Provider Bulletin

Reference: B0900268 **July 2009**

colorado.gov/hcpf

In this issue:

Denver Club Building
518 17th Street, 4th floor
Denver, Colorado 80202

ACS Contacts

Billing and Bulletin Questions
303-534-0146
1-800-237-0757

Claims and PARs Submission
P.O. Box 30
Denver, CO 80201

Correspondence, Inquiries, and Adjustments
P.O. Box 90
Denver, CO 80201

Enrollment, Changes, Signature authorization and Claim Requisitions
P.O. Box 1100
Denver. CO 80201

All Providers

No Delay in Payments

Based on notification from the Office of State Planning and Budgeting and the State Controller, we are not required to delay payments scheduled to be made June 30, 2009. There are adequate funds available to make payments to providers and for other state expenses during fiscal year 2008-2009 (FY 08-09). If you have questions about claims processing or the payment cycle, please contact ACS Provider Services at 303-534-0146 or 1-800-237-0757. If you have questions about our policy, please contact Joanne Lindsay at Joanne.Lindsay@state.co.us or 303-866-3144.

Independence Day Holiday

Due to the observance of Independence Day on Friday, July 3, 2009, claim payments will be processed on Thursday, July 2, 2009. The processing cycle includes electronic claims accepted before 6:00 P.M. MST on Thursday.

Provider Rate Decreases

The FY 09-10 Long Bill, SB09-259, included a $30.8 million reduction to physical health providers in the form of a 2% rate reduction. The Joint Budget Committee (JBC) gave the Department of Health Care Policy and Financing (the Department) flexibility to implement this reduction to avoid an across-the-board rate cut in order to minimize the impact on clients and providers. As a result, the following reductions and changes will be effective July 1, 2009:

Physician Services

All non-Evaluation and Management (E&M) practitioner service rates will be reduced by 2%.

Radiology/Imaging Services

For outpatient clinics, all radiology/imaging service rates will be reduced by 2%. In addition, **effective July 13, 2009**, prior authorization will be required on all Positron Emission Tomography (PET) scans, non- emergent Computed Tomography (CT) scans, and Magnetic Resonance Imaging (MRIs). Details on prior authorization criteria will follow shortly. Please check the "What's New" link on the Department's Web site at colorado.gov/hcpf for more information in the upcoming weeks. Please contact Jagruti Shah at Jagruti.Shah@state.co.us or 303-866-2245 with questions.

Durable Medical Equipment (DME)/Supply

- All DME and supplies/disposables in which there is a Maximum Purchase/Rental Amount will be reduced by 1.97%
- DME with no maximum purchase price will be reimbursed at the current manufacturer's suggested retail price (MSRP) less 19.97%
- Supplies/disposables with no maximum purchase price will be reimbursed at the actual acquisition invoiced cost. Code A9901 shall be billed to cover handling at 18.03% of the actual acquisition cost of the product
- The following benefit/cost limitations will be implemented:

Procedure Code	Description	New Limit
A4310	Insertion tray without drainage bag & without catheter	2 units per month
A4338	Indwelling catheter, Foley type	2 units per month
A4357	Bedside drainage bag, per set	2 units per month
A4358	Urinary drainage bag, per item	2 units per month
E1161	Manual adult size wheelchair, includes tilt-in-space	Maximum Purchase Amount $2,100
E1235	Wheelchair, pediatric size, rigid, adjustable, with seating system	Maximum Purchase Amount $1,800
E1340*	Repair or non-routine service for DME requiring the skill of a technician, unit per 15 minutes	Maximum allowable $25.00 per unit
K0739	Repair or non-routine service for DME other than oxygen requiring the skill of a technician, unit per 15 minutes	Maximum allowable $25.00 per unit
K0740	Repair or non-routine service for oxygen equipment requiring the skill of a technician, unit per 15 minutes	Maximum allowable $25.00 per unit

* Effective August 1, 2009, Procedure Code E1340 will no longer be recognized.

Dental Services

Resin-based composite restorations will be reimbursed at the equivalent amalgam rate.

Procedure Code	Procedure Code Description	New Rate
D2391	Resin Based Comp One Surface Posterior	$56.16
D2392	Resin Based Comp Two Surfaces Posterior	$71.76
D2393	Resin Base Comp Three Surface Posterior	$84.76
D2394	Resin Base Comp 4 or > Surface Posterior	$100.88

Crowns on posterior molar teeth will be reimbursed at the equivalent rate for pre-fabricated stainless steel crowns.

Procedure Code	Procedure Code Description	New Rate
D2791	Crown Full Cast Base Metal for Tooth # 1, 2, 3,14,15, 16, 17,18,19, 30, 31, 32	$71.76

Third molar removal is a pre-authorized procedure and prophylactic extractions will be disallowed. Third molars exhibiting non-restorable carious lesions, recurrent infection, cyst and tumors as well as those molars contributing to the resorption of adjacent teeth and destruction of bone are candidates for removal.

Procedure Code	Procedure Code Description	Prior-Authorization for Tooth # 1,16,17,32
D7210	Surgical Removal of Erupted Tooth Requiring Elevation	Yes
D7220	Removal Impacted Tooth- Soft Tissue	Yes
D7230	Removal Impacted Tooth -Partially Bony	Yes
D7240	Removal Impacted Tooth- Complete Bony	Yes
D7241	Removal Impact Tooth- Complete Bony- Surgical Complications	Yes

All Other Acute Care Services

Rates will be reduced by 2%, including:

- Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program
- Transportation - emergency and non-emergent
- Vision
- Therapy – occupational, physical, and speech
- Ambulatory Surgery Center
- Laboratory
- Drugs - administered in an office setting

The Department will monitor expenditures and utilization throughout FY 09-10 to ensure that the implemented reductions will allow us to meet the total reduction in the Long Bill. We thank all of the stakeholders, advocates, and providers who offered their ideas, support, and feedback during this difficult decision making process. Please contact Christy Hunter at Christy.Hunter@state.co.us or 303-866-2086 if you have any questions.

Report Suspicion of Provider Fraud

Program Integrity has established an easy way to report suspicion of provider fraud, waste or abuse of Medicaid and CHP+ funds. Anyone can make a report through the confidential email address: ReportProviderFraud@hcpf.state.co.us. All reports are investigated by Program Integrity staff. Please contact Sandi Barnes at 303-866-3535 if you have any questions.

Dental Providers

Dental Procedures in Ambulatory Surgical Centers (ASC)

Effective July 1, 2009, Current Procedural Terminology (CPT) code 41899, "unlisted procedure, dentoalveolar structures", has been added to the Diagnosis-Related Grouper (DRG) 9 for ASCs, enabling these facilities to bill for dental services.

Clients ages 0 through 20 and qualifying adult clients under the state plan with extensive dental needs and/or conditions which compromise the ability of the dentist to provide care in a private office may now be treated by their dentist in these facilities. Dentists will bill fee-for-service Current Dental Terminology (CDT) codes at current rates on the 2006 ADA paper claim form and check box number 38 (other) as the place of treatment.

Providers should check the "What's New" link at colorado.gov/hcpf for continuing updates. For ASC billing questions, please contact Eric Wolf at Eric.Wolf@state.co.us or 303-866-5963. For CDT billing questions, please contact Marcy Bonnett at Marcy.Bonnet@state.co.us or 303-866-3604.

Administration of Fluoride Varnish

Effective July 1, 2009, trained medical personnel may administer fluoride varnish for moderate to high caries risk Medicaid children, ages 0 through 4, in conjunction with an oral evaluation and counseling with a primary caregiver after performing a risk assessment. Risk assessment forms may be found at http://www.cavityfreeatthree.org/GetMaterials/ProviderMaterials and documentation should be part of the client's medical record. Medical personnel that can bill directly for these services include MDs, DOs, and nurse practitioners. Trained medical personnel employed through qualified physician offices or clinics can provide these services and bill using the physician's or nurse practitioner's Medicaid provider number. Children ages 0 through 4 (until the day before their fifth birthday) are eligible to receive this service and both services must be provided together.

In order to provide this benefit and receive reimbursement, the medical provider must have participated in on-site training from the Cavity Free at Three team or have completed Module 2 (child oral health) and Module 6 (fluoride varnish) at the Smiles for Life curriculum at http://www.smilesforlife2.org/powerpoints.html. It is also recommended that providers view the videos on the Lap to Lap Child Oral Exam and the Application of Fluoride Varnish at http://www.smilesforlife2.org/videos.html. Documentation for this training should be saved in the event of an audit.

Dental providers inclusive of unsupervised dental hygienists are also able to provide these services. While encouraged, no additional training is required for qualified dental personnel.

The maximum allowable benefit per eligible and high risk child will be four (4) times per fiscal year. Dental offices and medical offices are encouraged to communicate with one another to avoid duplication of services and/or nonpayment of services.

The billing procedures for medical personnel are as follows:

For children ages 0-2 (until the day before their third birthday):

In private practice, children ages 0 through 2, **D1206** (topical fluoride varnish) and **D0145** (oral evaluation for a patient under three years of age and counseling with primary caregiver) should be billed on a Colorado 1500 paper claim form or electronically as an 837P (Professional) transaction.

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs): D1206 and D0145 should be itemized on the claim with a well child visit but reimbursement will be at the current encounter rate.
The diagnosis V72.2 should be used as a secondary diagnosis. Billing is on the UB-04 paper claim form or electronically as an 837I (Institutional) transaction.

For children ages 3 and 4 (from their first birthday until the day before their fifth birthday):
In private practice, children ages 3 and 4, D1206 and **D1330** (oral hygiene instructions [in place of D0145]) should be billed on a Colorado 1500 paper claim form or electronically as an 837P transaction.
FQHCs and RHCs: For children ages 3 and 4, D1206 and D1330 should be itemized on the claim with a well child visit but reimbursement will be at the current encounter rate. The diagnosis V72.2 should be used as a secondary diagnosis. Billing is on the UB-04 paper claim form or electronically as an 837I transaction.

The billing procedures for dental personnel are as follows:
Effective July 1, 2009, the policy of the Department will be to **disallow D1203 for all children under six (6)** and to reimburse providers for D1206 only.

For children ages 0-2 (until the day before their third birthday):
In private practice, children ages 0 through 2, D1206 and D0145 should be billed on a 2006 ADA paper claim form or electronically as an 837D (Dental) transaction.
FQHCs and RHCs: D1206 and D0145 should be itemized on the claim and reimbursement will be at the current encounter rate. The diagnosis V72.2 should be used as a secondary diagnosis. Billing is on the UB-04 paper claim form or electronically as an 837I transaction.

For children ages 3 and 4 (from their third birthday until the day before their fifth birthday):
In private practice, children ages 3 and 4, D1206 should be billed on a 2006 ADA paper claim form or electronically as an 837D transaction.
FQHCs and RHCs: For children ages 3 and 4, D1206 should be itemized on the claim and reimbursement will be at the current encounter rate. The diagnosis V72.2 should be used as a secondary diagnosis. Billing is on the UB-04 paper claim form or electronically as an 837I transaction.
Please contact Marcy Bonnett at marcy.bonnett@state.co.us or 303-866-3604 with questions.

DME/Supply Providers

Changes in DME Wheelchair Repair

Effective July 1, 2009, Prior Authorization Request (PAR) requirements have been eliminated from 66 wheelchair repair procedure codes. A listing of the codes, with associated fiscal yearly or fiscal three-year quantity limitations and reimbursement rates, appears in Attachment A of this bulletin. The State's fiscal year is from July 1st to the following June 30th. Please note, should a quantity limit or reimbursement rate be exceeded for any of the 66 procedure codes, a PAR will be required. For repairs on privately-owned wheelchairs for Medicaid clients living in a nursing home, the PAR process will continue.

Items	Eliminated PAR	Maintained PAR	Initiated 1 Fiscal Year Quantity Limit	Initiated 3 Fiscal Year Quantity Limit	Established Rate
Top 53 Wheelchair Repair Procedure Codes	X		X		
Repair Codes E2216, E2217, E2218, E0960, K0044	X		X		X
Motors and gear boxes (3 Procedure Codes) E2368, E2369, E2370	X			X	
Front caster repairs/replacement (3 Procedure Codes) K0071, K0072, K0077	X			X	

Items	Eliminated PAR	Maintained PAR	Initiated 1 Fiscal Year Quantity Limit	Initiated 3 Fiscal Year Quantity Limit	Established Rate
Repair nursing home resident privately-owned wheelchair		**X**			

Please contact Doug van Hee at Doug.Vanhee@state.co.us or 303-866-4986 with questions.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier Accreditation Under Review

In the June 2009 Provider Bulletin (B0900267), the Department announced that suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers must comply with the Medicare program's accreditation standards in order to bill Medicaid. Based upon preliminary feedback, this requirement is under review. If you have any questions or concerns about the requirement, please contact Doug van Hee at Doug.Vanhee@state.co.us or 303-866-4986.

Correction to 2009 Supply HCPCS Codes Bulletin (B0900261)

On page 185 of the DME/Supply HCPCS bulletin, codes L8030 and L8039 were incorrectly listed as *no PAR required*. Both procedures require prior authorization by the Colorado Foundation for Medical Care (CFMC). The corrected bulletin, 2009 Supply HCPCS Codes (B0900261 - Revised 06/09) has been posted at colorado.gov/hcpf ➡Providers ➡Provider Services ➡Bulletins.

Home Health, Private Duty Nursing (PDN), and Home and Community Based Services (HCBS) Providers

Provider Rate Decreases

Effective July 1, 2009, the Department is implementing targeted provider rate reductions and other efficiency targets in order to achieve a two percent (2%) reduction in total expenditure for Home Health, Private Duty Nursing and Home and Community-Based Services (HCBS) providers. These reductions and efficiency targets will reduce expenditures by approximately $7.6 million for the State FY beginning July 1, 2009. The Department will publish a comprehensive list of efficiency proposals at colorado.gov/hcpf in the near future. Individual program rate adjustment explanations and schedules are included in Attachment B of this bulletin. Please contact ACS Provider Services at 303-534-0146 or 1-800-237-0757 with questions.

Hospital Providers

Hospital Readmission Policy

Clients of the Colorado Medical Assistance Program should only be discharged from inpatient hospital care when medically stable.

On occasion, a client is discharged from a hospital and readmitted to the same hospital within 24 hours for symptoms related to, or for evaluation and management of, the prior stay's medical condition. Colorado Medicaid Program policy requires hospitals to bill these tandem admissions as a single hospital stay. The effect of this rule is that the hospital will receive payment only one time for what is essentially one episode of care.

Although the Medicaid Management Information System (MMIS) does not automatically deny tandem admissions, the Department's Quality Improvement Organization (QIO), CFMC, conducts medical record reviews of both admissions retroactively for compliance with the Department's policy. Currently the QIO reviews the readmissions for medical necessity and compliance with our billing requirements but has not been reviewing to determine if the two admissions are for related care.

Effective July 1, 2009, all claims for hospital readmissions, in which a client is readmitted to the same hospital within twenty-four hours of discharge, will be denied unless the readmission is completely unrelated to the first admission. This will apply to all claims for second admissions dated July 1, 2009 or later.

Claims for readmissions within twenty-four hours will be reviewed by the QIO. When two hospitalizations are found to be related, the second admission will be denied. Initially, the Department intends to implement this policy through retrospective reviews conducted by the QIO. However, the Department is in the process of implementing a system change that will automatically deny hospital readmissions within twenty-four hours at the same hospital. Once the Department has completed this change to the MMIS, additional information will be published in an upcoming bulletin article.

If a hospital receives a denial of a readmission from the QIO, the hospital may follow the normal procedures for requesting reconsideration or an appeal of a determination by the QIO.

Transfers of clients among units of a hospital, when billed as two separate admissions, will also be denied. This is consistent with Colorado Medicaid Program billing requirements and is not a change or clarification in policy. The Colorado Medicaid Program does not recognize Distinct Part Units (DPUs) or any other units of a hospital separately from the general acute care hospital under which they are licensed.

Hospitals may not submit two claims for a client who is admitted to a general acute care hospital and then transferred to the hospital's DPU. A single claim should be submitted covering the dates of service from the admission to the general acute care hospital through the discharge from the DPU. Stays at Transitional Care Units or any other location that is not part of the hospital are not billable under the hospital's Medicaid provider number and will be denied if billed as such. Please contact Eric Wolf at Eric.Wolf@state.co.us or 303-866-5963 with questions.

Non-Reimbursement for Serious Reportable Events

Serious reportable events are identified as avoidable errors that occur during hospitalization. Momentum is currently building around ending payment for these events by national groups, states, health care facilities, and others to improve patient safety. The Department plans to adjust reimbursement for hospital claims that include serious reportable events. The objective of the policy is to protect patient safety and ensure high quality care.

As of October 1, 2009, reimbursement will not be increased for additional costs resulting from the twelve following events also identified for non-reimbursement by the Centers for Medicare and Medicaid Services (CMS) for Medicare patients:

1. Foreign object inadvertently left in patient after surgery;
2. Death/disability associated with intravascular air embolism;
3. Death/disability associated with incompatible blood;
4. Stage 3 or 4 pressure ulcers after admission;
5. Hospital-acquired injuries: fractures, dislocations, intracranial injury, crushing injury, burn and other unspecified effects of external causes;
6. Catheter-associated urinary tract infection;
7. Vascular catheter-associated infection;
8. Mediastinitis after coronary artery bypass graft surgery;
9. Manifestations of poor glycemic control;
10. Surgical site infection following certain orthopedic procedures;
11. Surgical site infection following bariatric surgery for obesity; and
12. Deep vein thrombosis & pulmonary embolism following certain orthopedic procedures.

In addition, no reimbursement will be made for:

1. Surgery performed on the wrong body part;
2. Surgery performed on the wrong patient; and
3. Wrong surgical procedure on a patient.

This policy will cover claims submitted under the Medicaid fee-for-service program and Child Health Plan Plus (CHP+) and will also apply to claims for patients who are dually eligible for Medicaid and Medicare. Retrospective review of claims through the MMIS will identify serious reportable events through claims data. Reimbursements will be adjusted retroactively through the same process currently used for random retrospective claims review. The Department anticipates very few adjustments.

The Department will amend contracts with managed care organizations participating in CHP+ and in the Medicaid Managed Care program. The Colorado Indigent Care Program (CICP), which is also administered by the Department, will not be impacted by this policy because it is a grant-funded discount program. There is no claims level data and providers are not paid based upon specific services provided.

Patients will not be billed or balance-billed for services related to serious reportable events. The Department will collaborate with hospitals to assure appropriate reimbursement for cases in which a patient receives subsequent care for a serious reportable event in a hospital other than the original site in which the event occurred. Please contact Eric Wolf at Eric.Wolf@state.co.us or 303-866-5963 if you have any questions.

Pharmacy Providers

Reimbursement Rate Change

Effective July 1, 2009, the Average Wholesale Price (AWP) reimbursement methodology will change to AWP minus 14% for brand name medications and AWP minus 40% for generic medications, however; rural pharmacies will continue to be reimbursed at AWP minus 12% for all prescriptions.
Previously, the Department reimbursed pharmacy claims using the lesser of four (4) pricing methodologies including: Federal Upper Limit, AWP minus 13.5% for brand name medications and AWP minus 35% for generic medications; Direct Price plus 18%; and Submitted Charge.

Preferred Drug List (PDL) Update

Effective July 1, 2009, the following medications will be preferred agents on the Medicaid PDL and will be covered without a prior authorization:

Antihistamines (newer generation):
cetirizine and loratadine in all dosage forms

Angiotensin Receptor Blockers:
Atacand, Avapro, Benicar, Cozaar, Diovan and Micardis

Angiotensin Receptor Blocker Combinations:
Atacand-HCT, Avalide, Benicar-HCT, Hyzaar, Diovan-HCT, and Micardis-HCT

Anticholinergic Inhalants:
ipratropium nebulizer solution, Atrovent HFA and Spiriva

Anticholinergic and Short Acting Beta-2 Agonist Combinations:
albuterol/ipratropium nebulizer solution and Combivent inhaler

Corticosteroid Inhalants:
Pulmicort in nebulizer solution and Flexhaler, Flovent HFA and diskus and Qvar inhalers

Corticosteroid and Long-Acting Beta-2 Agonist Combinations:
Advair diskus products only

Short-acting Beta-2 Agonists:
albuterol nebulizer solution, Ventolin HFA, ProAir HFA and Proventil HFA

Long-acting Oral Opiates:
Kadian (morphine ER), methadone and morphine ER

Skeletal Muscle Relaxants:
baclofen, dantrolene, tizanidine, methocarbamol and cyclobenzaprine

The complete PDL and prior authorization criteria for non-preferred drugs are posted at colorado.gov/hcpf ➡Providers ➡Pharmacy ➡Preferred Drug List (PDL).

Global Prior Authorization

In order to protect the health of our most vulnerable Medicaid clients, qualified individuals are exempt for one year from prior authorization requirements for non-preferred drugs (also known as a global prior authorization). They will also be exempt from prior authorization requirements for non-PDL drugs currently requiring prior authorization. The Department implemented this policy on June 1, 2009.

In order to qualify for the global prior authorization, an individual must have a “focal point of care”, must be taking four or more medications, and/or taking high risk medications and must have a qualifying diagnosis.

For more information or to download the Global Prior Authorization form, go to colorado.gov/hcpf ➡Providers ➡Pharmacy ➡Prior Authorization Policies.

Mail Order Pharmacy Update

Since April 1, 2009, qualifying Medicaid fee-for-service clients have been permitted to receive their outpatient maintenance medications from mail order pharmacies. Clients may qualify if they have a physical hardship that prevents them from obtaining their maintenance medications from a local pharmacy.

Pursuant to Senate Bill 09-252, enacted into law on May 18, 2009, the qualifying criteria were expanded to include Medicaid clients with third party insurance that allows the use of mail order pharmacies in order to receive their maintenance medications.

A client, or the client's physician, must complete and submit an enrollment form to the Department that attests the client meets the one of the qualifying criteria. The enrollment form and instructions are posted at colorado.gov/hcpf ➡Providers ➡Pharmacy ➡Mail Order Prescriptions.

Out-of-state mail order pharmacies will be permitted to enroll as Medicaid providers but may only mail maintenance medications to clients that have enrolled for the mail order pharmacy benefit.

For more information on how to enroll as a Medicaid provider, contact ACS Provider Services toll free at 1-800-237-0757. Local pharmacies, which are not mail order pharmacies, may continue to occasionally mail any type of medication to any Medicaid clients without the clients having to enroll for the mail order pharmacy benefit. Please contact the Help desk at 1-800-365-4944 if you have any questions.

Rx Review Program

As a result of legislation passed in the 2007 legislative session, the Department created a medication management therapy program known as the Rx Review Program for Medicaid clients who are high drug utilizers (five or more drugs each month for three months in a row). The Department is looking to contract with pharmacists within the client's community to provide a comprehensive medication evaluation, which includes a review of all prescription medications as well as over-the-counter and nutritional supplements, to identify drug-drug interactions, drug-over the counter/supplement interactions, drug duplication, or use of multiple providers, if any. If you are a pharmacist who is interested in participating in this program, please contact Megan Wood at megan.wood@state.co.us.

Colorado Cares Rx

In accordance with SB 09-132, the Department will make information available to the public concerning lower-cost prescription drug programs through the Colorado Cares Rx Web site. The Department will research programs or mechanisms by which people may be able to save money when purchasing prescription drugs and post links to the respective Web sites at www.coloradocaresrx.com. Various programs could be beneficial for Coloradans without medical insurance or those with limited ability to receive medicines through other health care programs.

Please make your clients aware of this Web site so that they may be able to save money when purchasing the medications that they need.

July and August 2009 Denver Provider Billing Workshops

Provider billing workshops include both Colorado Medical Assistance Program billing instructions and a review of Colorado Medical Assistance Program billing procedures.

The July and August 2009 workshop calendars are included in this bulletin and are posted at colorado.gov/hcpf ➡Providers➡ Provider Services ➡Training & Workshops.

Who Should Attend?

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

Reservations are required

Reservations are necessary for ***all workshops***.

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

Press "**5**" to make your workshop reservation. You must leave the following information:

- Colorado 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.

All Workshops held in Denver are located at: ACS
Denver Club Building
518 17th Street, 4th floor
Denver, Colorado 80202

Beginning Billing Class Description

These classes are for new billers, billers who would like a refresher, and billers who would like to network with other billers about the Colorado Medical Assistance Program. Currently, the class covers in-depth information on resources, eligibility, timely filing, reconciling remittance statements, and paper claim completion for the UB-04 and the Colorado 1500. *These classes do **not** cover any specialty billing information.* The fiscal agent provides specialty training throughout the year in their Denver office.

The classes do <u>not</u> include any hands-on computer training.

Enrollment Application Workshop Description

This workshop focuses on the importance of correctly completing the Colorado Medical Assistance Program Provider Enrollment Application.

Newly enrolling providers, persons with the responsibility for enrolling providers within their groups, association representatives, and anyone who wants to better understand the Colorado Medical Assistance Program enrollment requirements should attend.

Specialty Classes Descriptions

Dental

The class is for billers using the 2006 ADA/837D claim format. The class covers billing procedures, claim formats, common billing issues and guidelines specifically for the following provider types: Dentists, Dental Hygienists

Federally Qualified Health Centers (FQHCs)

This class is for billers using the UB-04/837I and CO1500/837P format. The class covers billing procedures, new coding requirements, Encounter Payments, common billing issues and guidelines specifically for FQHC providers.

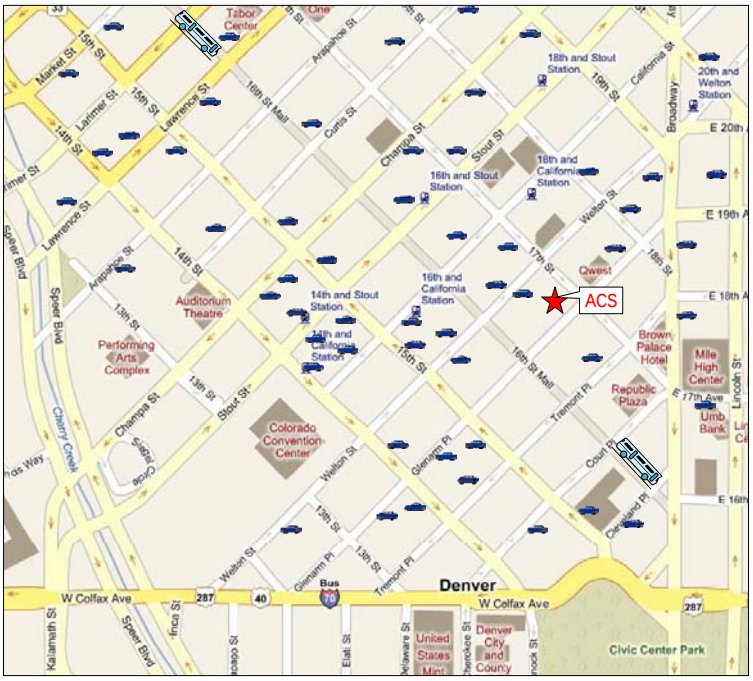
Hospital (IP/OP)

This class is for billers using the UB-04/837I claim format. The class covers billing procedures, common billing issues and guidelines specifically for: In-patient Hospital, Out-patient Hospital *(This is **not** the class for FQHC/RHC providers)*

Practitioner

This class is for providers using the CO1500/837P format. The class covers billing procedures, common billing issues and guidelines specifically for the following provider types:

- Ambulance
- Anesthesiologists
- ASC
- Family Planning
- Independent Labs
- Independent Radiologists
- Nurse Practitioner
- Physician Assistant
- Physicians, Surgeons



Driving directions to ACS, Denver Club Building, 518 17th Street, 4th floor, Denver, CO:
Take I-25 toward **Denver**
Take exit **210A** to merge onto **W Colfax Ave (40 E),** 1.1 miles
Turn **left** at **Kalamath St,** 456 ft.
Continue on **Stout St,** 0.6 miles
Turn **right** at **17th St,** 0.2 miles
ACS is located in the Denver Club Building on the west side of Glenarm Place at 17th Street (Glenarm is a two-way street).
Parking: Parking is not provided by ACS and is limited in the Downtown Denver area.
Providers attending workshops are urged to carpool and arrive early to secure parking or use public transportation.
= Light Rail Station: A Light Rail map is available at:
http://www.rtd-denver.com/LightRail/lrmap.htm
= **Free** MallRide: MallRide stops are located at every intersection between RTD's Civic Center Station and Union Station.
= Commercial parking lots: Lots are available throughout the downtown area. The daily rates are between $5 and $20.

July 2009

Sun	Monday	Tuesday	Wednesday	Thursday	Friday	Sat
			1	2	3	4
5	6	7	8	9	10	11
12	13	14 Beginning Billing – Colorado 1500/837P 9:00AM-2:00PM IP/OP – 3:00PM-4:30 PM	15 Provider Enrollment 9:00AM – 12:00PM	16 Beginning Billing – UB-04/837I 9:00AM-2:00PM Practitioner – 2:00-4:00 PM	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

August 2009

Sun	Monday	Tuesday	Wednesday	Thursday	Friday	Sat
						1
2	3	4	5	6	7	8
9	10	11 Beginning Billing – Colorado 1500/837P 9:00AM-2:00PM	12	13 Beginning Billing – UB-04/837I 9:00AM-2:00PM FQHC – 2:00-4:00 PM	14 Dental – 9:00AM-12:00PM	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

Please direct questions about Colorado Medical Assistance Program billing or the information in this bulletin to
ACS Provider Services at 303-534-0146 or 1-800-237-0757 (toll free).
Please remember to check the Provider Services section of the Department's Web site at colorado.gov/hcpf.

Wheelchair Repair Codes
Fiscal Year Equals July 1 to Following June 30
*New Rate

HCPCS	Description	Qty	Cost EA
E0951	Heel loop/holder	2 per fiscal yr	$ 14.90
E0952	Toe loop/holder	2 per fiscal yr	$ 14.90
E0960	Wheelchair Accessory, shoulder harness/straps or chest strap, including Hardware	1 per fiscal yr	$ *105.00
E0961	MWC Accessory, wheel lock brake extension handle	2 per fiscal yr	$ 14.60
E0971	MWC Accessory, anti-tipping device	2 per fiscal yr	$ 31.78
E0974	MWC Accessory, anti-rollback device	2 per fiscal yr	$ 29.79
E0978	W/C Accessory, positioning belt, safety belt, pelvic strap, each	1 per fiscal yr	$ 28.79
E0981	W/C Accessory, seat upholstery	1 per fiscal yr	$ 71.37
E0982	W/C Accessory, back upholstery	1 per fiscal yr	$ 66.72
E0995	W/C Accessory, calf rest / pad	2 per fiscal yr	$ 14.95
K0739	Repair requiring skill of a technician – Limit 5 units per month	5 units/cal month	$ 25.00
E2210	W/C Accessory, bearings, any type	16 per fiscal yr	$ 4.92
E2211	MWC Accessory, pneumatic propulsion tire	2 per fiscal yr	$ 30.67
E2212	MWC Accessory, tube for pneumatic propulsion tire	2 per fiscal yr	$ 6.50
E2213	MWC Accessory, insert for pneumatic propulsion tire (removable)	2 per fiscal yr	$ 22.80
E2214	MWC Accessory, pneumatic caster tire	2 per fiscal yr	$ 26.99
E2215	MWC Accessory, tube for pneumatic caster tire	2 per fiscal yr	$ 7.20
E2216	MWC Accessory, foam filled propulsion tire	2 per fiscal yr	$ *29.72
E2217	MWC Accessory, foam filled caster tire	2 per fiscal yr	$ *31.90
E2218	MWC Accessory, foam propulsion tire	2 per fiscal yr	$ *30.00
E2219	MWC Accessory, foam caster tire	2 per fiscal yr	$ 27.15
E2220	MWC Accessory, solid (rubber/plastic) propulsion tire	2 per fiscal yr	$ 21.38
E2221	MWC Accessory, solid (rubber/plastic) caster tire (removable)	2 per fiscal yr	$ 19.15
E2222	MWC Accessory, solid (rubber/plastic) caster tire with integrated wheel	2 per fiscal yr	$ 15.79
E2223	MWC Accessory, valve	2 per fiscal yr	$ 4.20
E2224	MWC Accessory, propulsion wheel excludes tire	2 per fiscal yr	$ 73.50
E2225	MWC Accessory, caster wheel excludes tire	2 per fiscal yr	$ 13.04
E2226	MWC Accessory, caster fork	2 per fiscal yr	$ 28.75
E2368	PWC Component, motor, replacement only	2 per 3 fiscal yrs	MSRP
E2369	PWC Component, gear box, replacement only	2 per 3 fiscal yrs	MSRP
E2370	PWC Component, motor and gear box combination, replacement only	2 per 3 fiscal yrs	MSRP
E2374	PWC Accessory, hand or chin control interface, standard remote joystick	1 per 3 fiscal yrs	$ *534.02

Wheelchair Repair Codes
Fiscal Year Equals July 1 to Following June 30
*New Rate

HCPCS	Description	Qty	Cost EA
E2375	PWC Accessory, non-expandable controller, replacement only	1 per fiscal yr	$ 642.42
E2376	PWC Accessory, expandable controller, replacement only	1 per fiscal yr	$ 1,006.70
E2381	PWC Accessory, pneumatic drive wheel tire	2 per fiscal yr	$ 57.14
E2382	PWC Accessory, tube for pneumatic drive wheel tire	2 per fiscal yr	$ 15.58
E2383	PWC Accessory, insert for pneumatic drive wheel tire	2 per fiscal yr	$ 113.91
E2384	PWC Accessory, pneumatic caster tire	2 per fiscal yr	$ 60.68
E2385	PWC Accessory, tube for pneumatic caster tire	2 per fiscal yr	$ 37.13
E2386	PWC Accessory, foam filled drive wheel tire	2 per fiscal yr	$ 112.88
E2387	PWC Accessory, foam filled caster tire	2 per fiscal yr	$ 50.62
E2388	PWC Accessory, foam drive wheel tire	2 per fiscal yr	$ 37.39
E2389	PWC Accessory, foam caster tire	2 per fiscal yr	$ 20.52
E2390	PWC Accessory, solid (rubber/plastic) drive wheel tire	2 per fiscal yr	$ 32.09
E2391	PWC Accessory, solid (rubber/plastic) caster tire	2 per fiscal yr	$ 15.38
E2392	PWC Accessory, solid (rubber/plastic) caster tire with integrated wheel	2 per fiscal yr	$ 40.41
E2393	PWC Accessory, valve for pneumatic tire tube	2 per fiscal yr	$ 4.20
E2394	PWC Accessory, drive wheel excludes tire	2 per fiscal yr	$ 57.56
E2395	PWC Accessory, caster wheel excludes tire	2 per fiscal yr	$ 40.91
E2396	PWC Accessory, caster fork	2 per fiscal yr	$ 42.40
K0019	Arm pad	2 per fiscal yr	$ 14.63
K0038	Leg strap	1 per fiscal yr	$ 27.55
K0039	Leg strap, H style	1 per fiscal yr	$ 47.03
K0040	Adjustable angle footplate	2 per fiscal yr	$ 83.83
K0041	Large size footplate	2 per fiscal yr	$ 52.75
K0042	Standard size footplate	2 per fiscal yr	$ 36.58
K0043	Footrest, lower extension tube	2 per fiscal yr	$ 19.93
K0044	Footrest, upper hanger bracket	2 per fiscal yr	$ *30.00
K0045	Footrest, complete assembly	2 per fiscal yr	$ 138.12
K0046	Elevating legrest, lower extension tube	2 per fiscal yr	$ 19.38
K0047	Elevating legrest, upper hanger bracket	2 per fiscal yr	$ 79.43
K0052	Swing-away detachable footrests	2 per fiscal yr	$ 65.12
K0070	Rear wheel assembly, complete, with pneumatic tire, spokes or molded	2 per fiscal yr	$ 195.98
K0071	Front caster assembly, complete, with pneumatic tire	2 per 3 fiscal yrs	MSRP
K0072	Front caster assembly, complete, with semi-pneumatic tire	2 per 3 fiscal yrs	MSRP
K0077	Front caster assembly, complete, with solid tire	2 per 3 fiscal yrs	MSRP

* New Rate

Home Health and Private Duty Nursing Providers

The Home Health and Private Duty Nursing programs received a 2% rate reduction to all Nursing and Therapy services effective July 1, 2009. A 2% rate reduction was also applied to the Acute and Long-Term Maximum Daily Amount. Home Health Aide Basic and Extended rates remain unchanged from the FY 08-09 rate.

Home Health
FY 09-10 Rates

SERVICE TYPE	REVENUE CODE		CURRENT RATE	NEW RATE 7/1/2009	UNIT VALUE
	Acute Home Health	Long Term Home Health			
RN Assess and Teach	589	None	$ 99.45	$ 97.46	Acute only- one visit up to 2 ½ hours
RN/LPN	550	551	$ 99.45	$ 97.46	One visit up to 2 ½ hours
RN Brief 1st of Day	n/a	590	$ 69.61	$ 68.22	One Visit
RN Brief 2nd or >	Na	599	$ 48.73	$ 47.76	One Visit
HHA BASIC	570	571	$ 34.66	$ 34.66	One hour
HHA EXTENDED	572	579	$ 10.36	$ 10.36	For visits lasting more than one hour, extended units of 15-30 minutes
PT	420	421 (for 0-17 years LTHH)	$ 108.76	$ 106.58	One Visit up to 2 ½ hours
PT for HCBS Home Mod Evaluation	424	424	$ 108.76	$ 106.58	1-2 visits
OT	430	431 (for 0-17 years LTHH)	$ 109.47	$ 107.28	One visit up to 2 ½ hours
OT for HCBS Home Mod Evaluation	434	434	$ 109.47	$ 107.28	1-2 visits
S/LT	440	441 (for 0-17 years LTHH)	$ 118.18	$ 115.81	One visit up to 2 ½ hours
Maximum Daily Amount Acute Home Health			$ 463.39	$ 454.12	24 hours, MN to MN
Maximum Daily Amount Long Term Home Health			$ 361.54	$ 354.31	24 hours, MN to MN

Private Duty Nursing
FY 09-10 Rates

SERVICE TYPE	REVENUE CODE	CURRENT RATE	NEW RATE 7/1/2009	UNIT VALUE
PDN-RN	552	$ 39.29	$ 38.50	Hour
PDN-LPN	559	$ 29.50	$ 28.91	Hour
PDN-RN (group-per client)	580	$ 29.44	$ 28.85	Hour
PDN-LPN (group-per client)	581	$ 22.59	$ 22.14	Hour
"Blended" group rate / client*	582	$ 29.41	$ 28.83	Hour

* The "blended" rate is available on request for a Home Health Agency that provides Private Duty Nursing to multiple clients at group care settings. All Private Duty Nursing provided in those settings is billed at the same rate and revenue code for an RN or LPN.

HCBS- Elderly, Blind, and Disabled (EBD), Persons with Major Mental Illness (MI), and Persons Living with HIV/AIDS (PLWA)

The HCBS-EBD, MI, and PLWA programs received a 2% rate reduction to Adult Day Basic and Specialized, Alternative Care Facilities, Non-Medical Transportation, and Respite Care services effective July 1, 2009. All Personal Care, Homemaker, and Health Maintenance rates remain unchanged from the FY 08-09 rate.

FY 09-10 Rates

SERVICE TYPE	PROCEDURE CODE	CURRENT RATE	NEW RATE 7/1/2009	UNIT VALUE	COMMENTS
Adult Day Services					
Basic Rate	S5105	$ 23.14	$ 22.68	4-5 Hours	An individual unit is 4-5 hours per day
Specialized Rate	S5105	$ 29.57	$ 28.98	3-5 Hours	An individual unit is 3-5 hours per day
Alternative Care Facility	T2031	$ 49.01	$ 48.03	Day	May be different for clients with 300% income
Community Transition Services	T2038				1 Unit = 1 Transition
Community Transition Services Items	T2038 52				1 Unit = 1 Purchase
Consumer Direct Attendant Support Services	T2025				Assessed by CM; varies by client
Consumer Direct Attendant Support Services Administration	T2025 52				Assessed by CM; varies by client
Electronic Monitoring					
Installation	S5160				Negotiated by CM; varies by client
Service	S5161				Negotiated by CM; varies by client
Homemaker	S5130	$ 3.63	$ 3.63	15 minutes	
Home Modification	S5165	$10,000.00	$10,000.00	Lifetime Max	
IHSS Health Maintenance Activities	H0038	$ 6.82	$ 6.82	15 minutes	
IHSS Personal Care	T1019 KX	$ 3.63	$ 3.63	15 minutes	
IHSS Relative Personal Care	T1019 HR KX	$ 3.63	$ 3.63	15 minutes	No limits on IHSS benefits provided by parents of adult children. For all other relatives, the limitations on payment to family applies as set forth in 10 C.C.R. 2505-10, Section 8.485.200
IHSS Homemaker	S5130 KX	$ 3.63	$ 3.63	15 minutes	
Medication Reminder	S5185				1 Unit Per Month
Medication Reminder Install/Purchase	T2029				1 Unit = 1 Purchase
Non-Med. Transportation					
Med. Transp. Rate	T2001			1 Way Trip	Negotiated by CM; varies by client. Not to exceed Med. Transport Rates
Taxi	T2001	$ 49.91	$ 48.92	1 Way Trip	Taxi: up to $48.92 per trip, not to exceed the rate with the Public Utilities Commission
Mobility Van	T2001	$ 12.82	$ 12.56	1 Way Trip	Mobility Van: $12.56 per trip

FY 09-10 Rates

SERVICE TYPE	PROCEDURE CODE	CURRENT RATE	NEW RATE 7/1/2009	UNIT VALUE	COMMENTS
Wheelchair Van	T2001	$ 15.96	$ 15.64	1 Way Trip	Wheelchair Van: $15.64 per trip Wheelchair Van Mileage Add-On: 62 cents per mile
Personal Care	T1019	$ 3.63	$ 3.63	15 minutes	
Relative Personal Care	T1019 HR	$ 3.63	$ 3.63	15 minutes	Relative Personal Care cannot be combined with HCA Maximum reimbursement not to exceed 1776 units per year
Respite Care					
ACF	S5151	$ 54.58	$ 53.49	Day	Limit of 30 days per calendar year
NF	H0045	$ 121.70	$ 119.27	Day	Limit of 30 days per calendar year.
In Home	S5150	$ 3.12	$ 3.06	15 minutes	Limit of 30 days per calendar year Not to exceed the ACF per diem for respite care

HCBS- Persons with Traumatic Brain Injury (BI)

The HCBS-BI Waiver program received a 2% rate reduction to all services with the exception of Personal Care and Relative Personal Care, which remain unchanged from the FY 08-09 rate. These rates take effect on July 1, 2009.

FY 09-10 Rates

SERVICE TYPE	PROCEDURE CODE	CURRENT RATE	NEW RATE 7/1/2009	UNIT VALUE	COMMENTS
Adult Day Services	S5102	$ 48.74	$ 47.76	Day	At least 2 or more hours of attendance 1 or more days per week
Assistive Technology	T2029	$ -	$ -		Negotiated by SEP through prior authorization
Behavioral Programming	H0025	$ 13.74	$ 13.47	Half Hour	
Day Treatment	H2018	$ 77.32	$ 75.78	Day	At least 2 or more hours of attendance 1 or more days per week
Electronic Monitoring					
Installation	S5160				Negotiated by CM; varies by client
Service	S5161				Negotiated by CM; varies by client
Home Modifications	S5165	$10,000.00	$10,000.00	Lifetime Max	
Independent Living Skills Training	T2013	$ 25.01	$ 24.51	Hour	
Mental Health Counseling					
Family	H0004 HR	$ 14.22	$ 13.93	15 minutes	
Group	H0004 HQ	$ 7.96	$ 7.80	15 minutes	
Individual	H0004	$ 14.22	$ 13.93	15 minutes	Must obtain Department approval over 30 cumulative visits of counseling
Non-Medical Transportation	T2001				

FY 09-10 Rates

SERVICE TYPE	PROCEDURE CODE	CURRENT RATE	NEW RATE 7/1/2009	UNIT VALUE	COMMENTS
Med Trans. Rate	T2001			1 Way Trip	Negotiated by CM; varies by client. Not to exceed Med. Transport Rate.
Taxi	T2001	$ 49.91	$ 48.92	1 Way Trip	Taxi: up to $48.92 per trip, not to exceed the rate with the Public Utilities Commission.
Mobility Van	T2001	$ 12.82	$ 12.56	1 Way Trip	Mobility Van: $12.56 per trip.
Wheelchair Van	T2001	$ 15.96	$ 15.64	1 Way Trip	Wheelchair Van: $15.64 per trip. Wheelchair Van Mileage Add-On: 62 cents per mile.
Personal Care	T1019	$ 3.69	$ 3.69	15 minutes	Not to exceed 10 hours per day
Relative Personal Care	T1019 HR	$ 3.69	$ 3.69	15 minutes	Maximum reimbursement not to exceed 1776 units per year
Respite Care					
NF	H0045	$ 115.15	$ 112.85	Day	
In Home	S5150	$ 3.12	$ 3.06	15 minutes	All inclusive of client's needs
Individual Substance Abuse Counseling					
Family	T1006	$ 56.86	$ 55.72	Hour	
Group	H0047 HQ	$ 31.84	$ 31.21	Hour	
Individual	H0047 HF	$ 56.86	$ 55.72	Hour	
Transitional Living	T2016	$ 134.51	$ 131.82	Day	
Supported Living Program	T2033			Day	Per diem rate set by HCPF using acuity levels of client population

HCBS- Children with Autism (CWA)

The HCBS-CWA Waiver program rates remain unchanged from the FY 08-09 rates.

FY 09-10 Rates

SERVICE TYPE	PROCEDURE CODE	CURRENT RATE	NEW RATE 7/1/2009	UNIT VALUE
Behavior Therapies - Lead Therapist	H0004	$ 22.41	$ 22.41	15 minutes
Behavior Therapies - Senior Therapist	H0004 52	$ 11.66	$ 11.66	15 minutes
Behavior Therapies - Line Staff	H2019	$ 3.68	$ 3.68	15 minutes

Children's HCBS (CHCBS)

The CHCBS Waiver program received a 2% rate reduction to Case Management effective July 1, 2009. The IHSS Health Maintenance Activities rate remains unchanged from the FY 08-09 rate.

FY 09-10 Rates

SERVICE TYPE	PROCEDURE CODE	CURRENT RATE	NEW RATE 7/1/2009	UNIT VALUE
Case Management	T1016	$ 8.27	$ 8.11	15 minutes
IHSS Health Maintenance Activities	H0038	$ 6.82	$ 6.82	15 minutes

HCBS-Pediatric Hospice Waiver (PHW)

The PHW program rates remain unchanged from the FY 08-09 rates.

FY 09-10 Rates

SERVICE TYPE	PROCEDURE CODE	CURRENT RATE	NEW RATE 7/1/2009	UNIT VALUE	COMMENTS
Expressive Therapy	G0176 UD	$ 56.84	$ 56.84	1 Hour	Limited to 39 hours total per 365 days
Individual Counseling	H0004 UD	$ 14.21	$ 14.21	15 Minutes	Limited to 98 hours total per 365 days across all H0004
Family Counseling	H0004 UD HR	$ 14.21	$ 14.21	15 Minutes	Limited to 98 hours total per 365 days across all H0004
Group Counseling	H0004 UD HQ	$ 7.97	$ 7.97	15 Minutes	Limited to 98 hours total per 365 days across all H0004
Respite Care Unskilled	S5150 UD	$ 3.62	$ 3.62	15 Minutes	Up to 4 hour visit. Limited to 30 days (unique dates of service per 365 days)
Respite Care Unskilled	S5151 UD	$ 72.47	$ 72.47	1 Day	Limited to 30 days (unique dates of service per 365 days)
Respite Care Skilled RN/LPN	S9125 UD	$ 149.33	$ 149.33	1 Day	Limited to 30 days (unique dates of service per 365 days)
Respite Care Skilled RN/LPN	T1005 UD	$ 9.31	$ 9.31	15 Minutes	Limited to 4 hours per visit. Limited to 30 days (unique dates of service per 365 days)
Palliative/Supportive Care Skilled RN/LPN	S9126 UD	$ 137.32	$ 137.32	1 Day	
Palliative/Supportive Care Skilled RN/LPN	T2043 UD	$ 33.37	$ 33.37	1 Hour	Limited to 4 hours per visit.