplied by the number of units of service.
- The provider's submitted charge.

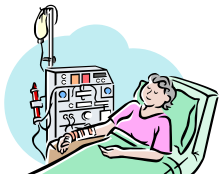
Under Medicare Part A benefits, Medicare reimburses 100% of the allowable charge for approved home health services. No crossover benefit is available from the Colorado Medical Assistance Program. If the member is not entitled to Part A Medicare but does have Part B coverage and the home health service provided is covered by Medicare, the Colorado Medical Assistance Program pays the Medicare coinsurance. Home health services are not subject to Medicare deductible.

Prescription Drugs

Prescription drugs are a benefit of the Colorado Medical Assistance Program and must be billed using the National Drug Code (NDC). For specific information, please refer to the Pharmacy Billing Manual.

Dialysis Centers

Dialysis services are reimbursed based on whichever of the following two calculations results in a **lesser amount**:



- The Medicare rate ceiling.
- The individual center's Medicare negotiated facility rate.

Medicare crossover claims are reimbursed based on whichever of the following two calculations results in a **lesser amount**:

- The Colorado Medical Assistance Program pays the sum of the reported Medicare coinsurance and deductible.
- The Colorado Medical Assistance Program allowed benefit minus the Medicare payment.

Psychiatric Residential Treatment Facilities (PRTFs)

The Colorado Medical Assistance Program reimburses Psychiatric Residential Treatment Facilities (PRTFs) at a determined daily (per diem) rate for each date billed. These centers use specific revenue codes to submit Colorado Medical Assistance Program claims.

Therapeutic Residential Child Care Facility (TRCCF)

Therapeutic Residential Child Care Facilities (TRCCF) provides services to mentally ill children and adolescents by treating mental disabilities and restoring members to their best possible functional level.

Colorado Medical Assistance Program mental health benefits are provided on a fee-for-service basis through TRCCFs to enrolled members who reside in the facility.

Hospice

Hospice service rates are determined by CMS and are adjusted according to the location of the member. The Colorado Medical Assistance Program pays based on whichever of the following two calculations results in a **lesser amount**:

- The established hospice rate
- The provider's submitted charge

Medicare crossover claims are reimbursed by the Colorado Medical Assistance Program as follows:

- The sum of the reported Medicare coinsurance and deductible.
- Nursing Facility room and board that is not covered by Medicare is paid by the Colorado Medical Assistance Program.

Benefits and Benefit Delivery Programs

Some of the programs and benefits are available through both the FFS and Capitation reimbursement methods. Providers should read information carefully to ensure that they apply appropriate policies to the correct services and programs. Also see Reimbursement Policies in this manual.

General Benefits/Limitations/Exclusions

The Colorado Medical Assistance Program pays enrolled providers for medically necessary health care benefits for eligible members after all other health care resources have been exhausted.

The Colorado Medical Assistance Program is an entitlement program, meaning that any person meeting the eligibility criteria is entitled to receive necessary medical services covered by the program without cost.

The Colorado Medical Assistance Program members are responsible for Colorado Medical Assistance Program co-payment described later in this section.

All benefit services are subject to applicable reimbursement policies including:

- Prior authorization requirements
- Referral requirements
- Utilization review
- Special consent requirements

Acute and Ambulatory Benefits

Acute and ambulatory benefit services may be provided under FFS reimbursement and through capitated Managed Care Programs. In some instances, managed care entities and FFS Colorado Medical Assistance Program share responsibility for service delivery.

FFS Prior Authorization Requirements

Under FFS reimbursement, the Colorado Medical Assistance Program prior authorizes:

- Expensive services such as transplantation and long term care.
- Procedures where inappropriate utilization has been reported in medical literature.
- Procedures that may be performed both for medical reasons and for cosmetic reasons.

FFS prior authorization approval assures the provider that the service is medically necessary and a Colorado Medical Assistance Program benefit. Capitated MCOs may have different prior authorization requirements. If a member is enrolled in a MCO, providers must follow the MCO rules.

- Approval of the Prior Authorization Request (PAR) does not guarantee Colorado Medical Assistance Program payment.
- PAR approval does not serve as a timely filing waiver.
- PAR approval does not override benefit eligibility requirements or benefit delivery requirements.

The member must meet all applicable eligibility requirements at the time services are rendered.

Example: If the service is approved under the EPSDT Program, the member must be age twenty or younger **at the time services are rendered**.

The member must be eligible for services under the FFS Reimbursement Program at the time services are rendered**.**

Example: If the member is enrolled in a Colorado Medical Assistance Program capitated prepaid health plan when services are delivered, the provider must look to the MCO for reimbursement.

All claims, including those for prior authorized services, must meet all claim submission requirements (e.g., timely filing, pursuit of third party resources, required attachments included, etc.) before payment can be made.

PARs are reviewed by the designated authorizing agency identified in Appendix B in the Provider Services Billing Manuals section. The authorizing agenc approves or denies requested services and sends notification of prior authorization action to each of the following parties:

- The requesting physician
- The proposed rendering provider (if identified on the PAR)
- The Colorado Medical Assistance Program member

The notification letter identifies the action taken on the PAR and, if services have been denied or modified, the member's appeal rights.

Instructions for submitting the PAR are described in the specialty sections specific to the service(s) being provided.

Out-of-State Benefits

The Colorado Medical Assistance Program provides the out-of-state services noted below. The service provider must be enrolled as a participant in the Colorado Medical Assistance Program.

Services to residents of Colorado border localities where the use of medical resources in the adjacent state is common. A listing of recognized Colorado border communities is in Appendix F in the Provider Services Billing Manual section.

Services to Colorado Medical Assistance Program members who live in other states under special circumstances, such as foster care placement.

Emergency services provided to Colorado Medical Assistance Program members who are traveling or visiting outside Colorado. Documentation of the emergency must be submitted with the claim.

Services needed because the individual's health would be endangered if he or she were required to return to Colorado for medical care. Services must be prior authorized.

Services that are unavailable in Colorado. Services must be prior authorized.

Long Term Care Benefits

All long term care services require prior authorization or pre-admission review by the Department's contractor. Long term care benefits include a variety of home and community based services as alternatives to institutional care.

Long Term Care Single Entry Point System

Colorado's Long Term Care Single Entry point system provides an efficient way for individuals to access long-term care services. The Single Entry Point (SEP) System is administered by Options for Long Term Care agencies (OLTCs) positioned geographically throughout Colorado.

The OLTCs conduct evaluations and needs assessment, care planning with the member, and ongoing case management to monitor the care plan, as well as coordinate service delivery and perform periodic reassessment of member needs. OLTC agencies arrange services for Home and Community Based Services members and evaluate options for members at home who are seeking nursing facility care. OLTCs perform pre-admission review and continuing care assessments and submit Colorado Medical Assistance Program FFS PAR requests as needed.

The Long Term Care Single Entry Point System helps individuals access long term care services

General Benefit Limits and Exclusions

The program does **not** pay for personal comfort items and unnecessary services. This exclusion does not apply to immunizations and inoculations.

- Items and services (e.g., free chest x-rays) for which no one incurs a legal obligation to pay are **not** benefits.
- Homeopathic therapy is **not** a benefit.
- Chiropractic services are **not** covered. Reimbursement for deductible and coinsurance will be made on Medicare crossover claims for Qualified Medicare Beneficiaries (QMBs).
- Acupuncture used for the medical management of acute or chronic pain, or as an anesthesia technique is **not** a benefit.
- Cosmetic surgery, intended solely to improve physical appearance, is **not** a benefit. Reconstructive surgery intended to improve function and appearance is a benefit if prior authorized.
- Routine or annual physical examinations are **not** benefits. Physical examinations for diagnostic disease evaluation, for nursing facility or Home and Community Based Services (HCBS) admission or placement, or under the Early Periodic Screening Diagnosis and Treatment (EPSDT) Program for members ages 20 and younger are a benefit.
- Non-prescription drugs and food supplements are **not** benefits.
- Under unusual or life threatening situations, over-the-counter drugs and food supplements may be a benefit if prior authorized.
- Hearing aids are **not** a benefit.
  Members ages 20 and younger may qualify for hearing aids under the EPSDT Program.
- Vision eyewear is **not** a benefit except as allowed under the EPSDT Program for members ages 20 and younger. Eyeglasses and contact lenses for members ages 21 and older are covered following related eye surgery.·
- Dental care is **not** a benefit except as allowed under the EPSDT Program for members ages 20 and younger. Extraction and surgical removal of damaged/diseased teeth is a covered benefit.
- Oral surgery related to the jaw or any structure contiguous to the jaw or reduction of fractures of the jaw or facial bones including dental splints or other devices is a covered benefit. Except in emergency circumstances, oral surgery requires prior authorization.

Sterilization, Hysterectomy, and Abortion Benefits

See the special billing instructions for Abortions, Hysterectomies, and Sterilizations in applicable Specialty Manuals located in the Provider Services Billing Manuals section.

Please note: *Abortion is only a benefit when due to rape, incest, or life endangerment.*

Co - payments

See the Provider Reimbursement section in this manual.

Third Party Resources (TPR) Coordination of Benefits

This manual describes policies for commercial health insurance coverage, Medicare coverage, and other liability programs such as accident coverage and victim compensation.

The terms Third Party Resources (TPR) and Third Party Liability (TPL) describe circumstances when a Colorado Medical Assistance Program member has health insurance or other potential resources -in addition to the Colorado Medical Assistance Program -that may pay for medical services.

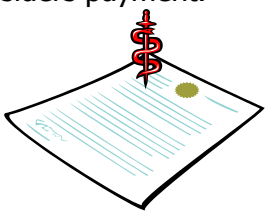
An estimated 10% of Colorado Medical Assistance Program members have other health insurance resources available to pay for medical expenses.

Colorado Medical Assistance Program eligibility is not restricted by having other insurance coverage.

Providers should take special care to apply only the policies and procedures appropriate to the specific resource.

Payer of Last Resort

Colorado Medical Assistance Program is called the payer of last resort because Federal regulations require that all available health insurance benefits be used before Colorado Medical Assistance Program considers payment.



With few exceptions, claims for members with health insurance resources are denied or rejected when the claim does not show insurance payment or denial information.

Commercial health insurance coverage often offers greater benefits than Colorado Medical Assistance Program, so it is advantageous for providers to pursue commercial health insurance payments.

Colorado Medical Assistance Program does not automatically pay commercial health insurance co payments, coinsurance, or deductibles. If the commercial health insurance benefit is the same or more than the Colorado Medical Assistance Program benefit allowance, no additional payment will be made.

Providers cannot bill members for the difference between commercial health insurance payments and their billed charges when Colorado Medical Assistance Program does not make additional payment.

Common Types of Health-Related Coverage

The more common types of health insurance coverage and members who have other resources include the following:

- Employed individuals who have commercial health insurance through employment or union membership.
- Children covered under commercial health insurance carried by an absent parent.
- Disabled individuals with coverage through employment or as a dependent through a family member's coverage.
- Individuals eligible for Medicare coverage because of age or disability.
- Individuals who have Medicare coverage and commercial Medicare supplemental plans.

Obtaining Information about Other Resources

Billing information for other resources should be obtained from the member. Providers should always ask the member about other insurance coverage. The Colorado Medical Assistance Program maintains a reference file of known commercial health insurance and Medicare coverage information used to reject or deny claims that do not show payment or denial by the commercial health insurer.

Eligibility Verification Information

Get commercial insurance information and Medicare information through eligibility verification

Providers may access the Colorado Medical Assistance Program's TPR reference information through electronic eligibility verification. Eligibility as well as information about commercial health insurance and Medicare may be verified electronically by utilizing the 270/271 Health Care Eligibility Inquiry and Response transaction, or manually by using a touch-tone telephone.

TPR information includes:

- Name and address of the commercial health insurer.
- Individualized commercial health insurance coverage information.
- Commercial health insurance coverage information.
- The individual's Medicare Health Insurance Claim (HIC) number.

TPR information reported through eligibility verification is furnished as a convenience to providers. Because TPR information is member-reported, the commercial health insurance portion of eligibility verification is not a guarantee that the information is accurate or timely. Providers should always question members about other insurance resources. TPR reference information is updated as new or revised coverage information is obtained.

Note: TPR information is not available from the State or from the County. Please do not contact these offices to request third party billing information.

Inaccurate TPR Information

The Colorado Medical Assistance Program collects information about members' TPRs from several sources.

Colorado Medical Assistance Program members and applicants are required to identify commercial health insurance coverage.

The Colorado Medical Assistance Program exchanges information with other state agencies and some commercial health insurance companies.

Providers report commercial health insurance coverage on Colorado Medical Assistance Program claims.

The Colorado Medical Assistance Program makes every attempt to maintain up-to-date TPR information. Providers may find, however, after submitting a commercial health insurance claim, Colorado Medical Assistance Program's records are inaccurate and that the commercial health insurance coverage is not in effect.

Unreported Health Insurance Coverage

Even if Colorado Medical Assistance Program records do not identify commercial health insurance coverage, providers who find that the member has such coverage should pursue those benefits before billing the Colorado Medical Assistance Program.

Commercial health insurers often offer greater benefits than the Colorado Medical Assistance Program.

When insurance benefits retroactively are identified, the Colorado Medical Assistance Program retracts previous payments and requires the provider to submit claims to the commercial health insurers.

Providers may report insurance coverage by contacting the Department's fiscal agent or by completing the health insurance information required on the Colorado Medical Assistance Program claim..

Discontinued Health Insurance Coverage

Providers should report members' discontinued insurance coverage to the Department's fiscal agent by sending a copy of the insurance carrier's letter or denial notice and identifying the member by name and State ID number so records can be updated.

Colorado Medical Assistance Program claims are honored if the claim correctly indicates that the other insurance company has denied benefits.

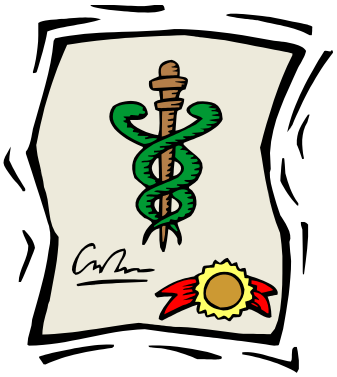
Providers who notify the Department's fiscal agent that TPR coverage has been discontinued are not required to continue sending claims to the commercial health insurers. Until Colorado Medical Assistance Program records are updated and the TPR coverage notation no longer appears on the electronic eligibility verification response, subsequent Colorado Medical Assistance Program claims must continue to show that the commercial insurers have denied benefits.

Commercial Health Insurance Resources

The following resources are not considered commercial health insurance resources, and the policies discussed in this section do not apply to these resources. Subsequent sections describe these resources.

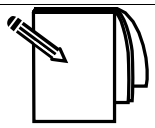
- Medicare
- No-fault automobile coverage
- Migrant Health Services
- Colorado Indigent Care Program
- Workers Compensation
- Victim Assistance Programs
- Indian Health Services coverage
- Colorado Health Care Programs (HCP) for Children

Pursuing Commercial Health Insurance Payments



When members accept Colorado Medical Assistance Program benefits, they assign their rights to health insurance payments to the Colorado Medical Assistance Program. Most insurance companies make direct provider payments when the policyholder assigns benefits to the provider. Providers should take necessary steps to obtain consent to release information and benefit assignment for direct payment.

Insurance coverage information is considered part of treatment, payment and operations as defined in the privacy regulations. Pursuing information regarding other coverage therefore is not in violation of HIPAA privacy as specified at 45 C.F.R. §164.501.



Policies applicable to Colorado Medical Assistance Program Managed Care Programs (HMOs and MCOs) are not discussed in this section of the provider manual. Colorado Medical Assistance Program Managed Care Enrollment is not treated as a TPR for Colorado Medical Assistance Program reimbursement purposes.

Commercial Managed Care Policies

Providers should not confuse Colorado Medical Assistance Program Managed Care enrollment with commercial managed care policies. Colorado Medical Assistance Program Managed Care enrollment refers to members who receive benefit services from a Colorado Medical Assistance Program-contracted Managed Care Organization (MCO). Commercial managed care policies are health coverage policies that exist in addition to the individual's Colorado Medical Assistance Program entitlement.

Members who have commercial managed care benefits must obtain MCO benefit services from the MCO. Colorado Medical Assistance Program claims for members who have commercial managed care coverage are rejected or denied.

Colorado Medical Assistance Program members are responsible for only co-payment amounts and may not be charged for any fees, including managed care co-payment.

Reporting Payments and Denials

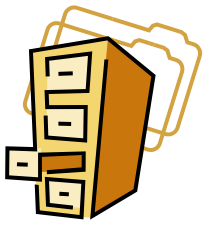
If a member's eligibility response record shows commercial health insurance coverage and the Colorado Medical Assistance Program claims for that member do not show insurance payment or denial information, those claims are rejected or denied.

Providers must report TPR payment and denial information on the claim form.

- Paper claim forms have designated fields for reporting TPR payments and denials.
- Electronic claim formats have designated fields for reporting commercial health insurance coverage.

Reporting commercial health insurance coverage on paper claim forms is slightly different from electronically reporting information. Directions for claim field completion to identify TPR payments and denials are available in the billing instructions for each claim form.

Audit Documentation



Providers must maintain records that support the accuracy of submitted claim information for a period of six years, including copies of commercial health insurance denials and payments. Providers should document, date, and sign notes about reported member discussions regarding TPR. Upon request, records must be submitted for Colorado Medical Assistance Program audit and review. Failure to provide requested audit materials may result in sanctions and recovery of Colorado Medical Assistance Program payments.

Special Claim Submission Circumstances

Commercial Benefit Limits

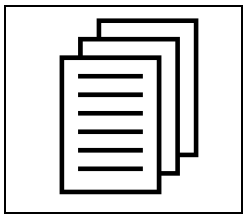
Commercial health insurance coverage may limit some benefits for a specific time period, often yearly time periods. If a periodic benefit limitation is exhausted, claims for services in excess of the benefit limit may be submitted directly to the Colorado Medical Assistance Program. The provider does not have to continue submitting claims to the TPR. The claim record must be completed to show that the other coverage denied benefits or that the service is excluded from coverage.

When the limitation period ends, the provider must submit claims to the commercial health insurer until the benefit is exhausted.

If the commercial health insurance coverage includes a lifetime benefit limit and that benefit is exhausted, claims for services provided in excess of the limit may be submitted directly to the Colorado Medical Assistance Program. Providers should contact Colorado Medical Assistance Program Provider Services for assistance.

In some instances, lifetime limitations can be recorded in the Colorado Medical Assistance Program reference files so that future Colorado Medical Assistance Program claims can be processed without completing TPR fields. In other instances, the provider may be instructed to continue completing the claim record to show that other TPRs have denied benefits or that the service is excluded from coverage.

Apportioned Payments



Under some circumstances, a commercial health insurance payment may be applied to more than one Colorado Medical Assistance Program claim submission. If the provider receives a third party lump-sum payment for multiple services billed to the Colorado Medical Assistance Program on separate claim records, the payment amount should be apportioned across the affected claims.

If payment cannot be divided and applied to each service, providers should apportion the payment on a percentage basis to the affected claims. Providers must maintain records to support submitted claim information including a detailed explanation of the apportionment method used.

Uncooperative Policyholders

Providers benefit from taking necessary steps to obtain required signatures and authorizations from members and policyholders. Some commercial health insurers refuse payment if the member or policyholder does not respond to requests for information.

Failure to Provide Information

If the member or policyholder refuses to provide required signatures or authorizations or does not respond to requests for information, Colorado Medical Assistance Program claims may be submitted through the reconsideration process. Claims must be received within 365 days of the date of service.

Reconsideration claims must be submitted on paper. Claims must be clearly marked "Reconsideration" and accompanied by a completed Request for Reconsideration form or letter describing the nature of the policyholder's refusal to cooperate and the steps taken to secure TPR payment from the provider.

The policyholder or member's refusal to transfer payment to the provider or to cooperate will be reported to State officials who may take further action.

Payments Made to Policyholders

Providers should always obtain an assignment of benefits for direct reimbursement by the commercial health insurers. If the commercial health insurance payment is sent to the member or policyholder, the provider should obtain payment and the payment voucher (e.g., Provider Claim Report [PCR] or Standard Paper Remit [SPR], etc.) from that member or policyholder for Colorado Medical Assistance Program billing purposes. If the member or policyholder refuses to transfer or make payment to the provider, Colorado Medical Assistance Program claims may be submitted through the reconsideration process. Claims must be received within 365 days of the date of service.

The policyholder or member's refusal to transfer payment to the provider or to cooperate will be reported to State officials who may take further action.

Invalid TPR Denials

Some reasons given by TPR are invalid for submitting the claim for Colorado Medical Assistance Program payment. Providers should ensure that all TPRs are appropriately pursued before submitting Colorado Medical Assistance Program claims. The following are examples of invalid TPR reasons for submitting Colorado Medical Assistance Program claims:

- No denial reason identified
- Duplicate claim
- Insufficient information for processing
- Claim in process

Retroactive Identification of Commercial Health Insurance Resources

When commercial health insurance coverage is identified after claims are paid, providers receive notification of the intent to recover payment and instructions for submitting claims to the commercial health insurer. The notification letter contains billing information and a complete explanation about the retroactive Colorado Medical Assistance Program payment recovery process.

Medicare Resources

Colorado Medical Assistance Program members may qualify for Medicare benefits because of age or disability. Individuals who have Medicare coverage and Colorado Medical Assistance Program entitlement are called "dually eligible."

The Colorado Medical Assistance Program administers very specific policies to coordinate benefits for Medicare-covered members. Information in this section applies only to Medicare benefit coordination. Do not apply these policies to other TPR.

Types of Medicare Coverage

Medicare pays benefits through the following two separate programs:

- Part A Medicare pays for institutional care
- Part B Medicare pays for professional services

Colorado Medical Assistance Program members may have the following coverage:

- Part A Medicare coverage only
- Part B Medicare coverage only
- Both Part A and Part B coverage

Qualified Medicare Beneficiaries (QMBs)

In compliance with the 1988 Medicare Catastrophic Coverage Act, the Colorado Medical Assistance Program pays Medicare deductibles and coinsurance for elderly and disabled individuals who have incomes below the Federal poverty level and resources at twice the Supplemental Security Income (SSI) level. Individuals who qualify for benefits under the Medicare Catastrophic Coverage Act are

called Qualified Medicare Beneficiaries (QMBs). QMBs may or may not be entitled to regular Colorado Medical Assistance Program benefits.

Individuals may qualify for the following benefits:

- Regular Medicare benefits with Colorado Medical Assistance Program benefits
- QMB Medicare benefits with Colorado Medical Assistance Program benefits
- QMB only benefits without Colorado Medical Assistance Program benefits

Colorado Medical Assistance Program Crossover Benefits

Regular Medicare + Colorado Medical Assistance Program	QMB Medicare + Colorado Medical Assistance Program	QMB-only benefits
The Colorado Medical Assistance Program processes Medicare crossover claims for Medicare benefits that are also Colorado Medical Assistance Program benefits and all regular Colorado Medical Assistance Program benefits. Calculation of the crossover payment is described below.	The Colorado Medical Assistance Program pays Medicare crossover coinsurance and deductible for all Medicare benefits including services that are not covered by regular Colorado Medical Assistance Program (e.g., chiropractic services) and all regular Colorado Medical Assistance Program benefits.	The Colorado Medical Assistance Program pays Medicare crossover coinsurance and deductible for Medicare covered benefits including services that are not covered by the regular Colorado Medical Assistance Program. There is no coverage for Colorado Medical Assistance Program-only benefits (e.g. pharmacy). QMB-only members may not be billed for crossover balances. QMB-only members are financially responsible for services that are not covered by Medicare.

Medicare crossover payments

Members are not responsible for remaining balances after Colorado Medical Assistance Program B crossover processing. For members under Medicare A (skilled nursing coverage) in nursing facilities, the member's patient payment is applied to the Medicare A coinsurance.

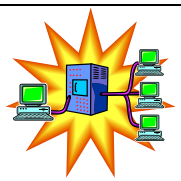
Medicare Part A crossover payments

Hospital inpatient & outpatient charges	Nursing Facility services	Clinic and facility services (e.g. Dialysis, Rural Health, Home Health, Independent Rehabilitation)
Provider payment is Colorado Medical Assistance Program's allowed benefit minus the Medicare payment **or** the Medicare determined deductible and coinsurance, **whichever is less**. If Medicare's payment equals or is greater than the Colorado Medical Assistance Program allowance, crossover claims are paid zero.	Provider payment is the Colorado Medical Assistance Program facility per diem minus the Medicare payment **or** the Medicare determined coinsurance, **whichever is less**. If Medicare's payment is greater than the Colorado Medical Assistance Program allowed facility per diem, crossover claims are paid zero. For Part B services paid by Part A, the Colorado Medical Assistance Program pays Medicare deductible and coinsurance.	Colorado Medical Assistance Program pays Medicare deductible and coinsurance.

Medicare Part B crossover payments

The Colorado Medical Assistance Program pays the Medicare deductible and coinsurance or the Colorado Medical Assistance Program-allowed benefit minus the Medicare payment, whichever is less. If Medicare's payment equals or is more than the Colorado Medical Assistance Program allowed benefit, crossover claims are paid zero.

Automatic Medicare Crossover Claims



If automatic crossover does not occur, providers must submit crossover claims.

Automatic crossover is an exchange of claim information between Medicare and the Colorado Medical Assistance Program. When automatic crossover occurs, providers do not have to submit a crossover claim to the Colorado Medical Assistance Program.

Medicare identifies claims selected for automatic crossover on a Medicare payment voucher (e.g., PCR or SPR). The crossover message states that the claim has been forwarded to the Colorado Medical Assistance Program for any additional benefits due. If the automatic crossover notice appears on the Medicare payment voucher, providers should allow 30 days for the Colorado Medical Assistance Program to process the crossover claim.

Providers must submit a copy of the SPR with paper claims. Be sure to retain the original SPR for audit purposes.

If the Medicare crossover message does not appear, providers should assume that automatic crossover will not occur and should submit a crossover claim to the Colorado Medical Assistance Program.

Automatic crossover is only available for claims processed by the Medicare Administrative Contactor (MAC) TrailBlazer Health Enterprises, LLC for Colorado.

If the Medicare Administrative Contractor is not the designated MAC, providers must submit crossover information.

Automatic crossover is not available for railroad retiree claims processed by Palmetto GBA . Crossover messages that may appear on Palmetto GBA SPR are inaccurate. Providers must submit crossover information for railroad retirees.

Medicare must allow charges on the Medicare claim.

Medicare-denied claims do not cross over because there are no residuals (e.g., coinsurance or deductibles) to be considered for payment by the Colorado Medical Assistance Program. If Medicare denies benefits, benefits are exhausted, or services are not covered by Medicare, providers may submit a claim directly to the Colorado Medical Assistance Program for services (not a crossover claim). If the claim is partially allowed by Medicare, the Colorado Medical Assistance Program will process denied billing lines. Providers should review their PCRs carefully to determine the benefits allowed by Medicare and the Colorado Medical Assistance Program.

If Medicare pays the entire claim at 100% of the allowed benefit, the claim does not cross over because there are no residuals (e.g., coinsurance or deductible) to be considered by the Colorado Medical Assistance Program. If only a portion of the claim is paid at 100%, automatic crossover does occur but no payment is made on the services paid at 100%.

Medicare adjustments do not cross over.

If Medicare adjusts a claim, the provider must submit a Colorado Medical Assistance Program adjustment. Adjustments may be submitted electronically or on paper. Paper adjustments must be accompanied by the Medicare SPR and adjustment documentation.

The member's HIC number must match Colorado Medical Assistance Program eligibility files.

If the member's Medicare ID number changes, automatic crossover is interrupted temporarily until the Colorado Medical Assistance Program eligibility file is corrected to reflect new information. If automatic crossover does not occur, providers must submit crossover claims.

The provider's Medicare provider number must be recorded in the Colorado Medical Assistance Program provider files.

Providers are responsible for furnishing Medicare provider information to Colorado Medical Assistance Program Provider Services. If the Medicare provider number is not recorded on Colorado Medical Assistance Program's provider enrollment file, automatic Medicare crossover is not possible.

When Medicare provider numbers change, the provider must furnish updated information to Colorado Medical Assistance Program Provider Services. If automatic crossover does not occur, providers must submit crossover claims.

The provider must accept Medicare assignment on claims for Colorado Medical Assistance Program members.

- If the provider does not accept Medicare assignment, automatic crossover does not occur. Providers cannot bill Colorado Medical Assistance Program members for Colorado Medical Assistance Program-covered services, including Medicare benefit services.
  If the provider does not accept Medicare assignment, the Colorado Medical Assistance Program will not pay crossover benefits. If the provider has not accepted Medicare assignment in error or Medicare processes the claim as unassigned in error, the provider may obtain the Medicare payment and processing information from the member and submit a crossover claim to the Colorado Medical Assistance Program. By submitting a Colorado Medical Assistance Program crossover claim, the provider is deemed to have accepted Medicare assignment after-the-fact

and must accept the combined Medicare and Colorado Medical Assistance Program payments as payment in full.

Automatic Crossover Denials

Claims may cross over automatically but appear on the Colorado Medical Assistance Program PCR as denied if the member is enrolled in a Colorado Medical Assistance Program MCO or has commercial health insurance coverage.

Providers should contact the Colorado Medical Assistance Program MCO for billing instructions if additional benefit is available for Colorado Medical Assistance Program Managed Care enrolled members.

Providers should submit claims to the commercial health insurer for individuals who have supplemental health insurance. If the supplemental health insurer denies benefits, the provider may submit a crossover claim with documentation of the commercial health insurance denial.

Delays in Crossover Processing

If Medicare or Colorado Medical Assistance Program system problems create delays in crossover processing, PCRs describe the problem and notify providers about appropriate action to take. Please carefully read and follow the instructions on the Colorado Medical Assistance Program PCR.

Provider-Submitted Crossover Claims

If automatic crossover does not appear on the Colorado Medical Assistance Program PCR within 30 days of the Medicare processing date — regardless of the reason and whether or not the Medicare crossover message appears — providers are responsible for submitting crossover claims, electronically or on paper.

Provider-submitted crossover claims (sometimes called hardcopy crossovers) should be submitted electronically. Each electronic claim format contains designated fields to report Medicare processing information. Instructions for completing Medicare crossover information are included in the billing instructions for each claim format.

When crossover claims are submitted electronically, providers must maintain auditable Medicare processing documents that support the accuracy of submitted claim information. The Colorado Medical Assistance Program must submit copies of audit information for audit and review upon request. Failure to provide requested audit materials may result in sanctions and recovery of Colorado Medical Assistance Program payments.

Crossover Timely Filing

Timely filing for Medicare crossover claims is 120 days from the date of Medicare processing. When automatic crossover occurs, timely filing is met. If automatic crossover does not occur, providers are responsible for filing claims in compliance with timely filing regulations.

Colorado Medical Assistance Program claims for Medicare-denied, non-covered, or exhausted benefits are not crossover claims and, for timely filing purposes, must be filed within 120 days of the date of service or within 60 days of the Medicare denial date, whichever is longer.

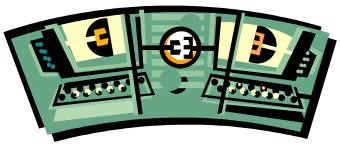
Claims for Medicare-Exhausted Benefits

Medicare applies dollar-based benefit limits to some practitioner services. Because of the dollar limit, Medicare may make a partial payment when the dollar limit is reached. In those instances, providers should contact the Department's fiscal agent.

Crossover Billing Tips

The following billing tips will help providers correctly submit crossover claims:

- Crossover claims must report the same information submitted to Medicare, including full charges (for Nursing Facility crossover submission, see the Nursing Facility Specialty Manual).
- Crossover claim information (e.g., Medicare payment date, Medicare disallowed charge, Medicare deductible, Medicare coinsurance, Medicare payment, and related computations) on the claim form must be accurate and complete to reflect information on the Medicare payment voucher.
- The net Colorado Medical Assistance Program billed amount must equal the sum of the reported Medicare coinsurance and deductible.
- Do not combine crossover claim services and Medicare denied services or benefits exhausted services on a single claim (paper or electronic). Medicare denied services or benefits exhausted services must be submitted as a "straight" Colorado Medical Assistance Program claim on a separate claim.



Other Third Party Resources

There are a variety of circumstances, other than commercial health insurance coverage, where services provided to a member may be payable by a third party. In some instances, liability is firmly established, such as with Workers Compensation. In others, however, there may be potential liability that has not been confirmed, such as with an automobile policy.

Established Third Party Liability

Where TPL is established, providers should submit claims to the responsible third party.

Workers Compensation

Services known to be billable to Workers Compensation should be billed to the Workers Compensation carrier. Colorado Medical Assistance Program claims instruct providers to identify services that are related to employment. The Colorado Medical Assistance Program does not deny payment because of potential TPL resulting from employment accidents, but providers cannot receive payment from both programs.

Health Care Programs (HCP) for Children with Special Needs

Providers who render services to children covered by the Colorado Health Care Programs (HCP) for Children with Special Needs should follow HCP billing instructions. The Colorado Medical Assistance Program does not deny claims for individuals who are enrolled in Colorado HCP, but providers cannot receive payment from both programs.

Potential Third Party Liability

Providers should not delay Colorado Medical Assistance Program claims submission where there is potential TPL. The Colorado Medical Assistance Program requires that claims be submitted within 120 days from the date of service. If providers subsequently receive payment from a third party, the Colorado Medical Assistance Program payment must be refunded.

Accident Liability

Colorado Medical Assistance Program claims instruct providers to identify services that are related to accidents. The Colorado Medical Assistance Program does not deny payment because of potential TPL

resulting from accidents. Providers should not hesitate to indicate that services are related to an accident for fear that the claim will be denied.

The Colorado Medical Assistance Program sends a questionnaire to members who have received services for a diagnosis that may be accident-related. The questionnaire asks for information from the member about other liability or benefits available.

If providers receive payment from a third party, they must return any Colorado Medical Assistance Program payment.

The Colorado Medical Assistance Program appreciates providers' assistance in recovering payments from TPRs. Providers are asked to notify the Department's fiscal agent if the member or the member's representative (e.g., attorney) requests detailed copies of bills for medical services paid by the Colorado Medical Assistance Program. Please copy and complete the Third Party Liability Reporting Form shown in Appendix G in the Provider Services Billing Manual section.

Victim Assistance Programs

Victim Assistance Programs **do not** represent potential TPL. The Colorado Medical Assistance Program does not deny claims for services to individuals who may be eligible for compensation from Victim Assistance Programs. Providers should submit claims to the Colorado Medical Assistance Program when the member is Medicaid eligible.

Colorado Indigent Care Program (CICP)

Individuals who are covered under the Colorado Indigent Care Program (CICP) are not eligible for Colorado Medical Assistance Program benefits. If an individual has Colorado Medical Assistance Program benefits, claims should be submitted for Colorado Medical Assistance Program reimbursement.

Returning Colorado Medical Assistance Program Payments

With the exception of Victim Assistance Programs, the Colorado Medical Assistance Program is the payer of last resort. Regardless of the payment source, when providers receive payment from a third party for services that have previously been paid by the Colorado Medical Assistance Program, the Colorado Medical Assistance Program payment must be refunded immediately.

Refunds must be made for the full amount of the Colorado Medical Assistance Program claim payment.

Providers may not retain a portion of the Colorado Medical Assistance Program payment to supplement a third party payment.

Refunds must be made for the full amount of the Colorado Medical Assistance Program payment.

- If the third party payment is the same or more than the Colorado Medical Assistance Program allowance for the billed service, the Colorado Medical Assistance Program does not make additional payment.
- If partial payment is due from the Colorado Medical Assistance Program, the provider should submit the third party payment information as part of an adjustment request. The Colorado Medical Assistance Program will retract the original payment and reprocess the claim for any additional payment due.

Providers may refund Colorado Medical Assistance Program payments using any of the following procedures:

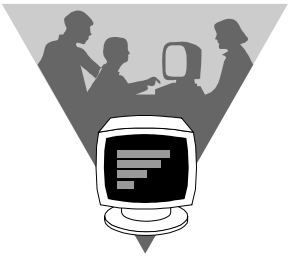
Submit an electronic adjustment transaction. The claim payment will be subtracted from the future payments for processed claims.

Submit a paper Refund to Medicaid or Returned Warrant Form accompanied by a business check for the full amount of the claim. The adjustment must identify the member, the transaction control number of the claim to be recovered, and the date(s) of service.

Contact the Department's fiscal agent for instructions on specific circumstances.

General Claim Requirements

With few exceptions, Colorado Medical Assistance Program claims must be submitted electronically.



Electronic claims may be submitted interactively (one transaction at a time) or in batch format. Batch may be submitted using batch submission software that must be developed by the provider or purchased from a certified software vendor, or by utilizing the HIPAA 837 transaction. Electronic filing reduces claim completion time, expenses, and claim processing time by eliminating paper handling, mailing time, and fiscal agent data entry.

Electronic claim submission is available for all claim types in the following electronic claim formats:

- CMS 1500/ 837 Professional (837P)
- UB-04/ 837 Institutional (837I)
- Dental/ 837 Dental (837D)
- Pharmacy/ NCPDP
- Early Periodic Screening, Diagnosis, Treatment (EPSDT)

Claim Submission

All claims, whether electronic or paper, are processed through the Colorado Medical Assistance Program's Medicaid Management Information System (MMIS). The fiscal agent processes claims and PCRs are either mailed to the provider or are available to the provider through the Web Portal File and Report Service (FRS). Providers are responsible for reconciling each PCR and resubmitting claims that do not appear on a PCR. Claims that are denied or rejected must be corrected and resubmitted by the provider in a timely manner.

Electronic claims and paper claims

- Electronic and paper claims are adjudicated and reported the same way within the MMIS.
- Electronic acceptance reports must be reviewed and reconciled.
- Both types of claims must be submitted timely and accurately.
- The Colorado Medical Assistance Program PCR must be reconciled for both electronic and paper claims.

Electronic Claim Submission Exemptions

Electronic claims format shall be required unless hard copy claims submittals are specifically authorized by the Department. Requests may be sent to the Colorado Medical Assistance Program, P.O. Box 30, Denver, CO 80201. The following claims can be submitted on paper and processed for payment:

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

- Reconsideration claims

Service Bureaus, Billing Services, and Claim Submission Software Vendors

Enrolled providers are responsible for the accuracy and timeliness of claim submission activities of agents, service bureaus, billing services, software vendors, and switch vendors.

Electronic Claims Submitted via Web-Portal

The Colorado Medical Assistance Program furnishes interactive computer software that allows providers to:

- Create and transmit claims electronically
- Transmit eligibility verification transactions
- Transmit claim reversals
- Transmit adjustment transactions
- Transmit Prior Authorization Requests (PARs)

See the Web Portal information in the Electronic Claim section of the Billing Manuals located in the Provider Services Billing Manuals section for more information.

Re-bills

Colorado Medical Assistance Program claim forms and provider agreements contain federally required certification statements that apply to Colorado Medical Assistance Program billings. The provider's signature acknowledges the provider's agreement to the terms and conditions of the certification statements. Paper claims that do not include the certification statements cannot be accepted and are returned to the provider.

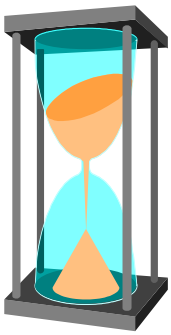
If an electronic claim is denied or rejected, the claim should be re-billed electronically.

If a paper claim re-bill is required:

- Resubmission of a previously denied claim may be submitted as a corrected legible photocopy of the original claim if the photocopy is clearly marked "Re-bill".
- Re-bills must be re-signed and the signature re-dated by the billing provider.

Timely filing

Colorado Medical Assistance Program claims must be filed in a timely manner. A claim is considered to be filed when the fiscal agent documents **receipt** of the claim.



With few exceptions, electronic claims can be submitted twenty-four hours a day, seven days a week. Electronic claim receipt is documented by the assignment of a Transaction Control Number (TCN). Electronic acceptance and rejection messages include the transaction date.

Paper claim receipt is documented by the fiscal agent's date stamp or the imprinted TCN.

Holidays, weekends, and dates of business closure do not extend the timely filing period.

Dated claim signatures, computerized or clerically prepared claim listings, and/or postmarks and certified mail receipts do not constitute proof of receipt for timely filing purposes.

The provider is responsible for assuring that each claim is received within the timely filing period. With the exceptions of paper claims that are returned to the provider because of missing information and rejected electronic claims, all claims filed with the fiscal agent appear on the PCR as paid, denied, or "in process" within 30 days of receipt. If claim information does not appear on the PCR within 30 days of an electronic transmission or paper claim mailing, the provider is responsible for contacting the fiscal agent to determine the status of the claim and **resubmitting the claim if necessary.**

Agent or software failure to transmit accurate and acceptable claims or failure to identify transmission errors in a timely manner needs to be resolved between the provider and the agent or software vendor. Failure to comply with filing requirements -including timely filing -because of software product failure or the action (or inaction) of a billing agent are not recognized as extenuating circumstances beyond the provider's control.

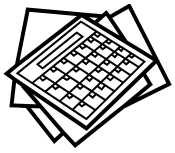
Original Timely Filing

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

Type of Service	Timely Filing Calculation
Nursing Facility; Home Health, Inpatient, Outpatient; all services filed on the UB-04	From the "through" date of service
Dental; EPSDT; Supply; Pharmacy; All services filed on the CMS 1500	From the date of each service (line item)
Home & Community Based Services	From the "through" date of service
Obstetrical services professional fees Global procedure codes: The service date must be the delivery date.	From the delivery date
Services billed separately; additional services	From date of service
Equipment rental - The service date must be the last day of the rental period	From the date of service

Medicare Crossover Claims

Timely filing for Medicare Crossover Claims is 120 days from the Medicare processing date shown on the Medicare payment report (Standard Paper Remit [SPR]).



Complete the Medicare fields on electronic and hardcopy crossover claims using the Medicare processing information on the Medicare payment report.

Maintain the Medicare payment report and the page describing the payment or denial reasons in the member's file.

When automatic crossover (the automated exchange of claims between Medicare and the Colorado Medical Assistance Program fiscal agent) occurs, timely filing requirements are met. If the automatic Medicare crossover claim does not appear on the Colorado Medical Assistance Program PCR within 60 days from the Medicare processing date, the provider is responsible for submitting the crossover claim to the Colorado Medical Assistance Program.

Adverse Action

Adverse action is any claim-specific action that does not result in Colorado Medical Assistance Program-authorized reimbursement for services rendered. The following are examples of adverse action:

- A claim rejection
- A claim denial
- A disputed payment on the Colorado Medical Assistance Program PCR
- Fiscal agent correspondence (including form letters) that identifies specific claims
- Claims that have been date-stamped by the fiscal agent or the Department and returned to the provider

Correspondence, reports, or forms that do not identify the member, service date(s), types of service, and billing provider are not recognized as proof of timely filing compliance. Prior authorization is not a timely filing waiver.

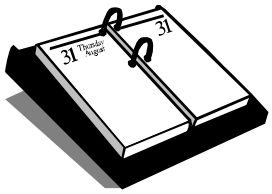
Follow up with the fiscal agent if claims do not appear on the Provider Claim Report within 30 Days

Checking Claim Status

Providers may follow up with the fiscal agent regarding claim status by calling Provider Services at the phone number listed in Appendix A in the Provider Services Billing Manual section. Providers can also utilize the HIPAA 276/277 Claim Status Request and Response transaction to inquire about claims. To use this method of determining claim status, the provider must be able to transmit compliant HIPAA transactions, or use a clearinghouse or switch vendor to transmit the data for them. Specific details for submitting and receiving this transaction are outlined in the 276/277 Companion Guide located in the Provider Services Specifications section.

Re-bills and adjustments and the sixty-day rule

Electronic and paper re-bills (resubmissions of previously denied claims) and adjustment requests must be filed with the fiscal agent and received within the timely filing period.



If the timely filing period expires, a re-bill or adjustment request must be received within 60 days of the last adverse action.

The date of the last adverse action must be entered in the Late Bill Override Date field of the electronic format.

If the provider submits a paper claim, the date of the last adverse action must be entered as follows:

- UB-04: Occurrence code 53 and the date are required in FL 31-34
- CMS 1500: Indicate "LBOD" and the date in box 19 – Additional Claim Information.
- 2006 ADA Dental: Indicate "LBOD" and the date in box 35 – Remarks

Proof of compliance with **all** timely filing and sixty-day rule requirements must be maintained in the provider's files. Compliance with the sixty-day rule is calculated by using one of the following dates:

- The PCR run date
- The electronic claim rejection date
- The correspondence date
- The date-stamp on returned claims

Timely Filing Continuity

Providers may continue to re-bill or adjust claims after the original timely filing period has expired if every submission meets applicable 60-day rule requirements.

If the original timely filing period expires, the next submission must be received within 60 days of the last adverse action. Calculate compliance with the sixty-day rule by counting backward sixty days from the last documented electronic transmission date. To determine timely filing continuity for paper claims, estimate the claim receipt date (allow ample mailing time) and count backward sixty days. If the last adverse action date falls within the sixty-day time period, the sixty-day rule requirement is met.

For example, if a claim is received on December 31st, the last adverse action must be dated after November 1st of the same year. If the last adverse action date occurred before the sixty-day period, the claim or adjustment is not within timely filing.

Copies of **all** PCRs, electronic claim rejections, and/or correspondence documenting compliance with timely filing and sixty-day rule requirements must be maintained in the provider's files.

Delayed processing by third party resources

If the timely filing period expires because of delays in getting third party payment or denial documentation, the fiscal agent is authorized to consider the claim to be filed timely if it is received within 60 days from the date of the third party payment or denial **or** within 365 days of the date of service, **whichever occurs first**.

- Providers should not submit or resubmit claims which will be received by the fiscal agent later than 365 days from the data of service. If extenuating circumstances exist for claims 365 or more days old, the provide may submit the claim for reconsideration. See, Section 11 on "Request for Reconsideration".

Providers must complete third party information on the electronic claim format and retain a copy of the third party payment or denial notice in their files. If a paper claim is required, the provider must complete the third party payment/denial fields, write "TPR Paid" or "TPR Denied" on the face of the claim, and retain a copy of the third party payment or denial notice. A copy of the third party payment or denial notice also may be attached to the claim. The provider is responsible for pursuing available third party resources in a timely manner.

Delayed/Retroactive Member Eligibility

If the timely filing period expires because eligibility determination is delayed or back-dated, the fiscal agent is authorized to consider the claim to be filed timely if it is received within 120 days of the date that the member's eligibility is approved. Each claim must have an attached Department-authorized form or letter from the County Department of Human/Social Services that verifies the eligibility determination delay or backdating, and the claim meets the following requirements:

- The document is an identifiable county document (e.g., correspondence printed on county letterhead or an imprinted or typeset form).
  - Identifies the verifying county staff member by name
  - Identifies the member for which services are being billed
- The Claim states specifically that eligibility was delayed and/or backdated and indicates the dates of eligibility.
- The Claim states the date that such action was entered into the State's eligibility system.

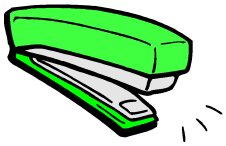
Do not submit claims without member state identification numbers. If eligibility determination is pending, file the claim with the required documentation described above as soon as an assigned number is available.

Delayed notification of Colorado Medical Assistance Program eligibility

Providers are expected to take appropriate and reasonable action to identify Colorado Medical Assistance Program eligibility in a timely manner. Some examples of appropriate action include:

- Reviewing past medical and accounting records for eligibility and billing information for services provided.
- Requesting billing information from the referring provider or facility where the patient was seen.
- Contacting the patient by phone or by mail.

It is not effective to rely solely on billing statements, collection notices, or collection agencies as the only means of obtaining eligibility and billing information. If the timely filing period expires because the provider is not aware that the member is Colorado Medical Assistance Program eligible, the fiscal agent is authorized to extend the timely filing period if the claim is received within 60 days of the date that the provider was notified of Colorado Medical Assistance Program eligibility.

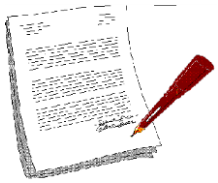


A signed Certification and Request for Timely Filing Extension form must be completed and attached to each claim for which an extension is requested. The State-approved certification form is reproduced in Certification & Request for Timely Filing Extension in the Provider Services Forms section. Providers may copy the form as necessary.

- Any alterations, additions, or deletions to the statements on the form will cause the claim(s) to be denied.
- Each form must be signed by the provider or an authorized agent/representative.
- Rubber stamped or photocopied signatures are not acceptable and will cause claim(s) to be denied.
- Misuse of the certification to obtain unwarranted timely filing extensions will result in recovery of improperly obtained payments.

Requests for Reconsideration

The provider must exhaust all authorized fiscal agent rebilling and adjustment procedures before filing a Request for Reconsideration with the fiscal agent.



- Requests for Reconsideration must be filed in writing with the fiscal agent within 60 days of the last adverse action, if initial timely filing has expired.
- Copies of all PCRs, electronic claim rejections, and/or correspondence documenting compliance with timely filing and sixty-day rule requirements must be submitted with the Request for Reconsideration.

Timely filing extensions for circumstances beyond the provider's control

Occasionally, the timely filing period may expire because of delays in obtaining eligibility or third party processing information. The Department authorizes the fiscal agent to extend the timely filing period under the following circumstances:

- Delayed Processing by Third Party Resources
- Delayed/Retroactive Member Eligibility
- Delayed Notification of Colorado Medical Assistance Program Eligibility
- Other Circumstances beyond the Provider's Control

Other circumstances beyond the provider's control

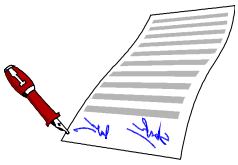
Reconsiderations that request timely filing waivers must contain a detailed description of the extenuating circumstances **beyond the provider's control** resulting in failure to meet timely filing requirements.

Exceptions are granted only where the provider is able to document that appropriate action to meet filing requirements was taken and that the provider was prevented from filing as the result of exceptional circumstances that could not have been foreseen or controlled. Employee negligence, employer failure to provide sufficient, well-trained employees, or failure to properly monitor the activities of employees and agents (e.g., billing services) are not extenuating circumstances beyond the provider's control.

General Claim Completion Instructions

The following general instructions help assure prompt, accurate claim processing:

Always read the instructions for the specific claim format being completed. The instructions describe each data field and the information required for accurate completion. Paper claims may be completed by computer, typewriter, or by hand. **All claim information must be legible**. Handwritten claims should be neatly printed. Do not strike over typing errors. Keep entries within the designated boxes and lines.



Paper claims that cannot be imaged are returned to the provider. Paper claims and attachments must meet minimum imaging requirements. Use black ink to complete the claim form. Faint printing caused by worn or poor quality typewriters or printer cartridges cannot be imaged.

Never use highlighters to mark paper claims or claim attachments. Highlighted information cannot be imaged. Use a broad black pen to circle or underline information requiring special attention.

If field completion is not required, leave the field blank. Do not enter comments or "N/A."

Do not submit "continuation" claims. Each paper claim form has a set number of billing lines available for completion. **Do not crowd more lines on the form**. Billing lines in excess of the designated number are not processed or acknowledged. Claims with more billing lines than allowed on the form must be split and each page fully completed and totaled.

Each paper claim form must be accompanied by any required attachments. Always attach required claim attachments **behind** the claim form. If several claims require the same attachment, the attachment must be photocopied as many times as necessary and stapled behind **each** of the submitted claim forms.

Claims for more than one occurrence of the same procedure on the same date should be billed on one billing line using multiple units of service and increasing the charges accordingly.

Claim Coding

All Colorado Medical Assistance Program claims require diagnosis codes and procedure codes. The appropriate diagnosis code must be entered on all claims. Procedure codes are dependent on the type of service and claim type.

Diagnosis Coding

The Colorado Medical Assistance Program recognizes only those diagnosis codes published in the ICD-10-CM by the U.S. Department of Health and Human Services, Public Health Service, and Center for Medicare and Medicaid Services (CMS).

ICD-10-CM codes must be entered properly on the claim form and must relate to the services for which charges are being submitted. The Colorado Medical Assistance Program provides benefits for services that are medically necessary. The diagnosis code must be specific and indicate an appropriate cause for and relationship to the services provided. In general, non-specific codes (e.g., for radiology examinations or gynecology examinations) are not acceptable for Colorado Medical Assistance Program reimbursement. Common medical practice indicates that some procedures are appropriate only when specific conditions are present. **Providers must assure that the diagnosis entered supports the validity and appropriateness of the billed service. DSMIV codes are not accepted.**

Diagnosis Coding for Members with AIDS or AIDS-related Diagnoses

Federal and State legislation impose severe penalties for failure to keep AIDS-related information confidential. This legislation, however, is not intended to prevent Colorado Medical Assistance Program providers from accurately and appropriately submitting Colorado Medical Assistance Program claims.

Colorado Medical Assistance Program providers, the State, and the fiscal agent are prohibited from disclosing any information related to public assistance applicants or members. Federal Regulation 430.331, State Statute 26-1-114, and HIPAA Privacy CFR 45 provide sanctions for disclosing confidential information. However, these legal documents do allow information to be disclosed for the purpose of administering a public assistance program.

Colorado Medical Assistance Program claim information is necessary for Colorado Medical Assistance Program administration. This information meets Federal and State requirements and is used to process claims, calculate costs, and project future funding. **Information shared for these purposes does not endanger the member's confidentiality.** AIDS or AIDS-related diagnoses codes should be entered on the claim form like any other diagnosis or condition.

Procedure Coding - HCPCS

The Colorado Medical Assistance Program uses the CMS HCPCS to identify services provided to Colorado Medical Assistance Program members. The HCPCS includes codes identified in the *Physician's Current Procedural Terminology (CPT)* and codes developed by CMS.

The State approves using HCPCS codes when submitting claims for services billed in the following formats:

- CMS 1500
- Institutional-Outpatient
- Dental
- EPSDT

Providers should use the most current CPT version. The Colorado Medical Assistance Program adds and deletes codes as they are published in annual revisions of CPT. The CPT can be purchased at local university bookstores or from the American Medical Association at the following address:

Book & Pamphlet Fulfillment: OP-341/9
American Medical Association
PO Box 10946
Chicago, IL 60610

Always use the current HCPCS publication when submitting the Colorado Medical Assistance Program claims. Updates and revisions to HCPCS listings are made through Colorado Medical Assistance Program bulletins located in the Provider Services Bulletins section.

HCPCS publications vary in length and are replaced annually. Providers should keep the current HCPCS publication with the Provider Manual.

Revenue Coding

The Colorado Medical Assistance Program Revenue Code Table contains, by type of service, revenue codes for billing services to the Colorado Medical Assistance Program. The listed revenue codes are not all Colorado Medical Assistance Program benefits. When valid non-benefit revenue codes are used, the claim must be completed according to the billing instructions for non-covered charges**. Claims submitted with revenue codes that are not listed are denied.**

Use the codes listed in the current revenue code table when submitting institutional claims. Notices of updates and revisions to the revenue code table are made in Colorado Medical Assistance Program bulletins. The current revenue code table is located in Appendix Q of the Appendices in the Provider Services Billing Manuals section.

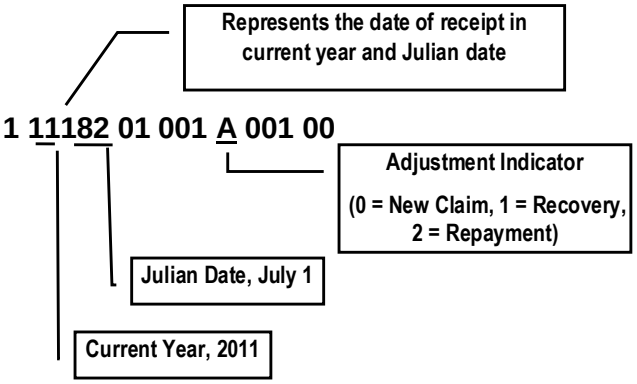
Claims Processing

Claims Processing Overview

The Department contracts with the fiscal agent for the processing of Colorado Medical Assistance Program claims. The fiscal agent receives and processes all Colorado Medical Assistance Program claims in accordance with established Colorado Medical Assistance Program policies. Claims can be submitted via paper, interactively via the Web Portal or via Electronic Data Interchange (EDI) using the 837 transactions.

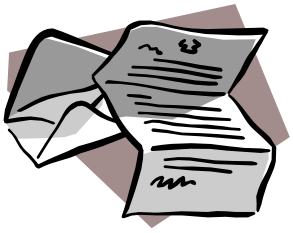
A unique, 17-digit, Transaction Control Number (TCN) is assigned to each claim for identification and tracking. The 2nd and 3rd digits represent the current year, and the 4th, 5th, and 6th digits represent the Julian date of receipt.

Transaction Control Number



Paper claims

When required information is not included or is illegible on paper claims, the claims are returned to the provider for correction and/or completion. Returned claims are date stamped and sent to the provider with a Return To Provider (RTP) form letter. The date-stamped claim is proof of timely filing.

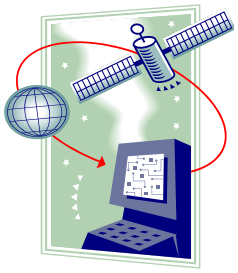


The provider should enter or correct the required information and check additional missing, invalid, or illegible information to avoid further processing delay. If needed, the provider may contact Colorado Medical Assistance Program Provider Services for assistance.

Do not attach the RTP letter or a copy to the corrected claim. Retain the RTP letter for your files.

Electronic Claims

When required information is not included on the claims, the claims are electronically rejected. The accept/reject report, or the 999 Acknowledgement when using any of the HIPAA 837 transactions, lists all the claims that have been accepted and rejected. The accept/reject report, is proof of fiscal agent receipt. Rejected claims are not processed and do not appear on the PCR.



After each system cycle, accepted claims pay, suspend, or deny.

Claims suspend when they have errors or, according to state guidelines, require manual review. Claims processors review suspended claims and process the claims according to State policy. See the Web Portal information in the Billing section of this manual.

Payment Cycle

Each Friday, the weekly payment cycle prepares claims for payment, processes the payment, updates the provider's Accounts Receivable (AR), if applicable, posts Electronic Funds Transfer (EFT) the next week, and produces a PCR. The fiscal agent receives warrants (checks) from the Colorado Financial Reporting System (COFRS)on Wednesdays, matches them to the PCR, and mails them to providers. Except when holidays create a one to two day delay, providers should receive their warrant by the beginning of the following week.

The Colorado Medical Assistance Program PCR is the official document that reports the results of claim processing. For every billing provider with claims processed during the week, a PCR is either mailed to the provider or posted electronically. If processing results in a payment, the PCR is accompanied by a warrant (check) or EFT issued by the State of Colorado.

Information on the PCR must be used to post payments, reconcile patient accounts, track claims, comply with timely filing requirements, and detect payment or billing errors. The PCR should be retained for reference. A service charge is applied to produce a duplicate PCR.

Providers may also request to receive the HIPAA 835 Health Care Claim Payment Advice for receiving claim payment information. To receive this transaction, the provider must be able to receive compliant HIPAA transactions, or use a clearinghouse to receive and transmit the data for them. To obtain more information about receiving this transaction, contact the Electronic Data Interchange (EDI) Support Unit at 800-237-0757, option 4.

General Information

PCR information varies according to the type of claim submitted, the type of provider submitting the claim, and the type of service provided (category of service). Providers who submit claims under more than one provider number receive a separate PCR for each billing provider number.

If the provider bills for more than one service category, claims for each category are displayed separately.

The PCR for a pharmacy submitting claims for prescription drugs and for medical supplies will have separate displays: One for drugs and one for supplies.

Providers select the order in which claim information is sorted. Within each category of service, claims may be sequenced by member last name, State ID, prescription number (pharmacy only), rendering provider number, rendering provider name, date of service, or patient account/invoice number. Requests for changes to the claim information sequence are handled by Colorado Medical Assistance Program Provider Services. See the Appendixes in the Provider Services Billing Manual section for contact information.

As appropriate and applicable, claim status information is printed for each category of service under the following headings: Claims Paid, Claims Denied, Claims In Process, Adjustments Paid, Adjustments Denied, Reconsiderations Paid, Reconsiderations Denied, and Reconsiderations in Process.

Provider Claim Report (PCR) Sections

Each PCR page carries a heading with the following information:

The name of the provider, the provider's Colorado Medical Assistance Program number, and the category of service for the identified claims.

Information about the PCR: The "Run Date," which identifies the date that the PCR was actually printed and is used for timely filing calculations; the "As Of Date," which identifies the cut-off date applicable to the claim information; and the page number of the PCR.

Claim detail information is reported under a number of headings according to the type of claim submitted and the adjudication status of the claim. Payments, Denials, and In-Process Claims are reported using distinctive headings.

If no claims are paid during the week, the PCR will not contain a paid claims section.

Each of the following sections appears on the PCR with a distinctive heading indicating the type of information presented:

Provider Identification

The first page of the PCR displays the provider's name and address.

Special Messages

The PCR notifies providers of special updates and policy and/or claims processing information. These messages contain the timeliest notification of changes in billing and payment conditions and should be read each time a PCR is received.

Messages are often repeated for two or more weeks to assure that infrequent billers have access to information in the same way as those providers who submit claims weekly. Even though the messages may appear unchanged over a several week period, providers should always read the PCR messages each time the PCR is received.

Claims Paid

Information in this section of the PCR must be used to reconcile patient accounts and make appropriate accounting and adjustment entries. The provider is responsible for reconciling the PCR.

The total number of paid claims and total dollar amount of the payment for the identified category of service is listed at the end of the PCR.

Claims Denied

Denied claims identify the reason for denial with a reference code. Claims that are denied as a duplicate claim display a second entry identifying the previously paid claim by the TCN and processing date.

Claims denied because of billing errors, incorrect eligibility information, etc., may be rebilled with additional or corrected information at any time during the applicable timely filing period. Rebilled claims appear on the PCR as a new claim with a new TCN.

The total number of denied claims is identified at the end of the Claims Denied section of the PCR.

Adjustments Paid

Claim payments may be adjusted for increased payment, decreased payment, or recovery without repayment. Adjustments that increase or decrease the payment amount are processed as two separate transactions. The first transaction recovers the previously made payment and the second transaction repays the claim at the corrected rate.

Original transactions are identified by a "0" in the 12th position of the TCN (refer to pages 1-2 of this section). Recovery transactions are identified by a "1" in the 12th position of the TCN and a "CR" notation following the claim payment amount. Repayment transactions are identified by a "2" in the 12th position of the TCN and show the full amount of the corrected payment.

If the previous payment is recovered without repayment, the adjustment is finalized with the recovery transaction and a repayment transaction does not appear. Overpayments are recovered by reducing the total payment amount for claims paid on the PCR. If the full recovery amount cannot be collected when the adjustment is finalized, an AR account is established to recover the balance from the future claim payments.

Following the last transaction in the Adjustments Paid section, the total number of adjustments paid is indicated as well as the net result, payment, or recovery for all adjustment transactions. If the net result of all adjustment transactions is a balance due from the provider (recovery), the total payment amount shows the notation "CR" following the dollar amount.

Adjustments Denied

Denied adjustments may result in a balance due. The recovery transaction retracts the original claim payment and, when the entire repayment transaction is denied, the repayment amount is zero.

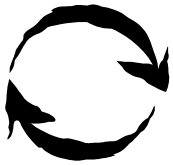
Denied adjustments identify the reason for denial. Adjustments that are denied as a duplicate of a previously processed adjustment identify the duplicate adjustment by TCN and processing date.

Denied adjustments may be resubmitted with additional or corrected information within the applicable timely filing period of the PCR showing the adjustment denial. Resubmitted adjustments display a new TCN.

The total number of denied adjustments is identified at the end of the Adjustments Denied section.

Claims in process

Claims that are being processed, but have not finalized at the time the weekly PCR is prepared, appear on the PCR as "Claims in Process".



Do not re-bill or submit adjustment transactions for claims in process. Suspended claims will be adjudicated and appear in the claims paid or claims denied sections on subsequent PCR.

Claims Denied for Third Party Liability

Third party resources must be pursued and third party payment or denial information must be reported on the Colorado Medical Assistance Program claim. When third party resources are available, claims without third party payment or denial information are denied. The PCR displays third party resources information to assist providers in submitting claim information to third party resources.

Payment Information

Claim payment information is reported on the PCR under the headings of Claims Paid, Adjustments Paid, or Reconsiderations Paid.

The total number of paid claims and the total dollar amount of the payment for the identified category of service is listed at the end of the PCR.

Incorrect payments must be adjusted and cannot be re-billed. The fiscal agent must receive requests for adjustment within the applicable timely filing period.

Accounts Receivable Information

An AR account is established when circumstances result in a provider owing money to the Colorado Medical Assistance Program.

A Credit Account is established when the net result of adjustment transactions is a credit balance and amount owing to the State that cannot be fully recovered from claim payments made on the same PCR, or when audit results determine that a provider has been overpaid or is otherwise indebted to the Colorado Medical Assistance Program.

Accounts receivable information for both types of accounts is displayed in the following format:

Beginning amount due the state	$ _____
Payment amount applied to A/R balance	$ _____
New credit amount due the state	$ _____
Percentage applied to credit amount	_____ %

Beginning credit amount due the State

The balance is due to the Colorado Medical Assistance Program at the beginning of the weekly payment period. This amount is the same as the ending balance shown on the previous PCR. If the AR account is established because of credits taken on the current PCR, the beginning amount appears as 0.00.

Payment Amount Applied to A/R Balance

The dollar amount applied to the AR balance from the claims paid is on the PCR. If the net result of claims and adjustments paid is a credit or recovery, the amount is added to rather than subtracted from the beginning AR balance.

New Interim/Credit Amount due the State

The updated balance due the State from the provider, calculated as the Beginning Credit Amount plus or minus the Payment Amount Applied to the A/R Balance or plus additional credits identified on the same PCR.

Percentage Applied to Payment/Credit Amount

The percentage of the current payment for paid claims and adjustments applied to the beginning amount due the State. The recovery percentage amount is determined by the State.

Total Check Amount

The amount of the warrant is enclosed with the PCR.

Denial Reason (Exc) Codes

A brief explanation of the denial codes if listed in the Denial Reasons column.

The following examples illustrate reconciliation of the AR information:

Example 1

Previously established AR with repayment deducted from current paid claims

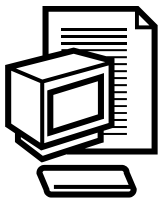
Claims paid from PCR	$400.00
Adjustments Paid from PCR	$200.00
Total Payments this PCR	
Beginning Amount Due	$600.00
Payment Applied	
New Credit Amount	400.00 (From previous PCR)
Percentage Applied	150.00 ($600.00 total payment times 25%)
	250.00 (To next week's PCR)
	25

Example 2

Newly created AR from recovery adjustments

Claims paid from PCR	0.00
Adjustments Paid from PCR	$200.00 CR
Total Payments this PCR	0.00
Beginning Amount Due	0.00
Payment Applied	200.00 (Negative adjustment amount) *When the net result of paid claims and adjustments is a negative or credit amount, the amount shown is added to rather than subtracted from the beginning balance.*
New Credit Amount	200.00 (To next week's PCR)
Percentage Applied	25

Re-bills



Denied claims can be re-billed. Claims that are paid incorrectly must be adjusted. Do not re-bill claims that appear on the PCR as "In-Process."

Re-bills must be received by the fiscal agent within the applicable timely filing period.

Re-bills should be submitted electronically if attachments are not required. Re-bills should be submitted as a newly created claim form or as a legible photocopy of the original claim that has been corrected. Draw a heavy, black line through all information for claim items

that have been paid. Adjust the total charges to reflect the re-bill amount. Mark the claim "REBILL," re-sign with an authorized signature, and re-date. The date should reflect the date the re-bill is signed.

Required attachments must accompany each applicable claim form.

Example: If three claims require the same report, the report must be copied three times and a copy of the report attached to each of the three claim forms.

Adjustments

Claims that appear in the Claims Paid section of the PCR may be adjusted electronically or on paper. The fiscal agent must receive requests for adjustment to paid claims within the applicable timely filing period. Copies of all Colorado Medical Assistance Program PCR and Acceptance/Rejection reports documenting applicable timely filing must be attached to the paper adjustment request or electronically document timely filing with the Late Bill Override Date (LBOD) field.

Providers should submit a CMS 1500 to request correction of underpayments, claims paid at zero, overpayments, and claims history information. If these corrections are not submitted as adjustments, but are re-billed, they will be denied as duplicates.

Payment Errors

The provider is responsible for notifying the fiscal agent immediately when payment errors occur. The CMS 1500 must indicate the appropriate corrected or additional information necessary for claim reprocessing. If a claim has been underpaid, the fiscal agent must receive a CMS 1500 adjustment within the applicable timely filing period.

Underpayments

If a claim has been underpaid, the fiscal agent must receive the CMS 1500 adjustment within the applicable timely filing period.

Claims are underpaid because of incorrect, missing, or inadequate submitted information. The adjustment must indicate the appropriate corrected or additional information necessary for claim reprocessing.

Claims paid at zero

A claim payment of $0.00 (zero) is a paid claim even though the provider does not actually receive payment. The most common reason for zero payment is third party payment deduction from the allowable Colorado Medical Assistance Program benefit or a Medicare crossover paid under lower-of-pricing. If a zero payment is incorrect, the provider must submit a CMS 1500. Re-billed zero payment claims are denied as duplicates.

Claims that are line item processed and document-adjudicated may show some line items as paid and others as denied. Line item denials show allowed charges as $0.00 with a code printed to the right of the procedure code modifier for the denied line. Denied line items may be re-billed.

Overpayments

Providers must report all overpayments to the fiscal agent immediately. Overpayments are adjusted and recovered upon discovery even if the timely filing period has expired. Adjustments to overpaid claims may be made in one of the following ways:

Overpayments are recovered through (1) the claims processing system with credit (recovery) amounts subtracted from current claim payments or (2) held as an AR balance designated for recovery against future claim payments.

The provider may send a personal check payable to the State of Colorado for the total claim payment amount. Send the check and a fully completed Refund to Medicaid or Returned Warrant form with attachments to the fiscal agent for processing. The check must be for the **full amount of the incorrect claim payment**.

If repayment of the claim is appropriate, the revised claim is processed through the claims processing system and the repayment appears on the PCR. The repayment amount is included in the warrant.

Warrants and PCRs containing large or numerous payment errors may be returned, non-negotiated, with an explanation to the fiscal agent.

Third Party Payments

The Colorado Medical Assistance Program is always the payer of last resort. If a third party pays for services that were previously processed and paid by Colorado Medical Assistance Program, notify the fiscal agent and refund the full Colorado Medical Assistance Program claim payment. Third party payment recoveries are processed in the same manner as overpayments.

Medicare Crossover Adjustments

Medicare adjustments to previously processed Medicare claims cannot be processed as automatic crossovers. Medicare adjustments may show the crossover message but automatic crossover processing is not possible. The provider must submit a CMS 1500 adjustment transaction and include the Medicare adjustment Standard Paper Remit (SPR) to correct the Colorado Medical Assistance Program payment.

Changes to claim history

An adjustment tranaction should be submitted to correct processed, non-payment related claim information to assure proper data for utilization review and cost reporting, e.g., a corrected date of service.

Requests for Reconsideration

The fiscal agent is the primary source for providers to obtain satisfactory resolution of submitted and processed claims and is authorized by the single state agency to apply all applicable State and Federal rules and regulations to process Colorado Medical Assistance Program claims.

Extenuating Circumstances

If claim filing requirements are not met because of circumstances beyond the control of the provider and all resources available through routine claim processing procedures have been exhausted, reconsideration is available to providers through the Colorado Medical Assistance Program Claims Processing unit.

The Claims Processing unit is authorized to evaluate and validate alternative information resources when the provider can show both of the following conditions:

- Appropriate action to meet filing requirements was taken
- The failure to meet filing requirements was caused by exceptional circumstances that could not have been foreseen or controlled by the provider

Billing and claim preparation errors are not recognized as beyond the provider's control. Examples include:

Employee negligence

The provider's failure to provide sufficient, well-trained employees

The provider's failure to monitor the activities of employees and agents (billing services)

Reconsideration is available only when extenuating circumstances or mitigating factors prevent compliance with filing requirements.

Request for Reconsideration Form

THE COLORADO MEDICAL ASSISTANCE PROGRAM
P.O. Box 30
Denver, CO 80201-0030

COLORADO
Department of Health Care Policy & Financing

Request for Reconsideration

All required information below must be completed. See the reverse side of the form for additional information.

Provider Identification - Required

Provider Name

Street Address

City, State, Zip Code

Billing Provider ID Number

Billing Provider NPI

Individual to Contact

Provider Telephone Number

Area Code **Number**

Client Identification - Required

Enter client's State ID Number

Date(s) of service

Date of last Provider Claim Report (PCR)

If requesting an adjustment of a paid claim, you must enter the TCN:

Important: Do not use this form to rebill claims or request routine adjustments. Use this form only after all routine processing procedures have been exhausted and the adverse action is the result of circumstances beyond the provider's control.

Identification of Attachments - Required

Please indicate the documents attached to this request. Incomplete requests will be denied or returned.

Required for all requests

- ☐ Fully completed and signed claim form(s) with all required attachments, reports and consent forms for each claim form
- ☐ Documents showing proof of compliance with ***all*** timely filing requirements for each claim form

Required, if applicable to extenuating circumstances

- ☐ Certification of delayed eligibility notification
- ☐ Eligibility documentation
- ☐ Third Party Resource payment or denial information
- ☐ Medicare payment or denial information
- ☐ PRO/PAR documentation
- ☐ Correspondence from State of Colorado
- ☐ Other documentation - Please identify

Description of Extenuating Circumstances and Reason for Reconsideration Request - Required

Provider Signature **Date**

Submitting Requests for Reconsideration

Requests for reconsideration should be submitted in writing on Request for Reconsideration forms. These forms may be ordered from the fiscal agent. Instructions for completing the Request for Reconsideration forms appear on the reverse side of the form.

The Requests for Reconsideration forms should be sent to the fiscal agent using the post office mailing address for the appropriate claim type. The forms should be attached to the front or on top of the claim(s) and any related claim information.

Providers may write the word "Reconsideration" on the claim form and submit the required information in a letter. However, requests for reconsideration that are not submitted using the Request for Reconsideration form may be processed using routine claim processing procedures. Reconsideration claims that do not include required information will be denied.

Administrative Procedures

Reconsideration claims are acknowledged on the Colorado Medical Assistance Program PCR and appear under three headings: Reconsiderations In Process, Reconsiderations Paid, or Reconsiderations Denied. Reconsideration claims that are processed as adjustments appear in the Adjustment Section of the PCR. Colorado Medical Assistance Program PCR information constitutes official written notification of reconsideration activity.

Providers should contact Colorado Medical Assistance Program Provider Services for assistance in preparing requests for reconsideration or to ask questions about reconsideration processing.

If a request for reconsideration is denied, the provider may—if additional information or documentation is available to support it—resubmit the request to the Claims Processing unit within the applicable timely filing period. The resubmitted request must include all of the following:

- The Request for Reconsideration form
- Processable claims
- Documents proving compliance with all timely filing requirements
- A letter of explanation

If all means of achieving satisfactory claim resolution through the fiscal agent and the Claims Processing unit have been exhausted, providers may file a written appeal with the Division of Administrative Hearings, Colorado Department of Personnel, General Support Services, at the address indicated in Appendix A of the Appendices of the Provider Services Billing Manuals section.

Appeals submitted to the Division of Administrative Hearings must be received within thirty days from the mailing date of the last notice of adverse action.

Colorado Medical Assistance Program Eligibility Response System (CMERS)/Interactive Voice Response System (IVRS)

The **Colorado Medical Assistance Program Eligibility Response System (CMERS)** is an automated voice response system that furnishes providers with:

- Colorado Medical Assistance Program Eligibility
- Provider Warrant Information
- Claim Status Information
- Instructions on Using CMERS

In addition to these services, the new IVRS (effective as of August 5, 2010) also provides:

- Unlimited Eligibility Inquiries – the previous IVRS had a limit of three eligibility inquiries per call.
- Providers are able to check claim status by Provider ID/National Provider Identifier (NPI) with Member ID and Date of Service, or by Transaction Control Number (TCN).
- Providers are offered a guarantee number (audit number) for member eligibility.

To access the **CMERS/IVRS** call toll free: **800-237-0757**.

For **Eligibility Verification by Faxback** call toll free: **800-493-0920**.

You can also visit us online in the Provider Services section of the Department's Web site at www.colorado.gov/hcpf to access provider enrollment documents, Provider Bulletins, Billing Manuals, fee schedules, and forms.

Web Portal functionality includes: claim submission, claim status inquiries, member eligibility verification, and provider demographic updates.

The Web Portal can be accessed at www.colorado.gov/hcpf at "secured sites".

To reset your Web Portal password please call 303-866-4473.

To report technical problems with the Web Portal, call CGI toll free at 888-538-4275.

This section includes the following instructions:

- **Verify Member Eligibility**
  - Using State Member ID
  - Using Member's SSN
- **Claim Status**
  - By TCN
  - By Member ID
- **Warrant Information**
- **Prior Authorization Information**
- **EDI Services**
  - Report Retrieval
  - Batch Issues

- Retrieval Batch
- Verify Training Partner (TP) ID

- **Billing Questions**
- **Program Benefits**
- **Billing Workshop Reservations**

CMERS/IVRS User Instructions

To Verify Member Eligibility

You can verify eligibility two ways:

- Using the **State Member ID** + the Member's Birth Date

  OR –

- Use the **Member's Social Security Number** + the Member's Birth Date

To Verify Member Eligibility Using the <u>State Member ID</u>:

1. **Call the Colorado Medical Assistance Voice Response System toll free at 800-237-0757.**
2. **Press 1 to Verify Member Eligibility.**

   This action will route your call to the Provider validation section of the IVRS. The system will ask you to enter your Medicaid or CHP+ Provider Number or your National Provider Identification Number (NPI).
3. **Press 1 to enter your Medicaid or CHP+ Provider Number.**

   OR –

   Press 2 to enter your National Provider Identification Number (NPI).
4. **Enter the applicable ID (Medicaid or CHP+ Provider Number or NPI).**

   Provider Numbers are 8-digits and NPI numbers are 10-digits.

If the Provider Number or NPI you entered is an invalid length, the system will ask you to check the ID and reenter it (repeat step 4).

If the Provider Number or NPI is a valid length, the system will read back the digits you entered and ask you to confirm that they are correct.

5. **Press 1 if the Provider Number or NPI is correct.**

   OR –

   Press 2 if the Provider Number or NPI is incorrect (repeat step 4).

If the Provider Number you entered is invalid or inactive and the provider cannot be found, the system will ask you to:

Press 1 to reenter the Provider Number or NPI (repeat step 4).

OR –

Press 0 to speak to a Provider Services Agent.

To Verify Member Eligibility Using the <u>State Member ID</u>:

If the Provider Number or NPI you entered is valid and active, the system will route your call to the Eligibility Verification section of the IVRS.

Press 1 for Eligibility by the State Member ID

When entering the Member ID you will need to enter the member's 7-digit Member ID, beginning with the letter portion of the ID. You will need to press the number key on your phone pad that corresponds to the letter of the Member ID. For example, for the letter B press the number 2 key.

1. **Press the number key corresponding to the letter of the Member ID.**

   The system will ask which of the letters on the number key you want. For example, if you pressed the number 2 the system will ask, "If your letter is A, press 1. If your letter is B, press 2. If your letter is C, press 3."

2. **Press the appropriate selection for the letter of the Member ID.**

   The system will read back the selected letter and ask you to confirm that it is correct.

3. **Press 1 if the letter is correct.**

   OR –

   Press 2 if the letter is incorrect. This option will take you back to step 7.

4. **Enter the remaining six digits of the Member ID.**

   If the Member ID you entered is an invalid length, the system will ask you to check the ID and reenter it (go back to step 7).

   If the Member ID is a valid length, the system will read back the digits you entered and ask you to confirm that they are correct.

5. **Press 1 if the digits are correct.**

   OR –

   Press 2 if the digits are incorrect. This option will take you back to step 10.

6. **Enter the Member's birth date** using the two-digit month, two-digit day and four-digit year (MMDDYYYY) format.

To Verify Member Eligibility Using the <u>State Member ID</u>:

1. **Enter the Date of Service** using the two-digit month, two-digit day and four-digit year (MMDDYYYY) format. Press the * (star) key to enter today's date. Future dates are not valid. The date of service must be within the last 365 days.

   If the member is located in the system using the information you entered, the system will provide eligibility status.

   Press 1 to repeat the eligibility message.

   OR –

   Press 2 to hear the audit number (guarantee number) for the member's eligibility.

   OR –

   Press 3 to continue.

   - If the Date of Service entered is a future date: the system will ask you to reenter the date (see step 13).
   - If the Date of Service entered is an invalid date: Press 1 to enter another date, or Press 0 to speak to a Provider Services agent.
   - If the Member ID or Social Security Number cannot to be accessed by the automated system, you will be transferred to a Provider Services agent.

- If the Social Security Number entered is invalid: Press 1 to enter another SSN or ID, or Press 0 to speak to a Provider Services agent.
- If the Member ID entered is invalid: Press 1 to enter another Member ID or SSN or Press 0 to speak to a Provider Services agent.
- If you entered an invalid NPI: Press 1 to re-enter, or Press 0 to speak to a Provider Services agent.
- If you entered an invalid Provider Number: Press 1 to re-enter, or Press 0 to speak to a Provider Services agent.
- If the Provider Number entered is not currently active: Press 1 to enter a different Provider Number, or Press 0 to speak to a Provider Services agent.
- If the combination of SSN + DOB or Member ID + DOB entered do not match our records: Press 1 to reenter, or Press 0 to speak to a Provider Services agent.

To Verify Member Eligibility Using the Member's Social Security Number:

1. **Call the Colorado Medical Assistance Voice Response System toll free at 800-237-0757.**
2. **Press 1 to Verify Member Eligibility.**

   This action will route your call to the Provider validation section of the IVRS. The system will ask you to enter your Medicaid or CHP+ Provider Number or your National Provider Identification Number (NPI).
3. **Press 1 to enter your Medicaid or CHP+ Provider Number.**

   OR –

   Press 2 to enter your National Provider Identification Number (NPI).
4. **Enter the applicable ID (Medicaid or CHP+ Provider Number or NPI).**

   Provider Numbers are 8-digits and NPI numbers are 10-digits.

   If the Provider Number or NPI you entered is an invalid length, the system will ask you to check the ID and reenter it (repeat step 4).

   If the Provider Number or NPI is a valid length, the system will read back the digits you entered and ask you to confirm that they are correct.
5. **Press 1 if the Provider Number or NPI is correct.**

   OR –

   Press 2 if the Provider Number or NPI is incorrect (repeat step 4).

   If the Provider Number you entered is invalid or inactive and the provider cannot be found, the system will ask you to:

   Press 1 to reenter the Provider Number or NPI (repeat step 4).

   OR –

   Press 0 to speak to a Provider Services Agent.

   If the Provider Number or NPI you entered is valid and active, the system will route your call to the Eligibility Verification section of the IVRS.
6. **Press 2 for Eligibility by Social Security Number.**
7. **Enter the member's Social Security Number.**

Social Security Number must be a 9-digit number.

If the Social Security Number you entered is an invalid length, the system will ask you to check the number and reenter it (repeat step 4).

If the Social Security Number you entered is valid, the system will read back the number you entered and ask you to confirm that it is correct.

To Verify Member Eligibility Using the Member's Social Security Number:

1. **Press 1 if the number is correct.**

   OR –

   Press 2 if the number is incorrect. This option will take you back to step 4.

2. **Enter the Member's birth date** using the two-digit month, two-digit day, and four-digit year (MMDDYYYY) format.

3. **Enter the Date of Service** using the two-digit month, two-digit day, and four-digit year (MMDDYYYY) format. Press the * (star) key to enter today's date. Future dates are not valid. The date of service must be within the last 365 days.

   If the member is located in the system using the information you entered, the system will provide eligibility status.

   Press 1 to repeat the eligibility message.

   OR –

   Press 2 to hear the audit number (guarantee number) for the Member's eligibility.

   OR –

   Press 3 to continue.

   - If the Date of Service entered is a future date: the system will ask you to reenter the date (see step 13).
   - If the Date of Service entered is an invalid date: Press 1 to enter another date, or Press 0 to speak to a Provider Services agent.
   - If the Member ID or Social Security Number cannot to be accessed by the automated system, you will be transferred to a Provider Services agent.
   - If the Social Security Number entered is invalid: Press 1 to enter another SSN or ID, or Press 0 to speak to a Provider Services agent.
   - If the Member ID entered is invalid: Press 1 to enter another Member ID or SSN or Press 0 to speak to a Provider Services agent.
   - If you entered an invalid NPI: Press 1 to re-enter, or Press 0 to speak to a Provider Services agent.
   - If you entered an invalid Provider Number: Press 1 to re-enter, or Press 0 to speak to a Provider Services agent.
   - If the Provider Number entered is not currently active: Press 1 to enter a different Provider Number, or Press 0 to speak to a Provider Services agent.
   - If the combination of SSN + DOB or Member ID + DOB entered do not match our records: Press 1 to reenter, or Press 0 to speak to a Provider Services agent.

For Claim Status

You can check claim status two ways:

- By TCN

  OR –

- By Member ID

To Check Claim Status by TCN:

1. **Call the Colorado Medical Assistance Voice Response System toll free at 800-237-0757.**

   Press 2 for Claim Status.

   This action will route your call to the Provider validation section of the IVRS. The system will ask you to enter your Medicaid or CHP+ Provider Number or your National Provider Identification Number (NPI).

2. **Press 1 to enter your Medicaid or CHP+ Provider Number.**

   OR –

   Press 2 to enter your National Provider Identification Number (NPI).

3. **Enter the applicable ID (Medicaid or CHP+ Provider Number or NPI).**

   Provider Numbers are 8-digits and NPI numbers are 10-digits.

   If the Provider Number or NPI you entered is an invalid length, the system will ask you to check the ID and reenter it (repeat step 4).

   If the Provider Number or NPI is a valid length, the system will read back the digits you entered and ask you to confirm that they are correct.

4. **Press 1 if the Provider Number or NPI is correct.**

   OR –

   Press 2 if the Provider Number or NPI is incorrect (repeat step 4).

   If the Provider Number you entered is invalid or inactive and the provider cannot be found, the system will ask you to:

   Press 1 to reenter the Provider Number or NPI (repeat step 4).

   OR –

   Press 0 to speak to a Provider Services Agent.

To Check Claim Status by TCN:

If the Provider Number or NPI you entered is valid and active, the system will route your call to the Claim Status section of the IVRS.

1. **Press 1 for claim status by TCN.**
2. **Enter the TCN for the claim.**

   The TCN is a 17-digit number.

   If the TCN you entered is an **invalid** length, the system will ask you to check the number and reenter it (repeat step 4).

   If the TCN you entered is **valid**, the system will read back the number you entered and ask you to confirm that it is correct.

3. **Press 1 if the number is correct.**

   OR –

Press 2 if the number is incorrect. This option will take you back to step 4.

The system will play the claim information for the TCN entered.

4. **Press 1 to repeat the claim information.**

   Press 2 to hear the audit number for the claim.

   Press 3 to enter another date of service.

   Press 4 to enter another TCN.

   Press 5 to enter another Provider number.

   Press 9 for the Main Menu.

   Press 0 to speak with a Provider Services agent.

To Check Claim Status by <u>Member ID</u>:

1. **Call the Colorado Medical Assistance Voice Response System toll free at 800-237-0757.**
2. **Press 2 for Claim Status.**

   This action will route your call to the Provider validation section of the IVRS. The system will ask you to enter your Medicaid or CHP+ Provider Number or your National Provider Identification Number (NPI).
3. **Press 1 to enter your Medicaid or CHP+ Provider Number.**

   OR –

   Press 2 to enter your National Provider Identification Number (NPI).
4. **Enter the applicable ID (Medicaid or CHP+ Provider Number or (NPI).**

   If the Provider Number or NPI you entered is an invalid length, the system will ask you to check the ID and reenter it (repeat step 4). Provider Numbers are 8-digits and NPI numbers are 10-digits.

   If the Provider Number or NPI is a valid length, the system will read back the digits you entered and ask you to confirm that they are correct.
5. **Press 1 if the Provider Number or NPI is correct.**

   OR –

   Press 2 if the Provider Number or NPI is incorrect (repeat step 4).

   If the Provider Number you entered is invalid or inactive and the provider cannot be found, the system will ask you to:

   Press 1 to reenter the Provider Number or NPI (repeat step 4).

   OR –

   Press 0 to speak to a Provider Services Agent.

   If the Provider Number or NPI you entered is valid and active, the system will route your call to the Claim Status section of the IVRS.
6. **Press 2 for Claim Status by Member ID**

   When entering the Member ID you will need to enter the member's 7-digit Member ID, beginning with the letter portion of the ID. You will need to press the number key on your phone pad that corresponds to the letter of the Member ID. For example, for the letter B press the number 2 key.

To Check Claim Status by Member ID:

7. **Press the number key corresponding to the letter of the Member ID** The system will ask which of the letters on the number key you want. For example, if you pressed the number 2 the system will ask, "If your letter is A, press 1. If your letter is B, press 2. If your letter is C, press 3."
8. **Press the appropriate selection for the letter of the Member ID**

   The system will read back the selected letter and ask you to confirm that it is correct.
9. **Press 1 if the letter is correct.**

   OR –

   Press 2 if the letter is incorrect. This option will take you back to step 7.
10. **Enter the remaining six digits of the Member ID.**

    If the Member ID you entered is an invalid length, the system will ask you to check the ID and reenter it (repeat step 10).

    If the Member ID is a valid length, the system will read back the digits you entered and ask you to confirm that they are correct.
11. **Press 1 if the digits are correct.**

    OR –

    Press 2 if the digits are incorrect. This option will take you back to step 10.
12. **Enter the Beginning Date of Service** using two-digit month, two-digit day, and four-digit year (MMDDYYYY). Press the * (star) key to enter today's date.
13. **Press 1 if your End Date of Service is the same as the Beginning Date of Service**

    OR –

    Press 2 if the End Date of Service is different than the Beginning Date of Service

    If you pressed 1, the system will play the claim information for the Member ID and Date(s) of Service entered.
14. **If you pressed 2: Enter the End Date of Service** using two-digit month, two-digit day, and four-digit year (MMDDYYYY).

    To Check Claim Status by Member ID:

    The system will play the claim information for the Member ID and Date(s) of Service entered.

    If there are less than 15 claims found for the Member ID and Date(s) of Service, the status for each claim will be played back-to-back along with the applicable TCN.

    Press 1 to repeat the claim information.

    Press 2 to hear the audit number for the claim.

    Press 3 to enter another date of service.

    Press 4 to enter another TCN.

    Press 5 to enter another Provider number.

    Press 9 for the Main Menu.

    Press 0 to speak with a Provider Services agent.

<u>If there are 15 or more claims found for the Member ID and Date(s) of Service</u>, you will hear the following message: *There are more than 15 claims found for the Member ID and dates of service entered.*

Press 1 to search again using a different End Date of Service.

Press 2 if you know the 17-digit TCN for this claim.

Press 3 if you have entered a group NPI number and we can narrow the search by changing to an individual NPI.

Press 9 for the Main Menu.

Press 0 to speak with a Provider Services agent.

For Warrant Information

You can check warrant information using your Medicaid or CHP+ Provider Number.

For Warrant Information:

1. **Call the Colorado Medical Assistance Voice Response System toll free at 800-237-0757.**
2. **Press 3 for Warrant Information.**

   This action will route your call to the Warrant Information section of the IVRS.
3. **Press 1 to enter your Medicaid or CHP+ Provider Number.**
4. **Enter your Medicaid or CHP+ Provider Number.**

   Provider Numbers are 8-digits.

   If the Provider Number you entered is an invalid length, the system will ask you to check the ID and reenter it (repeat step 3).

   If the Provider Number is a valid length, the system will read back the digits you entered and ask you to confirm that they are correct.
5. **Press 1 if the Provider ID is correct**

   OR –

   Press 2 if the Provider ID is incorrect (repeat step 4).

   If the Provider Number you entered is invalid or inactive and the provider cannot be found, the system will ask you to:

   Press 1 to enter a different Provider Number (repeat step 4).

   OR –

   Press 0 to speak to a Provider Services Agent.

   If the Provider Number you entered is valid and active, the system will play the current warrant information.

<u>If payment (warrant) information is found for the Provider ID</u>, the system will play the latest payment amount as follows: *The latest payment amount of <WARRANT AMOUNT> with warrant number <LAST WARRANT NUMBER> was issued on <WARRANT DATE>. The audit number for this transaction is <AUDIT NBR>.*

After the warrant information plays, you have several options:

Press 1 to repeat the message

OR –

Press 2 to enter a different Provider Number.

OR –

Press 9 to return to the Main Menu.

OR –

Press 0 to speak to a Provider Services agent.

If no payment (warrant) information is found for the Provider ID, the system will play the following message: *There is no payment information for this Provider Number <PROV NUM>.*

After the message, you have several options:

Press 1 to enter a different Provider Number.

OR –

Press 9 to return to the Main Menu.

OR –

Press 0 to speak to a Provider Services agent.

Prior Authorization Information

1. **Call the Colorado Medical Assistance Voice Response System toll free at 800-237-0757.**
2. **Press 4 for Prior Authorization information.**
3. **Press 1 to enter your Medicaid or CHP+ Provider Number.**

   OR –

   Press 2 to enter your National Provider Identification Number (NPI).
4. **Enter the applicable ID (Medicaid or CHP+ Provider Number or NPI).**

   Provider Numbers are 8-digits and NPI numbers are 10-digits.

   If the Provider Number or NPI you entered is an invalid length, the system will ask you to check the ID and reenter it (repeat step 4).

   If the Provider Number or NPI is a valid length, the system will read back the digits you entered and ask you to confirm that they are correct.
5. **Press 1 if the Provider Number or NPI is correct.**

   OR –

   Press 2 if the Provider Number or NPI is incorrect (repeat step 4).

   If the Provider Number you entered is invalid or inactive and the provider cannot be found, the system will ask you to:

   Press 1 to reenter the Provider Number or NPI (repeat step 4).

   OR –

   Press 0 to speak to a Provider Services Agent.

   If the Provider Number or NPI you entered is valid and active, the system will route your call to a Provider Services call center agent who specializes in Prior Authorization information.

EDI Services, Report Retrieval, Batch Issues, and Verify a Trading Partner (TP) ID

1. **Call the Colorado Medical Assistance Voice Response System toll free at 800-237-0757.**
2. **Press 4 for "All Other Questions".**
3. **Press 2 for EDI Services, Report Retrieval, Batch Issues, or to Verify a TP ID.**
4. **Press 1 to enter your Medicaid or CHP+ Provider Number.**

   OR –

   Press 2 to enter your National Provider Identification Number (NPI).
5. **Enter the applicable ID (Medicaid or CHP+ Provider Number or NPI).**

   Provider Numbers are 8-digits and NPI numbers are 10-digits.

   If the Provider Number or NPI you entered is an invalid length, the system will ask you to check the ID and reenter it (repeat step 4).

   If the Provider Number or NPI is a valid length, the system will read back the digits you entered and ask you to confirm that they are correct.
6. **Press 1 if the Provider Number or NPI is correct.**

   Your call is forwarded to a Provider Services Call Center Agent for assistance.

   OR –

   Press 2 if the Provider Number or NPI is incorrect (repeat step 4).

   If the Provider Number you entered is invalid or inactive and the provider cannot be found, the system will ask you to:

   Press 1 to reenter the Provider Number or NPI (repeat step 4).

   OR –

   Press 0 to speak to a Provider Services Agent.

   If the Provider Number or NPI you entered is valid and active, the system will route your call to a Provider Services call center agent who specializes in EDI information.

Billing Questions or Program Benefits

1. **Call the Colorado Medical Assistance Voice Response System toll free at 800-237-0757.**
2. **Press 4 for "All Other Questions".**
3. **Press 3 for Billing Questions or Program Benefits.**
4. **Press 1 to enter your Medicaid or CHP+ Provider Number.** ***OR –***

   Press 2 to enter your National Provider Identification Number (NPI).
5. **Enter the applicable ID (Medicaid or CHP+ Provider Number or NPI).**

   Provider Numbers are 8-digits and NPI numbers are 10-digits.

   If the Provider Number or NPI you entered is an invalid length, the system will ask you to check the ID and reenter it (repeat step 4).

If the Provider Number or NPI is a valid length, the system will read back the digits you entered and ask you to confirm that they are correct.

6. **Press 1 if the Provider Number or NPI is correct.**

OR –

Press 2 if the Provider Number or NPI is incorrect (repeat step 4).

If the Provider Number you entered is invalid or inactive and the provider cannot be found, the system will ask you to:

Press 1 to reenter the Provider Number or NPI (repeat step 4).

OR –

Press 0 to speak to a Provider Services Agent.

If the Provider Number or NPI you entered is valid and active, the system will route your call to a Provider Services call center agent who specializes in billing and program benefits.

Billing Workshop Reservations

1. **Call the Colorado Medical Assistance Voice Response System toll free at 800-237-0757.**
2. **Press 4 for "All Other Questions".**
3. **Press 5 for Billing Workshop Reservations.**

This action will route your call to the Billing Workshop message center. You will need the Billing Workshop section of the most recent Provider Bulletin to make a reservation.

You will be asked to leave the following information in a voicemail to make a reservation: date, location, time, and name of the workshop you are registering for. You will need the names of all attendees you are registering and your Provider Number (if you are registering attendees with different Provider Numbers you only need to leave one number on the message). Include your address and phone number. You will be contacted within 10 days by mail or phone with a registration confirmation. Please speak clearly.

If you are unable to attend the workshop for which you made your reservation please follow steps 1-3 above and leave a message with your name and the names of the other attendees who are canceling along with your Provider Number.

Colorado Medical Assistance Program FaxBack Eligibility System

FaxBack Dialogue

Voice response

For FaxBack access eligibility information, instructions and the corresponding prompts are listed below.

The FaxBack telephone number is: 800-493-0920 Toll free

Note: Non-italicized text represents instructions.

Greeting

Voice: ***Welcome to the Colorado Medical Assistance Voice Response System.***

If you are calling from a touch-tone phone, press any key now.

For touch-tone, if caller enters "**", speak message:

– OR –

For rotary, wait 5 seconds. If no response, speak message:

Voice: ***This system can only be accessed using a touch tone telephone. If you are using a rotary dial phone, please hang up and contact Medicaid or CHIP ++Provider services, Monday through Friday between 7:30am and 5:30pm. All providers call 1-800-237-0757 Toll Free.***

Wait 5 seconds. If no response, repeat message.

Wait 5 seconds. If no response, Go To Exit.

Upon entry of any key.

Voice: ***To request eligibility verification, press 1 followed by the pound sign.***

To request provider warrant information, press 2 followed by the pound sign.

To request Claim Status, press 3 followed by the pound sign

For instructions on using the voice response system, press 4 followed by the pound sign.

To connect to a child health plan plus rep, please call 1-800- 359-1991.

Child health plan plus will be referred to as CHIP +throughout the AVR system.

At any time during the recording you may transfer to a provider services agent by pressing #99.

If 1# is keyed: Go To Provider Number.

If 2# is keyed: Go To Provider Warrant Request.

If 3# is keyed: Go To Claim Status Inquiry

If 4# is keyed: Go To Instructions.

If invalid data is entered,

Voice: ***That was an invalid entry.***

Repeat previous voice instruction.

If invalid data is entered three times,

Voice: ***I'm sorry your request cannot be completed without all the required information. If you need assistance, please call Medicaid or CHIP +Provider services, Monday through Friday between 7:30am and 5:30pm. All providers call 1-800-237-0757 Toll Free.***

Go To Exit.

Instructions

Voice: ***You can contact Medicaid or CHIP +Provider services, Monday through Friday between 7:30am and 5:30pm. All providers call 1-800-237-0757 Toll Free.***

Please enter information from your telephone keypad as instructed. You may enter data as soon as you wish. You do not have to listen to the entire instruction.

To repeat a prompt at anytime during the call, press star star.

To connect with a Medicaid Representative at any time, press #99.

Throughout the script, if ** is keyed, repeat the previous prompt.

Voice: ***If, as you are entering data, you realize that you have made a mistake, press star star, and re-enter the correct data after the prompt begins.***

Throughout the script, if ** is keyed while the user is entering data (responding to a prompt), clear the field and repeat the previous prompt.

Voice: ***To verify Colorado Medical Assistance Eligibility, you need the following information:***

Your Medicaid, NPI or CHIP +Provider number.

The member's Medicaid State ID or Social Security number, and

The member's birth date.

The State ID number appears on the Medicaid card. The State ID number consists of an alphabetical letter followed by six digits. Please have the required information ready to enter.

If you do not wish to continue, press 9 followed by the pound sign to end this call.

If 9# is keyed: Go To Exit.

Data Collection

Provider Number

Voice: ***Please enter your eight-digit Medicaid or CHIP +Provider number followed by the pound sign. You may also enter your ten-digit NPI number followed by the pound sign.***

If invalid data is entered,

Voice: ***That was an invalid entry.***

Repeat previous voice instruction.

If invalid data is entered three times,

Voice: ***I'm sorry your request cannot be completed without all the required information. If you need assistance, please call Medicaid or CHIP +Provider services, Monday through Friday between 7:30am and 5:30pm. All providers call 1-800-237-0757 Toll Free.***

Go To Exit.

Member ID Menu

Voice: ***For eligibility information by State ID number, press 1 followed by the pound sign.***

For eligibility information by Social Security number, press 2 followed by the pound sign.

If 1# is keyed: Go To Member Menu.

If 2# is keyed: Go To Member Social Security Menu.

If invalid data is entered,

Voice: ***That was an invalid entry.***

Repeat previous voice instruction.

If invalid data is entered three times,

Voice: ***I'm sorry your request cannot be completed without all the required information. If you need assistance, please call Medicaid or CHIP +Provider services, Monday through Friday between 7:30am and 5:30pm. All providers call 1-800-237-0757 Toll Free.***

Go To Exit.

Member ID Alpha Character

Voice: ***Please press the star key and enter the alpha character of the State ID followed by the pound sign. For help entering alpha characters, press the pound sign.***

If # is keyed:

Voice: ***Entering the alpha character of the State ID requires the entry of the star key plus two numbers for that character. The first number indicates which key on the phone the letter is associated with. The second number indicates the position of that letter on the key. For example, to enter the letter, "N", you would press star six two, followed by the pound sign. The letters "P", "R", and "S" are assigned in that order to key 7. To enter the letter "Q", press star, one, one, followed by the pound sign. The letters "W", "X", and "Y" are assigned in that order to key 9. To enter the letter "Z", press star, one, two, followed by the pound sign.***

If the entry does not consist of a letter:

Voice: ***The entry is not a valid alpha character.***

Repeat previous voice instruction.

If invalid data is entered three times,

Voice: ***I'm sorry your request cannot be completed without all the required information. If you need assistance, please call Medicaid or CHIP +Provider services, Monday through Friday between 7:30am and 5:30pm. All providers call 1-800-237-0757 Toll Free.***

Go To Exit.

Member ID Numeric Characters

Voice: ***Please enter the remaining six digits of the State ID followed by the pound sign.***

If the number does not consist of six digits:

Voice: ***The number is invalid. Please enter 6 digits.***

Repeat previous voice instruction.

If invalid data is entered three times,

Voice: ***I'm sorry your request cannot be completed without all the required information. If you need assistance, please call Medicaid or CHIP +Provider services, Monday through Friday between 7:30am and 5:30pm. All providers call 1-800-237-0757 Toll Free.***

Go To Exit.

Member Social Security Number

Voice: ***Please enter the member's 9 digit Social Security number followed by the pound sign.***

If the number does not consist of nine digits:

Voice: ***The number is invalid. Please enter 9 digits.*** Repeat previous voice instruction.

If invalid data is entered three times,

Voice: ***I'm sorry your request cannot be completed without all the required information. If you need assistance, please call Medicaid or CHIP +Provider services, Monday through Friday between 7:30am and 5:30pm. All providers call 1-800-237-0757 Toll Free.***

Go To Exit.

Member Date of Birth

Voice: ***Enter the month, date, and the four-digit year of the member's birth date followed by the pound sign. If you need instructions for entering the date, press the pound sign now.***

If the pound key is entered:

Voice: ***Dates are entered using an eight-digit format, two digits for the month, two digits for the day, and four digits for the year. For example, to enter January twenty fifth, nineteen ninety-four, enter zero one for the month, two five for the day, and one nine nine four for the year.***

If the number does not consist of eight digits:

Voice: ***The date is invalid. You must enter eight digits. Remember to enter the century as well as the year.***

Repeat previous voice instruction.

Or if the date is greater than the date of inquiry:

Voice: ***The date is invalid. The date cannot be a future date. Remember to enter the century as well as the year.***

Repeat previous voice instruction.

If invalid data is entered three times,

Voice: ***I'm sorry your request cannot be completed without all the required information. If you need assistance, please call Medicaid or CHIP +Provider services, Monday through Friday between 7:30am and 5:30pm. All providers call 1-800-237-0757 Toll Free.***

Go To Exit.

Service/Inquiry Date

Voice: ***Press 8 followed by the pound sign for today's date, otherwise enter the month, day and four digit year of the date of service followed by the pound sign.***

If eight pound is entered, use today's date as the inquiry date.

If the number does not consist of eight digits or is an invalid date:

Voice: ***The date is invalid. You must enter eight digits. Remember to enter the century as well as the year***

Repeat previous voice instruction.

Or if the date is greater than the date of inquiry:

Voice: ***The date is invalid. The date cannot be a future date. Remember to enter the century as well as the year***

Repeat previous voice instruction.

If the entered date is more than 366 days before today's date:

Voice: ***We cannot verify eligibility for a date greater than one year prior to today.***

Repeat previous voice instruction.

If invalid data is entered three times,

Voice: ***I'm sorry your request cannot be completed without all the required information. If you need assistance, please call Medicaid or CHIP ++Provider services, Monday through Friday between 7:30am and 5:30pm. All providers call 1-800-237-0757 Toll Free.***

Go To Exit.

Use the Service/Inquiry date as From date of Service and To date of service.

Confirm Input

If the eligibility request was obtained by State ID number (1 on the Member ID menu):

Voice: ***Verifying Medicaid or CHP+ eligibility for State ID number*** **Repeat State ID entered by user ,** ***born on*** **Repeat birth date entered by user**, ***for*** **Repeat Service/Inquiry Date.**

– OR –

If the eligibility request was obtained by Social Security Number (2 on the Member ID menu):

Voice: ***Verifying Medicaid or CHP+ eligibility for Social Security number*** **Repeat Social Security number entered by user**, ***born on*** **Repeat birth date entered by user**, ***for*** **Repeat Service/Inquiry Date.**

Confirm Menu

Voice: ***If all the information is correct, press 1 followed by the pound sign.***

To re-enter the State ID number, press 2 followed by the pound sign. (will say social security number if applicable)

To re-enter the date of birth, press 3 followed by the pound sign.

To re-enter the date of service, press 4 followed by the pound sign.

If 1# is keyed: Go To Continue.

If 2# is keyed: Go To Member ID Alpha Character or Member Social Security Number and return.

If 3# is keyed: Go To Member Date of Birth and return.

If 4# is keyed: Go To Service/Inquiry Date and return.

If invalid data is entered,

Voice: ***That was an invalid entry.***

Repeat previous voice instruction.

If invalid data is entered three times,

Voice: ***I'm sorry your request cannot be completed without all the required information. If you need assistance, please call Medicaid or CHIP +Provider services, Monday through Friday between 7:30am and 5:30pm. All providers call 1-800-237-0757 Toll Free.***

Continue

Voice: ***Please stay on the line while we access the eligibility records.***

Go to Eligibility Responses.

Eligibility Responses

If a response is received:

Voice: ***Thank you for waiting.***

The member's eligibility status is given for the date requested.

Eligibility Information Menu

Voice: ***For benefit limitation information, press 1 followed by the pound sign.***

For managed care information, press 2 followed by the pound sign.

For Medicare or other insurance information, press 3 followed by the pound sign.

To obtain eligibility information on another member, press 4 followed by the pound sign.

To return to the main menu, press 5 followed by the pound sign.

To end the call, press 9 followed by the pound sign.

If 1# is keyed: Go To Benefit Limitations

If 2# is keyed: Go To Managed Care

If 3# is keyed: Go To Other Coverage

If 4# is keyed: Go To Member ID Menu

If 5# is keyed: Go To Greeting Main Menu

If 9# is keyed: Go To Exit

If invalid data is entered,

Voice: ***That was an invalid entry.***

Repeat previous voice instruction.

If invalid data is entered three times,

Voice: ***I'm sorry your request cannot be completed without all the required information. If you need assistance, please call Medicaid or CHIP +Provider services, Monday through Friday between 7:30am and 5:30pm. All providers call 1-800-237-0757 Toll Free.***

Go To Exit.

End of Script

If number of inquiries is equal to 3 then

Voice: ***A maximum of three inquiries per call.***

Go To Exit.

If number of inquiries is less than 3 then Go To Member ID Menu.

Claim Status Inquiry

Data Collection

Provider Number

Voice: ***Please enter your eight-digit Medicaid or CHIP +Provider number followed by the pound sign. You may also enter your ten-digit NPI number followed by the pound sign.***

If invalid data is entered,

Voice: ***That was an invalid entry.***

Repeat previous voice instruction.

If invalid data is entered three times,

Voice: ***I'm sorry your request cannot be completed without all the required information. If you need assistance, please call Medicaid provider services, Monday through Friday between 7:30am and 5:30pm. All providers call 1-800-237-0757 Toll Free.***

Go To Exit.

Claim Status Inquiry Menu

TCN Character

Voice: ***Please Enter the 17 digit TCN followed by the pound sign.***

Check that the TCN entered was a 17-digit TCN. Anything other than a 17 digit entry is invalid.

If invalid data is entered,

Voice: ***That was an invalid entry.***

Repeat previous voice instruction.

If invalid data is entered three times,

Voice: ***I'm sorry your request cannot be completed without all the required information. If you need assistance, please call Medicaid provider services, Monday through Friday between 7:30am and 5:30pm. All providers call 1-800-237-0757 Toll Free.***

Go To Exit.

Member ID Alpha Character

Voice: ***Please press the star key and enter the alpha character of the State ID followed by the pound sign. For help entering alpha characters, press the pound sign.***

If # is keyed:

Voice: ***Entering the alpha character of the State ID requires the entry of the star key plus two numbers for that character. The first number indicates which key on the phone the letter is associated with. The second number indicates the position of that letter on the key. For example, to enter the letter, "N", you would press star six two, followed by the pound sign. The letters "P", "R", and "S" are assigned in that order to key 7. To enter the letter "Q", press star, one, one, followed by the pound sign. The letters "W", "X", and "Y" are assigned in that order to key 9. To enter the letter "Z", press star, one, two, followed by the pound sign.***

If the entry does not consist of a letter:

Voice: ***The entry is not a valid alpha character.***

Repeat previous voice instruction.

If invalid data is entered three times,

Voice: ***I'm sorry your request cannot be completed without all the required information. If you need assistance, please call Medicaid provider services, Monday through Friday between 7:30am and 5:30pm. All providers call 1-800-237-0757 Toll Free.***

Go To Exit.

Member ID Numeric Characters

Voice: ***Please enter the remaining six digits of the State ID followed by the pound sign.***

If the number does not consist of six digits:

Voice: ***The number is invalid. Please enter 6 digits.***

Repeat previous voice instruction.

If invalid data is entered three times,

Voice: ***I'm sorry your request cannot be completed without all the required information. If you need assistance, please call Medicaid provider services, Monday through Friday between 7:30am and 5:30pm. All providers call 1-800-237-0757 Toll Free.***

Go To Exit.

Confirm Input

Voice: ***Verifying Claim Status request for TCN*** **Repeat TCN entered by user** ***for State ID number*** **Repeat State ID entered by user .**

Confirm Menu

Voice: ***If all the information is correct, press 1 followed by the pound sign.***

To re-enter the TCN, press 2 followed by the pound sign.

To re-enter the State ID, press 3 followed by the pound sign.

If 1# is keyed: Go To Continue.

If 2# is keyed: Go To TCN Character and return.

If 3# is keyed: Go To Member ID Alpha Character and return.

If invalid data is entered,

Voice: ***That was an invalid entry.***

Repeat previous voice instruction.

If invalid data is entered three times,

Voice: ***I'm sorry your request cannot be completed without all the required information. If you need assistance, please call Medicaid provider services, Monday through Friday between 7:30am and 5:30pm. All providers call 1-800-237-0757 Toll Free.***

Continue

Voice: ***Please stay on the line while we access the claim records.***

Go to Claim Status Responses.

Claim Status Responses

If a response is received:

Voice: ***Thank you for waiting.***

The current status of the requested claim will be given.

Voice: ***To enter another claim inquiry request, press 1 followed by the pound sign.***

To end this call, press 9 followed by the pound sign.

If 1# is keyed: Go To Data Collection, Claim Status Inquiry Menu.

If 9# is keyed: Go To Exit.

If invalid data is entered,

Voice: ***That was an invalid entry.***

Repeat previous voice instruction.

If invalid data is entered three times,

Voice: ***I'm sorry your request cannot be completed without all the required information. If you need assistance, please call Medicaid provider services, Monday through Friday between 7:30am and 5:30pm. All providers call 1-800-237-0757 Toll Free.***

Go To Exit.

Common Prompts & Responses

The following prompts and responses are common to every portion of the text as referenced.

Exit

Voice: ***Thank you for using the Colorado Medical Assistance Voice Response System.***

Time-Out

After each prompt, allow 5 seconds for the user to begin entering requested information. If a response is not keyed, repeat the previous voice instruction. Allow a 5-second pause for the user to begin entering information.

If a response is not keyed: Repeat the previous voice instruction. Allow another 5 seconds pause for the user to begin entering information.

If a response is not keyed after the second prompt repeat: Go To Incomplete Information.

Incomplete

Voice: ***I'm sorry; your request cannot be completed without all of the required information. If you need assistance, please call Medicaid or CHIP +Provider services, Monday through Friday between 7:30am and 5:30pm. All providers call 1-800-237-0757 Toll Free.***

Go To Exit.

General Provider Information Revisions Log

Revision Date	Section/Action	Pages	Made by
03/09/2007	*Client Eligibility – Updated PE description*	*30*	*jg*
03/09/2007	*Client Eligibility – Updated Benefits and Replaced PE card*	*31*	*jg*
03/09/2007	*Client Eligibility – Added Anthem information*	*32*	*jg*
03/09/2007	*Client Eligibility – Added paragraph to Important Eligibilty Information*	*34*	*jg*
04/23/2007	*Inactivation of enrollment – Corrected No claim activity from one year to 24 months*	*24*	*jg*
05/25/2007	*Updated PE and BCCP program information*	*30-32*	*jg*
06/04/2007	*Moved and Updated CMERS section*	*91-101*	*jg*
06/15/2007	*Corrected PE and BCCP program information*	*30-32*	*jg*
06/25/2007	*Updated EDI phone number*	*76*	*jg*
07/30/2008	*Replaced Reconsideration form and instructions*	*87-88*	*jg*
10/06/2008	*Added CHOW and Tax ID change information*	*16*	*jg*
06/11/2009	*Information updates, TOC verification and Reformatted*	*Throughout*	*vr/jg*
07/10/2009	*TOC verification and Reformatted*	*Throughout*	*jg*
10/19/2009	*Updated Crossover Billing Tips*	*59*	*vr*
02/17/2010	*Updated Web site links*	*Throughout*	*jg*
02/17/2010	*Replaced EOMB with SPR*	*53, 56, 57, 66 & 81*	*jg*
03/21/2011	*Updated links and information in How to Use the Manual* *Updated Manual Maintenance* *Updated Termination of Enrollment* *Updated Inactivation of Enrollment* *New MIC example* *Added CMERS/IVRS information* *Added Web Portal FRS* *Updated TCN* *Updated Adjustment Transmittal* *Updated Request for Reconsideration* *Added CMERS/IVRS Instructions* *Separated out FaxBack Instructions*	*2* *3* *13* *14* *18* *24* *48* *57* *66* *68* *71* *83*	*jg*
12/05/2011	*Replaced 997 with 999*	*57*	*ss*
01/27/2012	*Changed authorizing agent to authorizing agency*	*Throughout*	*jg*

Revision Date	Section/Action	Pages	Made by
06/03/2013	*Updated Outpatient Hospital Services cost ratio language Revised timely filing to algin with State Rule*	*29 55-58*	*ja*
06/17/2013	*Replaced Request for Reconsideration and Adjustment Transmittal forms*	*69,70,72*	*jg*
09/23/2013	*Replaced 1-800-237-0044 with 1-800-237-0757 in CMERS section*	*74-85*	*jg*
09/27/2013	*Updated IVRS section with improvements as stated in the October 2013 Provider Bulletin*	*23-24*	*cc*
02/03/2014	*Added abortion information*	*37*	*jg*
05/14/2014	*Removed references to the Primary Care Physician Program*	*10*	*Mm*
8/22/14	*Replaced all CO 1500 references with CMS 1500*	*Throughout*	*ZS*
8/22/14	*Replaced all client references with member*	*Throughout*	*ZS*
8/27/14	*Updated all weblinks for the Department's new website*	*Throughout*	*MM*
11/21/14	*Removed Appendix H information, added Timely Filing document information*	*63*	*rm*
02/17/2015	*Updated Adjustment Page*	*69*	*Bl*
5/12/2015	*Changed font to Tahoma, replaced mention of adjustment transmittal form with Refund to Medicaid or Returned warrant Forms, changed adjustment transmittal to CMS-1500 or adjustment transaction or CMS 1500 adjustment transaction, changed the Request for Reconsideration form to new logo.*	*Throughout, 73, Throughout, 74*	*JH*
05/13/2015	*Cleaned up empty spaces/pages, minor formatting, and TOC page number updates.*	*Throughout*	*bl*
7/28/15	*Audited for ICD-9 codes and there are none in the manual. Replaced mentions of ICD-9 with ICD-10.*	*Throughout*	*JH*
8/31/15	*There is no mention of Carewebqi/ColoradoPAR.*	*Throughout*	*JH*
09/09/2015	*Updated TOC and accepted changes*	*Throughout*	*bl*

Note: *In many instances when specific pages are updated, the page numbers change for the entire section. Page numbers listed above, are the page numbers on which the updates/changes occur.*