



CMS LiveWire

✧ E-News for Office Administrative Personnel ✧

Health Care Financing Division
Colorado Medical Society

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WE WANT TO HEAR FROM YOU!
Send us your comments,
ideas for articles, and
coding/billing tips &
tricks.

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**New CMS Member
Benefit!**
athenahealth

Colorado Access Non-Renewal of Medicaid HMO Contract

Effective September 1, 2006, Colorado Access will no longer have any Medicaid physical health plan (AHP) members. The Department of Health Care Policy and Financing is working on a plan to transition AHP enrolled members into Fee-For-Service, the Primary Care Physician Program or Denver Health Medicaid Choice.

What Does This Mean?

- Colorado Access will be responsible for Medicaid AHP members through August 31, 2006.
- AHP network providers will continue to file claims and appeals to Colorado Access for AHP enrollees for dates of service up to and including August 31, 2006.
- For dates of service beginning September 1, 2006, AHP network providers that are enrolled Medical Assistance Program providers need to file claims with the State's fiscal agent.

Transition Plan

- The Department is working with Colorado Access to help clients maintain continuity of care by keeping current provider-client relationships.
- Clients with special health care needs and pregnant clients in their third trimester are having individual transition plans developed.
- Existing prior authorizations will be transferred to assist continuity of care.
- AHP network providers that are not existing Medical Assistance Program providers will be invited to enroll.

Remember

- Verify Medical Assistance Program eligibility
- All Medical Assistance Program claims must be filed (received by the fiscal agent) within 120 days of the date of service in order to receive payment. Clients wishing to enroll in the Primary Care Physician Program or the HMO, Denver Health Medicaid Choice, are directed to call HealthColorado at:
 - (303) 839-2120 or
 - 1-888-367-6557 (outside the Denver metro area) or
 - TTY (hearing impaired) 1-888-876-8864

[Click here](#) to access the August newsletter including a copy of the letter being mailed to Colorado Access Clients.

Reminder: Medicare Payment Hold

A brief hold will be placed on Medicare payments for all claims during the last 9 days of the Federal fiscal year (September 22 through September 30, 2006). These payment delays are mandated by section 5203 of the Deficit Reduction Act of 2005. No interest will be accrued and no late penalties will be paid to an entity or individual by reason of this one-time hold on payments. All claims held during this time will be paid on October 2, 2006.

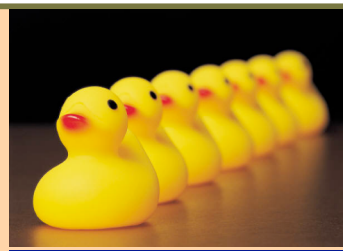
This policy only applies to claims subject to payment. It does not apply to full denials, no-pay claims, and other non-claim payments such as periodic interim payments, home health requests for anticipated payments, and cost report settlements. Please note that payments will not be staggered and no advance payments will be allowed during this 9-day hold.



"How Can We Better Serve You?"

The CMS Health Care Financing Division is currently re-evaluating the services we provide for members and their staff - and we need your input.

Please take a few minutes to complete this [Practice Viability Survey](#) and let us know what you think.



"Help Us Get Our Ducks in a Row!"

We need to identify what CMS members (and their staff) feel are the most needed managed care reforms - What contracting changes would restore some level of fairness and balance to the system. Please complete the [Managed Care Contracting Survey](#). Your input is vital!

Commercial Insurance Updates

-Aetna

Retroactive Payment - Aetna will reimburse the following services that were not paid on claims retroactively to August 15, 2005. CPT preventive medicine E/M service and a problem-focused E/M service appended with CPT modifier 25. CPT E/M service code appended with CPT modifier 57 when billed with a major procedure (defined as one with a global period of 90 days or more). Physicians can resubmit these CPT modifier 25 and 57 claims retroactive to August 15, 2005 for payment. [Click here](#) for additional information. - *AMA PSA Update July 21, 2006*

-Anthem

Please register your National Provider Identifier (NPI) with Anthem as soon as possible to help ensure that our systems have your correct NPI information. After receiving your NPI, register it by completing our [online submission form](#). If you're registering more than one NPI, please complete a form for each NPI. If you have numerous NPIs to submit (for a provider practice or large organization), we'll soon be implementing a "bulk" submission process. Be sure to check <http://www.anthem.com> periodically for more information about this process.

Medicaid Updates

EPSDT Toolkit - In a 2005 survey Medicaid learned that the majority of Medicaid providers surveyed were not fully aware of benefits covered under EPSDT. In response to this, Medicaid has added an [EPSDT Toolkit](#) to their website. The Toolkit includes age-specific exam forms, links to Parent & Provider Resources, billing information & much more.

Medicare Updates

Do You File Medicare Claims Electronically? - Did you know that you could obtain information regarding your Medicare patients' eligibility for selected Medicare Preventive Services? The Medicare Learning Network has developed a guide to help you entitled, "Determining a Medicare Beneficiary's Eligibility for Medicare Preventive Services". This [guide](#) provides information on interpreting a Medicare beneficiary's preventive services next-eligible-date data. It is intended to supplement the educational materials already available for the following eligibility inquiry screens used to access Common Working File (CWF) records: ELGA: Part A HIPAA compliant Direct Data Entry query, ELGB: Part B HIPAA compliant Direct Data Entry query, ELGH: Home Health provider HIPAA compliant Direct Data Entry query, HIQA: Part A provider Direct Data Entry query, HIQH: Home Health provider Direct Data Entry query & HUQA: Clearinghouse and Vendor Transaction.

A Message From the AMA: Medicare Enrollment Update - Since the implementation of the new enrollment requirements on May 1, 2006, CMS contractors continue to receive numerous applications which are incomplete. A rough estimate provided to the AMA by Medicare suggests that as many as 50% - 60% of applications are being rejected for being incomplete (and this includes the follow-up request for missing information). Medicare is seeking data from their contractors to get a firm percentage and will share that information publicly once it is available. CMS has prepared a [tip sheet](#) aimed at helping physicians and other providers understand the enrollment requirements. The AMA is tracking Medicare's progress on processing applications and will be following up to obtain this data.

Miscellaneous

Did you know? Most of us know that consistently waiving patient balances may be considered a breach of contract. But, did you know it is **against the law** for a health care provider to routinely waive copays & deductibles? To view the entire regulation [click here](#). (**Next month: Determining Financial Hardship**)

Did you also know? Colorado has State Law that lists the steps that must be followed when notifying a patient that their outstanding debt will be sent to collections. [Click here](#) to access House Bill 04-1285. - *Contributed by Patty Ferguson, Western Ob/Gyn Associates*



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"Advocating excellence in the profession of medicine."