Provider Bulletin

Reference: B1000289 **October 2010**

colorado.gov/pacific/hcpf

In this issue:

Did you know...?

In order to ensure appropriate processing and correct payment, providers billing multiple procedures must bill the procedure with the highest allowed amount on the first line of the claim. For pricing information, please refer to the Medicaid Fee Schedules on the Provider Services Home page of the Department's Web site.

All Providers

Upcoming Security Changes to Web Portal

Changes are in the development stages for some of the Web Portal's security configurations. This will affect how providers use the Trading Partner Administrator's ID to create and administer their users' access to Web Portal functionality. The Department of Health Care Policy and Financing (the Department) anticipates that the following changes will be implemented in the Web Portal during this winter.

- The Trading Partner Administrator's ID (COTPxxxxxxA ID) will no longer be allowed to have any other roles assigned except for Trading Partner Admin.
- The role of Trading Partner Admin will no longer be allowed to be assigned to any other user names aside from the COTPxxxxxxA ID. Users who have already assigned the Trading Partner Admin role to multiple users will need to replace it with the Restricted Admin role as the administrator back-up. The Restricted Admin role will allow password resets and account un-suspension for User Names.
- When User Names are created, they will no longer be able to begin with "COTP" or mimic the pattern of "COTPxxxxxxA." Users who have IDs similar to the "COTPxxxxxxA" ID will be required to change their user name.
- The User Name and Roles fields will be disabled on the User Maintenance screen.

These changes are being created in order to ensure all Trading Partner Administrators and their users are in compliance with State security procedures. This will also prevent users from engaging in actions that violate the Web Portal User Agreement. All Web Portal users are required to read and accept the security policies noted in the Web Portal User Agreement. Users are encouraged to familiarize themselves with these policies to ensure their compliance. Compliance will prevent Web Portal access from being revoked by the Department and/or prevent providers from being sanctioned.

There are several resources available to users who would like additional information or a refresher course on the Web Portal's security policies, and how the Trading Partner Administrator's ID is used to create and administer user names. An online Web-Based Training (WBT) is available on the left-hand menu of the main Web Portal page, titled Trading Partner Administrator Training.

ACS A Xerox Company

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

ACS Contacts

Billing and Bulletin Questions
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

In addition, users can refer to the Trading Partner Administrator User Guide and the Web Portal User Agreement for guidance on Web Portal security policies.
Users with questions about Web Portal security policies are encouraged to contact the Department's Security Administrator at hcpfsecurity@state.co.us. Questions about changes to the Web Portal can be directed to Tanya Ward at Tanya.Ward@state.co.us.

CMS National Correct Coding Initiative (NCCI)

To comply with federal legislation, Colorado Medicaid will, over the coming months, adopt the Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) standard payment methodologies.

Why are we making this change?

A provision of the federal Patient Protection and Affordable Care Act requires that state Medicaid agencies integrate the NCCI payment methodologies into their claims payment systems by October 1, 2010.

What do the NCCI payment methodologies do?

These methodologies prevent reimbursement for services that should not be billed together as well as preventing the reimbursement for units of service in excess of the number that a provider would report under most circumstances for a single client on a single date of service.

The methodologies apply to both Current Procedural Terminology (CPT) Level I codes and Healthcare Common Procedure Coding System (HCPCS) Level II codes.

When will the change take place?

Over the course of the next several months, the following NCCI methodologies will be applied to the claims adjudication of a select number of codes and code pairs for all practitioner and Ambulatory Surgery Centers:

- NCCI Edits – Physicians
- Medically Unlikely Edits

Following that implementation, Colorado Medicaid will be implementing the remainder of the CMS-required NCCI edits for practitioners and ASCs, as well as the following additional NCCI methodologies:

- Medically Unlikely Edits (those not implemented 10/1/2010)
- NCCI Edits – Physicians (those not implemented 10/1/2010)
- NCCI Therapy Edits
- Hospital Outpatient Prospective Payment System

How big an impact will this have on providers?

The NCCI edits were originally implemented by Medicare carriers on January 1, 1996, and many private payers also use them for their claims processing. Most likely, you have already encountered the application of these methodologies to claims submitted for adjudication and payment by Medicare and private payers. These methodologies will now also apply to Medicaid claims.

We will keep you informed of the implementation progress, as well as providing guidance on how Colorado Medicaid will be implementing these national edits based on direction provided by CMS. If you have any questions about the Department's implementation of the NCCI, please contact Teresa Knaack at Teresa.Knaack@state.co.us or 303- 866-2573. For more information on the NCCI, please visit the CMS Web site at http://www.cms.gov/NationalCorrectCodInitEd/01_overview.asp#TopOfPage.

Claims Paying at "0" - Lower of Pricing for Medicare Crossover Claims

The Medicaid Management Information System (MMIS) compares the *Medicaid allowable – Medicare paid* to the *Medicare coinsurance* + *Medicare deductible*.

- If Medicare did not pay more than the Medicaid allowable, Medicaid reimburses the lesser of the two.
- If the difference is 0, Medicaid reimburses $0.00.
- If Medicare paid more than the Medicaid allowable, Medicaid reimburses $0.00.
- If Medicare paid the same as the Medicaid allowable, Medicaid reimburses $0.00

New Benefit for Screening, Brief Intervention and Referral to Treatment (SBIRT) Update

With the passing of HB 10-1033, the legislature approved funding to cover Screening, Brief Intervention and Referral to Treatment (SBIRT) services for Colorado Medicaid clients. The SBIRT benefit is available to providers in order to screen clients aged 12 and up that are determined to be at risk for substance abuse and intervene or refer to treatment. These services became effective August 11, 2010, therefore, the Department will honor claims with dates of service from August 11, 2010 and forward.

Screening shall include the use of a Colorado Medicaid approved, evidence based screening tool that helps providers identify clients at risk for substance abuse problems. Once the client has been determined to be at risk, providers may be reimbursed for Brief Intervention that includes single or multiple sessions focused on motivational discussion to increase insight and awareness regarding substance use and motivation toward changes in behavior. Follow-up sessions may also include referral to treatment for clients who may need more in-depth substance abuse services.

The following screening tools have been approved by Colorado Medicaid for use in SBIRT services:

- The Alcohol Use Disorders Inventory Test (AUDIT)
- The Drug Abuse Screening Test (DAST)
- The Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)
- The CRAFFT, which has been validated for adolescents
- The Problem Oriented Screening Instrument for Teenagers (POSIT)

The table below lists the codes, description, and reimbursement rates:

Procedure	Description	Rate
99408	Alcohol and/or substance use structured screening (eg, AUDIT, DAST, CRAAFT), and brief intervention services; 15-30 minutes	$29.68
99409	Greater than 30 minutes	$64.75
H0049	Alcohol and/or drug screening	$29.68
H0050	Alcohol and/or drug service, brief intervention	$64.75

Providers who will be billing SBIRT services are required to obtain SBIRT services training. Details on SBIRT training will be made available to providers by November 30th.

Please continue to check the Provider Services Billing Manual section on the Department's website for the SBIRT billing manual for additional information about this new benefit. If you have any questions, please contact Anna Davis at Anna.Davis@state.co.us or 303-866-2113.

Columbus and Veteran's Day Holidays

Columbus Day Holiday

Due to the Columbus Day Holiday on Monday, October 11, 2010, the claims processing cycle will include electronic claims accepted before 6:00 P.M. Mountain Time on Thursday, October 7, 2010. The receipt of warrants and EFTs may also be delayed by one or two days. State offices will be closed on Monday, October 11, 2010. ACS offices will be open during regular business hours.

Veteran's Day Holiday

The Veteran's Day holiday on Thursday, November 11, 2010 will delay the receipt of warrants and EFTs by one or two days. State offices will be closed on Thursday, November 11, 2010. ACS offices will be open during regular business hours.

FQHC Providers

Services Incident to Physician's Professional Services

The Department has been asked to clarify what services may be billed by a Federally Qualified Health Center (FQHC) for reimbursement by the Medicaid encounter fee.

The Colorado Medicaid Program has adopted federal guidance on this question. In general, FQHCs may not bill encounters for services provided incident to the services of the following providers. Face-to-face encounters may only be billed for visits with physicians, nurse practitioners, physician assistants and nurse midwives.

FQHCs may also bill visits by these same providers to clients in other locations, such as the hospital or the home. Such visits must be billed on the Colorado 1500 form or as an 837 Professional (837I) transaction. Reimbursement is based on the physicians' fee schedule.

The federal guidance for FQHCs in the Medicare Benefit Policy Manual, Chapter 13, §30, reads as follows:

> The term "visit" is defined as a face-to-face encounter between the patient and a physician, physician assistant, nurse practitioner, certified nurse midwife, visiting nurse, clinical psychologist, or clinical social worker during which an RHC/FQHC service is rendered. … Encounters with (1) more than one health professional; and (2) multiple encounters with the same health professional which take place on the same day and at a single location, constitute a single visit. An exception occurs in cases in which the patient, subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment."

The Colorado Medicaid Program has adopted this definition with one exception, which is to allow a visit to a dentist to also be billed as an encounter (10 CCR 2505-10, 8.700.4.A.1.a). An optometrist is not covered under Colorado rules.

The Medicare Benefit Policy Manual, Chapter 13, §60.1, provides additional information as follows: Services and supplies incident to a physician's professional services are covered as RHC or FQHC services as long as they are an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness. In other words, there must be a physician's personal service rendered to which the nonphysician's service (or the supply) is an incidental, although integral part. This does not mean, however, each occasion of service by a nonphysician (or the furnishing of a supply) need also always be the occasion of the actual rendition of a personal professional service by the physician.

> This requirement is also met for nonphysician services furnished during a course of treatment in which the physician performs an initial and subsequent service with a frequency which reflects his or her active participation in and management of the course of treatment. However, the direct personal supervision requirement explained in §60.3 must still be met with respect to every nonphysician service for it to be covered as an incident to service. Although incident to services are covered, they are covered as part of an otherwise billable encounter. If no medically necessary face-to-face encounter with a physician or midlevel practitioner, CP or CSW has also occurred during the visit with the incident to staff then no encounter can be billed.

In §80.1, the manual extends the same guidance to services provided incident to an encounter with a nurse practitioner, a physician's assistant or a certified nurse midwife.

FQHCs are reminded that the encounter rate is based on cost, and that all costs of rendering services to Medicaid clients are taken into account when setting the encounter rate for each FQHC.

For any questions or concerns about this billing instruction, please contact Eric Wolf at Eric.Wolf@state.co.us or 303-866-5963.

Hospital Providers

Changing Inpatient Status to Outpatient

The following provides information for prospective payment hospital providers billing for services when a hospital's Utilization Review Committee (URC) determines that an inpatient stay did not meet criteria for inpatient admission. When a physician orders a client to be admitted to an inpatient bed but, upon subsequent review by a treating physician or by a nurse participating in the URC, it is determined that an inpatient level of care does not meet the hospital's admission criteria, the claim type may be changed from inpatient to outpatient.

The hospital may submit an outpatient claim (Type of Bill 13x) to receive payment for medically necessary outpatient services that were furnished to the client. All of the following conditions must be met:

1. The change in patient status from inpatient to outpatient is made prior to discharge while the client is still in the hospital.
2. The hospital has not submitted a claim to Medicaid or other liable insurance for the inpatient admission.

3. A treating physician makes the determination or concurs with the nurse on the URC and orders are written for the change to outpatient.
4. Outpatient Observation Services may be billed back to the time of admission only if medical necessity is met for the Observation Services.
5. Because the claim may be examined in post-payment review, the order and the reasons for the determination must be clearly documented with date, time, and signatures of physician and/or team members as appropriate.

Any change in status after discharge should be thoroughly documented in the client record for retrospective audit purposes. The following applies in this situation:

1. Prior to submitting any claim, a utilization review nurse determines that the case does not meet inpatient medical necessity.
2. The case is sent to a physician on the URC who agrees that the case does not meet medical necessity.
3. The hospital may bill for outpatient services only. No observation charges may be applied to the bill.

If a client is dually eligible, Medicare guidelines must be followed. Those guidelines can be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0622.pdf.

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

Changes to DRG System

New ICD-9-CM Diagnosis and Procedure Codes Crosswalk

The following versions of the Centers for Medicare and Medicaid Services (CMS) Grouper will be 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

ICD-9 codes are updated every year. ICD-9 codes that were not part of the original Version 24.0 DRG grouper need to be mapped to the ICD-9 codes used by the DRG Version 24.0 Grouper.

This will allow claims billed with new diagnosis and/or procedure codes to appropriately group to the existing Version 24.0 DRGs.

The updated crosswalk table effective October 1, 2010 will be located on the Department's Web site at colorado.gov/hcpf in the Reference Material section under the DRG Relative Weights link as soon as it is available. It will also appear in Appendix W of the Appendices in the Provider Services Billing Manuals section. After the updates to the system are completed, the affected claims with discharge dates on or after October 1, 2010 will be re-processed.

Until the crosswalk table is updated, claims that include new ICD-9-CM codes will not group and may automatically deny. Hospitals do not need to resubmit claims denied for this reason. The Department will automatically adjust claims denied 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

As previously announced, the Department anticipates implementation of the 3M Company's All Patient Refined Diagnosis Related Groups (APR-DRG) software for adjudication of inpatient hospital claims on July 1, 2011. Thereafter, new ICD-9 codes will automatically be included.

The Department appreciates your patience as we work toward completion of the annual update. If you have any questions, please contact Eric Wolf at Eric.Wolf@state.co.us or at 303-866-5963.

Inpatient and Outpatient Hospital Billing Instructions Update

As of October 1, 2010, the Inpatient and Outpatient Hospital Billing Instructions for Colorado Medicaid are being updated with the following information.

Please note that these additions are clarifications of existing policy provided in response to questions from hospitals. These additions do not represent new policies or changes in policy. The Inpatient and Outpatient Hospital Billing manual is located in the Provider Services Billing Manuals section of the Department's Web site.

A. Newborns of mothers with commercial insurance

Regarding newborns whose mothers have commercial insurance as a payer, per Colorado Revised Statutes 10-16-104 (1)(c)(I) and 10-16-104 (1)(c)(II)(C), the newborn is automatically covered by the commercial insurance for the first 31 days of life. A premium payment and notification are required to provide coverage for the newborn beyond the first 31 days. The required premium must be furnished to the insurer within the first 31 days after date of birth in order to have coverage continue beyond the first 31-day period.

The commercial insurance must be billed before Medicaid is billed. Most commercial insurers, however, deny coverage for the newborn when the mother is a dependent on a parent's policy.

B. Coding claims for newborns who remain hospitalized

If a newborn remains in the hospital after the mother is discharged (i.e., the baby is not well), the second admission, beginning on the date of the mother's discharge, should be the principle diagnosis for the condition for which the baby remains in the hospital rather than a V-code such as V 27.1, indicating delivery.

C. Mother not covered by Medicaid

If the delivering mother does not have insurance but the baby becomes a Medicaid client, the hospital may bill newborn charges (not the delivery) from the date of birth.

Feel free to contact Eric Wolf at Eric.Wolf@state.co.us or 303-866-5963 with questions.

Hospital Readmission Policy and Condition Code B4

The following describes a change in the capability of the Medicaid Management Information System (MMIS) and is not a change in policy.

Colorado Medicaid requires a hospital to bill related admissions as a single hospital stay when 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 client's prior stay medical condition. The effect of this rule is that the hospital will receive only one payment for what is considered one episode of care.

Until now, hospital claims for readmissions within 24 hours have been retrospectively reviewed by Medicaid's Quality Improvement Organization (Colorado Foundation for Medical Care), and payment has been recouped if the two hospitalizations are determined to be related.

Effective October 1, 2010, the MMIS will automatically deny subsequent claims for readmissions to the same hospital within 24 hours. Providers will have to submit an adjustment claim to correctly reflect the dates of service for the full episode of care. To indicate that a readmission is completely unrelated to the first admission, a claim may be coded with condition code B4 which will allow the separate episode of care.

The Quality Improvement Organization will continue to retrospectively review all readmissions within 24 hours which are paid with use of condition code B4. If the Department determines that the readmission is not completely unrelated to the first admission, the Department will recoup payment.

Because Colorado Medicaid does not recognize distinct part units, transfers of clients among units of a hospital, when billed as two separate admissions, will continue to be denied.

Please contact Eric Wolf at Eric.Wolf@state.co.us or 303-866-5963 with questions.

Nursing Facility Providers

Post Eligibility Treatment of Income (NF PETI) Fee Schedule 2010 Update

Effective October 1, 2010, the reimbursement of PETI services will be in accordance with the updated NF PETI fee schedule published as Attachment A of this bulletin. The new fee schedule reflects the new rates issued by the Department on July 1, 2010. The following is a summary of the key NF PETI program requirements:

- The NF PETI fee schedule lists dental, hearing and vision services by procedure code with the related reimbursable amount. The NF PETI fee schedule is not all-inclusive, nor does the inclusion of any code imply that the service is a routinely approved request.
- Only non-Medicaid benefits are potential NF PETI expenses. For all procedures that are a potential adult Medicaid benefit, a Medicaid provider must determine whether a client meets the Medicaid criteria to qualify for the benefit. If a valid Medicaid claim is submitted and then denied reimbursement, the nursing facility may submit a PETI request to the Department with a copy of the denial notice.

- Medical necessity and the absence of other payment sources are two criteria that must be met to justify the use of PETI funds.
- Medically necessary services that are not listed on the fee schedule may be submitted to the Department for NF PETI consideration. A notation of 'MP' in the NF PETI Fee column indicates the procedure is manually priced by the Department. The nursing facility must submit a PETI request to the Department for all such MP codes even when the billing amount is below the first $400 PETI expense for the year. Providers are not required to submit claims to Medicaid if the service is not a Medicaid benefit.
- The reimbursement amount is the same whether or not the provider is enrolled in the Colorado Medical Assistance Program. A Medicaid provider may not ordinarily collect more from the beneficiary than the allowable PETI fee established by the NF PETI fee schedule.
- PETI requests are subject to additional verification of medical necessity as deemed appropriate by the Department. Failure to provide required documentation will result in the denial of the NF PETI request.

Please contact Rose-Marie Nelson at Rose-Marie.Nelson@state.co.us or 303-866-3167 if you have any questions.

Pharmacy Providers

Pharmacy & Therapeutic (P&T) Committee News

The Department is currently requesting that individuals interested in serving on the P&T Committee submit their Curriculum Vitaes (CVs) and a conflict of interest disclosure information to Jim Leonard at Jim.Leonard@state.co.us. Please see the Pharmacy and Therapeutics (P&T) Committee Web page for a copy of the form and more details.

Next P&T Committee Meeting:
Tuesday, October 5, 2010
1:00 P.M. - 5:00 P.M.
This meeting will be held on the Anschutz Medical Campus in Aurora. Please see the Pharmacy and Therapeutics (P&T) Committee Web page for full location details.

Preferred Drug List (PDL) Update

Effective October 1, 2010, the following medications will be preferred agents on the Medicaid PDL and will be covered without a prior authorization:

Erythropoiesis Stimulating Agents
Procrit – Clients must meet eligibility criteria

Oral Bisphosphonates
Alendronate tabs in 5mg, 10mg, 35mg and 70mg

Meglitinides
None preferred
Biguanides
Generic metformin in 500mg, 850mg and 1000mg immediate-release tablets preferred; generic metformin extended-release 500mg tablets preferred
Hypoglycemic Combinations
None Preferred
Thiazolidinediones
Actos
Newer Generation Diabetes Agents
Byetta, Januvia, Onglyza – Please see the PDL for additional information.

ADHD and Stimulants
Generic methylphenidate IR and SR, generic mixed amphetamine salts products in IR and XR, CONCERTA, generic dexmethylphenidate, and FOCALIN XR
Overactive Bladder Agents
oxybutynin and oxybutynin ER

The complete PDL and prior authorization criteria for non-preferred drugs are posted on the Preferred Drug List (PDL) Web page.

For questions or comments regarding the PDL, please contact Jim Leonard at Jim.Leonard@state.co.us.

Updated Prior Authorization (PA) Criteria

Please see the October PDL for PA criteria relating to PDL classes.
PA criteria have been added to Appendix P for Rybix ODT products. Effective October 1, 2010, Rybix ODT will require a PA. Rybix will be approved for clients who are unable to swallow oral tablets or unable to absorb oral medications. Appendix P can be viewed under *Provider Services & Billing Manuals* Web page.

October and November 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 October and November 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

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

All this information is necessary to process your reservation successfully. Look for your confirmation by mail within one week of making your reservation.

If you have not received a confirmation within at least two business days prior to the workshop, 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.

*The Beginning Billing 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.

October and November 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

FQHC/RHC
This class is for billers using the UB-04/837I and Colorado 1500/837P 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 Colorado 1500/837P 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 Colorado 1500/837P 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 Colorado 1500/837P 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.

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.

Occupational, Physical and Speech Therapy
This class is for billers using the Colorado 1500/837P format for therapies. The class covers billing procedures, common billing issues and guidelines specifically for Occupational, Physical and Speech Therapists providers.

Supply/DME
This class is for billers using the Colorado 1500/837P 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.)

Vision
This class is for ophthalmologists, optometrists, and opticians billing on the Colorado 1500/837P format. The class covers billing procedures, common billing issues and guidelines specifically for practitioners providing vision services.

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 **Welton St, 0**.5 mi
Turn **right** at **17th St,** 0.2 miles
The Denver Club Building will be on the right

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**

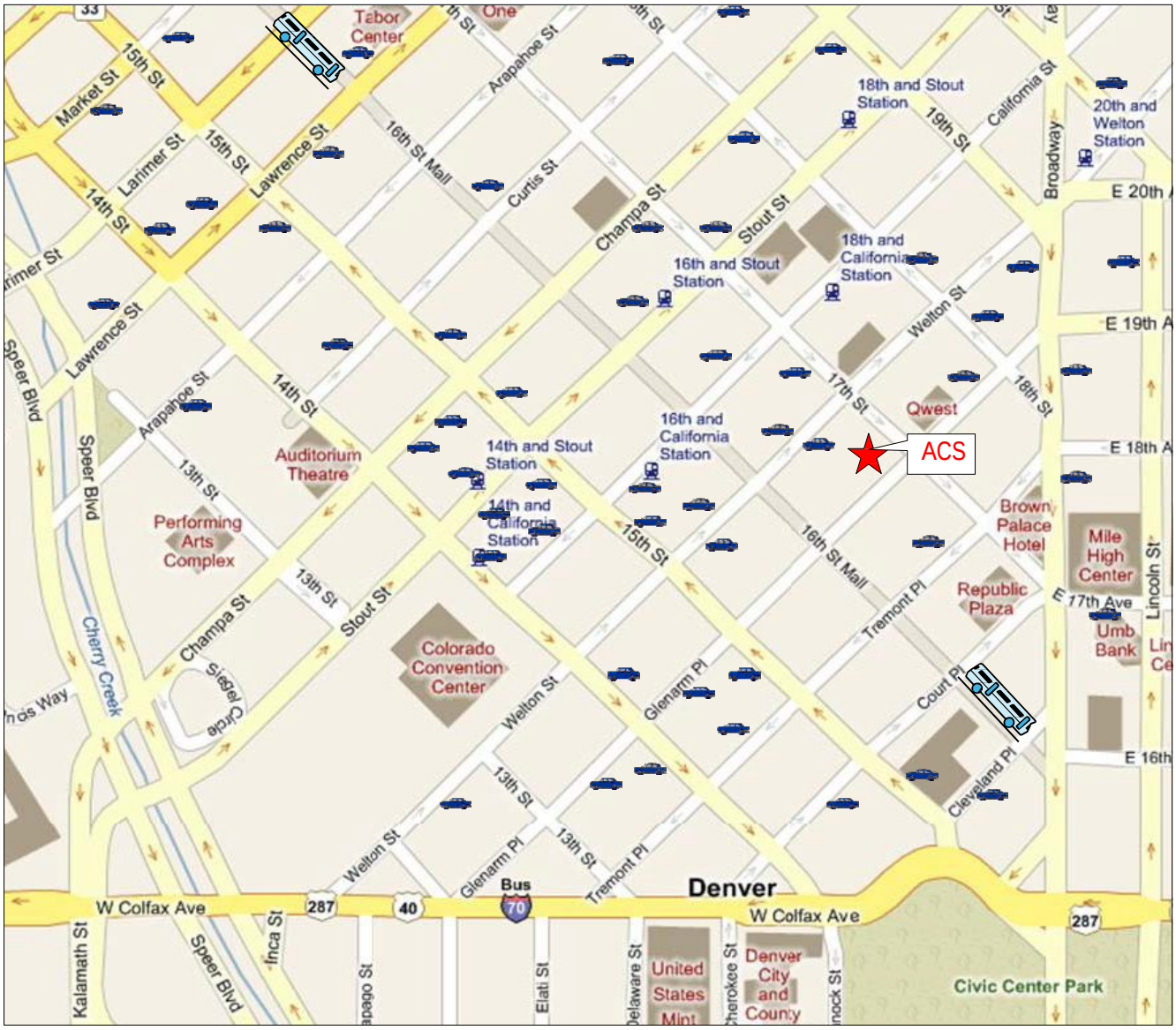
A Light Rail map is available at: http://www.rtd-denver.com/LightRail_Map.shtml

= **Free MallRide**

The 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.

October 2010

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
					1	2
3	4	5	6	7	8	9
10	11 *Columbus Day*	12 Beginning Billing – CO -1500 9:00 am-11:30 am Web Portal 837P 1:00 pm-2:00 pm Vision 3:00 pm-4:30 pm	13 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	14 Dental 9:00 am-12:00 pm	15 Beginning Billing – CO -1500 9:00 am-11:00 am HCBS-EBD 11:00 am-1:00 pm HCBS-BI 1:00 pm-2:30 pm HCBS-DD 3:00 pm-4:30 pm	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

November 2010

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	1	2	3	4	5	6
7	8	9 Beginning Billing – CO -1500 9:00 am-11:30 am Web Portal 837P 1:00 pm-2:00 pm OT/PT/ST 3:00 pm-4:30 pm	10 Beginning Billing – UB-04 9:00 am-11:30 am Web Portal 837I 1:00 pm-2:00 pm FQHC/RHC 3:00 pm-4:30 pm	11 DME PAR 9:00 am-12:00 pm DME Billing 12:00 pm-1:30 pm *Veterans' Day*	12 Beginning Billing – UB-04 (WebEx) 9:00 am-12:00 pm	13
14	15	16	17	18	19	20
21	22	23	24	25 *Thanksgiving*	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 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

PETI Dental Fee Schedule Effective October 1, 2010			
Procedure Code	**Cost Per Unit**	**Medicaid Benefit**	**Procedure Description per ADA-CDT**
D0120	$20.49	No	Periodic oral evaluation. Exam for a patient of record - a periodic scheduled check up or recall
D0140	$30.12	Yes	Limited oral evaluation - problem focused.
D0150	$34.64	Yes	Comprehensive oral evaluation - new or established patient
D0160	$62.76	Yes	Detailed and extensive oral evaluation - problem focused by report
D0170	$28.17	No	Re-evaluation - limited, problem focused. (Established patient; not post-operative visit)
D0180	$37.66	Yes	Comprehensive periodontal evaluation
D0210	$51.20	Yes	Intraoral - complete series (including bitewings). Full mouth set of x-rays - X-rays of all the teeth
D0220	$12.05	Yes	Intraoral - periapical - first film. X-ray showing all of a tooth.
D0230	$10.04	Yes	Intraoral - periapical - each additional film. X-ray showing all of the tooth
D0240	$17.57	Yes	Intraoral - occlusal film. A larger x-ray of several teeth in the upper or lower jaw
D0250	$25.10	Yes	Extraoral - first film. X-ray of the head or face
D0260	$20.58	Yes	Extraoral - each additional film. X-ray of the head or face. After the first x-ray in a series
D0270	$11.54	Yes	Bitewing - first film. One x-ray of the upper and lower teeth closed together
D0272	$18.57	Yes	Bitewings - two films
D0274	$26.10	Yes	Bitewings - four films. Four x-rays of the upper and lower teeth closed together
D0277	$38.66	Yes	Vertical bitewings – 7 to 8 films
D0330	$46.18	Yes	Panoramic film. Large single x-ray showing all the teeth and both jaws.
D0460	$23.59	Yes	Pulp vitality tests. Use of testing methods to find out if the nerve of a tooth is alive or dead
D0999	$15.23	No	Unspecified diagnostic procedure as performed by an unsupervised dental hygienist in unsupervised practice for a dental screening
D1110	$37.63	No	Prophylaxis - adult (hygienists)
D1110	$37.63	No	Prophylaxis - adult (DDS or under dentist's license)
D1204	$15.37	No	Topical application of fluoride - Adult
D1351	$23.05	No	Sealant - per tooth
D2140	$55.32	No	Amalgam - one surface - primary or permanent
D2150	$70.68	No	Amalgam - two surfaces - primary or permanent
D2160	$84.76	No	Amalgam - three surfaces - primary or permanent
D2161	$99.37	No	Amalgam - four or more surfaces - primary or permanent
D2330	$66.07	No	Resin-based composite - one surface anterior
D2331	$81.95	No	Resin-based composite - two surfaces anterior
D2332	$97.32	No	Resin-based composite - three surfaces anterior
D2335	$121.90	No	Resin-based composite - four or more surfaces anterior
D2391	$55.32	No	Resin-based composite - one surface posterior
D2392	$70.68	No	Resin-based composite - two surfaces posterior
D2393	$83.49	No	Resin-based composite - three surfaces posterior
D2394	$99.37	No	Resin-based composite - four or more surfaces posterior
D2710	MP	No	Crown - Resin Based Composite
D2720	$172.48	No	Crown - Resin Composites with high noble metal.
D2721	MP	No	Crown - Resin Composites with predominantly base metal

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Procedure Code	**Cost Per Unit**	**Medicaid Benefit**	**Procedure Description per ADA-CDT**
D2791	$70.68	No	Crown - Full cast base metal for tooth # 1, 2, 3, 14, 15, 16, 17, 18, 19, 30, 31, 32
D2910	$44.56	No	Re-cement inlay – onlay - Partial coverage restoration.
D2920	$45.59	No	Re-cement crown
D2932	$143.42	No	Pre-fabricated resin crown
D2933	$148.03	No	Pre-fabricated stainless steel crown with resin window
D2940	$47.12	No	Sedative filling
D2950	$115.25	No	Core build-up including any pins
D2951	$28.17	No	Pin retention
D2952	$176.71	No	Cast post and core in addition to crown Indirectly fabricated
D2953	$120.88	No	Each additional indirectly fabricated cast post-same tooth
D2954	$140.34	No	Pre-fabricated post and core in addition to crown
D2955	$120.88	No	Post Removal (not in conjunction with endodontic treatment
D2957	$68.12	No	Each additional pre-fabricated post-same tooth
D2980	$116.27	No	Crown repair, by report
D2999	MP	No	Unspecified restorative procedure by report
D3110	$33.81	No	Pulp cap direct (excluding final restoration)
D3120	$33.81	No	Pulp cap - indirect (excluding final restoration).
D3220	$79.39	No	Therapeutic pulpotomy (excluding final restoration)
D3221	$96.62	No	This is a type of emergency partial root canal therapy done to relieve pain and infection
D3310	$297.08	No	Endodontic therapy, Anterior tooth (excluding final restoration)
D3320	$351.88	No	Endodontic therapy, Bicuspid tooth (excluding final restoration)
D3330	$423.59	No	Endodontic therapy, Molar (excluding final restoration)
D3351	$169.84	No	Apexification/recalcification - initial visit (apical closure/calcific repair of perforation - root resorption, etc.
D3352	$104.49	No	Apexification/recalcification - interim medication replacement
D3353	$212.56	No	Apexification/recalcification - final visit (includes completed root canal therapy)
D3410	$273.00	No	Apicoectomy/periradicular surgery - anterior
D3421	$307.83	No	Apicoectomy/periradicular surgery - bicuspid (first root)
D3425	$358.54	No	Apicoectomy/periradicular surgery - molar (first root)
D3426	$147.51	No	Apicoectomy/periradicular surgery (each additional root)
D3430	$112.68	No	Retrograde filling - per root
D3450	$223.74	No	Root amputation - per root
D3470	$332.93	No	Intentional replantation (including necessary splinting)
D3920	$190.03	No	Hemisection (including any root removal), not including root canal therapy
D3950	$103.46	No	Canal preparation and fitting of preformed dowel or post
D3999	MP	No	Used for a procedure that is not adequately described by a code. Describe procedure.
D4210	$251.00	Yes	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant
D4211	$95.88	Yes	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant
D4240	$297.19	Yes	Gingival flap procedure, including root planing--four or more contiguous teeth or tooth bounded spaces per quadrant
D4245	$353.93	No	Apically positioned flap

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Procedure Code	**Cost Per Unit**	**Medicaid Benefit**	**Procedure Description per ADA-CDT**
D4274	$284.27	No	Distal or proximal wedge
D4320	$208.98	No	Provisional splinting - intracoronal
D4321	$185.73	Yes	Provisional splinting - extracoronal
D4341	$101.91	Yes	Periodontal scaling and root planning - four teeth per quadrant
D4342	MP	No	Periodontal scaling and root planning - one to three teeth per quadrant
D4355	$75.30	Yes	Full mouth debridement to enable comprehensive evaluation and diagnosis
D4381	$70.78	Yes	Localized delivery of antimicrobial agents into diseased crevicular tissue - per tooth
D4910	MP	No	Periodontal maintenance
D5110	$800.00	No	Complete denture - maxillary
D5120	$800.00	No	Complete denture - mandibular
D5130	$750.00	No	Immediate denture - maxillary
D5140	$750.00	No	Immediate denture - mandibular
D5211	$499.40	No	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)
D5212	$501.96	No	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)
D5213	$777.00	No	Maxillary partial denture - cast metal framework with resin denture base. (including clasps, rests, etc.)
D5214	$777.00	No	Mandibular partial denture - cast metal framework with resin denture base. (incl. claps, rests and teeth)
D5281	$426.13	No	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)
D5410	$37.90	No	Adjust complete denture - maxillary
D5411	$37.90	No	Adjust complete denture - mandibular
D5421	$37.90	No	Adjust partial denture - maxillary
D5422	$37.90	No	Adjust partial denture - mandibular
D5510	$72.21	No	Repair broken complete denture base
D5520	$75.81	No	Repair missing broken teeth - complete denture (each tooth)
D5610	$86.56	No	Repair resin denture base
D5620	$121.90	No	Repair cast framework
D5630	$110.64	No	Repair or replace broken clasp
D5640	$76.83	No	Replace broken teeth - per tooth
D5650	$68.14	No	Add tooth to existing partial denture
D5660	$115.25	No	Add clasp to existing partial denture
D5710	$240.73	No	Rebase complete maxillary denture
D5711	$241.76	No	Rebase complete mandibular denture
D5720	$231.00	No	Rebase maxillary partial denture
D5721	$231.00	No	Rebase mandibular partial denture
D5730	$153.66	No	Reline complete maxillary denture (chairside)
D5731	$153.66	No	Reline complete mandibular denture (chairside)
D5740	$151.61	No	Reline maxillary partial denture (chairside)
D5741	$153.15	No	Reline mandibular partial denture (chairside)
D5750	$250.00	No	Reline complete maxillary denture (laboratory)
D5751	$250.00	No	Reline complete mandibular denture (laboratory)
D5760	$193.10	No	Reline maxillary partial denture (laboratory)

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Procedure Code	**Cost Per Unit**	**Medicaid Benefit**	**Procedure Description per ADA-CDT**
D5761	$193.10	No	Reline mandibular partial denture (laboratory)
D5810	$340.10	No	Interim complete denture (maxillary)
D5811	$340.61	No	Interim complete denture (mandibular)
D5820	$281.71	No	Interim partial denture (maxillary)
D5821	$281.71	No	Interim partial denture (mandibular)
D5850	$84.00	No	Tissue conditioning maxillary
D5851	$84.00	No	Tissue conditioning mandibular
D5860	$822.08	No	Overdenture - complete
D5861	$819.52	No	Overdenture – partial
D5862	$281.71	No	Precision attachment
D5867	$135.73	No	Replacement of replaceable part of semi-precision or precision attachment. (male or female component)
D6210	MP	No	Pontic - Cast high noble metal
D6211	$410.78	No	Pontic - cast predominantly base metal
D6240	MP	No	Pontic - porcelain fused to high noble metal
D6241	$422.57	No	Pontic - porcelain fused to predominantly base metal
D6242	MP	No	Pontic - porcelain fused noble metal
D6545	$317.56	No	Retainer - cast metal for resin bonded fixed prosthesis
D6720	MP	No	Crown - resin with high noble metal
D6721	MP	No	Crown - resin with predominantly base metal
D6722	MP	No	Crown - resin with noble metal
D6750	MP	No	Crown - porcelain fused to high noble metal
D6751	$420.00	No	Crown - porcelain fused to predominantly base metal
D6752	MP	No	Crown - porcelain fused to noble metal
D6791	$412.32	No	Crown - full cast predominantly base metal
D6920	$410.78	No	Connector bar
D6930	$68.63	No	Re-cement fixed partial denture
D6940	$174.15	No	Stress breaker
D6950	$268.39	No	Precision attachment
D6970	$182.34	No	Cast post and core in addition to fixed partial denture retainer
D6971	MP	No	Cast post and core as part of fixed partial denture
D6972	$142.39	No	Prefab post and core in addition to fixed partial denture retainer
D6973	$117.29	No	Core build up for retainer including any pins
D6975	$299.12	No	Coping – metal
D6976	$117.81	No	Each additional cast post - same tooth
D6977	$75.29	No	Each additional prefabricated post - same tooth
D6980	$158.78	No	Fixed partial denture repair
D6999	MP	No	Unspecified fixed prosthodontic procedure
D7140	$65.77	Yes	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	$112.96	Yes	Extraction - surgical removal of erupted tooth
D7220	$128.01	Yes	Extraction - removal of impacted tooth – soft tissue
D7230	$163.66	Yes	Extraction - removal of impacted tooth – partially bony
D7240	$200.80	Yes	Extraction - removal of impacted tooth – completely bony
D7241	$243.30	No	Extraction - removal of completely bony - with unusual surgical complications
D7250	$123.49	Yes	Extraction - surgical removal of residual tooth roots - cutting procedure

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Procedure Code	**Cost Per Unit**	**Medicaid Benefit**	**Procedure Description per ADA-CDT**
D7260	$316.77	Yes	Oroantral fistula closure
D7261	$397.49	Yes	Primary closure of sinus perforation
D7270	$224.34	No	Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth
D7272	$365.76	No	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization
D7280	$196.68	No	Surgical access of an unerupted tooth
D7290	$197.20	No	Surgical repositioning of teeth
D7310	$118.32	No	Alveoloplasty in conjunction with extractions-four or more teeth or tooth spaces per quadrant usually in preparation for a prosthesis
D7320	$174.15	No	Alveoloplasty not in conjunction with extractions-four or more teeth or tooth spaces per quadrant no extractions performed in an edentulous area
D7471	$256.10	No	Removal of lateral exostosis
D7510	$91.37	Yes	Incision and drainage of abscess – intraoral soft tissue
D7520	$156.12	Yes	Incision and drainage of abscess – extraoral soft tissue
D7530	$141.07	Yes	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue
D7540	$291.14	Yes	Removal of reaction-producing foreign bodies - musculoskeletal system
D7999	MP	Yes	Unspecified oral surgery procedure
D9110	$47.69	Yes	Palliative (emergency) treatment of dental pain - minor procedures
D9220	$179.42	Yes	Deep sedation/general anesthesia-first 30 minutes
D9221	$63.25	Yes	Deep sedation/general anesthesia each additional 15 minutes
D9230	$28.68	No	Analgesia – anxiolysis - inhalation of nitrous oxide
D9241	$151.60	Yes	Intravenous conscious sedation/analgesia - first 30 minutes
D9242	$59.24	Yes	Intravenous conscious sedation/analgesia - each additional 15 minutes
D9248	$128.05	No	Non-intravenous conscious sedation
D9310	$47.69	Yes	Consultation (diagnostic services provided by dentist or physician other than requesting dentist or physician.
D9410	$90.00	No	House/extended care facility call-Dentist
D9410	$20.00	No	House/extended care- Independent Hygienists
D9420	$100.41	Yes	Hospital call-dentist
D9911	$31.76	No	Application of desensitizing resin for cervical and/or root surface - per tooth
D9940	$243.81	No	Occlusal guard to reduce unnatural wear on teeth from grinding, bruxisum, bruxing
D9951	$71.20	No	Occlusal adjustment - limited - Used to adjust some permanent teeth 1-32, on a per visit basis
D9952	$202.39	No	Occlusal adjustment - complete
D9999	MP	No	Unspecified adjunctive procedures

Audiology NF PETI Fee Schedule Effective September 1, 2010 until further Notice		
Procedure Code	**NF PETI Fee Amount**	**Product or Service Description**
V5008	$20.00	Hearing service-cerumen removal per ear limited to 2x/year or as ordered by MD-copy of order must be submitted
V5010	$53.68	Hearing Aid Evaluation test
V5011	$60.00	Fitting/Orientation/Checking of Hearing Aid*
	$30.00	Checking of hearing aid by audiologist other than dispensing audiologist
V5014	MP	Hearing Aid repair/modification following warranty period
V5130	$860.00	Hearing Aid-ITE. Pricing is all inclusive for one hearing aid. Two year warranty required
V5140	$1,022.03	Hearing Aid-BTE. Pricing is all inclusive for one hearing aid. Two year warranty required
V5247	$1045.18 per unit	Hearing Aid, digitally programmable analog BTE - pricing is all inclusive for one hearing aid. Two year warranty required.
V5250	$1045.18 per unit	Hearing Aid, digitally programmable analog --CIC-- pricing is all inclusive per one hearing aid. Two year warranty required.
V5251	$1045.18 per unit	Hearing aid, digitally programmable analog, ITE -pricing is all inclusive per one hearing aid. Two year warranty required.
V5256	$1358.73 per unit	Hearing aid, digital, ITE-all inclusive for one hearing aid. Two year warranty required.
V5257	$1358.73 per unit	Hearing aid, digital, BTE-all inclusive for one hearing aid. Two year warranty required
V5258	$1358.73 per unit	Hearing aid, digital, CIC-all inclusive for one hearing aid. Two year warranty required.
V5264	$65 per unit	Ear mold/insert, not disposable, any type
V5266	MP	Batteries
	MP	Assistive listening device
	$125.00	Hearing aid comprehensive service warranty--Annual coverage for replacement or repair of one hearing aid. Protection for loss, damage or component failure.
	$10.00	Safety chain to prevent loss
	$20.00	Nursing facility visit
*Dispensing fee includes initial office visit, ear mold impressions and fittings of the proper hearing aid, the first five post fitting follow-up visits as necessary for adjustments and hearing aid orientation. New hearing aids must be provided with batteries for one year.		

Vision Services PETI Fee Schedule Effective September 1, 2010 until further Notice		
Procedure Code	**NF PETI Fee Amount**	**Product or Service Description**
	$50.00	Eye exam--exams are generally paid by Medicare and Medicaid and should be appropriately billed to them prior to submitting a request for payment to NF PETI
	$50.00	Glasses frames-client may elect more expensive frames but must make private arrangement to pay for the excess cost of the preferred frames
	MP	Lenses by prescription
	MP	Tinted sun glasses only when prescribed for client as medically necessary
	MP	UV lenses only when prescribed for client as medically necessary
	MP	Safety cord to prevent loss