Provider Bulletin

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colorado.gov/pacific/hcpf

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Did you know...?

There are changes to Dental Prior Authorization Requests (PARs) submitted through the Colorado Medical Assistance Program Web Portal (Web Portal).

Beginning on February 1, 2012, the Web Portal PAR option will not be available and is anticipated to be unavailable for up to six weeks. Dental PARs will need to be submitted on paper to the fiscal agent, ACS.

For additional information, please refer to the "Prior Authorization Request (PAR) Changes" notice dated January 19, 2012 in the Provider Services *Provider Information* Colorado Medical Assistance Program Web Portal section of the Department's Web site.

All Providers

Coverage for Adults without Dependent Children (AwDC)

Coverage for Adults without Dependent Children (AwDC) is preparing for implementation. Beginning April 1, 2012 through May 15, 2012, the County Departments of Human/Social Services, Medical Assistance sites and Colorado's Eligibility and Enrollment Medical Assistance Program (EEMAP) vendor, MAXIMUS, Inc, will process applications for enrollment into the AwDC expansion program. The expansion will offer regular Medicaid benefits to 10,000 applicants who have been determined eligible during that processing period. Benefits will begin on May 1, 2012. Currently, the Department is awaiting approval from the Centers for Medicare & Medicaid Services (CMS) to enroll eligible applicants through a randomized member selection process to provide an equitable distribution of enrollment positions across the state. All applicants determined eligible after the initial randomized selection process, as well as those who were not selected for initial enrollment, will be placed on the a waitlist for AwDC. All individuals on the waitlist will be included in the randomized member selection process as funding permits and as enrollment becomes available.

All AwDC expansion clients who are receiving benefits will be enrolled in the Department's Accountable Care Collaborative (ACC) Program through one of the program's Regional Care Coordination Organizations (RCCOs) for their area based on the applicant's address on file. Through the ACC, clients select a program enrolled primary care medical provider who will serve as their focal point of care and help coordinate specialty and other necessary services. Many of the state's primary care providers who have been serving this expansion population through the state's Colorado Indigent Care Program (CICP) are enrolled in the ACC. The Department encourages primary care providers not enrolled in the ACC to enroll by contacting the RCCO in their area. More information about the ACC or finding the RCCO for a particular region can be found on the Department's ACC Web page at colorado.gov/pacific/hcpf.

Please contact Susan Mathieu at Susan.Mathieu@state.co.us or Jeff Konrade-Helm at Jeffrey.Konrade-Helm@state.co.us with questions.

Accountable Care Collaborative (ACC) Update

The ACC is a new Colorado Medical Assistance Program to improve clients' health and reduce costs. As of December 2011, the ACC program has roughly 70,000 enrollees.

Benefits of being an ACC Primary Care Medical Provider (PCMP)

- Administrative Support: RCCOs are charged with assisting providers in navigating Medicaid administrative systems.

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 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

- Practice Support: RCCOs are responsible for supplying providers with practical tools and resources to fulfill the basic elements of a Medical Home. Practice support may include clinical tools, client materials, operational practice support, data, reports, and other resources.
- Data Analytics and Reporting Capabilities: Through the Statewide Data and Analytics Contractor, PCMPs will receive client level utilization data on the clients in their panel.
- Per Member per Month Payment (PMPM): PCMPs will receive $3 per member per month reimbursement for providing medical home level services and are eligible for an additional $1 based on regional performance. While the program is in the initial phase, PCMPs are receiving $4 PMPM.

Interested providers are encouraged to contact the RCCO in their area. For contact information please refer to the ACC Contact Information sheet.

Becoming a PCMP does not ensure that clients will be enrolled in your panel. The contracting and enrollment processes may take several months.

ACC Referral Requirement

- There is currently a grace period in effect for referrals. During this grace period, PCMPs are expected to provide a referral for their clients to see specialists and other primary care providers; however, claims without a referral submitted by specialists and other primary care will be processed for payment.
- The grace period will remain in effect until the policy is fully re-evaluated with stakeholders.
- All providers will be given notice about any change before it occurs.

Contact Kathryn Jantz at Kathryn.Jantz@state.co.us or Greg Trollan at Greg.Trollan@state.co.us with questions.

Changing Provider Contact Information for the Colorado Medical Assistance Program Recovery Audit Contractor (RAC) Program

The Department's RAC, CGI Federal, would like to provide an avenue for providers wishing to supply CGI Federal with contact information different from the contact information on file with the Department or with the fiscal agent, ACS. RAC Program contact information is only used for the RAC Program audits. The purpose is to allow a provider to identify a particular person to receive all RAC related correspondence.

For providers wishing to provide or change their contact information, please call the CGI Medicaid Services Call Center at 1-855-210-3438, Option 2 (Colorado); or by emailing CGI Federal at rac.medicaid@cgifederal.com.

In the near future, providers may view and update contact information on the CGI Federal Colorado RAC Web site, which is currently being developed. Once it is fully implemented, the Department will announce its web address in a future provider bulletin. When the RAC Web site is complete, providers will be able to update or change contact information using any of the aforementioned methods.

Provider Outreach Page (POP) LIVE

The Provider Outreach Page (POP) for the Colorado Medicaid Electronic Health Record (EHR) Incentive Program has launched successfully. The POP is meant to serve as a central source of information for eligible providers and hospitals to learn more about the Colorado Medical Assistance Program EHR Incentive Program requirements and applicable certified EHR technology. Additionally, the POP will provide program participants with detailed resources to help them prepare for the Registration and Attestation (R&A) System when the Colorado R&A system launches in March 2012. These resources include:

- CMS program overview and Frequently Asked Questions (FAQs)
- Office of the National Coordinator (ONC) for Health Information Technology resources for choosing/verifying certified EHR technology
- Colorado specific FAQs
- Link to the Department's Web site

- Links to the Colorado Regional Health Information Organization (CORHIO) & Colorado Regional Extension Center (CO-REC) Can Help! Web sites
- Checklists for R&A preparation (both federal and state)
- Eligibility worksheets
- Attestation worksheets
- Colorado Medical Assistance Program EHR Incentive Coordinator contact information

The launch of the POP is a huge step in ensuring that program stakeholders across the state are aware of the Colorado EHR Incentive Program requirements, eligibility, and R&A processes. When used effectively, it will allow providers to be fully prepared with all the required information needed for the next steps in the R&A process and ultimately, receiving their incentive payment. Please visit the POP Web site for more information. For questions regarding the program, contact the Colorado EHR Incentive Program Coordinator via email at MedicaidEHR@corhio.org or 720-285-3232.

Add-A-Baby Process Training

The Department is offering an Add-A-Baby process training via WebEx on Thursday, February 22, 2012 from 1:00 P.M. - 3:00 P.M. The training will cover the following:

- An overview of the process
- Submission of various forms (typed, handwritten, and online)
- Who to contact for follow up requests, emergent requests
- Common errors when submitting forms

This training is for providers, Community Based Organizations, Certified Application Assistance Sites, Medical Assistance sites and others who assist Medicaid or CHP+ prenatal eligible mothers report the birth of their newborns.

Click here to register. Registration must be received by February 15, 2012 in order to participate.

Please contact Shawna Moreno at Shawna.Moreno@state.co.us or 303-866-4456 with questions.

President's Day Holiday

Due to the Presidents' Day holiday on Monday, February 20, 2012, claim payments will be processed on Thursday, February 16, 2012. The processing cycle includes claims accepted by Thursday before 6:00 P.M. Mountain Time. The receipt of warrants will be delayed by one or two days. State and the ColoradoPAR Program offices will be closed on Monday, February 20, 2012. ACS offices will be open during regular business hours.

Home and Community Based Services Providers

Implementing Amendments to the Home and Community Based Services (HCBS) Waivers Serving People with Developmental Disabilities

Amendments to the Home and Community Based Services (HCBS) for persons with Developmental Disabilities (DD), HCBS-Supported Living Services (SLS) and HCBS-Children's Extensive Support (CES) waivers were effective December 1, 2011. These amendments affect Day Habilitation Services and Supports (DHSS), Behavioral Services and Dental Services and introduce Prevocational Services.

The HCBS waiver amendments modify service definitions to include specific services, qualifications, procedures, and limitations, and provide specific exclusions to services as applicable. Additionally, Prevocational Services are added to the HCBS-DD and HCBS-SLS waivers to prepare clients for community employment.

New service definitions, exclusions and limitations in the HCBS-DD, HCBS-SLS and HCBS-CES waivers shall be implemented for clients during development of initial Service Plans and at the time of the Continued Stay Review (CSR) meetings held December 1, 2011 and thereafter.

Revisions to Service Plans prior to the annual CSR that include changes in DHSS, Behavioral Services, Dental Services and Prevocational Services shall adhere to the new service definitions, exclusions, and limits.

In the HCBS-DD waiver, the amount of DHSS in the Service Plan shall not exceed 4,800 units. One unit = 15 minutes. This is equivalent to 1,200 hours per year, or an average of 24 hours per week.

In the HCBS-SLS waiver, the DHSS limit of 4,800 units is not applicable and the maximum combined units for all day program services (DHSS, Supported Employment and Prevocational Services) in the HCBS-SLS waiver remains at 7,112 units per year.

Behavioral Services in the HCBS-DD, HCBS-SLS, and HCBS-CES waivers are identified by specific types of services being provided and include Behavioral Consultation Services, Behavioral Plan Assessment Services, Individual/Group Counseling Services and Behavioral Line Services. Behavioral Services is no longer identified based on the provider's qualifications as Lead Therapist, Senior Therapist, Behavior Plan Specialist, and Behavior Line Staff. Please refer to Attachment A for rates, procedure codes, modifiers and service limitations.

Behavioral Services are limited per Service Plan year as follows:

HCBS-DD and HCBS-SLS waivers (one unit = 15 minutes)

- Behavioral Consultation Services: 80 units
- Behavior Plan Assessment Services: 40 units; one assessment
- Individual/Group Counseling Services: 208 units
- Behavioral Line Services: 960 units with prior authorization by the Division for Developmental Disabilities.

HCBS-CES Waiver

- Behavior Plan Assessment Services: 40 units; one assessment

Existing Service Plans may continue. Providers who are serving individuals with existing Service Plans that include Behavioral Lead, Senior and Plan Specialist may continue submitting claims for those services under the current codes and will be reimbursed at the current rates. If one of these services is amended in the current Service Plan year, the new service categories and reimbursement rates apply.

New service definitions, limitations, and rates apply to services identified in all initial Service Plans with service start dates of December 1, 2011 or later and all CSR meetings held December 1, 2011 or later.

Preventative and Basic Dental Services in the HCBS-DD and HCBS-SLS waivers are limited to $2,000 per Service Plan year. Major Dental Services are limited to $10,000 for the life of the waiver, July 1, 2009 through June 30, 2014. This includes the cost of all dental services now excluded as of December 1, 2011, but previously approved or provided.

The HCBS waiver amendments define the provider qualifications within the new service definitions. Please refer to the amended HCBS waivers posted on the DDD Web site located on the Colorado Department of Human Services' "What's New" web page.
Please contact Lori Thompson at Lori.Thompson3@state.co.us with questions.

Home Health Providers

Home Health Telehealth

Effective February 1, 2012, the Colorado Medical Assistance Program will reimburse for Home Health Telehealth services. Telehealth allows a home health agency to collect clinical information via electronic transmission from the client's home to the home health agency for evaluation and management. The purpose of providing Telehealth services is to manage and monitor the care of clients whose medical needs can be appropriately and cost-effectively met at home, through the monitoring of data and early intervention.

Reimbursement Guidelines for Telehealth Services

1. Home Health Telehealth services must be prior authorized before an agency can bill for Telehealth services.

2. The unit of reimbursement for Home Health Telehealth is one day and is only reimbursed for those days on which the client information is reviewed and responded to as needed.
3. The initial visit to install the equipment and train the client may be billed as a set-up visit. Only one set-up visit may be billed per client.
4. Payment for approved Home Health Telehealth services is based on the established fee schedule, unless a lower amount is billed.
5. The purchase and maintenance of the equipment is the responsibility of the home health agency. The agency must ensure that the equipment is Food and Drug Administration (FDA) certified or Underwriter Laboratories (UL) listed/certified.
6. Providers may submit a claim for Telehealth services only when there is at least one other home health service on the claim. Providers may not submit a claim for Telehealth services only.

Description/Service	Revenue Code	Procedure Code	Reimbursement	Units of Service
Acute Home Health Telehealth	583	98969	$9.45	1 unit = 1 day limited to 31 units/month
Long-Term Home Health Telehealth	780	98969	$9.45	1 unit = 1 day limited to 31 units/month
Initial Set Up – Acute Home Health	583	98969 plus TG modifier	$50.00	May only be billed one time per patient per agency
Initial Set-Up – Long-Term Home Health	780	98969 plus TG modifier	$50.00	May only be billed one time per patient per agency

Contact Guinevere Blodgett at Guinevere.Blodgett@state.co.us or at 303-866-5927 with questions.

Pharmacy

Cost of Dispensing and Acquisition Cost Surveys

The Department has contracted with Mercer Government Human Services Consulting (Mercer), a part of Mercer Health & Benefits LLC, to conduct a pharmacy cost of dispensing (COD) survey and an acquisition cost survey to evaluate its pharmacy reimbursement components. These surveys will help the Department understand and approximate both the cost of prescription medications and dispensing prescription medications to Colorado Medical Assistance Program clients.

The Department requests provider participation in the COD and acquisition cost surveys of Colorado pharmacies that dispense prescription medications to Colorado Medicaid recipients.

For information regarding the surveys, visit the Pharmacy section of the Department's Web site. To keep pharmacies informed, the web page will be periodically updated. For any questions, please contact Mercer at Co.RX_Reimbursement@mercer.com.

Other Coverage Code

In order to bill the Colorado Medical Assistance Program for claims where the client has a third party insurer, pharmacies must first bill the third party insurer. The Pharmacy Billing Manual includes the details that must be provided with billing claims for patients with other coverage. Additional training materials regarding use of the Other Coverage Code fields are available in the *Pharmacy Billing Manual* section of the Department's Web site.
As a reminder, Qualifier 06 in Field 351-NP should only be used if the prior payer is still on Version 5.1.

351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Ø1=Amount Applied to Periodic Deductible (517-FH) Ø2=Amount Attributed to Product Selection/Brand Drug (134-UK) Ø3=Amount Attributed to Sales Tax (523-FN) Ø4=Amount Exceeding Periodic Benefit Maximum (52Ø-FK) Ø5=Amount of Copay (518-FI) Ø6=Patient Pay Amount (5Ø5-F5) Ø7=Amount of Coinsurance (572-4U) Ø8=Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) Ø9=Amount Attributed to Health Plan Assistance Amount (129-UD) 1Ø=Amount Attributed to Provider Network Selection (133-UJ) 11=Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN) 12=Amount Attributed to Coverage Gap (137-UP) 13=Amount Attributed to Processor Fee (571-NZ)	Required if Other Payer-Patient Responsibility Amount (352-NQ) is used. *Payer Requirement:* Required if OCC = 4. Colorado will only reimburse for amounts submitted with qualifiers Ø1, Ø5, Ø6, and Ø7. Qualifier Ø6 should only be used if previous payer is still on Version 5.1

Pharmacy &Therapeutics (P&T) Committee News

The Department would like to welcome two new P&T Committee members, Dr. Bruce MacHaffie and Dr. Katy Trinkley. The Department would like to thank all of the experts that submitted curriculum vitae (CV) for consideration, selecting members for appointment was extremely difficult due to the wealth of talent in the pool. For a complete list of P&T Committee members, check the Pharmacy and Therapeutics Web page.

Preferred Drug List (PDL) Update

Effective January 1, 2012, the following medications became preferred agents on the Medicaid PDL and will be covered without a prior authorization:

Antiplatelets: Aggrenox, Effient, Plavix

Targeted Immune Modulators for RA: Enbrel and Humira

Newer Generation Antidepressants: Bupropion (IR, SR, XL), citalopram, fluoxetine, fluvoxamine, mirtazapine, nefazodone, paroxetine, sertraline, venlafaxine IR, ER (tab), XR (caps)

Please see PDL for updated criteria specific to Cymbalta.

Phosphodiesterase Inhibitors: Adcirca and Revatio are preferred, but an indication of Pulmonary Hypertension must be documented.

Endothelin Antagonists: Letairis

Prostanoids: Veletri and generic epoprostenol

Antiemetics: ondansetron and Zofran (brand) tablets (including ODT)
ondansetron suspension for children under 6

Please see PDL for criteria specific to Emend.

Proton Pump Inhibitors: Aciphex, lansoprazole 15mg OTC (currently available as Prevacid 24hr), Nexium Packets, generic omeprazole capsules (RX), Prevacid Solutab (Please note: only brand name Solutabs will be covered) (for children under 6) and Prilosec OTC

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

The complete PDL and prior authorization criteria for non-preferred drugs are posted on the PDL Web page.

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

Appropriate use of Proton Pump Inhibitors (PPI)

PPI Quantity Limits – Prior authorization will be required for proton pump inhibitor therapy beyond 100 days. Prior authorization will be approved for clients with Barrett's Esophagus, Erosive Esophagitis, GI Bleed, Hypersecretory Conditions (Zollinger Ellison), or Spinal Cord Injury clients with any acid reflux diagnosis. In addition, clients with documented continuation of symptomatic Gastroesophageal reflux disease (GERD) or recurrent peptic ulcer disease who have documented failure on step down therapy to an H2-receptor antagonist (of at least two weeks duration) will be approved for up to one year of daily PPI therapy.

Prior Authorization Criteria (Appendix P) Updates effective January 15, 2012

Quantity Limits were added for the following drugs:

Copaxone (glatiramer acetate injection) is limited to 1 unit per 30 days (1 unit = 1 kit = 30 day supply under approved dosing).

Duac Convenience Kit (clindamycin/benzoyl peroxide) is limited to 1 unit per 30 days (1 unit = 1 kit).

Aldara (imiquimod) is limited to 12 packets per 28 days without prior authorization.

Criteria has been added limiting high-dose citalopram utilization in response to the FDA Safety Communication regarding doses of citalopram exceeding 40mg per day. Doses greater than 40mg per day will require prior authorization.

Criteria has been added limiting use of low-dose Seroquel (quetiapine). Low-dose is being defined as less than 150mg per day, and this therapy is limited to a 30 day supply for dose titration unless the client is over 65 years of age or a prior authorization is obtained.

Criteria has been added requiring prior authorization for Cialis (tadalafil). Prior authorization will be approved for clients with documented benign prostatic hyperplasia (BPH) who have failed previous trials with finasteride, tamsulosin or non-selective alpha blockers. Please see Appendix P for more details.

Appendix P is posted on the Pharmacy Prior Authorization Policies web page.

Drug Utilization Review (DUR) Board Update

Next DUR Board Meeting:
Tuesday, February 21, 2012
6:30 P.M. - 9:00 P.M.
225 E. 16th Avenue
Denver, CO.
1st Floor Conference Room

February and March 2012 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 February and March 2012 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 to ensure there is space available.

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.

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.

February and March 2012 Specialty Workshop Class Descriptions

Dental

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

Dialysis
This class is for billers who bill for Dialysis services on the UB-04/837I and/or 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.

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

Waiver Programs

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

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

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

Outpatient Substance Abuse
This class is for billers using the Colorado 1500/837P claim format for outpatient substance abuse treatment services: substance abuse assessment, individual and family therapy, group therapy, alcohol/drug screening, case management and social/ambulatory detoxification. The class covers billing procedures, common billing issues and guidelines specifically for outpatient substance abuse 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.)*

Vision
This class is for ophthalmologists, optometrists, and opticians billing on the Colorado 1500/837P claim 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 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).

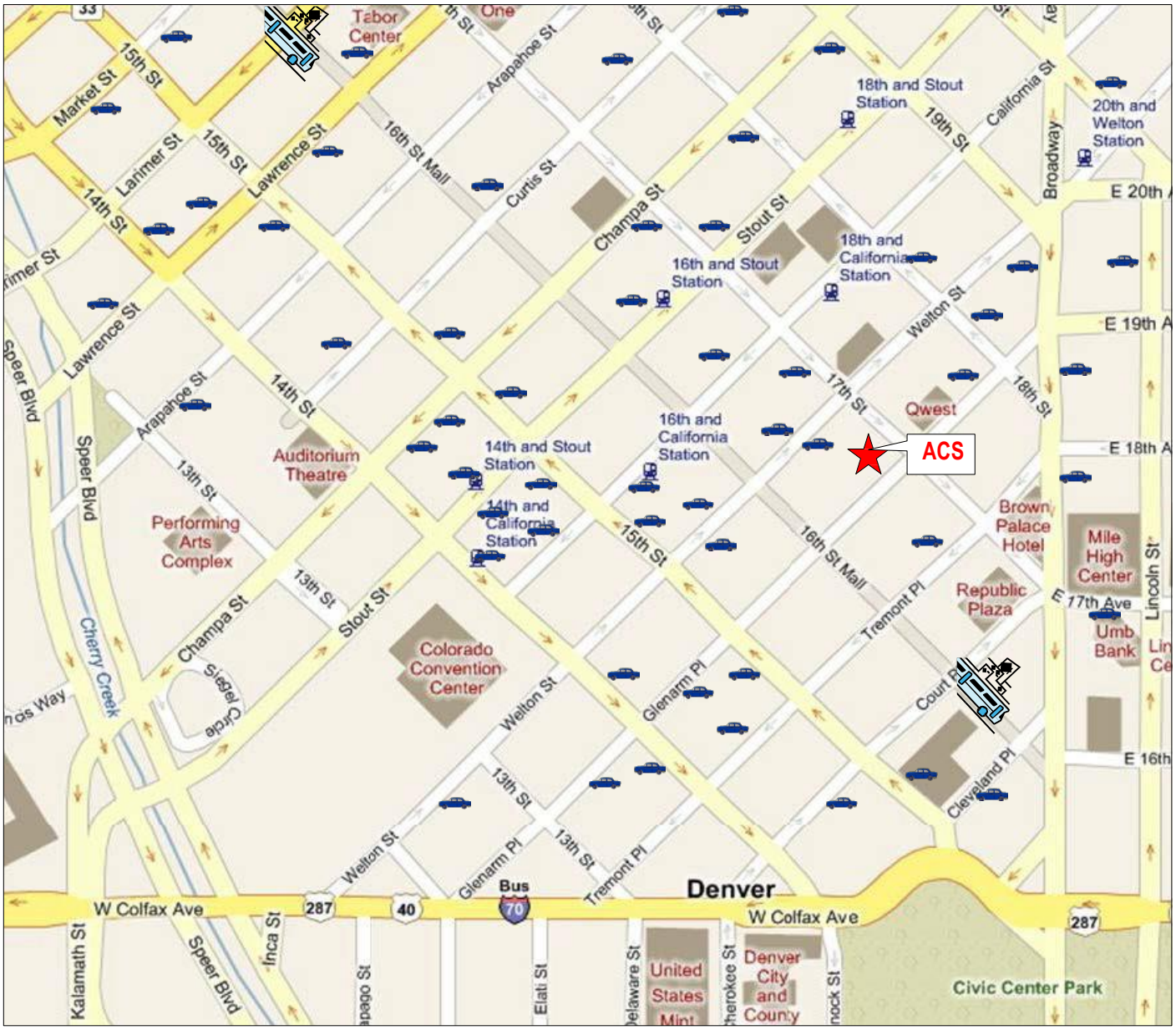
Parking is not provided by ACS and is limited in the downtown Denver area.

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.

February 2012

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			1	2	3	4
5	6	7 Beginning Billing – CO -1500 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM Substance Abuse 1:00 PM-3:00 PM	8 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	9 Supply/DME Billing 9:00 AM-11:00 AM Pharmacy 2:00 PM-3:00 PM Home Health 3:00PM-4:30 PM	10 WebEx - Beginning Billing – CO -15001500 9:00 AM-12:00 PM WebEx - FQHC/RHC 1:00 PM-4:00 PM	11
12	13	14	15	16	17	18
19	20 *Presidents' Day*	21	22	23	24	25
26	27	28	29			

March 2012

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				1	2	3
4	5	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 OT/PT/ST 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 IP/OP 1:00 PM-3:00 PM	15 Provider Enrollment - 9:00 AM--11:00 AM WebEx - Dental 1:00 PM-4:00 PM	16 Vision 9:00 AM-11:00 AM WebEx - Basic Billing for Waiver Providers 12:00 PM- 2:30 PM Web Portal 2:45 PM-3:30 PM	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

Please direct questions about Colorado Medical Assistance Program billing or the information in this bulletin to

ACS Provider Services at 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

HCBS Rates, Procedure Codes, Modifiers and Service Limitations

Effective **January 6, 2012**, the following Home and Community Based Services (HCBS) rates, procedure codes, modifiers and service limitations shall be implemented for each of the HCBS waivers identified below. A complete listing of all rates, procedure codes, modifiers and service limitations for the three HCBS waivers identified below may be found on the Colorado Department of Human Services Web site.

HCBS-Children's Extensive Support (HCBS-CES) Services Waiver						
Service Description	**Procedure Code**	**Modifiers**	**Support Level (Individual, Group)**	**Unit Designation**	**Unit Rate**	**Service Limitations**
Behavioral Services						
Lead Therapist	H2019	U7, TF, 22	Individual	15 Minutes	$29.34	Service is not available for new enrollments, at the time of any amendment to the current Service Plan or at the Continued Stay Review (CSR).
Senior Therapist	H2019	U7, TF	Individual	15 Minutes	$23.16	Service is not available for new enrollments, at the time of any amendment to the current Service Plan or at the CSR.
Plan Specialist	H2019	U7, 22	Individual	15 Minutes	$11.60	Service is not available for new enrollments, at the time of any amendment to the current Service Plan or at the CSR.

HCBS-Children's Extensive Support (HCBS-CES) Services Waiver						
Service Description	**Procedure Code**	**Modifiers**	**Support Level (Individual, Group)**	**Unit Designation**	**Unit Rate**	**Service Limitations**
Behavioral Line Services	H2019	U7	Individual	15 Minutes	$6.12	There is no limitation. The service definition has been clarified.
Behavioral Consultation	H2019	U7, 22, TG	Individual	15 Minutes	$23.00	
Behavioral Counseling	H2019	U7, TF, TG	Individual	15 Minutes	$23.00	
Behavioral Counseling	H2019	U7, TF, HQ	Group	15 Minutes	$7.75	

HCBS-Children's Extensive Support (HCBS-CES) Services Waiver						
Service Description	**Procedure Code**	**Modifiers**	**Support Level (Individual, Group)**	**Unit Designation**	**Unit Rate**	**Service Limitations**
Behavioral Plan Assessment	T2024	U7	Individual	DOLLAR	$1.00	For existing Service Plans, assessments may continue until any amendment to this service in a current Service Plan or at the CSR.

HCBS-Children's Extensive Support (HCBS-CES) Services Waiver						
Service Description	**Procedure Code**	**Modifiers**	**Support Level (Individual, Group)**	**Unit Designation**	**Unit Rate**	**Service Limitations**
Behavioral Plan Assessment	T2024	U7, 22	Individual	15 Minutes	$23.00	Maximum of 40 units may be authorized per Service Plan year. Applies for new enrollments, any amendment to a current Service Plan or at the CSR.

HCBS-Supported Living Services (HCBS-SLS) Waiver						
Service Description	**Procedure Code**	**Modifiers**	**Support Level (Individual, Group)**	**Unit Designation**	**Unit Rate**	**Service Limitations**
Behavioral Services						
Lead Therapist	H2019	U8, TF, 22	Individual	15 Minutes	$29.34	Service is not available for new enrollments, at the time of any amendment to the current Service Plan or at the Continued Stay Review (CSR).

HCBS-Children's Extensive Support (HCBS-CES) Services Waiver						
Service Description	**Procedure Code**	**Modifiers**	**Support Level (Individual, Group)**	**Unit Designation**	**Unit Rate**	**Service Limitations**
Senior Therapist	H2019	U8, TF	Individual	15 Minutes	$23.16	Service is not available for new enrollments, at the time of any amendment to the current Service Plan or at the CSR.
Plan Specialist	H2019	U8, 22	Individual	15 Minutes	$11.60	Service is not available for new enrollments, at the time of any amendment to the current Service Plan or at the CSR.

HCBS-Supported Living Services (HCBS-SLS) Waiver						
Service Description	**Procedure Code**	**Modifiers**	**Support Level (Individual, Group)**	**Unit Designation**	**Unit Rate**	**Service Limitations**
Behavioral Line Services	H2019	U8	Individual	15 Minutes	$6.12	Maximum of 960 units per Service Plan year. Applies for new enrollments, any amendment to this service in a current Service Plan or at the CSR.
Behavioral Consultation	H2019	U8, 22, TG	Individual	15 Minutes	$23.00	Maximum of 80 units per Service Plan year.
Behavioral Counseling	H2019	U8, TF, TG	Individual	15 Minutes	$23.00	Maximum of 208 units combined Individual and Group, per Service Plan year.
Behavioral Counseling	H2019	U8, TF, HQ	Group	15 Minutes	$7.75	Maximum of 208 units combined Individual and Group, per Service Plan year.

HCBS-Supported Living Services (HCBS-SLS) Waiver						
Service Description	**Procedure Code**	**Modifiers**	**Support Level (Individual, Group)**	**Unit Designation**	**Unit Rate**	**Service Limitations**
Behavioral Plan Assessment	T2024	U8	Individual	DOLLAR	$1.00	For existing Service Plans, assessments may continue until any amendment to this service in a current Service Plan or at the CSR.
Behavioral Plan Assessment	T2024	U8, 22	Individual	15 Minutes	$23.00	Maximum of 40 units may be authorized per Service Plan year. Applies for new enrollments, any amendment to a current Service Plan or at the CSR.
Prevocational Services						Maximum combined units of Specialized Habilitation, Supported Community Connections, Prevocational and Supported Employment is 7,112 units per plan year.

HCBS-Supported Living Services (HCBS-SLS) Waiver						
Service Description	**Procedure Code**	**Modifiers**	**Support Level (Individual, Group)**	**Unit Designation**	**Unit Rate**	**Service Limitations**
Prevocational Services	T2015	U8, HQ	Level 1	15 Minutes	$2.18	Maximum 7,112 units - See Above
Prevocational Services	T2015	U8, 22, HQ	Level 2	15 Minutes	$2.39	Maximum 7,112 units
Prevocational Services	T2015	U8, TF, HQ	Level 3	15 Minutes	$2.66	Maximum 7,112 units
Prevocational Services	T2015	U8, TF, 22, HQ	Level 4	15 Minutes	$3.13	Maximum 7,112 units
Prevocational Services	T2015	U8, TG, HQ	Level 5	15 Minutes	$3.88	Maximum 7,112 units

HCBS-Supported Living Services (HCBS-SLS) Waiver						
Service Description	**Procedure Code**	**Modifiers**	**Support Level (Individual, Group)**	**Unit Designation**	**Unit Rate**	**Service Limitations**
Prevocational Services	T2015	U8, TG, 22, HQ	Level 6	15 Minutes	$5.58	Maximum 7,112 units
Day Habilitation	T2021	All Modifiers	All Levels			See Limitation above under Prevocational
Supported Employment	T2019	All Modifiers	All Levels			See Limitation above under Prevocational
Dental Services						
Basic-Preventative	D2999	U8	Individual	DOLLAR	$1.00	$2,000 limitation without prior authorization from DDD. Diagnostic & Treatment are combined into a single billing service code.

HCBS-Supported Living Services (HCBS-SLS) Waiver						
Service Description	**Procedure Code**	**Modifiers**	**Support Level (Individual, Group)**	**Unit Designation**	**Unit Rate**	**Service Limitations**
Dental - Major	D2999	U8, 22	Individual	DOLLAR	$1.00	$10,000 limitation for major services for the life of the waiver period beginning July 1, 2009 through June 30, 2014.

Home and Community Based Services for Persons with Developmental Disabilities (HCBS-DD) Waiver						
Service Description	**Procedure Code**	**Modifiers**	**Support Level (Individual, Group)**	**Unit Designation**	**Unit Rate**	**Service Limitations**
Behavioral Services						
Lead Therapist	H2019	U3, TF, 22	Individual	15 Minutes	$29.34	Service is not available for new enrollments, at the time of any amendment to the current Service Plan or at the Continued Stay Review (CSR).
Senior Therapist	H2019	U3, TF	Individual	15 Minutes	$23.16	Service is not available for new enrollments, at the time of any amendment to the current Service Plan or at the CSR.
Plan Specialist	H2019	U3, 22	Individual	15 Minutes	$11.60	Service is not available for new enrollments, at the time of any amendment to the current Service Plan or at the CSR.

Home and Community Based Services for Persons with Developmental Disabilities (HCBS-DD) Waiver						
Service Description	**Procedure Code**	**Modifiers**	**Support Level (Individual, Group)**	**Unit Designation**	**Unit Rate**	**Service Limitations**
Behavioral Line Services	H2019	U3	Individual	15 Minutes	$6.12	Maximum of 960 units per Service Plan year. Applies for new enrollments, any amendment to this service in a current Service Plan or at the CSR.
Behavioral Consultation	H2019	U3, 22, TG	Individual	15 Minutes	$23.00	Maximum of 80 units per Service Plan year.

Home and Community Based Services for Persons with Developmental Disabilities (HCBS-DD) Waiver						
Service Description	**Procedure Code**	**Modifiers**	**Support Level (Individual, Group)**	**Unit Designation**	**Unit Rate**	**Service Limitations**
Behavioral Counseling	H2019	U3, TF, TG	Individual	15 Minutes	$23.00	Maximum of 208 units combined Individual and Group, per Service Plan year.
Behavioral Counseling	H2019	U3, TF, HQ	Group	15 Minutes	$7.75	Maximum of 208 units combined Individual and Group, per Service Plan year.

Home and Community Based Services for Persons with Developmental Disabilities (HCBS-DD) Waiver						
Service Description	**Procedure Code**	**Modifiers**	**Support Level (Individual, Group)**	**Unit Designation**	**Unit Rate**	**Service Limitations**
Behavioral Plan Assessment	T2024	U3	Individual	DOLLAR	$1.00	For existing Service Plans, assessments may continue until any amendment to this service in a current Service Plan or at the CSR.
Behavioral Plan Assessment	T2024	U3, 22	Individual	15 Minutes	$23.00	Maximum of 40 units may be authorized per Service Plan year. Applies for new enrollments, any amendment to a current Service Plan or at the CSR.
Prevocational Services						Maximum combined units of Specialized Habilitation, Supported Community Connections, Prevocational is 4,800 units per plan year.

Home and Community Based Services for Persons with Developmental Disabilities (HCBS-DD) Waiver						
Service Description	**Procedure Code**	**Modifiers**	**Support Level (Individual, Group)**	**Unit Designation**	**Unit Rate**	**Service Limitations**
Prevocational Services	T2015	U3, HQ	Level 1	15 Minutes	$2.18	Maximum 4,800 units - See Above

Home and Community Based Services for Persons with Developmental Disabilities (HCBS-DD) Waiver						
Service Description	**Procedure Code**	**Modifiers**	**Support Level (Individual, Group)**	**Unit Designation**	**Unit Rate**	**Service Limitations**
Prevocational Services	T2015	U3, 22, HQ	Level 2	15 Minutes	$2.39	Maximum 4,800 units - See Above.
Prevocational Services	T2015	U3, TF, HQ	Level 3	15 Minutes	$2.66	Maximum 4,800 units
Prevocational Services	T2015	U3, TF, 22, HQ	Level 4	15 Minutes	$3.13	Maximum 4,800 units
Prevocational Services	T2015	U3, TG, HQ	Level 5	15 Minutes	$3.88	Maximum 4,800 units
Prevocational Services	T2015	U3, TG, 22, HQ	Level 6	15 Minutes	$5.58	Maximum 4,800 units
Day Habilitation	T2021	All Modifiers	All Levels	15 Minutes		See Limitation above under Prevocational
Supported Employment	T2019	All Modifiers	All Levels	15 Minutes		The combined units of Day Habilitation, Prevocational, and Supported Employment cannot exceed 7,112 units.

Home and Community Based Services for Persons with Developmental Disabilities (HCBS-DD) Waiver						
Service Description	**Procedure Code**	**Modifiers**	**Support Level (Individual, Group)**	**Unit Designation**	**Unit Rate**	**Service Limitations**
Dental Services						
Basic-Preventative	D2999	U3	Individual	DOLLAR	$1.00	$2,000 limitation without prior authorization from DDD. Diagnostic & Treatment are combined into a single billing service code.
Major	D2999	U3, 22	Individual	DOLLAR	$1.00	$10,000 limitation for major services for the life of the waiver period beginning July 1, 2009 through June 30, 2014.