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8.010 [Repealed 05/15/2014 per House Bill 14-1123]

8.011.1 GENERAL EXCLUSIONS FROM COVERAGE

The paragraphs which follow set forth the general exclusions from coverage of the Medical Assistance Program.

8.011.11 Excluded from coverage are items and services which generally enhance the personal comfort of the eligible person, but are not necessary in the diagnosis of, nor contribute meaningfully to the treatment of an illness or injury, or the functioning of a malformed body member; this exclusion does not apply to inoculations and immunizations provided.

.12 Also excluded are items and services for which neither the eligible person, nor any other person or organization, incurs a legal obligation to pay; an example of such an exclusion is the free chest X-rays provided by health organizations. In applying this particular exclusion, the determining factor is that there is a not legal obligation to pay for the items or services, and not merely the fact that the patient is not charged because of other considerations. A legal obligation to pay exists even when reimbursement is expected only to the extent of the patient's insurance coverage.

This exclusion, therefore does not prohibit program payment for such services rendered to the following persons:

a. Indigents who because of their inability to pay are not charged by an institution which customarily charged for such services;

b. Patients whose need for services resulted from the act or negligence of another who is or may be legally liable for the patient's medical expenses. The existence of a third party's liability does not affect the patient's obligation to pay for the services he received nor the ability of the Medical Assistance Program to provide such coverage in his behalf. (The additional consideration, however, is that such third-party liability and possible benefits must be sought, explored, and secured wherever possible);

c. Individuals resident in homes for the aged when the agreement under which such residency is provided is inclusive of medical services and no payment is accepted from any person residing in the home regardless of their ability to pay. Payment could be made for services rendered by a source independent of such home or institution if that source customarily charges for such services. Thus, payment could be made for services furnished by a hospital or long-term care facility to which a resident of the home is sent (or for home health services by an agency), or for the services of a physician who is not an employee of such home. In addition, this sort of situation is true in certain types of nonprofit homes, certain homes operated by labor unions, and homes for members of religious orders, etc.

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8.013.2 REIMBURSEMENT PRINCIPLES

A. All claims, except out of state nursing home claims, must be submitted to the fiscal agent for the state with documentation showing that the above requirements have been met. (Out of state nursing home claims shall be paid in accordance with the Payment For Out Of State Nursing Home Care section of the Volume 8 staff manual.) All claims submitted to the fiscal agent must include:

1) A copy of the provider's current Medicaid provider agreement with its state (if applicable);

2) Its Colorado provider number; and

3) Complete address, including zip code.

In addition, providers must sign a provider agreement in order to receive reimbursement. The claim form and the information contained in it shall constitute provider agreement. Except as provided elsewhere in the Volume 8 staff manual, reimbursement for out of state care shall be as follows:

Reimbursement for inpatient hospital services shall be 90% of the Colorado urban or rural DRG payment rate. Out-of-state urban hospitals are those hospitals located within the metropolitan statistical area (MSA) as designated by the U.S. Department of Health and Human Services (DHHS).

Reimbursement for physician services shall be the lower of the following:

A. HCFA Common Procedure Coding System (HCPCs) fee;

B. Provider's Actual Charge.

Exceptions to the above reimbursement method are payments for outpatient clinical diagnostic laboratory tests performed by a physician or independent laboratory. These tests will be reimbursed at the lower of the provider's actual charge or a rate of reimbursement equal to the rate paid by Medicare.

Reimbursement for outpatient hospital services shall be 70% of billed charges.

The foregoing procedures shall be in effect for all out-of-state providers, except as provided for elsewhere in the staff manual Volume 8 regulations. Individual cases which are adversely affected by these procedures shall be presented to the Bureau of Medical Services, Director, Program Operations Division, Colorado Department of Social Services. Individual consideration shall be given to such cases.

The Department may negotiate a higher reimbursement rate for out-of-state hospital services that are prior authorized.

A. These are cases which require procedures not available in Colorado and which must be prior authorized.

B. The patient's physician may suggest where the patient should be sent, but the medical consultant for the Department is responsible for making the final determination based on the most cost effective institution consistent with quality of care.

REVISED

8.013.2 REIMBURSEMENT PRINCIPLES

8.013.2 A.

1. All claims, except out-of-state nursing home claims, must be submitted to the fiscal agent for the state with documentation showing that the above requirements have been met. (Out of state nursing home claims shall be paid in accordance with the Payment For Out Of State Nursing Home Care section of the Volume 8 staff manual.) All claims submitted to the fiscal agent must include:

    a. A copy of the provider's current Medicaid provider agreement with its state (if applicable);

    b. A Colorado provider number; and

    c. A Complete address, including zip code.

2. Additionally, providers must sign a provider agreement to receive reimbursement. The claim form and the information contained in it shall constitute provider agreement. Except as provided elsewhere in the Volume 8 staff manual, reimbursement for out-of-state care shall be as follows:

3. Reimbursement for inpatient hospital services shall be 90% of the Colorado urban or rural DRG payment rate. Out-of-state urban hospitals are those hospitals located within the metropolitan statistical area (MSA) as designated by the U.S. Department of Health and Human Services (DHHS).

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8. The Department may negotiate a higher reimbursement rate for out-of-state hospital services that are prior authorized.

    a. These are cases which require procedures not available in Colorado and which must be prior authorized.

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UNEDITED

8.041 CLAIMS REIMBURSEMENT AND STATUS FOR NATIONAL CORRECT CODING INITIATIVE (NCCI)

8.041.1 DEFINITIONS

Current Procedural Terminology (CPT) means the common medical procedure codes used for the purpose of billing medical services as defined by the American Medical Association (AMA).

Fiscal Agent means a vendor who is contracted by the Department to process and maintain the Medicaid Management Information System (MMIS) for purpose of processing claims.

Healthcare Common Procedural Coding System (HCPCS) means an alpha numeric code set as defined by CMS used for the purpose of billing services that are not identified under CPT.

Medically Unlikely Edits (MUE) means units of service edits. This edit restricts the maximum units of services per claim line that may be billed for a procedure code.

National Correct Coding Initiative (NCCI) means a set of claim edits developed by the Centers of Medicare and Medicaid Services (CMS) to promote NCCI methodologies and control improper coding leading to improper Medicaid payments.

Procedure to Procedure edit means the prevention of certain procedure codes from being billed with other procedure codes for the same patient by the same practitioner on the same date of service.

Remittance Statement means the electronic or hard copy statement sent by the Medicaid fiscal agent to advise a provider of claims reimbursement or claims status.

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B. **Fiscal Agent** means a vendor who is contracted by the Department to process and maintain the Medicaid Management Information System (MMIS) for purpose of processing claims.

C. **Healthcare Common Procedural Coding System (HCPCS)** means an alpha numeric code set as defined by CMS used for the purpose of billing services that are not identified under CPT.

D. **Medically Unlikely Edits (MUE)** means units of service edits. This edit restricts the maximum units of services per claim line that may be billed for a procedure code.

E. **National Correct Coding Initiative (NCCI)** means a set of claim edits developed by the Centers of Medicare and Medicaid Services (CMS) to promote NCCI methodologies and control improper coding leading to improper Medicaid payments.

F. **Procedure to Procedure edit** means the prevention of certain procedure codes from being billed with other procedure codes for the same patient by the same practitioner on the same date of service.

G. **Remittance Statement** means the electronic or hard copy statement sent by the Medicaid fiscal agent to advise a provider of claims reimbursement or claims status.

UNEDITED

8.040.2 SUBMISSION OF CLAIMS

Effective July 1, 1994, all Medical Assistance program providers shall be required to transmit in an approved electronic format to the fiscal agent for the Department all claims for goods and services which are benefits of the Medical Assistance program provided to eligible clients. Electronic claims format shall be required unless hard copy claims submittals are specifically authorized by the Department.

A transaction fee shall be required for each electronic claim transmission. This transaction fee shall be collected from the provider against current and future claims of the provider through a reduction in claim reimbursement and shall be so described on the Medicaid Remittance Statement.

Required information concerning the recipient, the service, charges, and provider shall be submitted in the prescribed format. Records verifying the type of service provided, the signed state approved certification statements and agreements which serve as a contractual basis for payment, and required client information or additional documentation which can be matched to the claim for services shall be retained in the provider's file for six years. This documentation shall be made readily available and produced upon request of the Secretary of the Department of Health and Human Services, the Department, and the Medicaid Fraud Control Unit and their authorized agents.

A. Hard Copy Claims

Hard copy (i.e., paper) claim forms shall be submitted only by authorization of the Department. The state approved certification statements contained on the claim form become effective and serve as a contractual basis for payment when the provider signs the form.

B. Automated Medical Payments System/Electronic Transfer of Claims

All providers shall be required to transmit claims for goods and services in the approved electronic format to the fiscal agent for the Department. Only those electronic formats which have been approved by the fiscal agent will be accepted for Automated Medical Payments System.

Before a provider can submit claims electronically, either directly to the fiscal agent or through a vendor or billing service, state approved provider certification agreements which contain all state approved certification statements and conditions shall be signed and accepted by both the provider and the Department. The state approved certification statements become effective and serve as a contractual basis for payment once the provider signs the form. A billing service shall also have a state approved billing service agreement signed and accepted by the Department before any claims will be accepted. The content of the agreements shall be determined by the Department.

If a provider chooses to submit claims for payment directly to the fiscal agent, source documents and source records used to create the claims shall be maintained in such a way that all electronic media claims can be readily associated and identified. These source documents, in addition to any work papers and records used to create electronic media claims, shall be retained by the provider for six years and shall be made readily available and produced upon request of the Secretary of the Department of Health and Human Services, the Department, and the Medicaid Fraud Control Unit and their authorized agents.

A corporation composed of satellite facilities with a common ownership may be considered as a primary provider and bill as such even though each individual facility has a provider number.

However, the submitted claims shall identify the facility providing the services. Original source documents used to create the claims transmission shall be maintained at the facility for six years.

If a provider utilizes a billing service to transmit claims, the provider shall provide source documents and any other data transfer materials necessary to create the electronic claim. The billing service shall retain the source documents and data transfer materials for a six year period except when these items are maintained by the provider. Original source documents and data transfer materials shall be made readily available and produced upon request of the Secretary of the Department of Health and Human Services, the Department, and the Medicaid Fraud Control Unit and their authorized agents. If the provider furnishes the information to the billing service on a computer disc or some other method of electronic transmission, then the source documents used to create the disc or transmission shall be retained by the provider for six years and made readily available and produced upon request.

If the billing service goes out of business, then upon cessation of business, the billing service shall immediately return all documents to each individual provider.

Upon receipt of the electronic transmission, the fiscal agent will process the claims to the M.M.I.S. If the transmission is rejected, the fiscal agent shall send an electronic acknowledgement of rejection to the sender. Claims denied through the M.M.I.S. shall be described on the Medicaid remittance statement.

Electronic transmission of claims shall be required of any provider or billing service. The Department also reserves the right to reject any electronic claims transmission methods.

Failure of the provider or billing service to maintain and certify appropriate records as required by the state approved provider agreements constitutes breach of the state approved provider agreement, and entitles the Department to recover any payments for goods and services made to the provider and to terminate any state approved provider agreement. Thirty day written notice by registered mail shall be used by either party to terminate a state approved provider agreement unless the Department determines that good cause as defined in 8.076.1.7. exists in which immediate termination is necessary. Recovery may be accomplished by withholding the amount from future payments or requiring the provider to make payments directly to the Department as described in 8.040.

Electronically submitted claims must have a certification field indicating that the sender has verified that the claim information transmitted is true and correct. A hard copy of this transmittal will be kept on file at the provider's or billing service's place of business. All claim transmissions which require a state authorized attachment for the purposes of reimbursement or certification of service, will be submitted on hard copy (i.e., paper) and maintained with the providers' original source documents for a period of six years.

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8.040.2 SUBMISSION OF CLAIMS

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B. A transaction fee shall be required for each electronic claim transmission. This transaction fee shall be collected from the provider against current and future claims of the provider through a reduction in claim reimbursement and shall be so described on the Medicaid Remittance Statement.

C. Required information concerning the recipient, the service, charges, and provider shall be submitted in the prescribed format. Records verifying the type of service provided, the signed state approved certification statements and agreements which serve as a contractual basis for payment, and required client information or additional documentation which can be matched to the claim for services shall be retained in the provider's file for six years. This documentation shall be made readily available and produced upon request of the Secretary of the Department of Health and Human Services, the Department, and the Medicaid Fraud Control Unit and their authorized agents.

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   iii. If a provider chooses to submit claims for payment directly to the fiscal agent, source documents and source records used to create the claims shall be maintained in such a way that all electronic media claims can be readily associated and identified. These source documents, in addition to any work papers and records used to create electronic

media claims, shall be retained by the provider for six years and shall be made readily available and produced upon request of the Secretary of the Department of Health and Human Services, the Department, and the Medicaid Fraud Control Unit and their authorized agents.

iv. A corporation composed of satellite facilities with a common ownership may be considered as a primary provider and bill as such even though each individual facility has a provider number. However, the submitted claims shall identify the facility providing the services. Original source documents used to create the claims transmission shall be maintained at the facility for six years.

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