Provider Bulletin

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colorado.gov/pacific/hcpf

In this issue:

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ColoradoPAR Program PARs
www.coloradopar.com

Did you know...?

The Provider Claim Report (PCR) contains important information outside of claims processing. The first two (2) pages of the PCR have communications from the Department of the Health Care Policy and Financing (the Department). Additionally, the PCR contains the following claims information: paid, denied, adjusted, voided, and in process. The PCR can be retrieved through the File and Report Service (FRS) via the Colorado Medical Assistance Program Web Portal (Web Portal).

All Providers

Medicaid Fee-for-Service Provider Rate Increases Effective July 1, 2014

Medicaid provider rate increases were approved during the 2013-2014 legislative session and are effective for dates of service July 1, 2014. The fee schedule located at the bottom of the Provider Services web page of the Department of Health Care Policy & Financing's (the Department) website (colorado.gov/pacific/hcpf) is being updated to reflect the following increase. 2% increase for most of the fee-for-service benefits including, but not limited to:

- Physician and clinic services
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services
- Emergency transportation services (EMT)
- Non-brokered non-emergent medical transportation services (NEMT)
- Inpatient hospital services
- Outpatient hospital services
- Laboratory & x-ray services
- Durable Medical Equipment (DME), supplies, and prosthetics
- Federally-Qualified Health Centers (FQHC)
- Mental health fee-for-service
- Non-physician practitioner services
- Tobacco cessation counseling for pregnant women
- Ambulatory Surgery Center Services (ASC)
- Dialysis center services
- Physical, occupational, and speech therapy services
- Audiology services
- Screening, brief intervention, and referral to treatment (SBIRT) services
- Dental services
- Family planning services
- Substance use disorder services
- Targeted case management for behavioral health
- Targeted case management for substance use disorders
- Vision services

- Mental health and substance abuse disorder rehabilitation services for children in psychiatric residential treatment facilities
- Extended services for pregnant women home health services
- Drugs administered in the office setting including vaccine administration
- Private Duty Nursing 2%
- Home Health 2%
- Hospice 2%
- Program for All-Inclusive Care for the Elderly (PACE) 2%

Please note that the room and board portion of hospice rates is not impacted by this rate increase and will continue to be indexed to the nursing facility rate where services were rendered.

(Rates paid to certain managed care organizations may also include corresponding increases, as the Department will pay the rates based on fee-for-service expenditures. Any managed care rates which fall outside the current actuarially sound rate ranges may require additional actuarial certification.

Home and Community-Based Services (HCBS)

Some HCBS services include:

- HCBS- Brain Injury (BI)
- HCBS- Community Mental Health Supports (CMHS)
- HCBS- Elderly, Blind, and Disabled (EBD)
- HCBS- Consumer Directed Attendant Support (CDASS)
- HCBS- Children's Waiver
- HCBS- Children with Life Limiting Illnesses (CLLI)
- HCBS- Children Residential Habilitation Program (CHRP)

The rates for services provided under the HCBS waivers operated by the Division for Intellectual Developmental Disabilities (DIDD) will increase by 2.5% for the services noted below, with dates of service beginning July 1, 2014.

- HCBS- Developmental Disabilities (DD)
- HCBS- Supported Living Services (SLS)
- HCBS- Children Extensive Support (CES)

Providers must submit claims with the new rates in order to receive the increase. Any claims submitted after July 1, 2014 with the old rates must be adjusted by the provider.

Family Planning Services

The Department intends to increase provider rates for certain family planning services that were impacted by rate reductions in recent years. The updates will increase reimbursement for codes for certain contraceptives to $35. These changes are effective July 1, 2014.

Single Entry Point Service Management

The Department intends to increase Single Entry Point Service Management by 2%. These changes are effective July 1, 2014.

General Information

Mass adjustments made by the Department can only be done if the original submitted charge on a claim is greater than the newly revised rate. Any claim on or after the date that new rates become effective, with a submitted charge lower than the corrected rate, must be adjusted by the provider. It is recommended that providers submit charges based on Usual & Customary rates, when applicable.

Updated fee schedules are forthcoming. Please refer to the Department's website, bottom of Provider Services or the Billing Manuals section for the appropriate rate and fee schedule.

Targeted Provider Rate Increases effective July 1, 2014

During the 2014 legislative session, the Colorado General Assembly approved a series of targeted rate increases to specific providers, codes and specialties.

These increases are aimed at addressing large inequities in rates and to demonstrate the Department's priority to pay for services that provide high value for members. Below is a brief description of each rate increase which, pending federal approval, will be effective July 1, 2014 in most areas.

Pediatric Hospice Waiver Services	The Department appropriated additional funds to increase rates for the waiver for Children with Life Limiting Illness (CLLI). This increase will improve access to services for children with life limiting illnesses. Further information regarding these rate increases with be forthcoming.
Extended/After Hours Rate Increase	The Extended/After Hours rate increase will allow providers to receive an extra $7.00 in reimbursement for rendering treatment during extended hours. The increase will act as an incentive for providers to remain open later or during the weekends to ensure members can receive care they need in less expensive settings. Billing instructions will be forthcoming in future Provider Bulletins.
Transitional Living Program for Brain Injury Members	The Transitional Living Program assists members with critical injuries in returning home and integrating back into their community after suffering a traumatic brain injury. The reimbursement rate will increase by 191% to incentivize provider participation in the program.
Pediatric Developmental Assessments	Reimbursement for developmental assessments (CPT T1026) is being increased by 50% to increase access to these services. Currently, access to these assessments is provided via waiting list. The rate increase is intended to increase current capacity and incentivize additional providers to offer assessments.
Single Entry Point (SEP) Funding Increase	Reimbursement for the Single Entry Points will increase by 10% to better reimburse for vital case management services. This increase will improve the member experience, increase their quality of life, and result in better health outcomes.
Ambulatory Surgical Center (ASC) – Surgeons	Surgeries can frequently be performed at a lower cost in the ASC setting rather than the outpatient hospital setting. The Department will invest $1,000,000 in ASCs. $500,000 will be allocated to incentivize surgeons to choose to perform more surgeries in the ASC setting while the other $500,000 will increase the reimbursement rates for ASC-specific codes. The rate increases will take effect between July through September 2014.
High-Value Specialist Services	Reimbursement for high-value specialist services will be increasing from 65% or less of Medicare reimbursement to 80% of the current Medicare rate. These increases will improve access for members and result in better health outcomes. A full list of high-value specialist codes can be found in Attachment A of this bulletin.
Mammography Codes Increase	Reimbursement for the following codes for advanced breast cancer imaging are being increased to 80% of current Medicare rate: • G0202 • G0204 • G0206 These increases will improve access to early detection and treatment, improving cure and recovery rates for Medicaid members.

Complex Rehabilitation Codes increase	Reimbursement for the following codes are being increased to 80% of the current Medicare rate: • 92608 • 97542 • 97755 Few providers currently offer these services and these increases will improve member access and attract additional providers.
Federally Qualified Health Centers (FQHCs)	Reimbursement rates for FQHC's will be revised using an alternative payment methodology in order to get FQHC's back to cost-based reimbursement.
Family Planning Codes	• Reimbursement codes with the prefix S4993 (oral contraceptives) will be increased to a flat rate of $35. • The following family-planning-specific codes will be increased by 15%: A4264, A4550, J7302, J7303, J7304 and J7307.

Additional information regarding targeted rate increases can be found on the Department's website → What's New → Provider Implementations→Targeted Rate Increases.

The Department appreciates all providers and stakeholders who participated in its Request for Input Process for these rate increases. This stakeholder process was not only important for receiving budgetary approval this year, but to also help the Department identify areas where value and access to services can be improved for our members in the future.

Please contact Jeremy Tipton at Jeremy.Tipton@state.co.us with rates questions.

ColoradoPAR Program

CareWebQI (CWQI) Prior Authorization Reminders:

- PAR numbers are generated approximately 24-72 hours after a request is approved or denied.
- A Permission Error message is displayed if the Medicaid ID number attached to the user's account is not inserted into Box 1 (Requesting Provider) or Box 7 (Billing Provider).
- Medicaid ID numbers are noted on the CWQI User Access Form when requesting access for the first time. Providers can access the CWQI section for additional information on the ColoradoPAR Program website (coloradopar.com) →CareWebQI → Permission Error Message**.**
- The Facility ID field in CWQI (Box 6) automatically defaults to "Facility-Unknown" and should not be changed.
- If the Submit button becomes inactive, the provider should verify that all possible clinical indications have been answered and the appropriate "document" buttons have been selected.
- For additional information, please refer to the CareWebQI 5.0 Medical User Guide or the Dental User Guide.

CareWebQI forms have recently been updated. Below is a list of current CareWebQI forms and definitions:

Form	Definition
CareWebQI New User Access Form	Used for first time access to CWQI
CareWebQI Reactivation Form	Used for account reactivation. Accounts are disabled after 6 months of inactivity
CareWebQI Termination Form	Used to terminate a staff member's account in CWQI
CareWebQI Additional Provider Form	Used to add additional facilities and/or physicians to your account

Form	Definition
CareWebQI Change of Employment Form	Used to update your account to a different location and/or company of employment
CareWebQI Exception Form	Used to request the ability to submit PAR's via fax or mail

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.

Financial Reporting System Transition

On July 1, 2014, the State of Colorado will replace its current payment financial system, the Colorado Financial Reporting System (COFRS), with a new system, the Colorado Operations Resource Engine (CORE). The new system is an enterprise-wide system that will be used by all three branches of Colorado government. It will provide new budgetary, procurement, and accounting functionality to the State, which are all integrated into one cohesive system.

The Department has been working with its vendor and other State staff to ensure all the existing interfaces between the Medicaid Management Information System (MMIS) and COFRS are updated accordingly. In testing the new interfaces, the Department does not anticipate any disruptions in payments to providers for the first payment in July 2014.

If a provider does encounter payment issues for the first payment in July 2014, please contact Tim Gaub at Tim.Gaub@state.co.us or the Department's Accounting Section at hcpfar@state.co.us**.**

Notification of Changes to Behavioral Health Organizations (BHOs)

Important change to BHOs

Through a competitive Request for Proposal (RFP) process, Colorado Access won the behavioral health contract for northeastern Colorado, effective July 1, 2014. Colorado Access will be doing business as Access Behavioral Care (ABC). Beginning July 1, 2014, Northeast Behavioral Health Partnership (NBHP) will no longer manage behavioral health services for northeastern Colorado. The northeast regions includes Larimer, Weld, Morgan, Logan, Sedgwick, Phillips, Washington, Yuma, Elbert, Lincoln, Kit Carson, and Cheyenne counties. All other BHO regions will remain the same.

What does this mean for providers?

Value Options, a delegate of NBHP, will no longer administer or manage behavioral health services for the northeast region of the state. Northeast Behavioral Health Partnership will complete payment of all outstanding obligations for covered services rendered to members that were enrolled with NBHP prior to July 1, 2014. Northeast Behavioral Health Partnership will ensure services continue to be provided for the duration of prior authorized service periods, as well as for inpatient admissions up until discharge. Access Behavioral Care has offered to contract with NBHP's current network of providers. Access Behavioral Care has conducted outreach to NBHP's current network of providers to facilitate the transition. Access Behavioral Care will be responsible for payment for all covered services rendered to enrolled members that begin on July 1, 2014 or after.

What does this mean for members?

Members that live in the northeast region of the state that were previously enrolled in NBHP will become members of ABC beginning July 1, 2014. Members will not experience a disruption in services and can keep the same behavioral health provider they had prior to this change.

Will there be a change in covered services?

No, covered services will not change.

Who to contact for more information on this transition?

Access Behavioral Care at 844-880-8508, or visit coaccess.com.
Northeast Behavioral Health Partnership at 888-296-5827, or visit nbhpartnership.com.
BHO Contact Information:

BHO	County/Counties served	Customer Service Phone Numbers and websites
Access Behavioral Care Denver	Denver	303-751-9030 or 1-800-984-9133 coaccess.com
Access Behavioral Care Northeast (effective July 1, 2014)	Larimer, Weld, Morgan, Logan, Sedgwick, Phillips, Washington, Yuma, Elbert, Lincoln, Kit Carson, and Cheyenne	970-221-8508 or 1-844-880-8508 coaccess.com
Behavioral Healthcare, Inc.	Adams, Arapahoe, and Douglas	720-490-4400 or 1-877-349-7379 bhicares.org
Foothills Behavioral Health Partners	Boulder, Broomfield, Gilpin, Clear Creek, and Jefferson	303-432-5950 or 1-866-245-1959 fbhpartners.com
Colorado Health Partnerships	Alamosa, Archuleta, Baca, Bent, Chaffee, Conejos, Costilla, Crowley, Custer, Delta, Dolores, Eagle, El Paso, Fremont, Garfield, Grand, Gunnison, Hinsdale, Huerfano, Jackson, Kiowa, Lake, La Plata, Las Animas, Mesa, Mineral, Moffat, Montezuma, Montrose, Ouray, Otero, Park, Pitkin, Prowers, Pueblo, Rio Blanco, Rio Grande, Routt, Saguache, San Juan, San Miguel, Summit, and Teller	1-800-804-5008 coloradohealthpartnerships.com
Northeast Behavioral Health Partnership (effective now through June 30, 2014)	Larimer, Weld, Morgan, Logan, Sedgwick, Phillips, Washington, Yuma, Elbert, Lincoln, Kit Carson, and Cheyenne	970-347-2374 or 1-888-296-5827 nbhpartnership.com

New HCPF Website Coming Soon

The Department's main website, colorado.gov/pacific/hcpf, will be moving to a new platform July 1, 2014. The Colorado Medical Assistance Web Portal (Web Portal) itself will not change, but the way providers navigate to the Web Portal when visiting colorado.gov/hcpf will be different. The look and feel of the website will be redesigned to align with the new brandCOLORADO standards. Providers will have a provider-focused section on the new site, which will include a link to the Web Portal.

The new website takes into account much of the feedback the Department has received including simpler navigation and removal of outdated information. The Department is working to build the website over the coming month and hopes to provide a preview of the new design in the next Provider Bulletin. For more information, please refer to the frequently asked questions (FAQs).

If any provider is interested in helping test the new website in June, please contact Christina Chavez at Christina.Chavez@state.co.us.

Note: All providers are reminded to update their contact information via the Web Portal or the Provider Enrollment Update Form as a way for clients to locate providers on the Department's 'Find a Provider' web page.

New Colorado Health Care Provider Training for Implementing Tobacco Cessation Guidelines in Clinical Practice

Colorado health care providers play a critical role in helping their patients quit tobacco, but many patients report their health care providers do not offer advice to quit. A recent Colorado survey shows almost 73% of smokers saw a health care provider in the previous 12 months, but only 68% of those adults were advised to quit by their provider. Smokers who were advised to quit were substantially more likely to try quitting (38%). These numbers illustrate the importance of health care professionals in helping Coloradans quit smoking. In order to better support health care professionals of all kinds, a new resource is now available.

The Colorado Department of Public Health and Environment's (CDPHE) State Tobacco Education and Prevention Partnership (STEPP), in partnership with the University of Colorado Anschutz Medical Campus School of Medicine's Behavioral Health and Wellness Program, has developed a one-hour training to provide an overview on several key components on the topic of promoting tobacco cessation;

- Implementing tobacco cessation clinical guidelines in practice
- The latest on medication protocols
- Practical tips on using motivational interviewing
- Information on resources such as the Colorado QuitLine
- Guidance on addressing emerging tobacco products such as e-cigarettes

The training also highlights the recently released 32nd tobacco-related Surgeon General's Report "The Health Consequences of Smoking-50 Years of Progress," which presents new data on the health consequences of smoking.

This free training is not just for doctors, but it can assist all health care professionals including those delivering smoking cessation treatment in clinical settings, those facilitating health systems or quality improvement initiatives, or anyone working on a clinical team. The training has been deployed as a webinar. Providers are encouraged to share this great resource with anyone in their network.

National Correct Coding Initiative (NCCI) Notification of Quarterly Updates

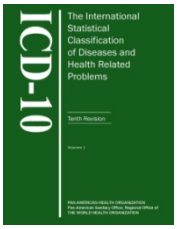
Providers are encouraged to monitor the Centers for Medicare & Medicaid Services (CMS) website for updates to the NCCI rules and guidelines. The updates are completed quarterly with the next update becoming available in July 2014. A link to the CMS NCCI website is also available on the Department's NCCI web page. Note: Annual update of the "Modifier 59 Article" has been posted on the Medicaid NCCI web page on the Medicaid.gov website.

International Classification of Diseases (ICD) – Version 10 Update

ICD-10 Implementation Delayed

On Monday, March 31, 2014 the Senate passed House Bill 4302, Protecting Access to Medicare Act of 2014, which is a temporary "fix" to the Medicare Sustainable Growth Rate (SGR) that postpones reduction in physicians' Medicare rates and also delays implementation of ICD-10 until October 1, 2015. President Barack Obama signed the legislation on Tuesday, April 1, 2014 solidifying the delay of ICD-10 implementation date.

The bill prohibits CMS from enforcing any mandate to switch to ICD-10 until at least October 1, 2015. The bill leaves CMS with many questions to answer; along with much of the Provider Community, the State of Colorado is awaiting such answers. The Department's ICD-10 Project Team will align, adjust, and share their implementation strategy as more information unfolds.



Below are general claim submission information:

- ICD-9 diagnosis and surgical procedure codes will be required on claims that contain Dates of Service (DOS) or Dates of Discharge (DOD) of September 30, 2015 and before.
- ICD-10 diagnosis and surgical procedure codes are required on claims that contain DOS or DOD of October 1, 2015 or after.

- Claims submitted with both ICD-9 and ICD-10 codes will reject. Providers will have to submit two different claims based on DOS or DOD.

Independence Day Holiday

Due to the Independence Day holiday on Friday, July 4, 2014, the receipt of warrants will be delayed by one or two days. The processing cycle includes claims accepted by Thursday, July 3, 2014 before 6:00 p.m. Mountain Time (MT). State, the Department's fiscal agent, and ColoradoPAR Program offices will be closed on Friday, July 4, 2014. Offices will re-open during regular business hours on Monday, July 7, 2014.

Ambulatory Surgery Centers (ASC)

Procedure Code Updates

The following procedure codes have been added to Grouper 10 as covered procedures in an ASC. The rate for the procedures will be assigned according to Grouper 10 reimbursement. An updated list of procedure codes and their reimbursement can be found in the Ambulatory Surgery Centers Billing Manual on the Department's website.

Procedure Code	Procedure Description
47563	Cholecystectomy with cholangiography
47564	Cholecystectomy with exploration of common duct

As it is often not possible to determine which procedure will be necessary until after surgery is underway, the decision to add these codes was based on the fact that the parent procedure code 47562 is already available in an ASC setting. No other changes are occurring at this time. Claims from an ASC for these procedure codes can be submitted to the Colorado Medical Assistance Program for DOS on or after January 1, 2014. Please contact Ana Lucaci at Ana.Lucaci@state.co.us **with questions**.

Dental Providers

DentaQuest

The second phase of the new statewide Medicaid dental program is scheduled to go live July 1, 2014. DentaQuest was selected as the Administrative Services Organization (ASO) through a competitive bidding process. DentaQuest is a highly experienced Medicaid dental program administrator, managing Medicaid dental programs in ten (10) other states. The Department will leverage their expertise in managing the Colorado Dental Program for children and adults.

The Department selected a single vendor to alleviate the administrative burden for Medicaid providers. With DentaQuest as the administrator, dental providers will have the following resources:

- DentaQuest will employ three (3) in-state provider relations representatives who will help providers navigate the program. They will offer training, grievances and appeals, as well as address questions regarding claims, prior authorizations and other program components.
- A state-of-the-art web portal will enable providers to manage their entire Medicaid member base from one central location. It can be used to submit claims and prior authorizations, attach X-rays and documentation, check history and eligibility, review remits and track payments.
- Direct deposit for faster reimbursement.
- Ability to report members with broken appointments. DentaQuest will contact these members to reinforce the importance of keeping their appointments, or calling ahead of time to cancel.

ICD-10 and Dental Claims

The 2006 American Dental Association (ADA) paper claim form and the electronic claim format (HIPAA X12 837D) do not currently require diagnosis codes. Dental claims processed by the Department's fiscal agent will not be affected with the implementation of ICD-10. Currently, Current Dental Terminology (CDT) procedure codes are used to report services provided to clients and will continue to be used until further notice. Please contact the Department's fiscal agent, at 1-800-237-0757 with questions.

Federally Qualified Health Centers Providers (FQHC)

Reminders for FQHCs

Mental Health: FQHCs should submit all mental health claims to Behavioral Health Organizations (BHO) for covered mental health services. For additional information, please refer to the August 2011 Provider Bulletin (B1100304).

Pharmacy IDs: FQHCs with a separate pharmacy should enroll the pharmacy with the Colorado Medical Assistance Program and obtain a separate Provider ID number.

Covered Services: Costs for services not provided to Medicaid members or services not covered by Medicaid should be identified in the cost report and will be excluded from the rate calculation.

Encounter Rate: FQHCs can bill up to two (2) encounters per day plus one (1) dental physical. If mental health services are provided, the FQHC should bill the BHO for the covered service. Mental health services billed to the BHO can be done on the same day as a physical health or dental health service.

Adult Dental: The Department implemented the adult dental benefit beginning April 1, 2014. FQHCs should refer to the April 2014 Provider Bulletin (B1400350) for further information. Note: This policy change affects the FQHCs as this service was only allowed for children under 21.

Claims Submission: When submitting claims, FQHC's should include all procedure and diagnosis codes that pertain to all of the services rendered to clients during their visit. The Department uses this information for utilization and management of benefits; submitting all pertinent codes for services provided during a visit will help better manage care in all venues.

Rate Increases for the Federally Qualified Health Centers (FQHCs)

The Department has received CMS approval on the provider rate increases for FQHC effective July 1, 2013. Accordingly, the Department will retroactively adjust all claims with DOS on or after July 1, 2013 to reflect the new rates. Adjustments will be noted on future Provider Claim Reports (PCRs).

Please contact Greg Linster at Greg.Linster@state.co.us with questions regarding FQHC rates or Richard Delaney at Richard.Delaney@state.co.us with questions related to coverage.

Hospital Providers

Medicaid Coverage for Correctional Facility Populations

The Department is creating new partnerships with the criminal justice community and Medicaid stakeholders to provide health coverage access to this population while reducing overall costs.

Colorado Medicaid will cover inpatient treatment for inmates admitted to a hospital outside a correctional facility for more than 24 hours if the inmate would have qualified for Medicaid in the community. Medicaid only covers medically necessary inpatient services while the inmate is admitted to the hospital, including physician services, medications, medical equipment, labs, and diagnostics. While Medicaid cannot cover services provided prior to hospital admission, once an inmate has been admitted to the hospital for more than 24 hours, Medicaid will cover services for the duration of inpatient stay, including the first 24 hours.

Providers should submit claims according to standard claim-submission procedures. For example, if a member has third-party liability, the provider must bill that insurance first. Medicaid can only make reimbursement payments directly to providers who have rendered services at standard Medicaid rates.

To indicate the patient was admitted and discharged upon the direction of a court or request of a law enforcement agency, hospitals should use source of admissions code "8" upon admission and patient status code "21" upon discharge.

For additional information regarding the Department's examination of Senate Bill 08-006, providers may refer to the Department's website → For Our Stakeholders → Eligibility Partners → Initiatives→Medicaid Eligibility for Inmates. For more information regarding the policy and procedures for handling application for hospitalized inmates, please review the Agency Letter 14-006.

School Based Health Center (SBHC) Providers

School Based Health Centers (SBHC) required to bill with Place of Service Code 03

Effective July 1, 2014, the Department will require all **non**-Federally Qualified Health Center (FQHC) providers to submit claims for services provided in SBHCs with a place of service code of "03". School Based Health Centers that are sponsored by FQHCs may use place of service code "03", but the code is not required as all FQHCs are assigned a unique Medicaid provider ID for each service location, including their SBHC. The unique provider ID for each FQHC-sponsored SBHC location allows the Department to isolate these SBHC claims for reporting purposes.

The Department is working towards improving its tracking, analysis, and reporting of claims data from SBHCs in order to evaluate the care provided. This new requirement is not intended to penalize providers, but rather allow the Department to identify SBHC-specific claims; the Department will be able to evaluate the scope, cost, and effectiveness of services provided in SBHCs and provide data directly back to provider organizations for their own benefit. All data released outside the Department will comply with the Colorado Medical Assistance Program's high standard for privacy and data protection.

Please contact Meredith Henry at Meredith.Henry@state.co.us or 303-866-4538 with questions.

Waiver Providers

Children with Life Limiting Illness (CLLI) Waiver Service Change

The Department is restructuring the service package for the CLLI Waiver effective July 1, 2014. The services have expanded and many of the current procedure codes will be changing. Below is a list of the new procedure codes and associated services effective July 1, 2014.

Procedure Code	Service	Modifiers	Rate
H2032	Art and Play Therapy	UD, HA	$15.41/15 min
H2032	Art and Play Therapy Group	UD, HA, HQ	$8.63/15 min
H2032	Music Therapy	UD	$15.41/15 min
H2032	Music Therapy Group	UD, HQ	$8.63/15 min
97124	Massage Therapy	UD	$17.20/15 min
G9012	Palliative/Supportive Care: Care Coordination	UD	$16.70/15 min
S9123	Palliative/Supportive Care: Pain and Symptom Management	UD	$67.43/hour
S5150	Respite: Unskilled (4 hours or less)	UD	$3.76/15 min
S5151	Respite: Unskilled (over 4 hours)	UD	$75.36/day
T1005	Respite: CNA (4 hours or less)	UD	$6.78/15 min
S9125	Respite: CNA (over 4 hours)	UD	$122.04/day
T1005	Respite: Skilled RN, LPN (4 hours or less)	UD, TD	$9.69/15 min
S9125	Respite: Skilled RN, LPN (over 4 hours)	UD, TD	$155.29/day
S0257	Therapeutic Life Limiting Illness Support-Individual	UD	$14.78/15 min
S0257	Therapeutic Life Limiting Illness Support-Family	UD, HR	$14.781/15 min
S0257	Therapeutic Life Limiting Illness Support-Group	UD, HQ	$8.28/15 min
S0257	Bereavement Counseling	UD, HK	$500.00 lump sum

The Children's HCBS Billing Manual and Prior Authorization Request (PAR) Form will be updated to reflect these changes.

For additional information, please refer to 10 C.C.R. 2505-10 § 8.504.6 (Page 84) on the Provider Eligibility requirements of providing these new and existing services. Please contact Candace Bailey at Candace.Bailey@state.co.us **with questions**.

Pharmacy Providers

Global Prior Authorization Form and Criteria

Effective June 1, 2014, a new Global Prior Authorization form and criteria will be used. The form and criteria are posted on the Prior Authorization Policies section under Forms and *Pharmacy* of the Department's website. The form must be fully completed prior to review; requests will be reviewed by a clinical pharmacist.

Osphena, Copaxone, and Sovaldi

Osphena is a new product for painful vaginal intercourse after menopause.

The Department does not approve products for sexual dysfunction and this is not a covered benefit. Prior authorizations will not be authorized.

Copaxone 40mg is not a preferred product and will require a prior authorization. The criteria for approval includes situations in which the member has severe intolerable injection site reactions to Copaxone 20mg.

Sovaldi (Sofosbuvir) interim criteria will become effective June 1, 2014. Please refer to the PDL on the Department's website.

Oral Allergen Extracts

There are three (3) new oral allergen extracts, Grastek, Ragwitek, and Oralair. The products will require a prior authorization. Criteria for the required prior authorization can be found in Appendix P within the Prior Authorization Policies section of the Department's website.

Preferred Drug List (PDL) Update

The following preferred products are effective July 1, 2014:

- Testosterone products will require a prior authorization, however, the preferred products will be Androgel 1.62%, Androderm, and brand name only depo-testosterone.
- Newer generation antihistamines and combination preferred products will be cetirizine and loratadine. All combination products will require a prior authorization.
- Angiotensin Receptor blockers preferred products will be irbesartan, Benicar, Diovan, and losartan. Combination preferred products will be Benicar-HCT, Diovan-HCT, losartan/HCTZ. Those members currently taking Avalide will be grandfathered.
- Fibromyalgia agent preferred products will be Lyrica and Savella.
- Long Acting Oral Opioid preferred products will be methadone, morphine sulfate ER, and fentanyl patches. If a member has tried and failed **one** of these preferred products, they can request a prior authorization for Butrans patches. To view criteria for all other products please refer to the PDL.
- Inhaled anticholinergics and combinations preferred products will be albuterol/ipratropium, ipratropium, Atrovent HFA, Combivent Respimat, and Spiriva.
- Inhaled beta 2 agonist preferred products will be albuterol solutions and Proair HFA inhaler.
- Long acting inhaled beta 2 agonists will all require a prior authorization.
- Inhaled corticosteroids preferred products will be budesonide nebules, Asmanex twist, Flovent HFA and diskus, and QVAR. Combination preferred products are Advair HFA and diskus and Dulera.
- Skeletal muscle relaxant preferred products will be baclofen, cyclobenzaprine, and tizanidine.
- Topical immunomodulators will still require a prior authorization but the preferred product will be Elidel.

Clinical Pearl: Long-Acting Insulin Conversions

Effective April 1, 2014, the Colorado Medical Assistance Program PDL changed its preferred insulin products for the treatment of patients with Diabetes mellitus. Updated formulary options are as follows:

Type of Insulin	Preferred Agents	Non-Preferred Agents
Rapid-Acting	Humalog Novolog	Apidra
Short-Acting	Humulin R	Novolin R
Intermediate-Acting	Humulin N	Novolin N
Long-Acting	Levemir	Lantus
Mixtures	Humalog Mix 75/25 Humalog Mix 50/50 Humulin 70/30 Novolog Mix 70/30 Novolin 70/30	None

One of the most significant changes of this formulary revision is the change of preferred long-acting agents from Lantus to Levemir. As such, prescribers and pharmacists alike may be tasked with having to convert members from Lantus to Levemir. As a general rule, the dose conversion between these products can be 1:1, or a unit per unit basis. However, there are slight pharmacokinetic variances between these products, so it is possible that patients may require dose adjustments to maintain appropriate glycemic control once a product is changed. As always, insulin dose up- or down-titration should occur on a member-specific basis. The following information provides a quick comparison of some of the similarities and differences between these two products.

	Lantus (insulin glargine)	Levemir (insulin detemir)
Availability	Prescription only	
Description	Human insulin analog (rDNA origin)	
Onset	1.1 hours	1.1 to 2 hours
Peak	No significant peak	No significant peak
Duration	10.8 to > 24 hours	7.6 to > 24 hours
Administration	SC once daily	SC once or twice daily
Appearance	Clear, colorless	Clear, colorless
Stability at room temperature	28 days	42 days

Dosing

The two (2) long-acting agents are typically dosed once daily. However, twice daily dosing is sometimes needed to maintain glycemic control. If high pre-dinner blood glucose levels are noted, the addition of a second dose of basal insulin is worth consideration. If a patient is already on a twice daily Lantus dosing regimen, continuing on a twice daily regimen when converting to Levemir is appropriate. Additionally, due to pen dispensing limitations, up to 80 units may be injected with one injection. Members requiring more than 80 units for a single dose will need to perform two separate injections. These injections may be given at the same time or split twice daily if better glycemic control is anticipated with this administration.

Monitoring

Members should be advised to monitor blood glucose closely during the transition and in the initial weeks following changes in insulin products. Re-education on the signs and symptoms of hypoglycemia (weakness or fatigue, shakiness, blurry vision, hunger, irritability, and confusion) is also warranted.

Other Formulary Considerations
Of note, all preferred brands of insulin will be covered in both their vial and/or pen formulations. In addition, all non-preferred insulin products can be approved for use if the patient has failed treatment with a comparable preferred product within the last month. The Colorado Medical Assistance Program defines treatment failure as a medication allergy or intolerable adverse effect. Prior authorizations for all non-preferred products will be approved for one year unless otherwise stated in the Colorado Medicaid PDL.

June and July 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.

June 2014

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
8	9	10 Beginning Billing – CO -1500 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM ***WebEx –** Audiology 1:00 PM-3:00 PM	11 Beginning Billing – UB-04 9:00 AM-11:30 AM Web Portal 837I 11:45 AM-12:30 PM ***WebEx –** Dialysis 1:00 PM-3:00 PM	12 Provider Enrollment 9:00 AM-11:00 AM ***WebEx –** IP/OP Hospital 1:00 PM-3:00 PM	13 Basic Billing Waiver 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM	14

July 2014

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
13	14	15 Beginning Billing – CO -1500 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM ***WebEx –** Transportation 1:00 PM-3:00 PM	16 Beginning Billing – UB-04 9:00 AM-11:30 AM Web Portal 837I 11:45 AM-12:30 PM Home Health 1:00 PM-3:00 PM	17 **All *WebEx –** Provider Enrollment 1:00 PM-3:00 PM	18 **All *WebEx –** Beginning Billing – UB-04 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM Practitioner 1:00 PM-3:00 PM	19

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

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

- The number of people attending and their names
- Contact name, address and phone number

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/pacific/hcpf for the most recent information.

Attachment A

Targeted Rate Increase - Final Recommendations

Code	Description
92002	EYE EXAM, NEW PATIENT
92004	EYE EXAM, NEW PATIENT
92012	EYE EXAM ESTABLISHED PAT
92014	EYE EXAM & TREATMENT
92018	NEW EYE EXAM & TREATMENT
92019	EYE EXAM & TREATMENT
92020	SPECIAL EYE EVALUATION
92060	SPECIAL EYE EVALUATION
92502	EAR AND THROAT EXAMINATION
92521	SPEECH/HEARING EVALUATION
92522	SPEECH/HEARING EVALUATION
92523	SPEECH/HEARING EVALUATION
92524	SPEECH/HEARING EVALUATION
92511	NASOPHARYNGOSCOPY
92520	Laryngeal function studies
92545	OSCILLATING TRACKING TEST
92553	AUDIOMETRY, AIR & BONE
92555	SPEECH THRESHOLD AUDIOMETRY
92556	SPEECH AUDIOMETRY, COMPLETE
92563	TONE DECAY HEARING TEST
92565	Stenger test, pure tone
92567	TYMPANOMETRY
92579	VISUAL AUDIOMETRY (VRA)
92585	AUDITOR EVOKE POTENT, COMPRE
92601	COCHLEAR IMPLT F/UP EXAM < 7
92607	EX FOR SPEECH DEVICE RX, 1HR
92609	USE OF SPEECH DEVICE SERVICE
92625	Tinnitus assessment
93922	EXTREMITY STUDY
93923	EXTREMITY STUDY
93924	EXTREMITY STUDY
93925	LOWER EXTREMITY STUDY
93926	LOWER EXTREMITY STUDY
93930	Upper extremity study
93931	UPPER EXTREMITY STUDY
93965	Extremity study
93970	EXTREMITY STUDY
93975	VASCULAR STUDY
93976	VASCULAR STUDY

Code	Description
93978	VASCULAR STUDY
93979	VASCULAR STUDY
93990	DOPPLER FLOW TESTING
95812	EEG, 41-60 MINUTES
95813	EEG, OVER 1 HOUR
95873	GUIDE NERV DESTR, ELEC STIM
95874	GUIDE NERV DESTR, NEEDLE EMG
95928	C MOTOR EVOKED, UPPR LIMBS
95929	C MOTOR EVOKED, LWR LIMBS
95953	EEG MONITORING/COMPUTER
95954	EEG monitoring/giving drugs
95956	Eeg monitoring, cable/radio
95958	EEG monitoring/function test
96111	DEVELOPMENTAL TEST, EXTEND
96440	CHEMOTHERAPY, INTRACAVITARY
96450	CHEMOTHERAPY, INTO CNS
97001	PT EVALUATION
97002	PT RE-EVALUATION
97003	OT EVALUATION
97004	OT RE-EVALUATION
97597	ACTIVE WOUND CARE/20 CM OR <
G0365	VESSEL MAPPING HEMODIALYSIS ACSS
G0389	Ultrasound exam AAA screen