Provider Bulletin

Reference: B1000283 **May 2010**

colorado.gov/hcpf

In this issue:

ACS A xerox Company

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

Did you know...?

The requesting provider must sign Supply/DME PARs in field 26 (Requesting Physician Signature). The original signature is required and must be the signature of the physician ordering the service. If the prescribing physician does not sign the PAR form, a copy of the **physician's** prescription or letter of medical necessity must be attached to the PAR. Do not send the original prescription. Send a copy on an 81/2 x 11 sheet of paper. The written diagnosis must be entered in field 11 (Diagnosis), even if a prescription is attached. A rubber stamp facsimile signature, "Signature on File", and "SOF" are not acceptable on the PAR.

All Providers

New Electronic Interactive Colorado 1500 Claim Form

The Department of Health Care Policy and Financing (the Department) is pleased to announce a new electronic interactive Colorado 1500 paper claim form available May 1, 2010. The interactive claim form can now be completed online! You can find the form in the Provider Services Forms section of the Department's Web site under Claim Forms. Once completed, the form can be printed and mailed to ACS at P.O. Box 30, Denver, CO 80201. Please note that the use of this form does not alter paper claim submission criteria. Please contact ACS Provider Services at 303-534-0146 or 1-800-237-0757 (toll free) with questions.

May 2010 Holiday

Due to the Memorial Day holiday on Monday, May 31, 2010 the receipt of warrants and EFTs will be delayed by one or two days.

May 2010 State Furlough Day

All Colorado State offices will be closed on Friday, May 28, 2010 due to a statewide furlough day. The fiscal agent, ACS, and the Provider Services Call Center will be open during regular business hours.

Please contact ACS Provider Services at 303-534-0146 or 1-800-237-0757 (toll free) with questions.

New Look for Medical Identification Cards (MICs)

On June 1, 2010, the Department will begin issuing Medical Identification Cards (MICs) with a new look. The new MICs will be bilingual – English and Spanish – and more informative. To see an example of the new card, please refer to the article on the Provider Services Home page.

These new cards do not replace those issued before June 1, 2010, therefore, please accept both versions. You may contact Roberta Lopez at 303-866-6114 or roberta.lopez@state.co.us if you have any questions.

Early Periodic Screening, Diagnosis & Testing (EPSDT) Providers

EPSDT and Medicaid Lead Testing Requirement for Children

All children enrolled in EPSDT/Medicaid must be tested for lead poisoning at 12 and 24 months of age.

If these children are not tested at these intervals, testing for lead levels in EPSDT/Medicaid children must be conducted between 36 and 72 months of age. Section 1905(r)(5) of the Social Security Act requires that any medically necessary service be provided to EPSDT clients. The Colorado Medical Assistance Program would like to remind providers of the Centers for Medicare and Medicaid Services (CMS) blood lead testing requirement and that it is a medically necessary service because all EPSDT/Medicaid children are considered to be at risk for lead poisoning.

A finger-stick blood lead test which generates a result greater than 10 micrograms/deciliter must be confirmed using a venous blood sample. Providers may defer blood level testing at the above intervals only if previous lead testing is documented in the child's health record.

While recent guidelines from the Centers for Disease Control suggest alternative methods of risk assessment for lead exposure, CMS blood lead testing requirements remain in effect.

For more information, please visit http://www.cdphe.state.co.us/ap/down/leadservices.pdf or contact George deCurnou at 303-866-6010 or George.deCurnou@state.co.us.

Durable Medical Equipment (DME) and Supply Providers

Reimbursement Rate Updates for Selected DME and Supply Codes

Effective April 15, 2010, reimbursement rates were updated for selected DME and Supply Healthcare Common Procedure Coding System (HCPCS) procedure codes that were previously priced on a claim-by- claim basis. These updates were implemented to reduce the number of claims that were suspended and manually priced.

The new rates were calculated based on the 2009 Medicare fee schedule and average Medicaid payments over the past fiscal year. For information regarding specific rate updates, please see the April 2010 fee schedule on the Provider Services Home page of the Department's Web site. Procedure codes included in the rate updates are noted on the fee schedule.

Please contact Teresa Knaack at 303-866-3064 or Teresa.Knaack@state.co.us if you have any questions.

DME Stakeholder Information Meeting

DME, Oxygen Benefit
May 14, 2010
1:30 p.m. – 3:30 p.m.
225 E 16th St, First Floor Conference Room
Denver, Colorado 80203

On May 14, 2010, the Department will host a Stakeholder Informational Meeting about adding policy elements to the DME Oxygen benefit. This is an informational session to present the current requirements, utilization, and plans for working with stakeholders to change the benefit policy for DME oxygen.

The meeting is open to all interested parties. Telephone participation is also available. Please contact Richard Delaney at 303-866-3436 or richard.delaney@state.co.us for more information.

Hospital, Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Providers

Medicaid Should Not Be Billed for Services When the Primary Diagnosis on the Claim Is a Behavioral Health Organization (BHO) Covered Diagnosis

Medicaid clients are generally enrolled in one of five managed care BHOs which are responsible for providing mental health services to their clients with covered diagnoses identified in the BHO contract. Each BHO has its own provider network. Providers must become part of a BHO network and/or receive authorization from the BHO network in order to provide services to BHO clients with covered diagnoses.

Hospital and FQHC/RHC providers have been erroneously submitting claims to Medicaid Fee-for-Service (FFS) for services provided to BHO-enrolled clients when the primary diagnoses are covered by the BHO contracts. Providers are required to check eligibility and managed care enrollment on all clients before rendering services. Providers may submit claims to Medicaid FFS only when the primary diagnosis is not covered by the BHO contract.

Any payments made by Medicaid for claims submitted in error to Medicaid FFS are considered overpayments that must be returned to the Department. Inpatient, outpatient and FQHC/RHC providers should review all past and present claims with primary mental health diagnoses. If the claims were submitted to Medicaid FFS in error, BHO participating network hospital and FQHC/RHC providers should correct the submission through the Web Portal and should submit the claims to the appropriate BHO for payment.

Hospital and FQHC/RHC providers which are not BHO participating network providers should correct the erroneous submissions though the Web Portal as well. However, except for emergency services, the BHOs are under no obligation to pay for services rendered without their pre-authorization. The Department will be auditing for incorrect FFS payments for clients with primary mental health diagnoses.

FQHC/RHC providers are allowed to submit a claim to Medicaid for mental health primary diagnoses only if the client was seen at an FQHC/RHC by a medical practitioner. Those claims must be submitted on the UB-04 paper claim form. The following statement must be entered in the remarks section (Field #80):

"Medical records affirm charges are not covered by mental health plan"

For further information on how and when to bill BHOs, and for a list of primary mental health diagnoses by ICD-9 codes, please see Appendix T of the Appendices in the Provider Services Billing Manuals section of the Department's Web site.

If you have questions, please contact Marceil Case at 303-866-3054 or marceil.case@state.co.us.

Inpatient and Outpatient Providers

Bundling of Related Inpatient and Outpatient Hospital Claims

This is a reminder of the existing bundling payment policy last referenced in bulletin B0400180 (08/04).

"Bundling" describes a single reimbursement package for related services. The Colorado Medical Assistance Program reimbursement for inpatient hospital care includes associated outpatient services provided in a 24-hour period immediately prior to the hospital admission. An outpatient claim will be denied if it should have been bundled into an inpatient admission. If the hospital provider disagrees with the denial, the provider may submit the claim to the fiscal agent (ACS) for reconsideration. A medical professional will review the claims and determine whether or not the claims are related.

If you have any questions, please contact Eric Wolf at 303-866-5963 or eric.wolf@state.co.us.

Medicaid and CHP+ Managed Care Providers

Capitation Payment Delay/Schedule Change UPDATE

Legislation was recently passed in the General Assembly that will repeal S.B. 09-265, which required that capitation payments for managed care contractors be delayed in June 2010 and paid retrospectively in July 2010 and going forward. If the new legislation is signed into law, **no changes to the current capitation payment schedule will be made.**

When a decision is made on the new legislation, Department contract managers will advise contractors via phone or e-mail. A summary of the decision will be provided in the June 2010 Provider Bulletin.

Pharmacy Providers

Medical Foods

Effective April 1, 2010, Medical Foods are a covered pharmacy benefit. Medical Foods have not been a pharmacy benefit since July 1, 2009; however, it was determined by the Department that these products are an allowable pharmacy benefit under the prescription vitamin category. The previous prior authorization criteria for these products will be reinstated. To review the criteria or to request prior authorization, go to the Department's Pharmacy Prior Authorization Policies Web page.

If you have any questions about Medical Foods, please contact Kim Eggert at Kimberly.Eggert@state.co.us.

Synagis Coverage

Effective May 1, 2010, pharmacy claims for Synagis will deny. The following statement will appear through the point-of-sale pharmacy system for all claim submissions:

Synagis is only a covered benefit during RSV season; please contact the Helpdesk at 800-365-4944 for more details.

Atypical Antipsychotics

Effective April 1, 2010, the following atypical antipsychotics are preferred drugs on the Medicaid Preferred Drug List (PDL): Abilify, clozapine, Clozaril, Geodon, Risperdal, risperidone, Seroquel, Seroquel XR and Zyprexa. All other atypical antipsychotics will be considered non-preferred, for example Saphris, Fanapt and Invega.

All clients currently stabilized on preferred or non-preferred drugs will receive authorization to continue on their treatment for up to 2 years under the grandfathering clause. At that time, the Department expects to have a computerized automatic prior authorization process in place to streamline approvals.

Clients stabilized on a non-preferred drug have received authorization automatically from the Department. Providers will not need to submit a prior authorization request (PAR) for these clients even if the quantity limits have been exceeded.

Clients stabilized on a preferred drug will only require a PAR if the quantity limits for the preferred atypical antipsychotic drugs has been exceeded. For example, if a client takes a medication more frequently in a day than the quantity limits allow, that client must have prior authorization.

The quantity limits are listed in the PDL effective April 1, 2010 on the Department's Pharmacy Preferred Drug List (PDL) Web page.

Providers will need to request prior authorization through the Department's Helpdesk at 1-800-365-4944 or by faxing a PAR to 1-888-772-9696. The PAR form is posted on the Department's Pharmacy Prior Authorization Policies Web page. In the Medical Justification section of the PAR form, you must write that the client is currently stabilized on their medication and qualifies for grandfathering.

If you have any questions regarding the prior authorization criteria, or procedure for obtaining prior authorization, please contact Kim Eggert at kimberly.eggert@state.co.us.

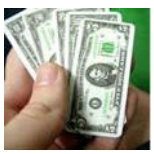
Change to Dispensing Requirements

Beginning June 1, 2010, the Department intends to revise the Dispensing Requirements. For Drug Enforcement Administration Schedule 2 through 5 drugs, 85% of the days' supply will have to lapse before a drug can be filled again. For non-scheduled drugs, the Dispensing Requirements will not change - 75% of the days' supply must lapse before a drug can be refilled.

In addition, beginning June 1, 2010, the inclusion of a Prior Authorization Code Type 2 on a pharmacy claim will no longer override the "refill too soon" edit (NCPDP edit 79). The Medicaid pharmacy claims system is receiving an enhancement so the "refill too soon" edit will not set for changes in dosing. However, if a client is entering or leaving a nursing facility and requires a "refill too soon" override, a PAR will have to be submitted by contacting the Prior Authorization Helpdesk at 1-800-365-4944.

The proposed revision to the Dispensing Requirements will be presented to the Drug Utilization Review (DUR) Board for their consideration on Tuesday, May 11, 2010. The Board meets at 225 East 16th Avenue, Denver, in the 1st floor conference room from 6:30 p.m. to 9:30 p.m. If you would like to submit comments or present testimony, please contact Kim Eggert at kimberly.eggert@state.co.us. For questions related to this proposed policy change, please contact Tom Leahey at thomas.leahey@state.co.us.

State Maximum Allowable Cost (SMAC) Rate Update



The SMAC rates for ondansetron, which became effective on March 22, 2010, were end dated effective April 13, 2010. Pharmacy claims for ondansetron with dates of service during the effective period may still be reimbursed based on the SMAC rates; however, the SMAC rates will not be used to determine reimbursement for pharmacy claims with dates of service before March 22, 2010 or after April 12, 2010.

For more information, please contact Tom Leahey at thomas.leahey@state.co.us.

Practitioners Performing Hysteroscopic Sterilizations

Reimbursement of Hysteroscopic Sterilizations

Effective May 1, 2010, the Department has modified its methodology for reimbursement of hysteroscopic sterilizations. Previously, reimbursement for both the practitioner's service and the device were included in the payment for CPT code 58565.

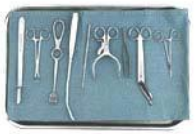
CMS recently established a HCPCS code specifically for the hysteroscopic sterilization tubal occlusion device (A4264). The practitioner's service is now reimbursed separately from the device and varies depending on the place of service.

The following billing instructions apply for hysteroscopic sterilizations performed on or after May 1, 2010:

When Performed in …		Coding	Modifier	Place of Service	Maximum Allowable
Practitioner's Office					
Practitioner bills	→	58565	FP	11 – Office	$664.00
Practitioner bills	→	A4264	FP	11 – Office	$1,415.00
Ambulatory Surgical Center					
Practitioner bills	→	58565	FP	24 – ASC	$448.00
ASC bills	→	58565	FP	24 – ASC	Group 3 Rate*
ASC bills	→	A4264	FP	24 – ASC	$1,415.00
Inpatient or Outpatient Hosp					
Practitioner bills	→	58565	FP	21 – Inpt 22 – Outpt	$448.00
Hospital bills	→	Appropriate revenue codes/DRGs including costs for the device		Reimbursement will vary by hospital and charges	
FQHC/RHC/Indian Health/Tribal 638 Facility					
Facility bills	→	Appropriate revenue code		Reimbursement will vary by facility-specific encounter rate	

* Effective May 1, 2010, CPT code 58565 was moved from ASC Group 9 to Group 3

Services/Supplies That Are Included in CPT Code 56585 (Not Separately Reimbursable)



The following services/supplies are included in the payment for 56585 and are not separately reimbursable:

- Anesthesia and anesthesia supplies – syringe, needle
- Surgical tray
- Other supplies – gloves, gowns, drapes, gauze, mask

Sterilization Consent Form Requirement

As with all sterilization services provided to Medicaid clients, detailed informed consent must be obtained from the client at least 30 days prior to the date of the procedure but no more than 180 days prior. Consent must be obtained using the federally-mandated sterilization consent form (known as the Med-178 form in Colorado). Claims for sterilization procedures must be accompanied by a completed Med-178 form and must therefore be submitted on paper.

More Med-178 information, including instructions for completion of the form, can be found in the Ambulatory Surgical Centers, Medical/Surgical Services, IP/OP Hospital and FQHC/RHC billing manuals in the Provider Services section of the Department's Web site. Blank forms can be found in the Provider Services Forms section. An electronic template can be found at http://www.hhs.gov/forms/HHS-687.pdf. This template must still be printed, signed, and submitted with the claim.

Additional Guidance

Practitioners who performed a hysteroscopic sterilization on or after May 1, 2010 . . .		
And have not yet submitted a claim	⇒	Follow the billing instructions outlined above based on the place of service.
And have already submitted a claim but did not include a line item for the device (when place of service is Office)	⇒	Wait until reimbursement is issued. Then adjust the claim via the Web Portal – Add an additional line item for the device (A4264) and resubmit.
And have already submitted a claim (when place of service is Outpatient or Inpatient Hospital)	⇒	No further action necessary. You will be reimbursed at the new reimbursement level based on place of service.

If you have additional questions, please contact Ginger Burton at ginger.burton@state.co.us.

Primary Care Providers

National Health Reform Primary Care Provider Rate Provision

President Obama signed the Patient Protection and Affordable Care Act on March 23, 2010. The Act requires in H.R. 4872, subtitle C, section 1202 that Medicaid payment rates to primary care physicians for furnishing primary care services be no less than 100% of Medicare payment rates in 2013 and 2014. The Department is speculating that the years are federal fiscal years; therefore, the first year of the rate increase would be October 1, 2012 and run through September 30, 2013.

The Department will keep you apprised of health care reform impacts to Colorado Medicaid providers as we learn more from CMS.

If you have any questions, please contact Jennifer St. Peter at Jennifer.St.Peter@state.co.us.

Substance Abuse Providers

Prior Authorization of Substance Abuse Inpatient Admissions

At present, the Department's Quality Improvement Organization reviews all requests for inpatient substance abuse treatment for clients under 21 years of age.

As of May 1, 2010 the Department will no longer require prior authorization for these admissions. The Department will continue to allow substance abuse treatment of these clients only in hospitals which have applied for and received approval by the Department as qualified to provide this type of treatment. The Department retains the right to retrospectively review claims.

For any questions or concerns, please contact Eric Wolf at 303-866-5963 or eric.wolf@state.co.us.

May and June 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 May and June 2010 workshop calendars are included in this bulletin and are also posted in the Provider Services Training 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

ACS needs all of the requested or your reservation cannot be processed successfully. Look for your confirmation by mail within one week of making your reservation.

If after one week you do not receive a confirmation, 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.

May and June 2010 Specialty Workshop Class Descriptions

Home Health

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

Nursing Facility

This class is for billers using the UB-04/837I claim format. The class covers billing procedures, common billing issues, PETI, Medicare Crossovers, and guidelines specifically for Nursing Facility providers.

Pediatric HH PAR Workshop

The Pediatric Home Health PAR workshop focuses on the PAR completion instructions for Pediatric Home Health procedures. This class is specifically for Pediatric Home Health providers.

Substance Abuse

This class is for billers using the CO1500/837P claim format. The class covers billing procedures, common billing issues, and guidelines specifically for practitioners or facilities with a substance abuse provider specialty.

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

Provider Enrollment Application Workshop

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.

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.

Supply/DME PAR
This 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)

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).

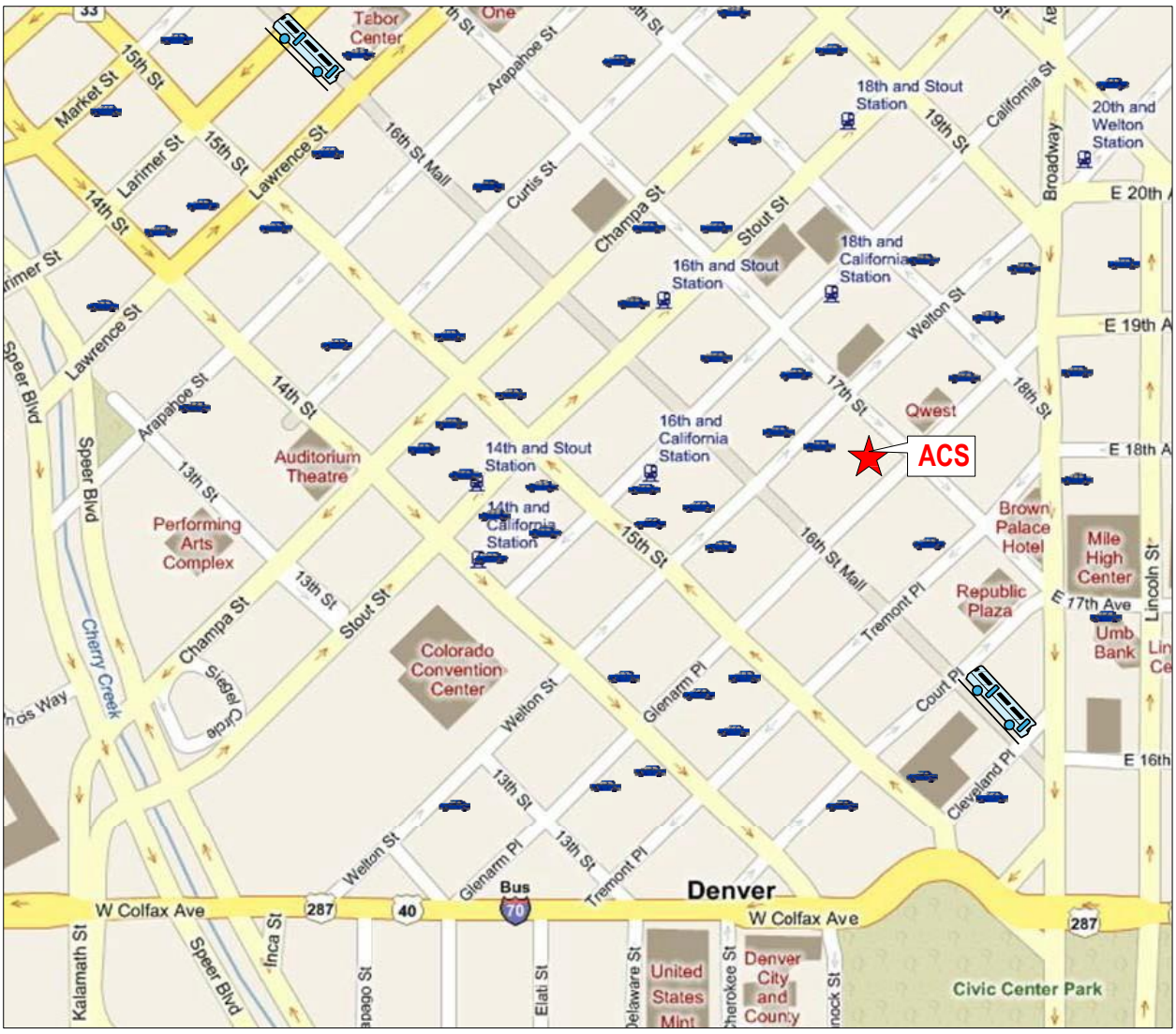
Parking: Parking is not provided by ACS and is limited in the Downtown Denver area.

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 note: *WebEx trainings are **not** for providers on the Front Range.*

Email all WebEx training reservations to workshop.reservations@acs-inc.com.

A meeting notification containing the Web site, phone number, meeting number, and password will be emailed or mailed to providers who sign up for WebEx.

May 2010 Workshop Calendar

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						1
2	3	4	5	6	7	8
9	10	11 Beginning Billing – CO -1500 9:00 am-11:30 am Web Portal 837P 1:00 pm-2:00 pm	12 Beginning Billing – UB-04 9:00 am-11:30 am Web Portal 837I 1:00 pm-2:00 pm Nursing Facility 3:00 pm-4:30 pm	13 DME PAR 9:00 am-11:00 am DME Billing 12:00 pm-1:30 pm	14 Pediatric HH PAR 1:00 pm-3:00 pm Home Health 3:00 pm-4:30 pm	15
16	17	18	19	20	21 Substance Abuse **(WebEx)** 9:00 am-12:30 pm	22
23	24	25	26	27	*28 State Furlough*	29
30	*31 Memorial Day*					

June 2010 Workshop Calendar

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		1	2	3	4	5
6	7	8 Beginning Billing – CO -1500 9:00 am-11:30 am Web Portal 837P 1:00 pm-2:00 pm Practitioner 3:00 pm-4:30 pm	9 Beginning Billing – UB-04 9:00 am-11:30 am Web Portal 837I 1:00 pm-2:00 pm	10 Provider Enrollment 9:00 am-12:00 pm	11 Beginning Billing – UB-04 **(WebEx)** 9:00 am-12:00 pm	12
13	14	15	16	17	18 NHVP **(WebEx)** 10:00 am-12:30 pm	19
20	21	22	23	24	25	26
27	28	29	30			

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/pacific/hcpf