Provider Bulletin

Reference: B1200331 **December 2012**

colorado.gov/pacific/hcpf

In this issue:

Xerox State Healthcare
Denver Club Building
518 17th Street, 4th floor
Denver, CO 80202

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

ColoradoPAR Program PARs
www.coloradopar.com

Did you know...?

When a CHP+ client's eligibility is in question, a provider can contact Maximus' provider customer service call center at 1-877-311-4540 for resolution.

When a Medicaid client's eligibility is in question, providers should contact the client's county of residence for resolution.

All Providers

ColoradoPAR

Mandatory PAR Submission into CareWebQI (CWQI)

Due to the demonstrated success of the electronic PAR process, the Department of Health Care Policy and Financing (the Department) is moving towards exclusive use of the CWQI for PAR submissions (including revisions) to the ColoradoPAR Program. Effective March 4, 2013 all PARs and revisions processed by the ColoradoPAR Program must be submitted using CWQI. After April 1, 2013, PARs submitted via fax or mail will not be entered into CWQI and subsequently not reviewed for medical necessity. These PARs will be returned to providers via mail. This requirement only impacts PARs submitted to the ColoradoPAR Program. The electronic PAR format will be required unless an exception is granted by the ColoradoPAR Program. Exceptions may be granted for providers who submit five (5) or less PARs per month

The following PARs are currently processed by the ColoradoPAR Program:

- Audiology
- Diagnostic imaging– limited to non-emergency Computed Tomography (CT) Scans and Magnetic Resonance Imaging (MRI), and all Positron Emission Tomography (PET) Scans
- Durable Medical Equipment (DME)/Supply- All (including repairs)
- Dental
- Home Health – Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Extraordinary and Long Term Home Health for Children
- Medical/surgical services
- EBI Bone Stimulator
- Second surgical opinions
- Physical and occupational therapy services
- Transportation
- Out-of-state non-emergency surgical services
- Organ transplantation
- Orthodontia
- Private Duty Nursing
- Vision

Online PAR Processing with CWQI

The Department encourages use of the CWQI online portal to submit PARs to the ColoradoPAR Program. PARs submitted through this portal have faster processing times and allow for greater continuity of care.

Submitting PARs through the CWQI portal allows the medical review staff to view medical documentation quickly and provide decisions faster than if documents are sent by fax or mail. All PARs will continue to be processed in a timely manner, regardless of submission method.

Submitting Clinical Documentation via CWQI

Clinical information is imperative for prior authorization review. When submitting PARs, please answer the clinical questions in CWQI and attach the relevant clinical information needed for determinations. It is the responsibility of the provider to submit all relevant supporting documentation so that medical reviews can be completed in a timely fashion. Suggested documents include clients' histories and physical reviews, progress and office notes, lab results, and current medications. If clinical information is missing or inadequate, messages will be sent to the submitter via the CWQI message system. Please stay up to date on these messages in order to keep PARs moving through the process. Missing or inadequate clinical information will result in lack of information (LOI) denials. PAR submitters have 24 hours to respond to requests for more information before LOI denials are issued.

ColoradoPAR Program

When submitting PARs to CWQI, please submit all clinical documentation, including digital X-rays, in the following forms:

doc; docx; xls; xlsx; ppt; pdf; jpg; gif; bmp; tiff; tif; and jpeg.

If the clinical documentation cannot be submitted electronically, fax or mail to:

Mail: ColoradoPAR Program
2401 NW 23rd Street, Suite 2D
Oklahoma City, OK 73107

Fax: 1-866-492-3176

To request an exception or for more information, please contact the ColoradoPAR Program at 1-888-454-7686.

Message Section on CWQI

As noted above, ColoradoPAR uses a message section in CWQI to communicate with providers. When PAR submitters log in to CWQI, there may be messages that need to be reviewed. Please check the message section before calling for information. Once the submitter has logged into CWQI, there is help available on how to use the message section.

CWQI Training

The ColoradoPAR Program offers CWQI training via WebEx every Wednesday and Thursday at 1:00 p.m. Mountain Standard Time (MST). The ColoradoPAR Program also offers training to providers who would like on-site training. For on-site training, please contact the ColoradoPAR Program at RES_ColoradoPAR@apshealthcare.com.

For WebEx trainings, please be sure to log on prior to the scheduled time for online training and to make sure the correct software is available for viewing the presentation. If technical assistance is needed with using the WebEx, please call 1-866-863-3910 *OR* see https://www.webex.com/login/attend-a-meeting for more information.

For more information, including updated training materials and schedules, please visit coloradopar.com or call 1-888-454-7686.

Peer-to-Peer and Reconsideration Processes for PARs Submitted to the ColoradoPAR Program

If a denial for a PAR is issued, a reconsideration can be requested through either of the processes noted below.

The Peer-to-Peer Process to discuss denial determination occurs when:

- A request is made by the provider, within five (5) calendar days after a denial decision, for a verbal discussion with a ColoradoPAR physician to discuss that denial determination; or
- The provider submits additional clinical information for review within the first five (5) calendar days following a denial decision.

The Reconsideration Process is a second review by a non-ColoradoPAR physician that must be requested by the provider within ten (10) calendar days of the denial decision. The process proceeds as follows:

- Review is completed by a physician of the same profession and specialty as the requesting physician;
- Review will include all information submitted and any additional information the provider wishes to submit;
- The reviewing physician may overturn or uphold the original denial decision.

Note: The Peer-to-Peer Process does not need to be used prior to the Reconsideration Process. The Peer-to-Peer Process is *not* available for Dental and Orthodontic providers at this time.

Please contact ColoradoPAR Program at 1-888-454-7686 with any questions.

Second Phase Update of National Correct Coding Initiative (NCCI) Implementation

The Department will be providing more information on the background and updates regarding the NCCI edits during the next few months, as the full NCCI implementation date draws nearer. For more information regarding the first phase of NCCI implementation, please refer to the November 2012 Provider Bulletin (B1200330).

The purpose of NCCI edits is to prevent improper payments when incorrect code combinations and units of service are reported.

The NCCI consists of coding policies and edits. Providers report procedures and services performed on clients utilizing Healthcare Common Procedure Coding System (HCPCS) codes. These codes are submitted on claims to Xerox State Healthcare (the Department's fiscal agent) for payment. NCCI policies and edits identify procedures and services performed by the same provider and client on the same date of service. Providers have most likely already encountered the application of such methodologies to claims submitted for adjudication and payment by Medicare and private payers. The coding policies of NCCI are based on coding conventions defined in the American Medical Association's (AMA) Current Procedural Terminology (CPT) Manual, national and local Medicare policies and edits, coding guidelines developed by National societies, standard medical and surgical practice, and/or current coding practice.

NCCI Methodologies:

1. NCCI edits, or procedure-to-procedure (PTP) edits that define pairs of HCPCS/current CPT codes that should not be reported together for a variety of reasons; and
2. Medically Unlikely Edits (MUEs), or units-of-service edits that define for each HCPCS/CPT code the maximum allowable units (e.g., claims for excision of more than one gallbladder or more than one pancreas).

Medically Unlikely Edits (MUEs) were developed by the Centers for Medicare and Medicaid Services (CMS) to reduce the paid claims error rate for Medicare claims. The MUEs are not utilization guidelines; providers should continue to only report services that are medically reasonable and necessary.

The NCCI methodologies are made up of the following four (4) components:

1. A set of edits;
2. A definition of types of claims subject to the edits;
3. A set of claims adjudication rules for applying the edits; and
4. A set of rules for addressing provider/supplier appeals of denied payments for services based on the edits.

Currently there are six (6) methodologies for the Colorado Medical Assistance Program:

1. NCCI PTP edits for practitioners and Ambulatory Surgical Centers (ASCs) services.
2. NCCI PTP edits for outpatient (OP) hospital services reimbursed based on CPT codes.
3. NCCI PTP edits for DME claims.
4. MUE units-of-service edits for practitioner and ASC services.
5. MUE units-of-service edits for OP hospital services reimbursed on CPT codes.
6. MUE units-of-service edits for supplier claims for DME.

The use of these codes will be limited to providers who submit claims which are reimbursed based on the CPT codes. Managed Care Organizations (MCOs) and any other provider type who may bill by encounter and school districts that are reimbursed on their costs will be excluded from the above editing.

More information can be found on the National Correct Coding Initiative (NCCI) Web page located in the Provider Services section of the Department's Web site (colorado.gov/pacific/hcpf).

Colorado Medical Assistance Program Accepting 'Meaningful Use' Submissions from Health Care Providers Using Electronic Health Records (EHR)

Providers meeting eligibility criteria can qualify for a limited-time incentive payment to help offset the costs of adopting EHR.

Individual health care professionals, such as physicians, nurse practitioners, certified nurse-midwives, dentists, and physician assistants can qualify for up to $63,750 from the Department for the purchase and use of a certified EHR system. Hospitals can also qualify for incentives if they meet Meaningful Use program requirements.

More than 1,289 individual health care professionals and 50 hospitals have already successfully registered with the Department to participate in the program, and 390 health care professionals and 23 hospitals have received incentive payments in the amount of $25,296,821 to date.

Incentive payments are only available for a limited time, so providers are encouraged to start the process as soon as possible to ensure they benefit from the program. To be eligible for the program, providers must meet Meaningful Use program requirements, which include a demonstrated commitment to serving Colorado Medical Assistance Program clients. For more information, please refer to the Colorado Registration & Attestation System (CO R&A)—Provider Outreach Page.

Add-A-Baby Project

The Add-A-Baby project operated by the Department will conclude on December 31, 2012. This temporary project was implemented in October 2009 to offer providers an alternative means for getting newborns of Colorado Medical Assistance Program eligible mother's enrolled into Medicaid. In an effort to avoid duplication of efforts and increase processing times, the Department is requesting providers work directly with the County or Medical Assistance (MA) Site.

The Department will continue to accept and process **emergent** requests for newborns that are:

- in need of Synagis®
- on the border of being admitted to the Neonatal Intensive Care Unit (NICU)
- in a NICU and are older than six (6) months old and have no medical benefits
- and/or in need of **immediate** medical attention

Emergent requests should be submitted using the Medicaid Add-A-Baby Request form. The form is located on the Reporting the Birth of Medicaid or CHP Prenatal Baby Web page Web page of the Department's Web site. Please continue to use the Colorado Medical Assistance Program Web Portal (Web Portal) to verify a newborn's eligibility.

Send an email to add-a-baby@hcpf.state.co.us or contact Shawna Moreno at 303-866-4456 with any questions or concerns.

Colorado Medicaid and Child Health Plan *Plus* (CHP+) Income Eligibility Policy Changes for Pregnant Women

On January 1, 2013, there will be changes in Colorado Medicaid and CHP+ income eligibility for some pregnant women. This change will automatically move pregnant women from the CHP+ Prenatal Care Program to Colorado Medicaid if their income is less than 186% of the federal poverty level (FPL). Women with incomes greater than 185% FPL will remain in CHP+.

These changes will occur all at once on January 1, 2013, as mandated by CMS. All pregnant women in the CHP+ Prenatal Program were mailed a letter on November 9, 2012 noting the changes. The letter was sent to all CHP+ prenatal care members due to the inability of identifying those income levels between 133%-185% FPL. Statewide, there are an adequate number of Medicaid providers to accommodate this change.

When a CHP+ prenatal care member transitions to Medicaid on January 1, 2013, it is important they continue to receive their prenatal care from a provider who accepts Medicaid as these pregnant clients are now Medicaid clients and no longer CHP+ clients. The majority of CHP+ pregnant clients see providers who serve both CHP+ and Medicaid clients. However, there are some clients who see providers who do not serve both programs.

The Department has a provider recruitment team who will be working with these providers to become Medicaid providers. If the CHP+ provider cannot accept Medicaid clients, clients are advised to change to a Medicaid provider for the continuation of care.

A toll free number to assist clients with finding Medicaid providers and answer any questions was provided in the member letter. The toll free number is: Denver metro 303-839-2120 or toll free at 1-888-367-6557. Clients will not need to fill out any paperwork at the time of their Medicaid transition.

CHP+ providers interested in enrolling as Medicaid providers may contact the Department at 303-866-2101 or MedicaidProviders@state.co.us.

Tax Season and 1099s

The Provider Enrollment Update Form or the Electronic Provider Enrollment Update Form can be used to update addresses, National Provider Identifiers (NPIs), licenses, and affiliations. In addition, an email address may be added or updated to receive electronic notifications.

The form is available in Enrollment for Existing Providers in the Provider Services Enrollment section and under Update Forms in the Provider Services Forms section of the Department's Web site. With the exception of updating provider licenses and NPI information, the updates noted above may also be made through the Web Portal. For providers who do not have the capability to make updates through the Web Portal, submission of a Provider Enrollment Update form is necessary. All updates related to the provider license and NPI information must be made using the Provider Enrollment Update Form.

December 2012 and January 2013 Holidays

Christmas Day Holiday

The Christmas Day holiday on Tuesday, December 25, 2012 will delay the receipt of paper warrants by one or two days. State, ColoradoPAR Program and the Department's fiscal agent offices will be closed on Tuesday, December 25, 2012.

The Department's fiscal agent offices will close at 12:00 p.m. on Monday, December 24, 2012 and at 3:00 p.m. on Monday December 31, 2012.

New Year's Day Holiday

The New Year's Day holiday on Tuesday, January 1, 2013 will delay the receipt of paper warrants by one or two days. State, ColoradoPAR Program and the Department's fiscal agent offices will be closed on Tuesday, January 1, 2013.

Martin Luther King Day Holiday

Due to the Martin Luther King Day holiday on Monday, January 21, 2013, claim payments will be processed on Thursday, January 17, 2013. The processing cycle includes claims accepted before 6:00 p.m. MST on Thursday, January 17, 2013. The receipt of warrants and EFTs will be delayed by one or two days.

Although State and ColoradoPAR Program offices will be closed on Monday, January 21, 2013, the Department's fiscal agent office will be open during regular business hours.

Hospital Providers

Inpatient Hospital International Classification of Diseases Ninth Revision, Clinical Modification (ICD-9-CM) Crosswalk Update

The Department has identified two (2) errors in the crosswalk implementation and is promptly making the necessary fixes. The errors were identified after the mass adjustment of the claims affected by the crosswalk was completed. A very few number of claims were affected since only two (2) new codes were involved. The two (2) new codes and the respective old codes crosswalk are:

Incorrect Crosswalk

New Code	Description	Previous Code	Description
649.81	Onset (spontaneous) of labor after 37 completed weeks of gestation but before 39 completed weeks gestation, with delivery by (planned) cesarean section, delivered, with or without mention of antepartum condition.	654.2	Previous cesarean delivery

Incorrect Crosswalk

New Code	Description	Previous Code	Description
649.82	Onset (spontaneous) of labor after 37 completed weeks of gestation but before 39 completed weeks gestation, with delivery by (planned) cesarean section, delivered, with mention of postpartum complication.	654.2	Previous cesarean delivery

Correct Crosswalk

New Code	Description	Previous Code	Description
649.81	Onset (spontaneous) of labor after 37 completed weeks of gestation but before 39 completed weeks gestation, with delivery by (planned) cesarean section, delivered, with or without mention of antepartum condition.	654.21	Previous cesarean delivery, delivered, with or without mention of antepartum condition
649.82	Onset (spontaneous) of labor after 37 completed weeks of gestation but before 39 completed weeks gestation, with delivery by (planned) cesarean section, delivered, with mention of postpartum complication.	654.21	Previous cesarean delivery, delivered, with or without mention of antepartum condition

Additionally, the ICD-9-CM code 996.88 was not loaded in the Medicaid Management Information System (MMIS) which caused some claims to deny incorrectly. The MMIS will be corrected and the diagnosis code will be added.

As the necessary MMIS changes are completed, all claims affected by these issues will be mass adjusted. Please refer to the November 2012 Provider Bulletin (B1200330) for more information regarding the crosswalk. A corrected copy of the crosswalk table is located on the Department's Web site in the Provider Services DRG Relative Weights section. Questions or concerns can be directed to Dana Batey at Dana.Batey@state.co.us or 303-866-3852.

Billing 340B Drugs for OP Hospitals

Billing requirements for hospital providers participating in the 340B drug purchasing program are as follows. The Department's reimbursement methodology for OP hospital services is based primarily on a percent of submitted charges until a cost settlement process is later completed. A hospital that is a 340B covered entity dispensing 340B drugs to Medicaid clients must bill the Colorado Medical Assistance Program at regular charge amounts. In the OP hospital setting specifically, the Department is not requiring that 340B drugs be billed at acquisition cost at this time.

Previous federal guidance may be found in the Federal Register, Vol. 65, No. 51 (March 14, 2000). In the regulation, Health Resources and Services Administration (HRSA) recommends that covered entities consult their respective state Medicaid agency for billing guidance. Please refer to the HRSA Web site for a list of releases.

Hospitals participating in the 340B drug purchasing program with open cost settlement years should contact Jeremy Tipton at Jeremy.Tipton@state.co.us or 303-866-5466 with questions.
If a hospital bills the Colorado Medical Assistance Program for 340B drugs, the hospital must be on the HRSA Medicaid Exclusion file.

Please refer to the HRSA Web site for details on how to be included in this file.

This notification only applies to OP hospitals billing for pharmacy drugs on the UB-04 paper claim form or when submitting via 837 Institutional (837I) electronic transactions. Pharmacy rules still apply when billing for fee-for-service pharmacy claims from the OP pharmacy. Please contact Jim Leonard at Jim.Leonard@state.co.us with questions.

Updates to Outpatient Cost-to-Charge Ratios

The Department is in the process of updating all hospitals' outpatient cost-to-charge ratios. Outpatient laboratory, occupational therapy, physical therapy, and hospital-based transportation claims are reimbursed based on the Colorado Medical Assistance Program fee schedule located at the bottom of the Provider Services home page. Outpatient hospital services are reimbursed on an interim basis at actual billed charges multiplied by 1) the most recent Medicare cost-to-charge ratio that has been sent to the Department, and 2) 68.8 percent (%).

The Department conducts a periodic cost audit and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 68.8% or billed charges less 68.8%.

It is the hospital's responsibility to notify the Department of changes to their Medicare outpatient cost-to-charge ratio. **All hospital cost-to-charge ratios will be updated with a January 1, 2013 effective date.**

If the hospital fails to provide the Department with this information by December 15, 2012, the Department may institute a default reduction in the hospital's cost-to-charge ratio. Please contact Marguerite Richardson at Marguerite.Richardson@state.co.us or 303-866-3839 with questions about this process or to submit the Medicare outpatient cost-to-charge ratios. Faxes may also be sent to 303-866-4411.

Home Health Providers

Benefit Coverage Standard

The Department will be publishing a written Home Health Services Benefit Coverage Standard to clarify the covered Home Health services that will be effective January 1, 2013.

The benefit coverage standard clarifies which services are covered by the Colorado Medical Assistance Program and when clients are eligible to receive these covered services. The Home Health Services Benefit Coverage Standard was approved in October 2012 by the Department's Medicaid Director. The Medical Services Board (MSB) approved the benefits coverage standard on November 9, 2012, to be incorporated by reference into rule. The rule was developed with the participation of many stakeholders, clients and families, advocates, providers, and other state agencies through the Department's Benefits Collaborative process.

To view these policies, once effective, please visit the Boards & Committees→ Benefits Collaborative→ Approved Benefit Coverage Standards section of the Department's Web site.

Please contact Guinevere Blodgett at Guinevere.Blodgett@state.co.us or 303-866-5927 with any questions.

Practitioners

Affordable Care Act (ACA) Payment to Primary Care Providers (PCPs) Rate Increase

On November 1, 2012, CMS released final regulations governing the implementation of the Medicaid primary care rate increase that was enacted as part of ACA. Higher payment is limited to the defined qualified physicians and advanced practice professionals practicing under the personal supervision of a qualified physician. To qualify for higher payment, physicians must self-attest as having a specialty in family medicine, general internal medicine, and/or pediatric medicine. The final rule indicates that any subspecialists related to these general specialties and recognized by the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), or the American Board of Physician Specialties (ABPS) may also qualify for the increase. The determination of being qualified in a specialty will be by appropriate Board certification or 60 percent (%) of their Medicaid claims that are for evaluation and management (E&M) and vaccine administration codes. Advanced practice professionals must self-attest that they provide services under the personal supervision of a qualified physician who has self-attested to a primary care specialty. Services eligible for the payment increase include evaluation and management procedures between 99201- 99499, and vaccine administration.

The Department is creating a process for physicians and advanced practice professionals to self-attest to a qualified specialty. Details on the self-attestation will be published when available; the Department anticipates having this information finalized by the end of the 2012 calendar year.

The Department will make supplemental payments to qualified providers as is allowed under the final regulations. The current plan is to reimburse by supplemental payments on a quarterly basis. The supplemental payments will begin in calendar year 2013 and cover services provided between January 1, 2013, and December 31, 2014. The Department will be providing regular updates regarding how to self-attest and finalized details of payment in future publications.

The final regulations were published in the Federal Register on Tuesday, November 6, 2012. For more information, contact Richard Delaney at Richard.Delaney@state.co.us or 303-866-3436.

Prenatal Plus Program

Seeking New Prenatal Plus Program Providers across Colorado

The Department is seeking additional Prenatal Plus Program providers to serve eligible clients in Colorado. The Prenatal Plus Program provides pregnant women at risk of negative maternal or infant health outcomes, including delivering a low birth weight or premature baby, access to services designed to enhance traditional prenatal care. Services include nutrition and psychosocial counseling, support, general client education, and targeted case management.

Prenatal Plus clients receive care from a team composed of a care coordinator, registered dietician, and a mental health professional. More information can be found on the Prenatal Plus Program Web page.

If interested in the process of how to become a Prenatal Plus Program provider, contact Kirstin Michel at Kirstin.Michel@state.co.us or 303-866-2844.

Tobacco Cessation Counseling Benefit for Pregnant Women

Effective since January 2012, tobacco cessation counseling for pregnant women and women in the early postpartum period (up to 60 days postpartum) is covered with certain limitations. Reimbursement for a limited number of units is available when the counseling is face-to-face and consistent with the counseling practices described in the U.S. Public Health Service publication, *Treating Tobacco Use and Dependence (2008 Update): A Clinical Practice Guideline*.

Coding Requirements:

CPT Codes and Modifiers	Description	Reimbursement	Max Units per Client per Year
99406 + **HD*** (individual session)	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	$10.12	5**
99407 + **HD** (individual session)	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	$19.67	3** (combined, indiv and/or group)
99407 + **HD + HQ** (group session)		$9.84	

* All claims must be submitted with the CPT codes *and* modifier(s) as listed above. Any claim for tobacco cessation counseling submitted without the appropriate modifier(s) will be denied.
**The unit limits above apply to each client per fiscal year (July 1 – June 30), not per provider. Delivery of this service should be coordinated among clinical prenatal care providers, maternity support service providers, and others.

One of the two following **diagnosis codes** must be used on the claim in addition to the **modifiers above**:

649.03	Tobacco use disorder complicating pregnancy, childbirth, or the puerperium; antepartum condition
649.04	Tobacco use disorder complicating pregnancy, childbirth, or the puerperium; postpartum condition

Provider Requirements:

Allowable **rendering provider types** include those listed below in addition to other providers acting under the supervision of one of these provider types.

Physician	Osteopath	Nurse Practitioner
Certified Nurse-Midwife	Physician Assistant	Registered Nurse

Provider Training:
All providers are required to complete a tobacco cessation counseling training course in order to deliver tobacco cessation counseling to pregnant women. This training requirement applies to both the practitioner who is furnishing the service directly, and the provider who is supervising others who are furnishing the service.

Upon request, health care professionals who provided and/or supervised the service must be able to show a certificate of completion of an approved prenatal-specific tobacco use cessation counseling training course dated prior to the date of service on the claim; recovery of reimbursements will be made from audited providers unable to provide proof of completion of an approved training.

At this time, approved trainings include:

- Marshall University – "Help Your Pregnant Patients Stop Smoking – A Web-Based CME Course"
- Dartmouth Medical School – "Smoking Cessation for Pregnancy and Beyond"
- American College of Obstetrics and Gynecology – "Smoking Cessation during Pregnancy"
- Colorado Department of Public Health and Environment (CDPHE) – "Tools to Help Pregnant Women Quit Smoking" (To request a certificate of completion from CDPHE, fill out an online request.)

Reminder: All Medicaid services provided to pregnant women and women in the postpartum period are copayment-exempt. Please remember to mark the pregnancy indicator on submitted claims.

Additional Information and Resources:

- Tobacco cessation prescription medications and other tobacco cessation products are available to Medicaid clients, including pregnant and postpartum women, with prior authorization. Visit the Pharmacy Tobacco Cessation Assistance Web page for information on prior authorization and referrals.
- Please visit the Department's Tobacco-Free Living Healthy Living Initiatives Web page for additional tobacco cessation information and a provider toolkit.
- Visit the Maternal Wellness – Smoking Cessation Web page of the CDPHE for a wealth of information on tobacco cessation during pregnancy.
- All Medicaid clients who smoke can be referred to the Colorado QuitLine at 1-800-QUIT-NOW. Free Prenatal Tobacco Cessation QuitLine materials are available.

Please contact Kirstin Michel at Kirstin.Michel@state.co.us or 303-866-2844 with any questions or concerns.

Immunizations

CPT Codes 90471 and 90473
As stated in the AMA CPT Manual under each code description, vaccine administration codes 90471 and 90473 cannot be billed together.

- 90471: immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one (1) vaccine (single or combination vaccine/toxid).
- 90473: immunization administration by intranasal or oral route; one (1) vaccine (single or combination vaccine/toxoid).

Note: for each additional vaccine, use 90472 or 90474 in conjunction with 90471 or 90473. Please see the CPT code descriptions in the AMA CPT Manual for more information.

CPT codes 90471 and 90473 are part of the vaccine administration code set 90471-90474, and must only be billed for adults (ages 19 and over) or children ages 0-18 for whom no counseling was given. For more information, please see the Immunization Benefit Billing Manual.

Providers billing codes 90471 and 90473 together will be doing so inappropriately, and may be subject to review by the Department's Program Integrity Section.

Please contact Amanda Belles at Amanda.Belles@state.co.us or 303-866-2830 with questions.

Changes for Colorado Medicaid clients aged 19 and 20
Effective **January 1, 2013**, immunizations for Colorado Medicaid clients aged 19 and 20 will no longer be provided through CDPHE's Colorado Immunization Program (CIP).
Immunizations for clients aged 19 and older (instead of aged 21 and older) will be a Colorado Medicaid benefit when recommended by the Centers for Disease Control's (CDC) Advisory Committee on Immunization

Practices (ACIP). The ACIP recommended vaccines, for Colorado Medicaid clients aged 0-18, is still covered and provided by the Vaccines for Children (VFC) Program.

In order to receive reimbursement for an immunization rendered to a client aged 19 and/or 20:

- The immunization must be appropriate for clients aged 19 and/or 20, as defined by the ACIP and as specified in Attachment A of this bulletin.
- Submission of claims for rendered immunizations must follow the appropriate billing process for clients aged 19 and older. For more information on appropriate billing practice, please refer to the Immunization Benefit Billing Manual (immunization coding as defined in Attachment A will be updated in the Immunization Benefit Billing Manual beginning January 1, 2013). **Note:** this is the same billing process previously used (prior to January 1, 2013) when billing for clients aged 21 and older.

Please refer to Attachment A of this bulletin for the Immunization Coding Quick Reference guide.

Please contact Amanda Belles at 303-866-2830 or Amanda.Belles@state.co.us with questions.

Pharmacy

Pharmacy and Therapeutics (P&T) Board Meeting

Tuesday, January 8, 2013
1:00 p.m. - 5:00 p.m.
225 E. 16th Avenue
Denver, CO 80203
1st Floor Conference Room

P&T Committee Open Positions Beginning in 2013

The Department stopped accepting curriculum vitaes (CV) submissions in November 2012 for the open positions. These positions will serve a two (2) year term from January 2013 - December 2014 and will be announced in the coming weeks.

Preferred Drug List (PDL) Update

As of October 1, 2012, the following were effective as preferred agents on the Medicaid PDL and are covered without a prior authorization (PA) unless otherwise indicated:

***Pancreatic Enzymes**: Creon and Zenpep
Antiplatelets: Aggrenox, Effient, Plavix, clopidogrel, ticlopidine
Targeted Immune Modulators for RA (self-administered): Humira and Enbrel
Antidepressants: buproprion IR, SR and XL, citalopram, fluoxetine, fluvoxamine, mirtazipine, nefazodone, paroxetine, sertraline, venlafaxine IR and ER tabs, venlafaxine XR capsules, Effexor IR and XR
PDE-5 Inhibitors: Revatio and Adcirca
Endothelin Antagonists: Letairis
Prostanoids: epoprostenol and Veletri
Antiemetics: ondansetron tablets, ondansetron ODT tablets, ondansetron suspension (for clients under six (6) years old), Zofran tablets
***PPIs:** Aciphex, lansoprazole 15mg OTC, Nexium (capsules and packets), omeprazole generic capsules, Prevacid solutabs (for clients under six (6) years)
***Triptans and Combinations:** Imitrex (tablets, nasal spray and injection), sumatriptan tablets, Maxalt MLT, naratriptan tablets

*Indicates that a class has been changed from the previous PDL.

The complete PDL and PA criteria for non-preferred drugs are located on the PDL Web page.

Coordination of Benefits (COB) Manager

Coordination of Benefits (COB) Manager has a planned implementation date of December 1, 2012. More information is available on the Pharmacy Web page as well as an educational presentation. Please feel free to call 1-855-438-6420 with questions.

Indian Health Services (IHS) Pharmacies

Effective January 1, 2013, the Prescription Drug Card System (PDCS) will move to an encounter based reimbursement for claims submitted from IHS pharmacies.

The Department is currently creating training materials that will be available for IHS pharmacy staff. Details and training materials are located on the Department's Pharmacy Benefit Web page. Jim Leonard at Jim.Leonard@state.co.us can be contacted with questions.

Medicare Part D

Due to Federal updates to Medicare Part D coverage, the Colorado Medicaid pharmacy benefit will soon be changing coverage for clients eligible for both Medicare and Medicaid. Currently, both benzodiazepines and barbiturates have been covered through the Medicaid pharmacy benefit for Medicare-Medicaid enrollees (formally known as "dual eligible clients"). Beginning January 1, 2013, benzodiazepines will no longer be covered for clients eligible for Medicare. Barbiturates will require prior authorization for all clients, and will only be covered by Medicaid for select indications. For more information and updates, please see Appendix P located in the Pharmacy section of the Department's Web site.

2012-2013 Synagis® Season

The 2012-2013 Synagis® season began November 15, 2012 and will end March 31, 2013. All Pharmacy PARs for Synagis® must be submitted by contacting the Pharmacy Clinical Call Center or by using the Synagis® Pharmacy Benefit Prior Authorization Request Form. The call center can be contacted 24 hours/7 days a week at 1-800-365-4944. There is a separate process for Medical prior authorization submissions. For additional information, please refer to the October 2012 Synagis® and Influenza Vaccines Provider Bulletin (B1200329).

Note: For a technical pharmacy denial such as incorrect Date of Birth (DOB) or invalid client ID, please correct the error and resubmit through the Pharmacy Benefits Management System (PBMS).

Enhanced Prior Authorization System (SMART PA)

The Department plans to implement several new SMART PA rules in the coming months. A brief description of the rule and the proposed implementation dates will be listed in later provider bulletins.

On December 8, 2012, the Department plans to implement a new SMART PA rule, concerning the Newer Diabetic Agents on the PDL. This will be an enforcement of the rule below:

- Approval for preferred products require a three (3) month trial of (or documented contraindication to) metformin therapy prior to initiation of therapy.

For details and training materials, please see the Department's Pharmacy Web page.

December 2012 and January 2013 Provider Workshops

Provider Billing Workshop Sessions and Descriptions

Provider billing workshops include both Colorado Medical Assistance Program billing instructions and a review of current billing procedures.

The current and following month's workshop calendars are included in this bulletin.

Class descriptions and workshop calendars are posted in the Provider Services Training section of the Department's Web site.

Who Should Attend?

Courses are intended to teach, improve and enhance knowledge of Colorado Medical Assistance Program claim submission. Staff who submit claims, are new to billing Medicaid services, need a billing refresher course, or administer accounts should consider attending one or more of the Provider Billing Workshops listed below.

December 2012

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
9	10	11 Beginning Billing – CO -1500 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM Practitioner 1:00 PM-3:00 PM	12 Beginning Billing – UB-04 9:00 AM-11:30 AM Web Portal 837I 11:45 AM-12:30 P IP/OP Hospital 1:00 PM-3:00 PM	13 Provider Enrollment 9:00 AM-11:00 AM	14 *WebEx - Basic Billing for Waiver Providers 9:00 AM-11:30 AM Web Portal 11:45 AM-12:30 PM	15

January 2013

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
6	7	8 Beginning Billing – CO -1500 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM Audiology 1:00 PM-3:00 PM	9 Beginning Billing – UB-04 9:00 AM-11:30 AM Web Portal 837I 11:45 AM-12:30 P Hospice 1:00 PM-3:00 PM	10 *WebEx - Practitioner 9:00 AM-11:00 AM *WebEx - Dental 1:00 PM-3:00 PM Web Portal 3:15 PM-4:00 PM	11 *WebEx – Beginning Billing – CO -1500 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM	12

Reservations are required for all workshops

Email reservations to: **workshop.reservations@xerox.com**

Or Call the Reservation hotline to make reservations: 1-800-237-0757 or 1-800-237-0044 Extension 5

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 e-mail within one week of making your reservation.

Reservations will only be accepted until 5 p.m. the Friday prior to the training workshop to ensure there is adequate space available.

If you have not received a confirmation 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:

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

***Please note:** *For WebEx training a meeting notification containing the Web site, phone number, meeting number and password will be emailed or mailed to providers who sign up.*

The fiscal agent's office 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 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 direct questions about Colorado Medical Assistance Program billing or the information in this bulletin to

Xerox State Healthcare 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

Attachment A

Immunization Coding Quick Reference
Practitioners billing for immunizations provided to Colorado Medicaid enrolled children, age 18 and under when vaccine is available at no-cost through the VFC Program, are paid only an administration fee for each immunization using CPT codes 90460 and 90471 – 90474. The immunization administration add-on code for each additional vaccine component in a given vaccine, 90461, is paid an administration fee of zero (0). Medically necessary vaccines for clients age 20 that are not available through the VFC Program are reimbursed at the lower of billed charges or Medicaid fee schedule for each immunization. Reimbursement is subject to change. Please refer to the bottom of the Provider Services home page on the Department's Web site for the current fee schedule.

Key

Ig – immune globulin	INJ – jet injection	SQ – subcutaneous
IM – intramuscular	IV – intravenous	vacc – vaccine

Code	Description	Valid Ages	Maximum Allowable Reimbursement	VFC Program Benefit
Immune Globulins				
90281	Human Ig, IM	All ages	$14.74	
90283	Human Ig, IV	All ages	$258.11	
90284	Human Ig, SQ	All ages	$581.13	
90287	Botulinum antitoxin, equine	All ages	$193.13	
90288	Botulism Ig, IV	All ages	$453.57	
90291	CMV Ig, IV	All ages	$360.04	
90296	Diphtheria antitoxin, equine	All ages	$40.65	
90371	Hep B Ig, IM	All ages	$165.56	
90375	Rabies Ig, IM/SQ	All ages	$95.24	
90376	Rabies Ig, heat-treated, IM/SQ	All ages	$94.22	
90378	RSV Ig, IM, 50mg (Synagis®)	0-3	$1,271.42	
90384	Rh Ig, full-dose, IM	All ages	$113.42	
90385	Rh Ig, mini-dose, IM	All ages	$51.62	
90386	Rh Ig, IV	All ages	$129.22	
90389	Tetanus Ig, IM	All ages	$112.01	
90393	Vaccinia Ig, IM	All ages	$114.21	
90396	Varicella-zoster Ig, IM	All ages	$108.49	
90399	Unlisted immune globulin	All ages	$56.14	

Code	Description	Valid Ages	Maximum Allowable Reimbursement	VFC Program Benefit
Vaccines, Toxoids				
90476	Adenovirus vacc, type 4, oral	All Ages	$34.39	
90477	Adenovirus vacc, type 7, oral	All ages	$34.39	

Code	Description	Valid Ages	Maximum Allowable Reimbursement	VFC Program Benefit
90632	Hep A vacc, adult, IM	19+	$77.65	
90633	Hep A vacc, ped/adol, 2 dose, IM	0-18	$0	√
90636	Hep A & Hep B vacc adult, IM	18+	$104.03	
90645	Hib vacc HbOC, 4 dose, IM	0-4	$0	√
90647	Hib vacc, PRP-OMP, 3 dose, IM	0-4	$0	√
90648	Hib-PRP-T	2 months-5 years	$0	√
90649	HPV vacc types 6,11,16,18 quadrivalent 3 dose, IM	9-18	$0	√
		19-26	$156.82	
90650	HPV vacc types 16, 18 bivalent 3 dose, IM	19-26	$156.82	
90654	Influenza virus vaccine, split virus, preservative free, for intradermal use	All ages	$18.38	TBD
90655	Flu vacc, 6-35 mo, preserv free, IM	0-2	$0	√
90656	Flu vacc, 3 yrs +, preserv free, IM	3-18	$0	√
		19+	$17.44	
90657	Flu vacc, 6-35 mo, IM	0-2	$0	√
90658	Flu vacc, 3 yrs +, IM	3-18	$0	√
		19+	$13.74	
90660	Flu vacc, live, intranasal	2-18	$0	√
		19-20	$20.58	
90669	Pneum conj vacc, polyval, < 5 yrs, IM	0-4	$0	√
90670	Pneumococcal Conj Vacc, 13 Valent, IM	0-5	$0	√
90675	Rabies vacc, IM	All ages	$189.33	
90680	Rotavirus vacc, pentavalent, oral	0-1	$0	√
90681	Rotavirus vacc, attenuated, oral	0-1	$0	√
90696	D Tap-IPV vacc, IM	4-6	$0	√
90698	DTaP – Hib – IPV vacc, IM	0-4	$0	√
90700	DTaP vacc, < 7 yrs, IM	0-6	$0	√
90702	DT vacc, < 7 yrs, IM	0-6	$0	√
90703	Tetanus vacc, IM	All ages	$51.84	
90704	Mumps vacc, SQ	All ages	$29.34	
90705	Measles vacc, SQ	All ages	$23.10	
90706	Rubella vacc, SQ	All ages	$25.51	
90707	MMR vacc, SQ	0-18	$0	√
		19+	$52.37	

Code	Description	Valid Ages	Maximum Allowable Reimbursement	VFC Program Benefit
90708	Measles-rubella vacc, SQ	All ages	$28.01	

Code	Description	Valid Ages	Maximum Allowable Reimbursement	VFC Program Benefit
90710	MMRV vacc, SQ	1-12	$0	√
90713	Poliovirus vacc, IPV, SQ, IM	0-18	$0	√
		19+	$62.55	
90714	Td vacc, 7 yrs +, preserv free, IM	7-18	$0	√
		19+	$50.53	
90715	Tdap vacc, 7 yrs +, IM	7-18	$0	√
		19+	$95.35	
90716	Varicella (chicken pox) vacc, SQ	0-18	$0	√
		19+	$100.46	
90718	Td vacc, 7 yrs +, IM	7-18	$0	√
		19+	$28.24	
90719	Diphtheria vacc, IM	All ages	$10.25	
90721	DTaP/Hib vacc, IM	0-6	$0	√
90723	DTaP-Hep B-IPV vacc, IM	0-6	$0	√
90732	Pneum polysacc vacc, 23 valent, adult or ill pat, SQ/IM	2+	$74.83	
90733	Meningococcal polysacc vacc, SQ	All ages	$116.22	
90734	Meningococcal conj vacc, serogrp A, C, Y, W-135, IM	10-18	$0	√
		19-25	$107.75	
90735	Encephalitis vacc, SQ	All ages	$114.31	
90736	Zoster vacc, SQ	Code 90736 is not a benefit at this time		
90740	Hep B vacc, ill pat, 3 dose, IM	0-18	$0	√
		19-20	$116.38	
90743	Hep B vacc, adol, 2 dose, IM	11-15	$0	√
90744	Hep B vacc, ped/adol, 3 dose, IM	0-18	$0	√
90746	Hep B vacc, adult, IM	18	$0	
		19+	$71.37	
90747	Hep B vacc, ill pat, 4 dose, IM	0-18	$0	√
		19+	$71.37	
90749	Unlisted vaccine/toxoid	All ages	Manually priced	
S0195	Pneum conj, polyvalent, IM, 5-9 yrs with no previous dose	5-9	$0	√