Medical Assistance Program Bulletin

Colorado Title XIX

Fiscal Agent

600 Seventeenth Street
Suite 600 North
Denver, CO 80202

Medical Assistance Program Provider Services
303-534-0146
1-800-237-0757

Mailing Addresses
Claims & PARs
P.O. Box 30
Denver, CO 80201-0030

Correspondence, Inquiries & Adjustments
P.O. Box 90
Denver, CO 80201-0090

Provider enrollment, Provider information, Changes, Signature authorization, and Claim requisitions
P.O. Box 1100
Denver, CO 80201-1100

Medical Assistance Program
Fiscal Agent Information
on the Internet
www.chcpf.state.co.us

Click on the Provider Services tab at the top of the web page

Medical Assistance Program bulletins contain important policy and billing information and should be shared promptly with billing staff.

Bulletins supplement information in the Medical Assistance Program Provider Manual and should be retained with the provider manual for reference. Retain all bulletins until published notification advises that the information is obsolete or reproduced in subsequent bulletins or provider manuals updates.

Please direct questions about bulletins and billing information to Medical Assistance Program Provider Services.

Distribution: All providers **June 2006**
Reference: B0600213

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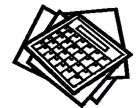
All Providers

Web Portal Update

New functionalities planned for June

Improved Batch Eligibility Responses- Retrieval of the batch eligibility response from the FRS will offer the ability to view and print a user-friendly response that is similar to the interactive response.



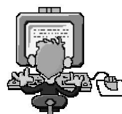
Claim Data Entry – The State ID and client name will now display on each claim data entry page. The Total Charge field will move from the Claim Info page to the Detail Line page. We hope these changes will assist you in the data entry of claims.

Postponed

Purge Functionality - The Purge functionality will allow trading partners to delete large number of claims and PARs. We continue to work on this functionality and will provide an update in the next bulletin.

Portal Tips for the Month

Login Reminders – After three attempts for a successful login you will be suspended. Trading Partner Administrators (TPA) will need to have either a backup TPA un-suspend them or call the State Security line at 303-866-4473. Other users must contact their TPA or Restricted Admin. Remember that passwords are case-sensitive. Remember to check the caps lock if you are experiencing login failures. We recommend to users to enter their password each time and not use the Internet Explorer AutoComplete feature. In addition to increasing the chance for login failure, this feature can increase a security risk for others to login with your username and password.



New Trading Partner Administrators – The first time you login you will not see claim submission, eligibility inquiry or PAR functionality in the portal menu. To access these services you must add the appropriate role to the user. After login, find the menu on the left of the main portal page. Under Administration click User Maintenance. Add a new user or modify an existing user by clicking on the user name in the grid. Move roles from the "Available" box to the "Assigned" box. Save the changes.

For additional details please review the Trading Partner Administrator User Guide and Training.

PAR- We are working on a solution to allow submission of miscellaneous codes, more than three lines, and adequate space for provider comments. In the interim, please use appropriate abbreviations and brief comments in the Provider Comment field.

Understanding Suspended Claims- Suspended claims are claims that are "in process" and are reviewed manually. When the status is changed it will be updated in the portal in an overnight process. Claim statuses can be checked using the Claim Status Inquiry functionality located in the Main Portal menu or in the Claim Lookup.

Eligibility Verification Response - "Fee-For-Service Medicaid"

If you receive a "Fee-For-Service Medicaid" eligibility verification response in the PCP field, it means the client has chosen to stay on regular or "straight" Medicaid. You need not take any special action. Provide services and bill your claims just as you do for any non-PCP Medical Assistance Program client. If you need additional help, please call Provider Services at 303-534-0146.

Old Age Pension Health and Medical Care Program

Effective May 1, 2006, the Executive Director of the Department of Health Care Policy and Financing approved changes to the provider payment for the Old Age Pension (OAP) Health and Medical Care Program.

Because the OAP Health and Medical Care Program is a State-funded program and not an entitlement, the authorized spending authority cannot be exceeded. The approved changes were established to allow the program to remain within the spending authority through the current State fiscal year.

The following provider payment rates are effective for dates of service from May 1, 2006 through June 30, 2006. Payments for services provided on or after July 1, 2006 will revert to pre-May 1, 2006 rates.

- Inpatient hospital services reimbursed at 10% of the Medical Assistance Program rate
- Outpatient services (including services received in outpatient hospital settings, federal qualified health centers, rural health centers and dialysis centers) reimbursed at 53% of the Medical Assistance Program rate
- Practitioner services reimbursed at 70% of the Medical Assistance Program rate
- Emergency transportation services reimbursed at 53% of the Medical Assistance Program rate
- Home health services (including hospice services) and supplies reimbursed at 53% of the Medical Assistance Program rate
- Emergency dental services reimbursed at 53% of the Medical Assistance Program rate
- Laboratory and x-ray services reimbursed at 53% of the Medical Assistance Program rate
- Pharmacy services reimbursed at 100% of the Medical Assistance Program rate
- Medical Supply services reimbursed at 53% of the Medical Assistance Program rate

Clients are eligible to apply for the Colorado Indigent Care Program (CICP) for benefits not covered by the OAP Health and Medical Care Program. Information on the CICP can be found on the Department's website at www.chcpf.state.co.us.

The Emergency Medical Services to Aliens Program may cover life and death emergency hospital admissions for non-citizen OAP Health and Medical Care Program clients.

Please continue to verify client eligibility through CMERS, FAXBack or the Web Portal. Clients covered by the OAP Health and Medical Care Program are identified by the following message: "The client that you entered is enrolled in the OAP Health and Medical Care Program. NOT Medicaid eligible. Limited benefits. Payment may be reduced. No guarantee of covered services or payment amounts. More information: www.chcpf.state.co.us".

As a reminder, the current rules for the OAP Health and Medical Care Program include:

- Maximum client co-payment of $300
- Co-payment amounts for services are the same as the co-payment amounts under the Medical Assistance Program
- There are no retroactive benefits (client can only be eligible from date of application). If claim overpayments are made in error, recoveries will be made retroactively.

More information concerning this program can be found on the Department's website:
www.chcpf.state.co.us
For questions regarding these changes, please contact:
Greg Tanner, Manager, Safety Net Financing at 303-866-5177

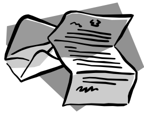
Updating Provider Information (Demographics)

Providers with TPIDs should update their information through the Web Portal. The Web Portal allows providers to verify and change the following:

- Addresses
- Affiliations
- County
- Email address
- Fax number
- Phone number
- Publications preference

Changes/Updates made through the Web Portal are effective within 24 hours.

Providers may also send updated information on their letterhead to Provider Enrollment (PO Box 1100; Denver, CO 80201-1100). Updates submitted on paper are effective within two weeks.



When demographic updates for individual provider numbers are completed by a group and submitted on paper:

1. The change must be on the group's letterhead,
2. Signed by the individual provider and
3. Signed by the authorized person from the group that is requesting the change.

The Fiscal Agent will charge for Turn-Around Documents (TADs)

Effective June 1, 2006, ACS will charge $2 dollar per page to providers requesting a copy of an enrollment approval letter and/or a turn-around document. Provider enrollment will verify if the letter and/or turn-around is a duplicate before requesting payment. If the letter and/or turn-around document is a duplicate, a check for the full amount must be received and be made payable to ACS before documents are mailed to the requester.

Please send your request and payment to:

Provider Enrollment
Attn: Document Request
P.O. Box 1100
Denver CO, 80202

Prior Authorization Request (PAR) Denial Reasons

Appendix Q, Prior Authorization Request Denial Reasons, in the Provider Services Billing Manuals Appendices section has been updated. The PAR Denial Reasons are listed alphabetically by PAR type and by numeric order within the PAR type. Appendix Q provides the Reason Code and the Description. To access the Appendices, please go to:

http://www.chcpf.state.co.us/ACS/Provider_Services/Billing_Manuals/Billing_Manuals.asp

and click on Appendices.

Trading Partners Submitting More than Five Eligibility Verification Batches per Day
Originally published in bulletin B0600211 (April 2006)

If a trading partner submits more than five (5) eligibility verification batches per day, the sixth and all additional batches that day will be processed off cycle. This means that batches in excess of the five (5) will not receive a response within the normal 2-hour period.

The Implementation Guide recommends trading partners limit requests to 99 per batch. Larger size limits will be considered on a "trading partner by trading partner" basis. Trading partners must request permission to submit batches larger than 99. The trading partner must have written permission from DHCPF. Those batches will be processed during off peak hours.

The fiscal agent will monitor the volume of eligibility requests per TP ID on a weekly basis. TP IDs with high volumes will be identified and their eligibility requests will be processed during off peak hours.

Sign-up Now for Electronic Bulletin Notification!

Are you receiving your Colorado Medical Assistance Program by email notification? Email notifications contain a link to the latest bulletin allowing providers to receive bulletin information up to a week sooner than bulletins sent by mail. Medical Assistance Program enrolled providers who do not have their email on file with the fiscal agent should complete and submit the attached Publication Preferences form (Attachment A). *Providers are responsible for ensuring that the fiscal agent has their current publications email address on file. The Colorado Medical Assistance Program is not responsible for undeliverable notifications due to incorrect email addresses.* Please fax or mail the completed form to the fiscal agent at the fax number/address on the form. Thank you for your prompt completion and submission of the form.

Important Email Information: *Providers can have only one email address on file with the fiscal agent. The person receiving the email notification should forward the email to all additional people needing the updated information.*

DURABLE MEDICAL EQUIPMENT (DME) AND SUPPLY PROVIDERS

Please be advised that there was an error on page 4 of the May 2006 Medical Assistance Program Bulletin (B0600212) regarding DME/supply claims paid by invoice. The "Codes Paid by Invoice" section should read, "All covered procedure codes currently paid on a "by invoice" basis will continue to be reimbursed as described on pages 3 and 4 of Provider Bulletin B0500206, December 2005. No changes are being made to the maximum allowable reimbursement for "by invoice" codes at this time, and no "by invoice" claims will be reprocessed regardless of the date of service.

We apologize for any inconvenience this may have caused.

HOME AND COMMUNITY BASED SERVICES (HCBS) PROVIDERS

New Quality Management Program

The Department of Health Care Policy and Financing is developing a Quality Management Program for the HCBS waiver programs. This program will measure, analyze, and improve the care and services provided to HCBS clients. There will be opportunities in the near future for provider input into the Quality Management Program.

CMS has recently increased their focus regarding quality for waiver programs. Look for more information and the opportunity for provider input in future Provider Bulletins.

NURSING FACILITY PROVIDERS

Nursing Facility PETI and the New Oral Cavity Conditions Rule

Several questions emerged after the Medical Assistance Program bulletins issued on April 1, and May 1, 2006 about the changed rule on oral cavity Medical Assistance Program benefits. Links to these bulletins are:

http://www.chcpf.state.co.us/ACS/Pdf_Bin/B0600211a.pdf
http://www.chcpf.state.co.us/ACS/Pdf_Bin/B0600212rev.pdf

In response to inquiries and concerns regarding the effects of the referenced rule on Nursing Facility PETI program for dental care, please note the following:

The NF PETI rule remains unchanged. Nursing facilities may submit PETI requests for qualified residents to cover dental services that are not a benefit of the Medical Assistance Program. This means that dental procedures that have been excluded from the Medical Assistance Program are potentially eligible PETI benefits if deemed medically necessary. The Department retains the right to request additional information and/or alternative treatment plans from the dental providers prior to approving a PETI request.

If the fiscal agent denies a correctly completed dental claim or Prior Authorization Request, the charges may be eligible for PETI. The client must be PETI eligible and a request for NF PETI reimbursement may be submitted to the Department by the facility. The process for filing the NF PETI Request remains the same.

To facilitate Medical Assistance Program Prior Authorization Requests, nursing facilities are encouraged to work with Medical Assistance Program dental providers to verify the claim's required concurrent or emergency medical conditions.

PHARMACY PROVIDERS

Proton Pump Inhibitors (PPIs)

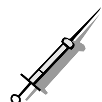
Changes have been made to the prior authorization criteria that apply to Nexium (all strengths), omeprazole (all strengths) and Prilosec 10mg and 40mg. Effective June 1, 2006, all PPIs will be subject to the same criteria for non-complicated diagnoses. Specifically, a client no longer has to try and fail on Aciphex, Prevacid and Protonix or show that those drugs are contraindicated for the client before receiving Nexium, omeprazole or Prilosec (10mg/40mg). A client may receive up to 90 days of any PPI with once daily dosing without a Prior Authorization (PA). A prior authorization with documentation of medical necessity is still required to receive more than once daily dosing during the first 90 days. Please go to the Department's website at: http://www.chcpf.state.co.us/HCPF/Pharmacy/phmindex.asp for details regarding the updated criteria and for the revised PPI prior authorization form.

Injectable Drugs Reminder

Practitioners and/or Clinics

- Injectable drugs given in a practitioner's office or a clinic must be billed by the practitioner or clinic using CMS codes on the CO-1500 claim format.
- According to Department policy (10 CCR 2505-10, Section 8.831), pharmacies cannot bill for injectable drugs given in a practitioner's office or clinic.
- Department policy in the Department's Pharmacy Billing Manual states that practitioners and clinics may not send clients to pharmacies to get injectable drugs for administration in the practitioner's office or clinic.

Pharmacies



- Injectable drugs intended for self-administration or administration in the client's home may be billed by the pharmacy through PDCS.
- Pharmacies may not bill directly for any drugs administered in the practitioner's office or in a clinic.

DAW-5 and Prior Authorization Type Codes 1, 2 and 4 Clarification

DAW-5 Dispense as Written – A DAW 5 code (substitution allowed-brand as generic) will be allowed only if:

1. The product being billed is a brand that is less expensive than the generic or
2. The product is a generic product but has been given a brand name indicator by First Data Bank.

All claims using a DAW 5 code will be reviewed for brand pricing of less than generic pricing and for the generic/brand indicator. Claims may be reversed if the code is used inappropriately.

Prior Authorization Type Code 1 – Use for emergency only. An emergency situation is defined as any condition that is life threatening or requires immediate medical intervention. In an emergency, pharmacies may dispense a 72-hour supply of covered outpatient prescription drugs if a prior authorization cannot be obtained. The client's physician must contact the PA Help Desk and request a PA the next business day.

Prior Authorization Type Code 2 – Refill too soon. This code can only be used when there is a dosage change or when a client is going into or out of a nursing home and is in need of medication. The pharmacy must request this authorization from the PA Help Desk.

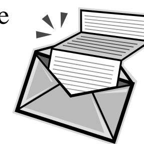
Prior Authorization Type Code 4 – Copay exemption for pregnant/postpartum clients. This code can only be used for clients who are pregnant or 90 days postpartum to exempt the client from copayments. This code will also override the prior authorization requirement for prenatal vitamins and other vitamins eligible for rebate. This code will not override the prior authorization requirement for any other medications. All other medications requiring a prior authorization will still require the physician to contact the PA Help Desk.

The PA Help Desk may be reached at 1-800-365-4944.

Claims using any Prior Authorization Type Code will be reviewed to ensure that the code has been used correctly.

Comprehensive NeuroScience Program

Starting June 1, 2006, the Colorado Medical Assistance Program will engage in a two-year project with Comprehensive NeuroScience (CNS) to provide prescribers information about the psychiatric medication utilization of their patients. This program is designed to help ensure that Colorado Medical Assistance Program clients receive the best care possible. This program will send educational alerts/letters to prescribers. The letters are designed to help prescribers know if the medication dosing is in line with FDA guidelines and, for children, research and consensus based guidelines. The messages are advisory and intended to be supportive. Prescribers are asked to review each case in the context of the guidelines and decide individually what is best for the patient. The program is also designed to notify prescribers about forgotten refills and alerts all involved prescribers if a patient obtains same class drugs from multiple prescribers. CNS is an independent company with experience in evidence-based and consensus-based standards for psychiatric medication prescribing.



Any questions about the program should be directed to Kim Eggert, Medical Assistance Program Pharmacist, at 303-866-3176 or kimberly.eggert@state.co.us.

SUBSTANCE ABUSE PROVIDERS

Outpatient Substance Abuse Treatment Benefits

Effective July 1, 2006, Outpatient Substance Abuse Treatment Services will be available to all Medical Assistance Program clients. Approved services must be provided by a qualified practitioner or facility with a substance abuse provider specialty type. Providers will be:

- Facilities licensed by the Alcohol and Drug Abuse Division (ADAD) of the Department of Human Services.
- Licensed physicians.
- Licensed non-physician practitioners as follows:
  - Psychologist, PhD.
  - Nurse Practitioner.
  - Licensed Clinical Social Worker (LCSW).
  - Marriage and Family Therapist.
  - Licensed Professional Counselor (LPC). ***and***
- The above licensed physician and non-physician practitioners must be certified or licensed addiction counselors with the following credentials:
  - Certified or Licensed Addiction Counselors (CAC II, CAC III or LAC) by Department of Regulatory Agencies (DORA).
    Or
  - Certified by the National Association of Alcohol and Drug Abuse Counselors (NAADAC) as an NCAC II or MAC.
    Or
  - A licensed physician certified in Addiction Medicine by the American Society of Addiction Medicine (ASAM).

Covered Services

The following services will be offered under the Outpatient Substance Abuse Treatment program:

1. Substance abuse assessment.
2. Individual and family therapy.
3. Group therapy.
4. Alcohol/drug screening.
5. Case Management.
6. Social/ambulatory detoxification.

Provider Specialty Numbers

New and existing providers will be required to apply for a provider number as Substance Abuse Specialty provider. Please refer to the ACS website for provider application and instructions.

Rates

The following rates and codes will apply to the Outpatient Substance Abuse Treatment program using the electronic Colorado 1500/837P format.

Code + Modifier	Code Description	Rates
H0001 + HF	Alcohol and/or drug assessment*	$102.00/assessment
H0004 + HF	Behavioral health counseling and therapy, per 15 minutes*	$8.50/15 minutes
H0005 + HF	Alcohol and/or drug services; group counseling by a clinician*	$24.00/session
H0006 + HF	Alcohol and/or drug services; case management (targeted) *	$17.00/encounter
H0014 + HF	Alcohol and /or drug services; ambulatory detoxification*	$154.00/day
S9445 + HF	Drug screening and monitoring*	$12.81/screening

* Please refer to the Substance Abuse section in the Provider Billing Manuals Specialty Billing Information for a comprehensive list of diagnostic codes and limits per service. Billing Manual sections are located at:

http://www.chcpf.state.co.us/ACS/Provider_Services/Billing_Manuals/Billing_Manuals.asp

June, July and August 2006 - Denver Provider Billing Workshops

General Information

Provider billing workshops include both Medical Assistance Program billing instructions and a review of Medical Assistance Program billing procedures. There are specific classes for new billers to the Medical Assistance Program and specialty training for different provider types. The schedule for June, July and August 2006 workshops follows.

Who Should Attend?

New and experienced receptionists, front desk personnel, admission personnel, office managers, billing services, and other billers should attend the appropriate workshops.

Do I need Reservations?

Yes, reservations are necessary for ***all workshops***. We are currently requesting reservations for both Statewide and Denver workshops to ensure that adequate space is available for all workshops.

Email reservations to: workshop.reservations@acs-inc.com or
Call Medical Assistance Program Provider Services to make reservations.
1-800-237-0757 or 303-534-0146

Press "**5**" to make your workshop reservation. This transfers you to a voice mail where you must leave the following information:

- Medical Assistance Program provider billing number
- The date and time of the workshop
- The number of people attending and their names
- Contact name, address and phone number

Without all of the requested information, your reservation will not be processed successfully.

Your confirmation will be mailed to you within one (1) week of making your reservation. If you do not receive a confirmation within one (1) week, please contact Provider Services and talk to a Provider Relations Representative.

Class Descriptions

Please see bulletin B0500202, December 2005 or the 2006 Denver and Statewide Workshop Schedule in the Provider Services Training and Workshops section of the Department's website at

http://www.chcpf.state.co.us/ACS/Provider_Services/Train_Workshops/train_workshops.asp

for a complete list of class descriptions.

All Denver workshops are located at:

ACS
600 Seventeenth Street
Suite 600 N (6th Floor, North Tower)
Denver, CO 80202

Denver Beginning Billing Schedule

9:00 – 3:00

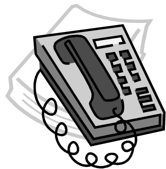
Beginning Training CO-1500/837P
06/13/06 – Tuesday
07/11/06 – Tuesday
08/22/06 – Tuesday

Beginning Training UB-92/ 837I
06/15/06 – Thursday
07/12/06 – Wednesday
08/24/06 – Thursday

Denver Specialty Training Schedule

Dental
07/14/06—Friday - 10:00-12:00

Supply/DME
08/16/06 – Wednesday - 11:00-1:00



Please direct questions about Medical Assistance Program billing or the information in this bulletin to Medical Assistance Program Provider Services at:
303-534-0146 or 1-800-237-0757 (Toll free Colorado)

Remember to check the Provider Services section of The Department's website at:
http://www.chcpf.state.co.us/ACS/Provider_Services/provider_services.asp
For Provider Updates and News

Colorado Department of Health Care Policy and Financing

Passive Enrollment Fact Sheet
Effective May 1, 2006

Passive enrollment encourages client participation in a Medicaid managed care health plan and promotes selecting a primary care physician as the client's medical home.

Clients included/excluded from passive enrollment

- Medicaid clients included are new and existing Fee-For-Service clients who reside in one of the following counties:
    1. Adams,
    2. Arapahoe,
    3. Denver, or
    4. Jefferson.
- Foster care children, Medicaid clients who reside in a nursing home and a small group of other Medicaid clients who do not qualify for full Medicaid benefits are excluded from the passive enrollment process.

Passive enrollment process

- All newly eligible clients and a portion of the existing Medicaid Fee-For-Service clients will be notified each month of the passive enrollment process.
- Clients in these four counties will be notified by mail that they can choose to enroll in one of the three Medicaid managed care health plans, or in the Medicaid Fee-For-Service Plan. The Medicaid managed care plans available are Colorado Access, Denver Health and the Primary Care Physician Program.
- Notified clients will have 30 days to make their choice. If notified clients do not call HealthColorado during the choice period, they will be enrolled with the managed care health plan listed in their letter (Colorado Access or Denver Health).
- Clients who are passively enrolled into a Medicaid managed care health plan and are displeased with their plan may choose another health plan during their first 90 days of enrollment with the managed care health plan.

Contact Information

- Medicaid clients wishing to choose a health plan or with questions about the Primary Care Physician Program should contact HealthColorado at (303) 839-2120. Medicaid clients with questions about the Medicaid Fee-For-Service Plan should contact the Department's customer service section at (303) 866-3513 or (800) 221-3943.
- Medicaid clients and providers with questions for Colorado Access should call (800) 511-5010.
- Medicaid clients and providers with questions for Denver Health Medicaid Choice should call (720) 956-2100.
- Medical Providers in the Primary Care Physician Program should contact Gloria Johnson at gloria.johnson@state.co.us **or** (303) 866-2993.
- Medicaid clients and providers with questions about the Passive Enrollment process should contact Craig Gurule at craig.gurule@state.co.us **or** (303) 866-2993.

Publication Preferences

Publication and Notification Preference

Medical Assistance Program updates and billing instructions are communicated through Medical Assistance Program publications. *An email notification with a link to the publication will be sent to providers when new bulletins, publication revisions and program updates are posted on the Provider Services Section of the Department's website. Providers are responsible for ensuring that the fiscal agent has their current publications email address on file. The Colorado Medical Assistance Program is not responsible for undeliverable notifications due to incorrect email addresses.*

All publications are available in the Provider Services section of the Department's website:

http://www.chcpf.state.co.us/ACS/Provider_Services/provider_services.asp

Please complete the following information:

Provider Name: ______________________ Medical Assistance Program Provider Number: ______________

Contact Name: ______________________ Telephone Number: (   ) ______________

Address: ______________________ ______ ______
Street/PO Box State Zip Code

Provider Publications Email Address: ______________________

Publications Media:
(Please check one)

- ☐ *Email notification with link to publication*
- ☐ *Another provider will receive email notification on my behalf. I understand that I am responsible for obtaining the notification from this provider and that I will **not** receive an email notification from the Colorado Medical Assistance Program.*
- ☐ *None (I understand that I am responsible for retrieving publications from the website and that I will **not** receive an email notification from the Colorado Medical Assistance Program).*

______________________ ______________
Authorized Signature Date

Please complete all of the above information and

Fax to: or **Mail to:**

Medical Assistance Program Provider Enrollment
303-534-0439

Medical Assistance Program Provider Enrollment
PO Box 1100
Denver, CO 80201-1100

Revised 04/26/05