Provider Bulletin

Reference: B1000274 **January 2010**

colorado.gov/pacific/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

Dual Eligibility

Providers are reminded that Medicaid is always the payer of last resort, therefore, services for dual-eligible clients - those with coverage from Medicare and Medicaid - must be billed first to Medicare. Please refer to the December, 2008 Provider Bulletin (B0800255) for an example of exceptions for Home Health services. Providers must be able to show evidence that claims for dual eligible clients, where appropriate, have been denied by Medicare prior to submission to the Colorado Medical Assistance Program. Per the Provider Participation Agreement, this evidence must be retained for six years following the Medicare denial. In the future, the Colorado Medical Assistance Program will require that the Medicare Standard Paper Remit (SPR) accompany any paper claims for dual-eligible clients which are submitted for reimbursement. Feel free to contact ACS Provider Services at 303-534-0146 or 1-800-237-0757 (Colorado toll free) Monday through Friday, 8:00 a.m. to 5:00 p.m. MT with questions.

Provider Co-pay Agreement

The Provider Participation Agreement exists in order to define the Department of Health Care Policy and Financing's (the Department) expectations of providers who perform services and submit billing, transactions, and/or data to the Colorado Medical Assistance Program. The Agreement is also established to facilitate business transactions by electronically transmitting and receiving data in agreed formats; to ensure the integrity, security, and confidentiality of the aforesaid data; and to permit appropriate disclosure and use of such data as permitted by law. In addition to several terms, the Provider Participation Agreement states that providers agree to accept as payment in full, amounts paid in accordance with schedules established by the Department. No supplemental charges will be billed to the client, except for amounts designated as co-payments by the Department. Providers will not bill the client for any covered items or services that are reimbursable under the rules and regulations of the Department, nor for any items or services that are not reimbursable but would have been had the provider complied with the rules and regulations of the Department. All payments received or applied from any other sources will be recorded on the claim.
For questions regarding the Provider Participation Agreement, ACS Provider Services at 303-534-0146 or 1-800-237-0757 (Colorado toll free).

Records Retention

Providers are reminded that they are required by their Provider Participation Agreement with the Colorado Medical Assistance Program and Colorado State Rule 8.130.1 to maintain records necessary to disclose the nature and extent of services provided to clients. These records include, but are not limited to:

- billing information;
- treatment prior authorization requests;
- all medical records, service reports, and orders prescribing treatment plans;
- records of items, including drugs, prescribed, ordered for, or furnished to recipients, and copies of original invoices for such items; and
- records of all payments received from the Medicaid Program.

These records must fully substantiate or verify claims submitted for payment and must be furnished on request to the authorized requesting agency. These records must be maintained for six years unless an additional retention period is required elsewhere. Please feel free to contact ACS Provider Services 303-534-0146 or 1-800-237-0757 (Colorado toll free) with questions.

Essential Community Providers (ECP)

The Department has a process through which community providers whose mission it is to serve low-income and medically underserved individuals may be designated by Medicaid as an Essential Community Provider (ECP). An ECP is defined as a health care provider that:

a. has historically served medically needy or medically indigent patients and demonstrates a commitment to serve low-income and medically indigent populations who make up a significant portion of its patient population or, in the case of a sole community provider, serves the medically indigent patients within its medical capability; and
b. waives charges for services on a sliding scale based on income and does not restrict access because of a client's financial limitation, pursuant to 26-4-114(3)(a)(b) CRS.

The following are benefits when becoming a designated ECP:

a. gives the opportunity to participate in Medicaid managed care contracts;
b. provides recognition in your community as a valuable asset serving the most vulnerable Coloradans assisting in receiving community support; and
c. promotes your organization when seeking funding.

ECP designation is good for three years after approval from the Department. For additional information on how to receive ECP designation and for an application, please visit the Essential Community Providers section of the Department's Web site at colorado.gov/pacific/hcpf. Please contact Christy Hunter at 303-866-2086 or christy.hunter@state.co.us with questions.

January and February 2010 Holidays

Due to the Martin Luther King holiday on Monday, January 18, 2010 and the President's Day holiday on February 15, 2010, the receipt of warrants and EFTs will be delayed by one or two days for both holidays.

State Furlough Day

All Colorado State offices will be closed on Friday, January 15, 2010 due to a statewide furlough day. ACS Government Solutions and the Provider Services Call Center will be open for business. Please contact ACS Provider Services at 303-534-0146 or 1-800-237-0757 (Colorado toll free) with questions.

Tax Season and 1099s

Please don't forget to update your current provider enrollment information with the fiscal agent. By using the ***Provider Enrollment Update Form***, you can update your address, National Provider Identifier, license, email address, affiliations and receive electronic bulletin notifications. The form can be found in the Provider Services section under Forms of the Department's Web site. With the exception of provider license information, the above updates may also be made through the Web Portal.
Updated provider license information must be made using the *Provider Enrollment Update form*.

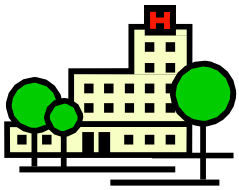
Hospital Providers

ICD-9-CM Codes Crosswalk – October 1, 2009

As reported in the October, 2009 bulletin (B0900271), the Department is updating our crosswalk for new ICD-9-CM codes (diagnosis and procedure codes) so that the DRG grouper currently in place is able to recognize new codes and group accordingly.

The following versions of the Centers for Medicare and Medicaid Services (CMS) Grouper are used to process Medicaid inpatient hospital claims:

Discharge Date	Grouper
On or after October 1, 2006	Version 24.0
October 1, 2005 to September 30, 2006	Version 23.0
October 1, 2004 to September 30, 2005	Version 22.0
October 1, 2003 to September 30, 2004	Version 21.0
October 1, 2002 to September 30, 2003	Version 20.0



Until the crosswalk table is updated, claims that include new ICD-9-CM codes will not group and consequently the system may automatically deny them. However, hospitals do not need to resubmit claims denied for this particular reason. The Department will automatically adjust claims that contain a new diagnosis code after the system's crosswalk has been updated with the new ICD-9-CM codes and that deny for any of the edits listed below:

0582	*DRG record not on database*
0583	*DRG return code 1 - Diagnosis not principal diagnosis*
0584	*DRG Return Code 2 - No DRG in major diagnostic category for principal diagnosis*
0585	*DRG pricing span not found*
0592	*DRG return code 6 - Illogical principal diagnosis*
0593	*DRG return code 7 - Invalid principal diagnosis*

Upon completion, the updated crosswalk table will be published on the Department's Web site and in a future provider bulletin.

The Department recognizes this problem and it is working on the necessary updates. We apologize for this inconvenience. If you have any questions, please send an email to Eric Wolf at eric.wolf@state.co.us.

Mental Health Providers

Billing Change for Mental Health Clients with Retroactive Enrollment

The Department implemented a policy in the Behavioral Health Organizations' (BHOs') September 2009 contract that no longer holds the BHOs responsible for reimbursement of claims where the service start date is more than 18 months prior to the Medicaid eligibility determination date. Effective November 1, 2009, providers should no longer submit these claims for services covered under the mental health contract to the BHOs. Instead, providers should now bill the claims as fee-for-service to Medicaid for reimbursement. Providers must bill using the appropriate paper claim form, as the dates of service are older than a year. If you have any questions, please contact Sarah Campbell at Sarah.Campbell@state.co.us or 303-866-2083.

Pharmacy Providers

Pharmacy and Therapeutics (P&T) Committee News

The Department will be announcing its new members for the Pharmacy and Therapeutics (P&T) Committee positions. Please check the Pharmacy and Therapeutics (P&T) Committee section of the Department's Web site for more information.

The next P&T Committee meeting will be held:
Tuesday, January 12, 2010
1:00 pm - 5:00 pm
225 E. 16th Ave,
1st Floor Conference Room
Denver, CO 80203

During the meeting, drug classes that will be under review include new reviews of Alzheimer's Agents and Multiple Sclerosis Interferon Products. Re-reviews include Growth Hormones, Intranasal Corticosteroids, Leukotriene Modifiers, Ophthalmic Agents to treat Allergic Rhinitis, Sedative Hypnotics (excluding

benzodiazepines), and Statins (including Statin combination products). Please submit written comments to pdl@state.co.us on or before January 11, 2010 for Committee consideration.

Preferred Drug List (PDL) Update

Effective January 1, 2010, the following medications will be Preferred Products on the Medicaid Preferred Drug List and will be covered without a prior authorization:

Newer Generation Antidepressants:
citalopram, fluoxetine, fluvoxamine, Lexapro (escitalopram), mirtazipine, nefazodone, paroxetine, sertraline, venalfaxine, venlafaxine ER tablets, Wellbutrin and bupropion in IR, SR and XL formulations

Phosphodiesterase Inhibitors:
Revatio (sildenafil)

Prostanoids:
generic IV epoprostenol

Endothelin Antagonists:
Letairis (ambrisentan)

Antiemetics:
Zofran and ondansetron tablets, ondansetron ODT (clients 12 years and under for ODT), ondansetron suspension, and Emend

Proton Pump Inhibitors:
Prilosec OTC, Aciphex, lansoprazole, and Prevacid Solutabs (clients 12 years and under for solutab)

Triptans and Triptan Combinations:
Maxalt MLT, Imitrex and sumatriptan generic tablets, and Imitrex (brand) nasal spray and Imitrex (brand) subcutaneous injection

The complete PDL and prior authorization criteria for non-preferred drugs are posted under Pharmacy in the Preferred Drug List (PDL) section of the Department's Web site. For questions or comments regarding the PDL, please contact Jim Leonard at 303-866-6342 or jim.leonard@state.co.us.

Azmacort

According to Abbott Laboratories, the inhaled triamcinolone aerosol product, Azmacort, was discontinued effective December 31, 2009, therefore, Azmacort is no longer available at pharmacies. Clients stabilized on Azmacort will need to be transitioned to an alternative product. Preferred Products in the Inhaled Corticosteroid class include: Flovent, Pulmicort and Qvar. Please refer to the Preferred Drug List (PDL) under the Pharmacy section of the Department's Web site for more information.

Physical Therapy (PT) and Occupational Therapy (OT) Providers

Prior Authorization Requirement Reminder

This is a reminder that a client may receive 24 units of Physical Therapy (PT) and 24 units of Occupational Therapy (OT) before a Prior Authorization Request (PAR) is required. A unit equals either a timed increment or a one-treatment session as described in the specific Current Procedural Terminology (CPT) procedure code book.

Units of service exceeding the initial 24 units for each therapy type will not be reimbursed without an approved PAR. This requirement includes PT and OT provided in an outpatient hospital setting. A client is eligible for another 24 units of service without a PAR when the client has not received any PT or OT services within a 366 consecutive day period. The 24 units accumulate from paid units per client, for each treatment modality, regardless of provider. If you have questions regarding this requirement, please contact ACS Provider Services at 303-534-0146 or 1-800-237-0757 (Colorado toll free).

Outpatient Hospitals and Practitioners

Notice to All Providers Billing Physician-Administered Drugs

All physician, outpatient hospital, EPSDT, and Medicare Part B crossover claims for physician-administered single-source and the 20 multiple-source drugs (as identified by the Centers for Medicare and Medicaid Services) must be submitted using both Healthcare Common Procedure Coding System (HCPCS) codes

and National Drug Code (NDC) numbers when using the electronic 837P (Professional) and 837I (Institutional) claim formats. Claims submitted for these drugs using only HCPCS codes or only NDC numbers will be denied. Claims submitted with NDC numbers that do not correspond to the correct HCPCS codes will also be denied.

The Department posts a list of the single-source and top 20 multiple-source drugs, and their corresponding NDCs and HCPCs, in the Billing Manuals section of the Department's Web site.

The list will be significantly expanded effective February 1, 2009. Providers are strongly recommended to review the list prior to the effective date. Since the list will be regularly updated, it is recommended that providers routinely submit both HCPCS and NDC numbers on all claims for physician-administered drugs, regardless of whether the drug is a single-source drug or is included on the list of top 20 multiple-source drugs.

Please contact Ethel Smith at ethel.smith@state.co.us or 303-866-3672 with questions.

Practitioners

Botulinum Neurotoxins Administered in the Office Setting

Botulinum neurotoxins are covered benefits for on-label, non-cosmetic use. Botulinum neurotoxins disrupt neurotransmission by inhibiting the release of acetylcholine at cholinergic nerve terminals of the peripheral nervous system and at ganglionic nerve terminals of the autonomic nervous system, inducing chemodenervation causing flaccid paralysis and/or decreased glandular secretion.

Although all botulinum toxins have a similar mechanism of action, the distinct product formulations and manufacturing procedures associated with the individual botulinum toxin products result in different biochemical, physical and clinical characteristics, including potency, duration, and safety profiles. Because of these differences, botulinum toxin products are not interchangeable.

To help differentiate these products, the FDA assigned new non-proprietary names (listed below in bold) to each of the three botulinum toxins currently available in the United States. The new nomenclature provides a new mechanism for uniquely identifying each toxin.

- BOTOX® (***onabotulinumtoxinA*)** is FDA-approved for the treatment of cervical dystonia, severe primary axillary hyperhidrosis, and strabismus and blepharospasm associated with dystonia, including benign essential blepharospasm or VII nerve disorders in patients 12 years of age and above. BOTOX® is reported using HCPCS code J0585 (Injection, onabotulinumtoxinA, 1 unit).
- DYSPORT™ (***abobotulinumtoxinA***) is FDA-approved for the treatment of cervical dystonia. DYSPORT™ is reported using HCPCS code J0586 (Injection, abobotulinumtoxinA, 5 units).
- MYOBLOC® (***rimabotulinumtoxinB)*** is FDA-approved for the treatment of cervical dystonia. MYOBLOC® is reported using HCPCS code J0587 (Injection, rimabotulinumtoxinB, 100 units).

Providers should recognize that the units of biological activity of one botulinum toxin product cannot be compared to nor converted into units of any other botulinum toxin product. A clear understanding of this important issue should reduce the risk of under- or over-dosing of patients due to incorrect unit administration.

HCPCS Code J0586 and descriptors associated with HCPCS codes J0585 & J0587 are effective January 1, 2010. Feel free to contact Teresa Knaack at teresa.knaack@state.co.us or 303-866-3064 if you have any questions.

Enjoy the Benefits of Direct Deposit

Providers who use Electronic Funds Transfer (EFT) can receive payments up to a week sooner than those receiving paper checks (warrants). EFT eliminates payment delays due to inclement weather, holidays, or post office mishaps.

Sign-up to receive payments via EFT today! Complete the EFT form located in the Forms section of the Department's Web site. You may also use the same form noted above to update your bank account information by indicating "Change" in the top-right corner and complete the form as directed. Please allow 30 days to process your EFT request.

You will receive paper warrants until EFT has been established or your update request has been processed. After 30 days, check with your bank to verify that EFT has been set up. You may contact the Department at 303-866-4372 with any EFT questions.

Electronic Provider Bulletin Notification

Help save postage costs by receiving an electronic notification containing a link to the most recent publication. Colorado Medical Assistance Program enrolled providers who are not receiving electronic notifications can complete and submit their information through the "(MMIS) Provider Data Maintenance" option via the Web Portal.

Providers may also complete and submit the Publication Preferences form located in the Forms section of the Department's Web site. Please fax or mail the completed form to the fiscal agent at the fax number or address on the form.

The Colorado Medical Assistance Program will not be responsible for undeliverable notifications due to incorrect email addresses. Providers may have only one email address on file with the fiscal agent.

January and February 2010 Provider Billing Workshops

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 January and February 2010 workshop calendars are included in this bulletin and are posted in the Provider Services Training & Workshops section of the Department's Web site.

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.***

January and February 2010 Specialty Workshop Class 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

Dialysis

This class is for billers who bill for Dialysis services on the UB-04/837I and/or CO1500/837P claim format. The class covers billing procedures, common billing issues and guidelines specifically for dialysis providers.
(This is not the class for Hospitals – please refer to the Hospital Class)

DME/Supply PAR Workshop

The PAR class focuses on completing the PAR correctly and avoiding common mistakes. This class is for DME/Supply providers who bill procedures requiring prior authorization.
(This class is not for Dental, HCBS, Nursing Facility, Pharmacy or Pediatric Home Health Providers.)

FQHC/RHC

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

HCBS-BI

This class is for billers using the CO1500/837P claim format for the following services: adult day care, non-medical transportation, home electronics, home modifications and personal care. The class covers billing procedures, common billing issues and guidelines specifically for HCBS-BI providers

HCBS-EBD

This class is for billers using the CO1500/837P claim format for the following services: adult day care, non-medical transportation, home electronics, home modifications and personal care. The class covers billing procedures, common billing issues and guidelines specifically for the following provider types:
HCBS-EBD HCBS-PLWA HCBS-MI

HCBS-DD

This class is for billers who bill on the CO1500 claim format for the following: Comprehensive Services (HCBS-DD), Supported Living Services (SLS), Children's Extensive Support (CES), Children's Residential Habilitation Program (CHRP) and Targeted Case Management (TCM). The class covers billing procedures, common billing issues and guidelines for HCBS-DD providers

Hospice

This class is for billers using the UB-04/837I format. The class covers billing procedures, common billing issues and guidelines specifically for Hospice providers.

IP/OP Hospital

This class is for billers using the UB-04/837I format. The class covers billing procedures, common billing issues and guidelines specifically for: In-patient Hospital, Out-patient Hospital

Supply/DME

This class is for billers using the CO1500/837P claim format. The class covers billing procedures, common billing issues and guidelines specifically for Supply/DME providers.

Transportation

This class is for emergency transportation providers billing on the CO1500/837P and/or UB-04/837I format. The class covers billing procedures, common billing issues and guidelines specifically for Transportation provider

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).

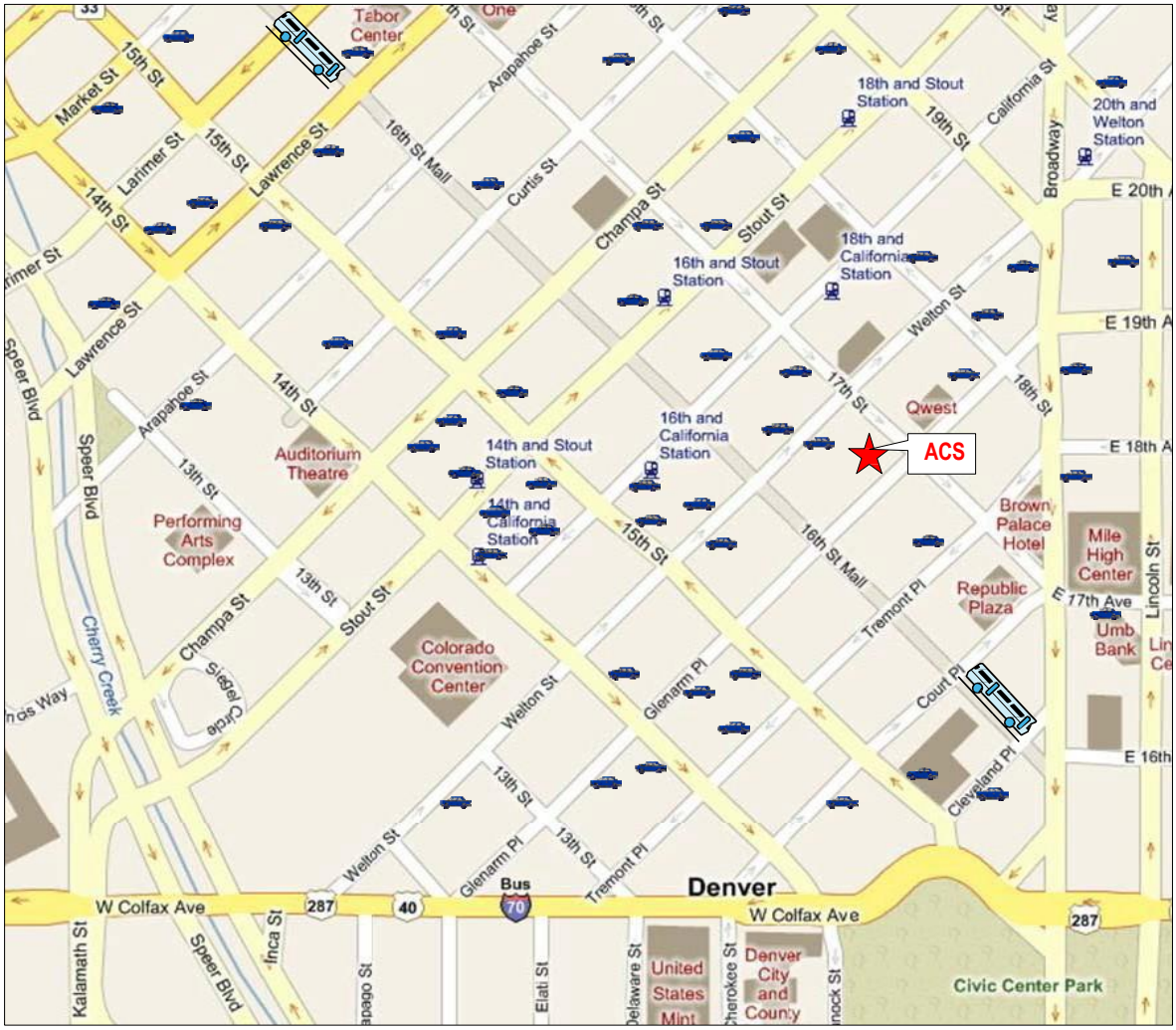
Parking: Parking is not provided by ACS and is limited in the Downtown Denver area.

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_Map.shtml

Free MallRide: MallRide stops are located at every intersection between Civic Center Station and Union Station.

Commercial parking lots: Lots are available throughout the downtown area. The daily rates are between $5 and $20.



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 (Colorado toll free).
Please remember to check the Provider Services section of the Department's Web site at colorado.gov/pacifi c/hcpf.

January 2010 Workshop Calendar

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
					1 *New Year's Day*	2
3	4	5	6	7	8	9
10	11	12 Beginning Billing - CO -1500//837P (Web Portal) 9:00 am - 2:00pm Vision - 3:00 pm - 4:30 pm	13 Beginning Billing - UB-04/837I (Web Portal) 9:00am-2:00 pm	14 Hospice - 9:00am-1:00pm IP/OP Hospital - 1:00pm -3:00pm	15 Beginning Billing - CO-1500 9:00 am –11:00am HCBS EBD - 11:00 am – 1:00pm HCBS BI - 1:00pm – 3:00pm HCBS- DD - 3:00pm -4:30pm *State Furlough*	16
17	18 *Martin Luther King Holiday*	19	20	21	22	23
24 31	25	26	27	28	29	30

February 2010 Workshop Calendar

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	1	2	3	4	5	6
7	8	9 Beginning Billing – CO -1500//837P (Web Portal) Substance Abuse - 3:00 pm-4:30 pm	10 Beginning Billing – UB-04/837I (Web Portal Dialysis – 3:00 pm-4:30 pm	11 Supply/DME PAR 101 - 9:00 am -11:00 am Supply/DME Billing - 12:00 pm-1:30 pm Pharmacy - 2:00 pm – 3:00 pm	12 Beginning Billing – CO-1500 **(WebEx)** 9:00am – 12:00pm FQHC/RHC **(WebEx)** - 1:00pm – 4:00 pm *State Furlough*	13
14	15 *President's Day*	16	17	18	19	20
21	22	23	24	25	26	27
28						