Provider Bulletin

Reference: B1100304 **August 2011**

colorado.gov/pacific/hcpf

In this issue:

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

ACS Contacts

Billing and Bulletin Questions
1-800-237-0757 or 1-800-237-0044

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...?

Help Desk Contacts for Providers - Providers who experience technical issues with the Web Portal, such as slowness in navigating, error messages with instructions to call the Help Desk, or Web Portal availability should contact the CGI Help Desk for assistance via e-mail (HelpDesk.HCG.Central.US@cgi.com), or phone (1-888-538-4275, option 1). Please do not contact the Governor's Office of Information Technology Help Desk.

Any providers who have questions regarding provider applications, client eligibility, claims processing, prior authorizations, report retrieval through the File and Report Service, etc. should contact ACS Provider Services at 1-800-237-0757 or 1-800-237-0044.

All Providers

Developmental, Depression, and Autism Screenings Policy

Effective for dates of service on or after August 1, 2011, the Department of Health Care Policy and Financing (the Department) has issued the following policy for developmental, depression, and autism screenings, and has set the following rates for Current Procedural Terminology (CPT) codes 96110 and 99420. The Colorado Medical Assistance Program will reimburse developmental screening code 96110 at $17.00 and depression screening code 99420 at $10.08.

Developmental Screening

The Colorado Medical Assistance Program covers developmental screening for children ages 0-4, **(up to 59 months)** using a standardized, validated developmental screening tool (e.g., PEDS, Ages and Stages) during the child's periodic visits. In the absence of established risk factors or parental or provider concerns, the American Academy of Pediatrics (AAP) recommends developmental screens at the 9th, 18th, and 30th months well-child visits.

Limitations:

- Three (3) screens per year for children aged 0-24 months
- Two (2) screens per year for children aged 25 months up to 59 months

Providers should report CPT code 96110, "Developmental testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report," when providing developmental screens.

- To report a positive screen:
  - Use a valid diagnosis code within category 315, "Specific delays in development," category 313, "Disturbance of emotions specific to childhood and adolescence," category 314, "Hyperkinetic syndrome of childhood," for specific delays in mental development.
  - Use a valid diagnosis code within category 783, "Symptoms concerning nutrition, metabolism, and development," for physiological delays.
- To report a negative screen:
  - Use diagnosis code V20.2, "Routine infant or child health check."

Providers should report CPT code 96111, "Developmental testing; extended (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report".

When a limited developmental screening suggests an abnormality in a particular area of development, more extensive formal testing will be needed to evaluate the concern.

Depression Screening

The Colorado Medical Assistance Program covers developmental screening for adolescents aged 11-20, using a standardized, validated depression screening tool (e.g., PHQ-9, Edinburgh Postnatal Depression Scale, Columbia Depression Scale, Beck Depression Inventory, Kutcher Adolescent Depression Scale) at the child's periodic visits.

Limitations:

- One (1) screen per year for adolescents aged 11-20 years
- Postpartum Depression Screening: providers may chose to screen postpartum adolescent clients for post-partum depression as part of the client's annual depression screen. However, post-partum depression screening is not currently a separately reimbursable service for Medicaid clients aged 21 and over.

Providers should report CPT code 99420, "Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)," when providing depression screens.

- To report a positive screen, use diagnosis code V40.0 "Mental and behavioral problems, Unspecified mental or behavioral problem".
- To report a negative screen, use diagnosis code V79.8 -"Special screening for mental disorder and other handicaps, other specified mental disorders and developmental handicaps".

Postpartum Depression Screening

Providers should report CPT code 99420 **with modifier HD**.

- To report a positive screen:
  - Use a valid diagnosis code within category 648, "Other current conditions in the mother classifiable elsewhere, but complicating pregnancy, childbirth, or the puerperium."
  - To report a negative screen:
    - Use diagnosis code V79.8, "Special screening for mental disorders and other handicaps, other specified mental disorders and developmental handicaps."

Autism Screening

The Colorado Medical Assistance Program covers autism screening for children aged 18 and 24 months, using a standardized, validated autism screening tool (e.g., M-CHAT) at the child's periodic visit.

Limitations:

- Two (2) screens per year between the child's 18 and 24 month visit.

Providers should report CPT code 96110, "Developmental testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report", **with modifier EP**, when reporting autism screens.

- To report a positive screen:

  Use diagnosis codeV40.3, "Other Behavioral Problems."

Note: Claims will deny if the diagnosis is not one of the specific codes or within the category listed under each screening criteria.

Screening Tools:

- The Colorado Medical Assistance Program does not require the use of a specific developmental screening tool, but providers must use a validated, standardized developmental screening tool.
- The Colorado Medical Assistance Program recommends the use of PHQ-9 depression screening tool, but other validated, standardized depression screening tools are also acceptable.

Referrals to Care:

If a behavioral health need is identified, the primary care clinician must offer to either:

- Provide the necessary services; or
- Refer the patient to a specialist.

Primary care providers who choose to refer a client to a specialist must assist with the referral process.

For more information on which Behavioral Health Organization (BHO) to refer pediatric clients, visit Medicaid Managed Care under *For Our Members* in the *Explore Additional Programs* → Adults the BHO section of the Department's Web site at colorado.gov/hcpf.

For policy details, please refer to the Developmental, Depression, and Autism Screening Policy Statement accessible under Approved Benefits Standards in the Benefits Collaborative section of Boards & Committees, Boards, and Collaboration of the Department's Web site at colorado.gov/pacific/hcpf.

Please contact Sheeba Ibidunni at Sheeba.Ibidunni@state.co.us or 303-866-3510 if you have any questions.

Providers Serving Pregnant Women

Office-Administered Injections:

Medicaid Coverage of Injections for Prevention of Preterm Birth

Effective for dates of service on or after August 1, 2011, Colorado Medicaid will cover 17α hydroxyprogesterone caproate (17P) injections for the prevention of preterm birth. According to the American College of Obstetricians and Gynecologists, clinical eligibility and exclusion criteria are as follows:

Eligibility Criteria:
History of a spontaneous preterm birth (< 37 weeks)
Singleton pregnancy
Initiation of 17P treatments between 16 weeks, 0 days and 20 weeks, 6 days and continuation until 36 weeks, 6 days or delivery, whichever occurs first

Exclusion Criteria:	17P is not for women with:
Known fetal anomaly	Multi-fetal pregnancy
Current or planned cervical cerclage	Short cervix and no prior preterm birth
Hypertension	Previous medically indicated preterm birth
Seizure disorder	

Billing Requirements:

The medical provider (not the pharmacy) must bill for 17P when administered in the office-setting. Providers must use the following codes and units when billing for 17P:

Injection Code	Q2042	Injection, hydroxyprogesterone caproate, 1 mg
Code Modifier	HD	Pregnant/parenting program
Diagnosis Code	V23.41	Supervision of pregnancy with history of preterm labor
Units	250	One unit of Q2042 equals 1 mg. The therapeutic dose of 17P is 250 mg per weekly injection.

No prior authorization is required but clinical records must document that the client meets all eligibility criteria for coverage of 17P for the prevention of preterm birth. The maximum allowable reimbursement for Q2042 is $0.08 per unit (250 units should be billed per weekly injection). Providers may also bill for the injection administration using 96473. Providers must bill their usual and customary charge for the injection and injection administration.

Please wait until August 12, 2011 before submitting claims for dates of service August 1-11, 2011.

Feel free to contact Ginger Burton at Ginger.Burton@state.co.us or 303-866-2693 with questions.

Labor Day Holiday

Due to the Labor Day holiday on Monday, September 5, 2011, claims will be processed on Thursday, September 1, 2011. The processing cycle includes claims accepted on or before Thursday at 6:00 P.M. Mountain Time (MT). The receipt of warrants will be delayed by one or two days.

The State and fiscal agent offices will be closed on Monday, September 5, 2011.

Durable Medical Equipment (DME) and Supply Providers

Durable Medical Equipment Oxygen Policy

The Department has adopted a new policy for DME oxygen coverage. The new policy was approved in July 2011 and will be implemented in September 2011.

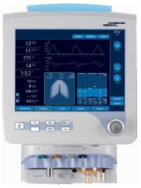
The Medicaid DME oxygen benefit changes several elements of coverage:

- Oxygen coverage is now determined by clinical criteria which is substantially similar to the Medicare oxygen clinical criteria. The clinical criteria will only apply to clients who are over the age of 20 and are not ventilator dependent.
- Suppliers are now required to obtain a Certificate of Medical Necessity for long term oxygen coverage, for clients who are over the age of 20 and are not ventilator dependent. Suppliers may use either the Medicare Certificate of Medical Necessity (CMS-484-Oxygen, available at cms.gov/forms) or the Colorado Medicaid Certificate of Medical Necessity for Oxygen Benefits. The Medicaid document is Attachment A of this bulletin, and is also available in the Provider Services Forms section and in the 2011 Supply HCPCS Codes Bulletin (B1100299) on the Department's Web site.
- Reimbursement for oxygen content for non-ventilator clients is now on a monthly fee and no longer reimbursed by volume.

The new policy will require usage of the Healthcare Common Procedural Coding System (HCPCS). The reimbursement for Medicaid only clients or dually eligible clients in the nursing home is as follows based on liters per minute (LPM). Note that there is no differentiation in Medicaid oxygen content reimbursement based on the type of system used by the client and there will no longer be separate oxygen content HCPCS for different settings:

	Modifier	Reimbursement	Monthly Units
Gaseous Contents			
E0441 <2 LPM	QE	95	1
E0441 2-4 LPM		190	1
E0441 >4-6 LPM	QF	285	1
E0441 >6 LPM	QG	403.20	1
Liquid Contents			
E0442 >2 LPM	QE	95	1
E0442 2-4 LPM		190	1
E0442 >4-6 LPM	QF	285	1
E0442 >6 LPM	QG	403.20	1
Gaseous and Liquid Contents for High Volume Clients			
S8120	TG	0.07	no limit
S8121	TG	0.77	no limit
S8120		BI	not applicable

	Modifier	Reimbursement	Monthly Units
Gaseous and Liquid Contents for High Volume Clients (continued)			
S8121		BI	not applicable
Gaseous Systems			
E0424	RR	no change	
E0425	RR	no change	
E0430	RR	no change	
E0431	RR	no change	
Liquid Systems			
E0434	RR	no change	
E0435	RR	no change	
E0439	RR	no change	
E0439	TT-RR	no change	
E0440	RR	no change	
Concentrators			
E1390	RR	no change	
E1391	RR	no change	
E1392	RR	no change	
K0738	RR	no change	



Claims for oxygen contents for clients on a ventilator should use HCPCS S8120 or S8121 and the modifier TG. In addition, a supplier has the opportunity to request a higher fee for clients receiving in excess of 6 liters per minute when the new reimbursement amount inhibits coverage. Suppliers must make arrangements to use the higher fee using Questionnaire 16, which is Attachment B of this Bulletin and available on the Department's Web site. The Questionnaire has also been added to the 2011 Supply HCPCS Codes Bulletin (B1100299).

Oxygen content HCPCS E0443 and E0444 will continue to be available for Medicare crossover claims but should not be used for Medicaid only clients or dually-eligible clients in nursing homes.

For a history of the DME Oxygen Benefits Collaborative, review the policy on the Department's Web site. For additional information, please refer to the DME Oxygen Policy Statement by visiting the Committees, Boards & Collaboration section of the Department's Web site and choose the Benefits Collaborative option.

Please contact Richard Delaney at Richard.Delaney@state.co.us or 303-866-3436 if you have questions about the new policy.

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

All suppliers of DME, with the exception of Pharmacies (where DME/Supplies are less than 5% of total income), must have an up-to-date Medicare accreditation letter or certificate. Providers must submit either document to the Colorado Medical Assistance Program in order for claims to be paid.

Accreditation must be current and the letter or certification must have an effective time period. If a provider has multiple sites, the letter or certification must state that each site has been approved for each Medicaid provider number.

Please verify that your accreditation certificate on file is current. If you have obtained a renewed certification, please submit it as soon as possible to avoid gaps in coverage and payment delays.

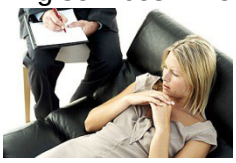
Please contact Anna Davis at Anna.Davis@state.co.us if you have further questions or want to verify your accreditation certificate is on file and current.

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

Update on FQHC/RHC Billing for Services when Primary Diagnosis on the Claim Is a 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 and providers must become part of a BHO network and/or receive authorization from the BHO to provide covered mental health services to BHO clients. BHO-covered diagnoses are found in Appendix T of the Appendices in the Provider Services Billing Manuals section of the Department's Web site.

FQHCs and RHCs must submit claims to the BHO when the primary diagnosis is a BHO-covered diagnosis and the only service or services provided were BHO-covered procedures as found in Appendix T. FQHCs and RHCs should check eligibility and managed care enrollment on all clients before rendering services. The Medicaid Fee-for-Service (FFS) payment system will reject any FQHC or RHC claim where the client's primary diagnosis is included in the BHO coverage and the only procedure(s) on the claim is included in the BHO coverage. The procedure code must be included on the claim. See the FQHC//RHC billing manual for a claim example.



FQHC or RHC claims with a BHO covered primary diagnosis that include a non-BHO covered procedure will be paid FFS. These FQHC or RHC claims*, as long as they include a BHO-covered primary diagnosis and a non-BHO covered procedure,* do not need to follow instructions for submitting a paper claim described in the May 2010 Provider Bulletin (B1000283), and may be submitted electronically.

Any payments made by the Colorado Medical Assistance Program for claims submitted in error to Medicaid as FFS are considered overpayments that must be returned to the Department. Except for emergency services, the BHOs are under no obligation to pay for services rendered without pre-authorization.

Please contact Richard Delaney at Richard.Delaney@state.co.us or 303-866-3436 if you have any questions.

Hospital Providers

Centers for Medicare and Medicaid Services (CMS) Diagnosis Related Group (DRG) System Reminder

The following versions of the 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

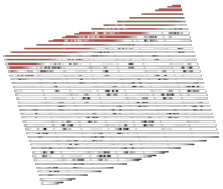
The complete CMS-DRG tables can be accessed on the Department's Web site in the Providers section under the Provider Services tab.

Additionally, the Department did not implement the 3M Company's All Patient Refined Diagnosis Related Groups (APR-DRG) software for adjudication of inpatient hospital claims on July 1, 2011 as was previously communicated. The Department appreciates your patience as work continues towards the implementation of the new APR-DRG grouper on a future date.

Please contact Jeremy Tipton at Jeremy.Tipton@state.co.us or Elizabeth Lopez at Elizabeth.Lopez@state.co.us with any questions.

Pharmacy Providers

Save the Date!



In preparation for the upcoming pharmacy reimbursement changes, the Department and the fiscal agent, ACS, will be hosting a webinar on August 29, 2011 from 1:30 PM - 2:30 PM. The webinar will focus on general reminders for pharmacies and will provide information regarding the methodology that will be used for pharmaceutical reimbursement. Details for accessing the session will be posted on the Department's Web site on August 1, 2011.

No Rate Reduction for Pharmacy Providers for Fiscal Year (FY) 2011-12

The June 2011 Provider Bulletin (B1100302) incorrectly included pharmacy in the 0.75% across-the-board rate reduction for FY 2011-12. The Colorado Legislature clarified that the across-the-board rate reduction does not apply to pharmacy providers. The Department plans to use rebates and other tools to meet the budget requirements for pharmacy services this fiscal year. Please contact Sonia Sandoval at Sonia.Sandoval@state.co.us or 303-866-6338 with any questions.

Pharmaceutical Reimbursement Calculation Changes

Historically, pharmacies in Colorado dispensing drugs, on an outpatient basis to fee-for-service Medicaid clients are reimbursed based on the lowest of five rates calculated by the Department.
The purpose of reimbursing pharmacies based on the lowest calculated rate using multiple methodologies is to ensure that the Colorado Medicaid program functions as a prudent purchaser of prescription drugs for Colorado Medicaid clients.

Based on changes in the availability of information regarding these rates beginning October 1, 2011, the Department is required to develop a new reimbursement methodology. The Department will implement a new reimbursement methodology based on a State Maximum Allowable Cost (MAC) price or Wholesale Acquisition Cost (WAC). Information regarding the calculation method used will be discussed at the Medical Services Board meeting on August 12, 2011.

State Maximum Allowable Cost (State MAC) Information

Do you have questions regarding the upcoming changes to the Pharmaceutical Reimbursement Calculation? Please visit the State MAC page to find information regarding the changes. You will find a State MAC Fact Sheet, Frequently Asked Questions, Current and Previous State MAC lists.

If you still have questions after reviewing the information on the Web site, please contact us at Colorado.SMAC@hcpf.state.co.us. Your question will be responded to by one of the members of the Pharmacy Benefits Unit.

Pharmacy Email Distribution List

Would you like to receive updates regarding Pharmacy related changes for Medicaid? Please send an email to Colorado.SMAC@hcpf.state.co.us and ask to be added to the email distribution list.

Drug Utilization Review (DUR) Board News

Next DUR Board Meeting:
Tuesday, August 23, 2011
6:30 PM - 9:00 PM

The meeting will be held at 225 E. 16th Avenue, Denver, CO 80203
1st Floor Conference Room

The upcoming DUR Board meeting will be addressing the following Drug Classes:

Bisphosphonates; Biguanides; Hypoglycemic Combinations; Meglitinides; Thiazolidinediones; Newer Diabetic Agents (DPP-4 inhibitors, amylinomimetics and incretin mimetics); Erythropoiesis Stimulating Agents; Stimulants and ADHD Treatments; and Drugs to treat Urinary Incontinence.

Interested parties that would like to present testimony to the DUR Board must sign up at least 24 hours in advance by contacting Jim Leonard at Jim.Leonard@state.co.us or 303-866-3502.
Please see our DUR page for more details.

Speech Therapy Providers

Correct Procedure Codes for Speech Therapy Services

As of May 27, 2011, the codes below are the correct procedure codes for speech therapy services. Providers may bill a maximum of five units of therapy per client per provider per date of service using these codes. Claims for these codes must be submitted using the 837 Professional (837P) transaction or the Colorado 1500 paper claim form.

Please contact Marcy Bonnett at Marcy.Bonnett@state.co.us or 303-866-3604 with any questions.

Code	Description*	Maximum number of units per client, per provider, per date of service	GN modifier must be placed on all speech therapy claims	Code	Description	Maximum number of units per client, per provider, per date of service
92506*	Evaluation of speech, language, voice, communication, auditory processing and /or oral rehabilitation status	1	GN	92609	Use of Speech device service	1
92507	Treatment of speech, language, voice, communication and/or auditory disorder individual	1	GN	92610	Eval of oral and pharyngeal swallowing function	1
92508	Speech/ Hearing Treatment, Group, 2 or more individuals	1	GN	92611	Motion Fluoroscopic evaluation of swallowing function	1
92520	Laryngeal function studies	1	GN	92612	Flexible fiber optic endoscopic eval by cine or video recording	1
92526	Treatment of swallowing dysfunction or oral	1	GN	92614	Flexible fiber optic endoscopic laryngeal sensory testing by cine or video recording	1
92597	Oral speech device evaluation	1	GN	92626	Eval of auditory Rehab status; first hour	1
92605	Evaluate for Device	1	GN	92627	Each additional 15 mins	4
92606	Non-speech device service	1	GN	96105	Assessment of aphasia per hour	2
92607	Evaluation for Speech Generating Device, first hour	1	GN	96111	Developmental testing; extended with interpretation and report, per hour	1
92608	Additional 30 minute eval for 92607	1	GN	97532	Development of cognitive skills, 15 minutes	3
				Q 3014	Telehealth, originating site facility fee	1

August and September 2011 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.

Provider billing workshops include both Colorado Medical Assistance Program billing instructions and a review of Colorado Medical Assistance Program billing procedures. The August and September 2011 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 1-800-237-0044

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.

Reservations will only be accepted until the Friday before the training workshop. This will ensure that there is space available and enough training materials.

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 presented in Denver are held 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 completion of the UB-04 and the Colorado 1500 paper claim forms.

The Beginning Billing classes do not cover any specialty billing information.

The fiscal agent provides specialty training throughout the year in their Denver office.

Classes do not include any hands-on computer training.

August and September 2011 Specialty Workshop Class Descriptions

Dialysis

This class is for billers who bill for Dialysis services on the UB-04/837I and/or Colorado 1500/837P claim formats. 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.)*

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.

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.

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.

Pharmacy
This class is for billers using the Pharmacy claim format/Point of Sale and/or PCF Format. The class covers billing procedures, common billing issues and guidelines specifically for Pharmacies. *(This is not the class for DME/ Supply Providers – please refer to DME/ Supply Provider Class.)*

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.

Practitioner
This class is for providers using the Colorado 1500/837P 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

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 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.)*

Transportation
This class is for emergency transportation providers billing on the Colorado 1500/837P and/or UB-04/837I formats. The class covers billing procedures, common billing issues, and guidelines specifically for Transportation 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 **Welton St.**, 0.5 miles.
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).

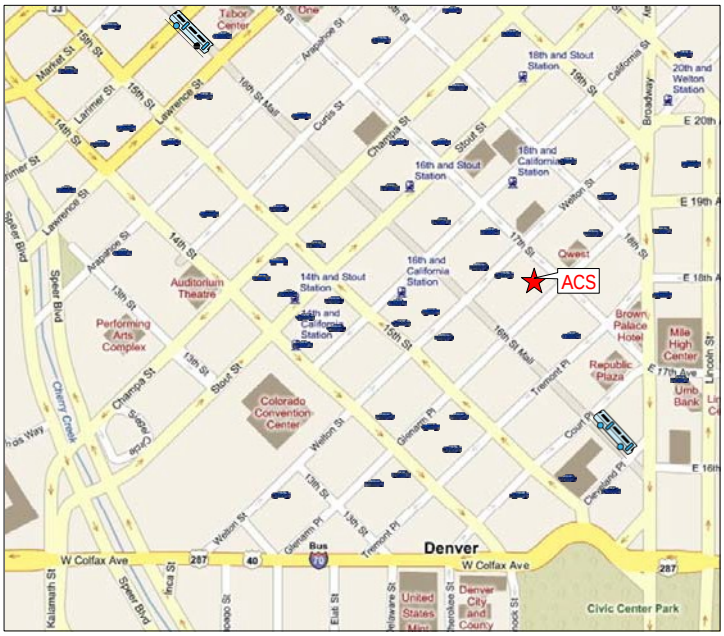
Parking: Parking is not provided by ACS and is limited in the downtown Denver area.

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: 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.

August 2011

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 11:45 AM-12:30 PM	10 Beginning Billing – UB-04 9:00 AM-11:30 AM Web Portal 837I 11:45 AM-12:30 PM Hospice 1:00 PM-3:00 PM	11 DME/Supply 9:00 AM-11:00 AM DME/Supply PAR 11:30 AM-1:30 PM Pharmacy 2:00 PM-3:00 PM	12 (WebEx) CO-1500 9:00 AM-12:00 PM (WebEx) FQHC/RHC 1:00 PM-4:00 PM	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

September 2011

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				1	2	3
4	5 *Labor Day*	6	7	8	9	10
11	12	13 Beginning Billing – CO -1500 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM Transportation 1:00 PM-3:00 PM	14 Beginning Billing – UB-04 9:00 AM-11:30 AM Web Portal 837I 11:45 AM-12:30 PM Dialysis 1:00 PM-3:00 PM	15 Provider Enrollment 9:00 AM-11:00 AM (WebEx) Practitioner 1:00 PM-3:00 PM	16 Pediatric HH PAR 1:00 PM-3:00 PM Home Health 3:00 PM-4:30 PM	17
18	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 1-800-237-0757 or 1-800-237-0044.

Please remember to check the Provider Services section of the Department's Web site at colorado.gov/pacific/hcpf.

Certificate of Medical Necessity for Oxygen Benefits

COLORADO MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR OXYGEN BENEFITS*

SECTION A Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and MEDICAID ID Medicaid #		SUPPLIER NAME, ADDRESS, TELEPHONE AND PROVIDER ID# Medicaid Provider ID #
PLACE OF SERVICE _____	HCPCS CODE	PT DOB _____/_____/_____ Sex ____(M/F)
NAME and ADDRESS of FACILITY if residing in a nursing facility	_____ _____ _____ _____	QUALIFIED PRACTITIONER NAME, ADDRESS, TELEPHONE and applicable NPI NUMBER or UPIN (____)_____-_____ UPIN or NPI #_____

SECTION B Information in this section does not have to be completed by the Qualified Practitioner.

EST. LENGTH OF NEED (# OF MONTHS): _____1–99 *(99=LIFETIME)*	DIAGNOSIS CODES (ICD-9): _____ _____ _____ _____

ANSWERS	ANSWER QUESTIONS 1–8. (Circle Y for Yes, N for No, or D for Does Not Apply, unless otherwise noted.)
a)_____mm Hg b)_____% c)____/____/____	1. Enter the result of most recent test taken on or before the certification date listed in Section A. Enter (a) arterial blood gas PO2 and/or (b) oxygen saturation test; (c) date of test.
	2.
1 2 3	3. Circle the one number for the condition of the test in Question 1: (1) At Rest; (2) During Exercise; (3) During Sleep
Y N D	4. If you are ordering portable oxygen, is the patient mobile within the residence or their mobile community? If you are not ordering portable oxygen, circle D.
_____LPM	5. Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter a "X".
a)_____mm Hg b)_____% c)____/____/____	6. If greater than 4 LPM is prescribed, enter results of most recent test taken on 4 LPM. This may be an (a) arterial blood gas PO2 and/or (b) oxygen saturation test with patient in a chronic stable state. Enter date of test (c).
ANSWER QUESTIONS 7-9 **ONLY** IF PO2 = 56–59 OR OXYGEN SATURATION = 89 IN QUESTION 1	
Y N	7. Does the patient have dependent edema due to congestive heart failure?
Y N	8. Does the patient have cor pulmonale or pulmonary hypertension documented by P pulmonale on an EKG or by an echocardiogram, gated blood pool scan or direct pulmonary artery pressure measurement?
Y N	9. Does the patient have a hematocrit greater than 56%?

SECTION C Narrative Description of Equipment and Cost

Narrative description of all items, accessories and options ordered

SECTION D Qualified Licensed Practitioner Attestation and Signature/Date

I certify that I am the qualified licensed practitioner who is responsible for the care of the patient identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

QUALIFIED LICENSED PRACTITIONER_____DATE _____/_____/_____

Signature and Date Stamps Are Not Acceptable.

Colorado Department of Health Care Policy and Financing Form Revision Date 8/2011 *RETAIN IN CLIENT'S FILE

QUESTIONNAIRE #16
OXYGEN CONTENTS IN EXCESS OF 6 LITERS PER MINUTE
OVERNIGHT PORTABLE OXYGEN FOR CLIENTS NEEDING OXYGEN BASED SOLELY ON SLEEP STUDY

Client Name: _____

Colorado Medicaid Client ID #: _____

OXYGEN CONTENTS IN EXCESS OF 6 LPM

This client was prescribed oxygen and is expected to use more than 6 liters per minute (LPM) regularly. The information requested below is required in order to determine appropriate reimbursement for the oxygen contents. Please answer the following questions in regard to the client's current condition. Use additional paper, if necessary. After you have completed this form, mail it to the

Department of Health Care Policy & Financing
Medicaid Program Division, Oxygen Benefits Management
1570 Grant Street
Denver, Colorado 80201-1818
Thank you for your cooperation.

Relevant Diagnosis(es): _____

How many estimated monthly deliveries and pounds or cubic feet of oxygen are necessary to supply oxygen contents to the client. _____

What is the distance from the supplier to the client's residence in miles. _____

What month did the client start using in excess of 6 LPM of oxygen contents on a regular basis? _____

OVERNIGHT PORTABLE OXYGEN FOR CLIENTS NEEDING OXYGEN BASED SOLELY ON SLEEP STUDY

Identify the circumstances necessitating coverage for portable oxygen for a client for whom oxygen is necessary only at night. _____

Is the portable oxygen necessary for the client to receive medical treatment outside of their residence?

Yes ___ No ___

For either purpose, attach a copy of the Certificate of Medical Necessity for Oxygen.

Provider Signature: _____

Date: _____

PLEASE PHOTOCOPY THIS BLANK FORM AS NEEDED