Provider Bulletin

Reference: B1400350 **April 2014**

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

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...?
Due to the NCCI implementation, electronically submitted claims are first processed by Verisk. Batch files are processed every hour, while claims submitted through the Colorado Medical Assistance Web Portal (Web Portal) are adjudicated once a day. To ensure claims are processed for the current payment cycle, submit claims as early as possible.

All Providers

ColoradoPAR Program

Prior Authorization Request (PAR) Reminders

PAR Revisions

A PAR revision is a request to change something on a current approved PAR. For example, requesting additional days, visits, units, etc., are reasons to request a revision. It is important to note that when entering a PAR revision request, "yes" should be selected in the dropdown on the Episode Edit screen for "revision" **only** if the request is truly a revision in CareWebQI (CWQI). "No" should be selected only if the request is **not** a revision. Doing so will allow the ColoradoPAR Program to process the requested revision in a correct and timely fashion.

Note:

- Revisions for procedure codes and/or unit additions cannot be processed once a PAR has expired.
- Physical Therapy/Occupational Therapy (PT/OT) PARs require either the "GP" or "GO" modifier.

Subscribe to Email Updates
ColoradoPAR Program

Expedited (Urgent) PARs

- Choose an "Expedited PAR" if a delay could:
  1. Seriously jeopardize the life or health of the client or the ability of the client to regain maximum function, or
  2. Subject the client to severe pain that cannot be adequately managed without the care or treatment requested in the PAR, per the opinion of a physician with knowledge of the client's medical condition.
- An "Approved" expedited review does not guarantee payment of claims and a PAR number is not generated immediately, as it is a review for medical necessity only.
- PAR numbers for expedited reviews will be processed as normal.

PAR Denial Options

If a denial for a PAR is issued, a reconsideration may be requested through either of the following processes:

Peer-to-Peer:

- 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 the denial determination; or
- The provider submits additional clinical information for review within the first five (5) calendar days following a denial decision.

Reconsideration:

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 utilized prior to the Reconsideration Process.

PAR Clinical Information and Indications

Attaching the correct clinical information and office notes at the time of the PAR creation will result in a more timely approval. The PAR review is delayed when the ColoradoPAR Program staff is required to obtain additional information from providers. This delay can ultimately cause a PAR denial for Lack Of Information (LOI). An LOI may affect the care and services provided to clients and require additional time if reconsiderations or resubmissions of PARs are needed.

Providers should check all clinical indications that apply to required PARs as this can often allow PARs to auto-authorize immediately. If there is no clinical documentation attached or clinical indicators selected, the PAR may not be processed in a timely manner.

To determine if a service or supply item requires a PAR through the ColoradoPAR Program, refer to the Department's Appendix M- Procedures Requiring Prior Authorization or Fee Schedule.

Additional information regarding PARs may be found on the Department's website (colorado.gov/hcpf) within the Billing Manuals.

Please contact the ColoradoPAR Program at 1-888-454-7686 with questions. For technical issues with CWQI such as error messages, account changes, or password resets, choose Option 1. For PAR questions choose Option 4.

Important Changes to Certain Social Security Administration (SSA) Services

Effective August 1, 2014, the SSA will discontinue providing Social Security number printouts. If a provider or client needs proof of their Social Security number and does not have their Social Security Card, they will need to request a replacement.

Effective October 1, 2014, the SSA will stop providing benefit verification letters in their office. When this change becomes effective, those needing benefit verification letters will need to request the letters through the Social Security website or via the Social Security's toll-free number at 1-800-772-1213.

For more information about how to get replacement Social Security cards after August 1, 2014, and how to obtain benefit verification letters after October 1, 2014, providers should refer to the Social Security Administration Publication No. 05-10544. Note: The document is available in both English and Spanish.

1099s Returned to the Department

1099s mailed on or before January 31, 2014

If 1099s are returned to the Department due to an incorrect address, the provider's Medicaid ID is put on hold and payments are withheld until an updated W-9 is received. The W-9 must be signed, dated within the last 30 days, and contain the correct address. Please include the eight (8) digit Medicaid provider ID number on the document for identification. If expecting a 1099, and it is not received, please email a W-9 to hcpfar@hcpf.state.co.us or call 303-866-4090.

Memorial Day Holiday

Due to the Memorial Day holiday on Monday, May 26, 2014, claim payments will be processed on Thursday, May 22, 2014. The processing cycle includes claims accepted by Thursday before 6:00 p.m. Mountain Time (MT). The receipt of warrants may be delayed by one (1) or two (2) days. The State, the Department's fiscal agent (Xerox State Healthcare), and the ColoradoPAR Program offices will all be closed on Monday, May 26, 2014. All offices will re-open for business on Tuesday, May 27, 2014.

Ambulatory Surgery Center (ASC) and Dialysis Center Providers

Ambulatory Surgery Center (ASC) and Dialysis Center Rates Effective July 1, 2013

On March 6, 2014, the Department received approval from the Centers for Medicare & Medicaid Services (CMS) for the ASC and Dialysis Center rate increase effective July 1, 2013.

Currently, the Department is in the process of updating the Medicaid Management Information System (MMIS) with the new rates. A mass adjustment of ASC and Dialysis Center claims will be reprocessed for proper reimbursement using the new July 1, 2013 rates and will appear on future Provider Claim Reports (PCRs).

The ASC billing manual was updated to include the new group rates.

Please contact Randie Wilson at Randie.Wilson@state.co.us for questions regarding Dialysis Rates, or contact Ana Lucaci at Ana.Lucaci@state.co.us with questions regarding ASC and Dialysis Centers.

Audiology Providers

Hearing Aids Rates Adjustments

The Department has discovered that some rates were incorrectly loaded which resulted in claim payment errors for hearing aids with dates of service (DOS) between October 1, 2013 and March 31, 2014.

Effective April 1, 2014, the following hearing aid procedure code reimbursement rates will be restored to the rates used prior to October 1, 2013. Please refer to the table below for the corrected reimbursement rates.

All affected claims with DOS between October 1, 2013 and March 31, 2014 will be retroactively adjusted by the Department's fiscal agent and paid based on the corrected rate.

Note: Mass adjustments made by the Department can only be done if the original submitted charge on the claim was greater than the newly revised rate. Any claims on or after October 1, 2013 with a submitted charge lower than the corrected rate must be adjusted by the provider.

The Department apologizes for any confusion and inconvenience this may have caused.

Code	Description	Correct Rate	Code	Description	Correct Rate
V5014	Repair/modification of a hearing aid	202.24	**V5247**	Hearing aid, digitally programmable analog, monaural, BTE	1001.35
V5060	Hearing aid, monaural, BTE	499.27	**V5250**	Hearing aid, digitally programmable analog, binaural, CIC	1001.35
V5244	Hearing aid, digitally programmable analog, monaural, CIC	1001.35	**V5251**	Hearing aid, digitally programmable analog, binaural, ITC	1001.35
V5245	Hearing aid, digitally programmable, analog, monaural, ITC	1001.35	**V5252**	Hearing aid, digitally programmable, binaural, ITE	1001.35
V5246	Hearing aid, digitally programmable analog, monaural, ITE	1001.35	**V5253**	Hearing aid, digitally programmable, binaural, BTE	1001.35

Code	Description	Correct Rate	Code	Description	Correct Rate
V5254	Hearing aid, digital, monaural, CIC	1301.75	**V5258**	Hearing aid, digital, binaural, CIC	1301.75
V5255	Hearing aid, digital, monaural, ITC	1301.75	**V5259**	Hearing aid, digital, binaural, ITC	1301.75
V5256	Hearing aid, digital, monaural, ITE	1301.75	**V5260**	Hearing aid, digital, binaural, ITE	1301.75
V5257	Hearing aid, digital, monaural, BTE	1301.75	**V5261**	Hearing aid, digital, binaural, BTE	1301.75

Reminder: When billing for a pair of hearing aids, each individual hearing aid must be listed on a separate line on the claim form and must have the appropriate modifier noted to indicate the ear for which it is fitted. The "RT" modifier indicates the hearing aid is for the right ear, and the "LT" modifier indicates it is for the left ear. Billing for two (2) units of a hearing aid, on the same line, without the appropriate modifier will result in a denial.

Please contact Alex Stephens at Alex.Stephens@state.co.us with questions.

Softband Hearing Aids for Children

Effective April 1, 2014, softband hearing aids (bone anchored hearing aids) are a covered benefit for children age 20 and under. All softband purchases require a PAR and must be accompanied by a signed letter from a physician documenting medical necessity. In addition, claims must be submitted on the Colorado 1500 (CO-1500) paper claim form and also include the invoice received for purchasing the item. The Colorado Medical Assistance Program reimburses softband devices using the following methodology: the invoice cost + 10%. Please see the table below for a list of procedure codes covered for softband devices.

The CO-1500 paper claim form is available in the Provider Services Forms section of the Department's website. All Audiology PARs and revisions processed by the ColoradoPAR Program must be submitted using CWQI. Clinical information is imperative for a PAR review. When submitting PARs, please answer the clinical questions in CWQI and attach the relevant clinical documentation needed for determinations.

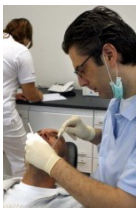
Please contact the ColoradoPAR Program at 1-888-454-7686 with PAR questions.

Please contact Alex Stephens at Alex.Stephens@state.co.us with questions regarding softband hearing aids for children.

Code	Description	PAR	Required Modifier	Allowed Units per Date of Service	Allowed Billing Provider Types
L8692	New. Auditory osseointegrated device, external sound processor, used without osseointegration, body worn, includes headband or other means of external attachment.	Always	UB	2	Physician, Pharmacy, Supply, Clinics, Osteopath, Audiologist.
L8691	Replacement. Auditory osseointegrated device, external sound processor.	Always	UB	1	

Dental Providers

Adult Dental Program Policy and Billing Information



Attachment A of this bulletin contains a complete list of dental procedure codes that may be billed for client's age 21 years and older with DOS on or after April 1, 2014. General information for dental providers, policy descriptions, and procedure code lists when billing for eligible adults are outlined below, in the attachment, and in the Dental Billing Manual (valid until June 30,2014).

General Dental Information

Eligibility for Services

All clients with Medicaid benefits age 21 years and older are eligible for adult dental services, however are subject to the limitations described in this bulletin and the Dental billing manual. It is the provider's responsibility to verify eligibility before providing services. Though the client should show their Colorado Medical Assistance Program Identification Card, the card does not guarantee eligibility. Additional information on how to verify eligibility is located in the general Provider Services section of the Billings Manuals section of the Department's website.

Post Eligibility Treatment of Income (PETI)

With the implementation of this new $1,000 adult dental benefit, nursing facilities will no longer be required to submit PETI requests for routine dental services for nursing facility residents (please see Attachment A). The new dental benefit will have no impact on other covered PETI services, such as hearing aids, eyeglasses, or health insurance premiums. Requests for these services will continue to be submitted to the Department for review and determination.

Claim Submission

Effective April 1, 2014, dental providers rendering services for clients in nursing facilities will need to be enrolled as a Colorado Medical Assistance Program Dental provider in order to submit claims for reimbursement. The dental provider must submit claims for services rendered to clients with Colorado Medicaid using the claims submission information in the Dental Billing Manual (valid until June 30, 2014). Please follow the guidelines described in the billing manual to ensure that submitted claims are paid accurately and in a timely fashion.

PARs

None of the covered dental services for adults, available April 1, 2014, will require a PAR.

Criteria for Providing Adult Dental Services in an Outpatient Hospital or ASC

Dental procedures requiring hospitalization may be a covered benefit, if the client meets at least one of the following criteria:

1. The client has a physical, mental, or medically compromising condition.
2. General anesthesia is required because local anesthesia will be ineffective due to acute infection, anatomic variations, or allergy.
3. The client is extremely uncooperative, unmanageable, anxious, or uncommunicative and has dental needs deemed sufficiently important that dental care cannot be deferred.
4. The client has sustained extensive orofacial and dental trauma.

To provide services in the hospital or ASC:

If a client meets any of the criteria above, the provider must do the following to provide care for the client in a hospital or ASC:

1. Make prior arrangements with the hospital or ASC.
2. Bill fee-for-service Current Dental Terminology (CDT) codes at current rates electronically as an 837 Dental (837D) transaction, selecting either "outpatient hospital" or "ambulatory surgery center" as the place of treatment or on the 2006 American Dental Association (ADA) paper claim form and check box number 38 ("other") as the place of treatment.
3. Bill for any x-rays taken in the facility when providing services to clients in either an outpatient hospital or an ASC. The provider must bill x-rays either electronically as an 837D transaction or on the ADA paper claim form.

4. All x-ray procedures with other dental procedures must be itemized. Hospital outpatient departments and ASC facilities will not be allowed to bill for dental x-rays performed during outpatient dental procedures. Follow the appropriate Medicaid guidelines located in the Dental Billing Manual (valid until June 30, 2014).

Unsupervised Dental Hygienists

Effective April 1, 2014, Colorado Medical Assistance Program-enrolled unsupervised dental hygienists as defined by the Department of Regulatory Agencies (DORA) may provide and be reimbursed for the following dental procedures for all adult clients age 21 years or older with Medicaid benefits:

D0120 – *Periodic oral evaluation-established patient*
D0140 – *Limited oral evaluation - problem focused, established patient*
D0180 – *Comprehensive periodontal evaluation– new or established patient*
D0210 – *Intraoral - complete film series*
D0220 – *Intraoral - periapical first film*
D0230 – *Intraoral - periapical each additional film*
D0240 – *Intraoral - occlusal film*
D0270 – *Bitewing - single film*
D0272 – *Bitewings - two films*
D0274 – *Bitewings - four films*
D0277 – *Vertical Bitewings – 7 to 8 radiographic images*
D0330 – *Panoramic radiographic image*
D0999 – *Unspecified diagnostic procedure - For screening and assessment purposes only*
D1110 – *Prophylaxis – adult (age 12 years and up)*

Coverage Policies and Procedure Code Tables

The Colorado Medical Assistance Program policies for dental benefit coverage for adults age 21 years and older are located in Attachment A of this bulletin. Please refer to the ADA publication CDT 2013 for detailed code information, clarification, and appropriate code selection.

Please contact Dawn McGlasson at Dawn.McGlasson@state.co.us with questions.

Old Age Pension (OAP) Dental Benefit

Beginning April 1, 2014 dental benefits will be available to OAP Health and Medical Care Program clients as well. Providers of dental services to OAP Health Care Program clients will be reimbursed at 100% of the Medicaid fee schedule rate. This benefit change does not affect claims processing and providers should continue to submit claims as usual.

Durable Medical Equipment (DME) Providers

Secondary/Back-Up Wheelchairs and National Correct Coding (NCCI) Procedure-to-Procedure (PTP) Edits

The Centers for Medicare & Medicaid Services indicated that certain wheelchair code combinations are disallowable according to the Durable Medical Equipment (DME) NCCI PTP code list.

However, the Department has recently received approval to continue allowing reimbursement on these items when they are specifically identified as wheelchair equipment designated for secondary/back-up use. Beginning April 1, 2014, all PARs and claims for secondary/back-up wheelchairs, as well as their related options/accessories, **must** be submitted with a TW modifier. Please send an email to HCPF_DME@hcpf.state.co.us with any questions.

Disposable Oxygen Probes

Effective April 1, 2014, disposable oxygen probes for use with oximeters are a covered benefit and may be billed using procedure code A4606. Disposable probes are limited to four (4) units (e.g. 4 probes) per month. When submitting a claim for multiple units, span billing must be used.

Please email HCPF_DME@hcpf.state.co.us with any questions.

DME - Oxygen Claim Edits

In compliance with NCCI, several procedure codes used for oxygen reimbursement have been denied based on PTP edits (edit 2021). The most affected procedure codes (E0441 and E0442) are the monthly oxygen contents procedure codes.

The Colorado Medical Assistance Program received approval from CMS for an exception to the edit for these codes that prevented payment for oxygen contents when billed with either an oxygen concentrator or stationary oxygen system. The claims that were denied for the NCCI edit will be reprocessed by the Department's fiscal agent.

Please contact Richard Delaney at Richard.Delaney@state.co.us or 303-866-3436 with questions.

Hospital Providers

Inpatient Hospital Billing for Children Age One (1) or Under

The Department has identified an issue with inpatient claims for children age one (1) and under in the All Patient Refined-Diagnosis Related Group (APR-DRG) grouper that can result in the assignment of a neonate APR-DRG when the client is over the age of 28 days. In conjunction with the fiscal agent, the Department is currently working to resolve the issue and a mass adjustment of affected claims will be processed. Providers do not need to take any action with the exception of monitoring future PCRs. Additional updates will be published in future Provider Bulletins.

Please contact Ana Lucaci at Ana.Lucaci@state.co.us with questions.

Outpatient Hospital Billing Edits for 'Other Diagnosis Not Covered'

The Department has identified a system change that affected Outpatient Hospital claims when the "Other Diagnosis Not Covered" edit sets and automatically denies the claim. The edits for "Other Diagnosis Not Covered" will be reconfigured to reflect previous Outpatient Hospital claims processing.
Please note that this only applies to Outpatient Hospital claims for "Other Diagnoses" and the "Principle Diagnosis Not Covered" edit which will continue to deny as intended.
A mass adjustment of impacted claims will be made and will be reflected on the future PCRs. Providers do not need to take any action to correct claims.

Please contact Ana Lucaci at Ana.Lucaci@state.co.us with questions.

Outpatient Hospital Rate Increases Effective July 1, 2013

On March 6, 2014, the Department received approval from CMS for the rate increases for Outpatient Hospital services effective July 1, 2013.

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 the facility has sent to the Department, and;
2) The Medicaid Percentage.

Note: Effective July 1, 2013, the Medicaid Percentage increased from 68.8% to 70.2%.

The Department is in the process of updating the MMIS with the new Medicaid Percentage information. Additionally, a mass adjustment of claims will be completed for affected Outpatient Hospital claims that need to be reprocessed for proper reimbursement using the July 1, 2013 Outpatient Medicaid percentage.

Please contact Luisa Sanchez de Tagle at Luisa.SanchezdeTagle@state.co.us or at 303-866-6277 with any questions.

Waiver Providers

Alternative Care Facility (ACF) Providers

ACF Training Requirement

Beginning April 1, 2014, all ACF providers must demonstrate completion of a self-paced training by submitting the completion certificate found on the last slide of the training located on the AFC web page of the Department's website.

The completed certificate may be scanned and emailed to Nicholas.Clark@state.co.us or faxed to 303-866-2786.

New ACF providers may also submit their completion certificate along with the Provider Enrollment application.

Please contact Nick Clark directly with any questions regarding the ACF training requirement change.

Pharmacy Providers

Hepatitis C Treatment

Note: The Department is not aware of any documentation that indicates that there are patient safety issues regarding Sovaldi. Given the demand for the medication, the generally slow progression of the disease, and the rapidly changing landscape of the treatments available for Hepatitis C, the Department will conduct further evaluation and review to determine the appropriate coverage criteria for Sovaldi. New therapies for Hepatitis C will not be approved until further analysis is done. Patients who have already started treatment will be allowed to complete treatment. The Department will continue to evaluate cases which are medically necessary to begin treatment immediately. Clinical documentation must be submitted supporting medical necessity in order to begin treatment. The normal PAR process should be utilized if this is the case.

Please fax any Sovaldi PARs to 303-866-3590 for consideration.

Pharmacy and Therapeutics (P&T) Meeting:

Tuesday, April 8, 2014
1:00 p.m. - 5:00 p.m.
225 E. 16th Street
Denver, CO 80203
1st floor conference room

Preferred Drug List (PDL) Update

Effective April 1, 2014, the following will be preferred agents on the Medicaid PDL and will be covered without a PAR (unless otherwise indicated):

Insulins:

- Rapid acting duration- Humalog and Novolog pens and vials
- Short acting duration- Humulin R vial
- Intermediate acting duration- Humulin N pen and vial
- Long acting duration- Levemir pen and vial
- Insulin mixtures- All mixtures will be preferred including pens and vials

Alzheimer Agents: generic donepezil tab, donepezil ODT, generic galantamine and galantamine ER, Namenda

Atypical Antipsychotics: Abilify, clozapine, Clozaril, Geodon, Latuda, olanzapine, risperidone, Risperdal, quetiapine, Seroquel IR, ziprasidone, Zyprexa

Growth Hormones: Norditropin, Saizen, Omnitrope

Nasal Corticosteroids: fluticasone, Nasonex

Leukotriene Modifiers: montelukast (generic Singulair)

MS Agents: Avonex, Betaseron, Rebif, Copaxone 20mg injections

Ophthalmic Antihistamines: cromolyn, Patanol, Pataday

Sedative Hypnotics: Lunesta, zaleplon, zolpidem

Statins: Crestor, atorvastatin, pravastatin, simvastatin

The complete PDL and criteria for non-preferred medications are available on the PDL web page.

April and May 2014 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 also posted in the Provider Services Training section of the Department's website.

Who Should Attend?

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

April 2014

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 ***WebEx –** NHVP 1:00 PM-3:00 PM	9 ***WebEx –** 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	10 Dental 9:00 AM-11:00 AM Web Portal 837D 11:15 AM-12:00 PM Practitioner 1:00 PM-3:00 PM	11 ***WebEx –** Basic Billing Waiver 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM	12

May 2014

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
4	5	6 Beginning Billing – CO -1500 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM ***WebEx –** Vision 1:00 PM-3:00 PM	7 Beginning Billing – UB-04 9:00 AM-11:30 AM Web Portal 837I 11:45 AM-12:30 PM ***WebEx –** Nursing Facility 1:00 PM-3:00 PM	8 DME/Supply 9:00 AM-11:30 AM FQHC/RHC 1:00 PM-3:00 PM	9 ***All WebEx:** Beginning Billing – CO -1500 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM Provider Enrollment 1:00 PM-3:00 PM	10
11	12	13	14 ***WebEx –** Dental 9:00 AM-11:00 AM	15	16	17

Reservations are required for all workshops

Email reservations to:
workshop.reservations@xerox.com
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

Or Call the Reservation hotline to make reservations: 1-800-237-0757, extension 5.

All the information noted above is necessary to process reservations successfully. Look for a confirmation e-mail within one week of making a reservation.

Reservations will only be accepted until 5:00 p.m. the Friday prior to the training workshop to ensure there is adequate space available.

If a confirmation has not been received at least two business days prior to the workshop, please contact the Department's fiscal agent and talk to a Provider Relations Representative.

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 website, phone number, meeting number and password will be emailed or mailed to those 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).

Free parking is not provided and is limited in the downtown Denver area. Commercial parking lots are available throughout the downtown area. The daily rates range between $5 and $20. Carpooling and arriving early are recommended to secure parking. Whenever possible, public transportation is also recommended.
Some forms of public transportation include the following:

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

Free MallRide – The MallRide stops are located on 16th St. at every intersection between the Civic Center Station and Union Station.

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

Xerox State Healthcare Provider Services at 1-800-237-0757.

Please remember to check the Provider Services section of the Department's website at colorado.gov/hcpf for the most recent information.

Procedure Code Table for the Adult Dental Benefit
(For services rendered on or after April 1, 2014)

D0100-D0999 I. Diagnostic

Clinical Oral Evaluations

D0120	periodic oral evaluation – established patient
D0140	limited oral evaluation – problem focused
D0150	comprehensive oral evaluation – new or established patient
D0180	comprehensive periodontal evaluation – new or established patient

Radiographs/Diagnostic Imaging (Including Interpretation)

D0210	intraoral – complete series of radiographic image
D0220	intraoral – periapical first radiographic image
D0230	intraoral – periapical each additional radiographic image
D0270	dental bitewing – single radiographic image
D0272	dental bitewings – two radiographic images
D0274	dental bitewings – four radiographic images
D0277	vertical bitewings – 7 to 8 radiographic images
D0330	panoramic radiographic image
→ limited to clients age 6 years or older	

Tests and Examinations

D0460	**pulp vitality tests**
→ includes multiple teeth & contra lateral comparison/s	

D1000-D1999 II. Preventive

Dental Prophylaxis

D1110	**prophylaxis – adult**
→ limited to twice annually; limited to clients age 12 years or older	

D2000-D2999 III. Restorative

Amalgam Restorations (Including Polishing)

D2140	amalgam – one surface, primary or permanent
D2150	amalgam – two surfaces, primary or permanent
D2160	amalgam – three surfaces, primary or permanent
D2161	amalgam – four or more surfaces, primary or permanent

Resin-Based Composite Restorations – Direct

D2330	resin-based composite – one surface, anterior
D2331	resin-based composite – two surfaces, anterior
D2332	resin-based composite – three surfaces, anterior
D2335	resin-based composite – four or more surfaces or involving incisal angle (anterior)
D2391	resin-based composite – one surface, posterior
D2392	resin-based composite – two surfaces, posterior
D2393	resin-based composite – three surfaces, posterior
D2394	resin-based composite – four or more surfaces, posterior

D7000-D7999 IV. Oral and Maxillofacial Surgery

Extractions (Includes local anesthesia, suturing, if needed, and routine postoperative care)

D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)

Surgical Extractions (Includes local anesthesia, suturing, if needed, and routine postoperative care)

D7250	surgical removal of residual tooth roots (cutting procedure)

Surgical Incision

D7510	incision & drainage of abscess – intraoral soft tissue
D7511	incision & drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)
D7520	incision & drainage of abscess – extraoral soft tissue

D9000-D9999 V. Adjunctive General Services

Unclassified Treatment

D9110	palliative (emergency) treatment of dental pain – minor procedure
→ This code can only be billed for minor dental procedures to relieve dental pain in emergencies. The nature of the emergency and the specific treatment provided must be documented in the patient's chart. This code may not be used for writing prescriptions dispensing medications in the office, or administering drugs orally. It may be used in conjunction with a problem focused examination code, radiographs, and other diagnostic procedures needed to support diagnosis prior to performance of the palliative treatment.	

Professional Visits

D9410	house/extended care facility call