Provider Bulletin

Reference: B1400353 **July 2014**

colorado.gov/pacific/hcpf

In this issue:

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

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...?

If a Colorado Medical Assistance Program provider chooses to no longer accept Medicaid members, the provider must submit a Provider Enrollment Update Form and complete the section titled "Terminate Enrollment." The form can be found on the Department of Health Care Policy & Financing's (the Department) website (Colorado.gov/pacific/hcpf) → For Our Providers → Provider Services → Forms.

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 on or after July 1, 2014. The fee schedule, located at the bottom of the Provider Services web page of the Department's website, 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) – 2.5%

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.
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 memberss can receive care they need in less expensive settings. For billing instructions, please refer to the Billing and Reimbursement for Office Visits During Non-Regular Office Hours article below.
Transitional Living Program for Brain Injury Clients	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 and 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 B 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 FQHCs will be revised using an alternative payment methodology in order to get FQHCs 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, J1050, J1055, J7302, J7303, J7304 and J7307.

Additional information regarding targeted rate increases can be found on the Department's website → Initiatives → 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 in assisting the Department with receiving budgetary approval this year, but also in helping the Department identify areas in which value and access to services can be imp roved for our members in the future.

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

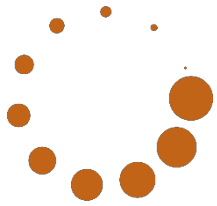
Colorado 835 Companion Guide Revision

The CO 835 Companion Guide has been recently updated. In addition, the SOAP+WSDL_HTTP+MIME CG link is now accessible on the Department's Specifications web page. Please contact the State's Fiscal Agent at 1-800-237-0757 with questions.

Billing and Reimbursement for Office Visits During Non-Regular Office Hours

Beginning July 1, 2014, the Colorado Medical Assistance Program will allow after-hours office visits as a covered benefit. Procedure code 99050 will be reimbursed at a rate of $7.00 per visit. In addition, the code may only be billed for a member's weekday visit that starts before 7:30 a.m. or after 5:30 p.m., as well as any time during the weekend. The reimbursement is only available to providers billing fee schedule services.

In order for a claim to process correctly, procedure code 99050 also requires an accompanying procedure code for covered Evaluation and Management (E&M) services (procedure codes 99201-99217, 99341-99350, and 99381-99397) and a place of service rendered outside of a hospital setting. Only one unit of the after-hours service can be reimbursed per member visit. The procedure code is entered as a line item on a claim with another line item for an E&M service in the range above.



To bill the after-hours procedure code for weekday visits only, providers must include a notation in the remarks field of the claim stating that the visit started before 7:30 a.m. or after 5:30 p.m.

Providers able to bill for these services include Physicians, Osteopaths, Family/Pediatric Nurse Practitioners, Nurse Midwifes, and Physician Assistants.

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

ColoradoPAR Program

The ColoradoPAR Program is the Utilization Management (UM) program for the Colorado Medical Assistance Program. The ColoradoPAR Program currently processes Prior Authorization Requests (PARs) for the following categories:

- Diagnostic imaging services limited to non-emergent Computed Tomography (CT) Scans, Magnetic Resonance Imaging (MRI), and all Positron Emission Tomography (PET) Scans.
- Durable Medical Equipment (DME) products including repairs and EBI Bone Stimulators.
- Home Health services including Pediatric Home Health and Private Duty Nursing (PDN). Home Health was formerly referred to as EPSDT Extraordinary and Long Term Home Health for Children.
- Medical/surgical services
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Second opinion surgical services
- Physical and Occupational Therapy services (OT/PT)
- Out-of-state transportation
- Out-of-state non-emergency surgical services
- Organ transplantation
- Vision Services

PAR Submissions and CareWebQI (CWQI) Information

All PARs and PAR revisions must be entered through CWQI. Providers can access the CWQI from the ColoradoPAR Program's website (coloradopar.com). For contact information and CWQI instructions, providers can go to the CWQI section of the ColoradoPAR website. To obtain eligibility of Colorado Medicaid members and obtain a final prior authorization ID, providers can go to the Colorado Medical Assistance Program Web Portal (Web Portal) **https://sp0.hcpf.state.co.us/Mercury/login.aspx located** on the Provider Services web page of the Department's website.

Back-Dating PARs

Services delivered without prior authorization shall not be reimbursed except for provision of services during an emergency, pursuant to 10 CCR 2505-10, Section 8.058.4 (Page 33), which can be found in the Rules and Regulations on the Department's website.

Other PAR Categories

For information regarding PAR categories not handled by the ColoradoPAR Program, providers can refer to Appendix D – Programs and Authorizing Agencies located on the Billing Manuals web page of the Department's website.

Prior Authorization Requests (PARs) with the New Dental Vendor, July 1, 2014

Beginning July 1, 2014, all PAR-revision requests on active PARs must be submitted directly to DentaQuest, the new Dental & Orthodontic vendor. As of July 1, 2014 the ColoradoPAR Program will no longer accept any new dental or orthodontic requests through CWQI. Any Dental or Orthodontic users who have used CWQI within the last three (3) years must also submit a CareWebQI User Termination form. The form is obtained from the ColoradoPAR Program website → CareWebQI Termination Form.

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.

Old Age Pension (OAP) Health Care Program Rate Increases

Effective for dates of service July 1, 2014, several reimbursement rates for the Old Age Pension (OAP) Health and Medical Care Program, will be increased. The following table displays the OAP Health and Medical Care Program reimbursement rates effective July 1, 2014:

Reimbursement Rates as a Percentage of Medicaid	
Claim Type	**Effective July 1, 2014**
Capitation	100%
Pharmacy	100%
Inpatient	10%
Outpatient	100%
Practitioner/Physician	100%
Dental	100%
Independent Laboratory	100%
Medical Supply	100%
Home Health	100%
Transportation	100%
Medicare Part A Crossover	100%
Medicare Part B Crossover	100%
Medicare UB92 Part B Crossover	100%

Please contact Cindy Arcuri at Cynthia.Arcuri@state.co.us or 303-866-3996 with questions.

New Health Care Policy and Financing (HCPF) Website Coming Soon

The Department's main website, colorado.gov/pacific/hcpf, will be moving to a new platform in mid-July 2014. The provider 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. There will be 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 issue of the Provider Bulletin. For more information, please refer to the frequently asked questions (FAQs).

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.

Financial Reporting System Transition

On July 1, 2014, the State of Colorado will replace its current financial system, the Colorado Financial Reporting System (COFRS), with a new system, the Colorado Operations Resource Engine (CORE). The new financial reporting 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, 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. After testing the new interfaces, the Department does not anticipate any disruptions in payments to providers.
If a provider does encounter payment issues after July 1, 2014, they should contact Tim Gaub at Tim.Gaub@state.co.us or the Department's Accounting Section at hcpfar@state.co.us.

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 before 6:00 p.m. Mountain Time (MT). State, the Department's fiscal agent, DentaQuest, 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.

Hospital Providers

Outpatient Hospital Supplemental Medicaid Payment Percentage Adjustment Factors for Federal Fiscal Year (FY) 2013-2014

This update is a technical change and does not impact reimbursement. No changes are being made to the final 2013-2014 Outpatient Hospital Supplemental Medicaid Payment amounts.
The Outpatient Hospital Supplemental Medicaid Payment is calculated by multiplying estimated outpatient billed costs by a percentage adjustment factor (PAF). The PAFs were listed in Attachment A-1 of the January 2014 Provider Bulletin (B1400346). The PAFs were determined and the Outpatient Hospital Supplemental Medicaid payment calculated based on outpatient billed costs that were not inflated. According to the State Plan, the outpatient billed costs must be inflated. To avoid being in violation of the State Plan, the outpatient billed costs must be revised. In order to maintain the calculation of the payment, the adjustment factors must be altered. No changes are being made to the final 2013-2014 calculated dollar amounts of the Outpatient Hospital Supplemental Medicaid Payments that will be made to hospitals. Based on a provider's fiscal year (FY), the percentage adjustment factors must be decreased by the following percentages:

Fiscal Year End	Percentage Adjustment Factor (PAF)
March 31	27.50%
April 30	26.79%
June 30	25.31%
August 31	23.75%
September 30	22.96%
October 31	22.14%
December 31	20.46%

A full list of the revised PAFs for FY 2013-2014 are located in Attachment A of this bulletin.
Please contact Matt Haynes at Matt.Haynes@state.co.us or 303-866-6305 with questions.

Practitioners

Obstetrical Services - Ultrasound Utilization Limit Reminder

For fee-for-service members, the Colorado Medical Assistance Program limits ultrasound utilization to three (3) per each uncomplicated or low-risk pregnancy. For more information, please consult the Maternity Services Benefits Coverage Standard or the Obstetrical Services Billing Manual on the Department's website → Provider Services → Billing Manuals → Colorado 1500 → Obstetrical Care
Please contact Kirstin Michel at Kirstin.Michel@state.co.us with questions.

Waiver Providers

Children with Life Limiting Illness (CLLI) Waiver Service Change

The Department has restructured the service package for the CLLI Waiver effective July 1, 2014. The services have been 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	$15.72/15 min
H2032	Art and Play Therapy Group	UD, HA, HQ	$8.80/15 min
H2032	Music Therapy	UD	$15.72/15 min
H2032	Music Therapy Group	UD, HQ	$8.80/15 min
97124	Massage Therapy	UD	$17.54/15 min
G9012	Palliative/Supportive Care: Care Coordination	UD	$19.97/15 min
S9123	Palliative/Supportive Care: Pain and Symptom Management	UD	$75.30/hour
S5150	Respite: Unskilled (4 hours or less)	UD	$5.34/15 min
S5151	Respite: Unskilled (over 4 hours)	UD	$96.15/day
T1005	Respite: CNA (4 hours or less)	UD	$7.00/15 min
S9125	Respite: CNA (over 4 hours)	UD	$124.48/day
T1005	Respite: Skilled RN, LPN (4 hours or less)	UD, TD	$15.23/15 min
S9125	Respite: Skilled RN, LPN (over 4 hours)	UD, TD	$274.07/day
S0257	Therapeutic Life Limiting Illness Support-Individual	UD	$24.41/15 min
S0257	Therapeutic Life Limiting Illness Support-Family	UD, HR	$24.41/15 min
S0257	Therapeutic Life Limiting Illness Support-Group	UD, HQ	$14.40/15 min
S0257	Bereavement Counseling	UD, HK	$1100.00 lump sum

The Children's HCBS Billing Manual and Prior Authorization Request form have been updated to reflect these changes.

For additional information, please refer to 10 C.C.R. 2505-10 § 8.504.6 (Page 84) found in the Program Rules and Regulations web page of the Department's website for additional information 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

Pharmacy and Therapeutics (P&T) Meeting

Tuesday, July 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 July 1, 2014, the following will be preferred agents on the Medicaid PDL and will be covered without a prior authorization (unless otherwise indicated):

Antihistamines (newer generation): cetirizine and loratadine generic dosage forms **Angiotensin Receptor Blockers, Combinations and Renin Inhibitors:** Benicar, Diovan (brand name), losartan, irbesartan, Benicar-HCT, Diovan-HCT (brand name), losartan/HCTZ **Anticholinergic Inhalants:** ipratropium nebulizer solution, Atrovent HFA and Spiriva **Anticholinergic and Short Acting Beta-2 Agonist Combinations:** albuterol/ipratropium nebulizer solution and Combivent inhaler
Corticosteroid Inhalants: Asmanex, budesonide nebulizer solution, Flovent (HFA and diskus) and Qvar inhaler
Corticosteroid and Long-Acting Beta-2 Agonist Combinations: Advair diskus, Advair HFA, Dulera
Fibromyalgia Agents: Lyrica and Savella
Short-acting Beta-2 Agonists: albuterol nebulizer solution and ProAir HFA
Long-acting Oral Opiates: methadone and morphine ER, fentanyl patches

- Butrans patches will be available after failing one preferred product

Skeletal Muscle Relaxants: baclofen, tizanidine and cyclobenzaprine
Topical Immunomodulators: Elidel will be preferred, however, it will still require prior authorization

The full PDL can be found the Department's website → Pharmacy → Preferred Drug List.

Other Drug Coverage Updates

Otezla will be approved for members who meet all of the following criteria:

- Member is 18 years of age or older
- Is not receiving rifampin, phenobarbital, carbamazepine, or phenytoin
- Does not have severe renal impairment (Crcl< 30 ml/min)
- Has failed a 12 week trial of two of the following: leflunomide, methotrexate, sulfasalazine, or cyclosporine and has also failed a 12 week trial of either ENBREL or HUMIRA. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interactions.)

Hetlioz will be approved for members who meet all of the following criteria:

- Have a documented diagnosis of non-24-hour sleep wake disorder (non-24 or N24) by a sleep specialist
- Member is completely blind

Sovaldi (Sofosbuvir)

- Will be approved on a case by case basis
- Will be evaluated based the meeting of all the following interim criteria:
  1. Must have chronic Hepatitis C (HCV) genotype 1, 2, or 4
  2. Member is 18 years of age and older
  3. Women of childbearing potential and their male partners must use two forms of effective (non-hormonal) contraception during treatment. Initial pregnancy test must be performed prior to beginning therapy.
  4. Sofosbuvir is prescribed by or in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist.
  5. Meets one of the following categories based on liver biopsy or other accepted test:
     - Members with serious extra-hepatic manifestations of HCV such as leukocytoclasic vasculitis, hepatocellular carcinoma meeting Milan criteria, membranoproliferative glomerulonephritis, or symptomatic cryoglobulinemia despite mild liver disease.
     - Members with compensated or decompensated cirrhosis defined by one of the following: Child-Turcotte Pugh class A or B (Score 5-9 ascites), hepatic encephalopathy, or variceal bleeding.

- Transplant patients with fibrosing cholestatic HCV or recipient who have cirrhosis from recurrent HCV and have been approved for re-transplantation
- Member is listed on the transplant list with a projected time to transplant of < 1 year.
- Member has a Metavir fibrosis score of 3-4

6. For members with Genotype 1, must be Hepatitis C treatment naïve.
7. The member does not have severe renal impairment (eGFR<30 ml/min/1.73m2) or end state renal disease requiring hemodialysis.
8. Member must be 6 months free of substance abuse/opioid/alcohol dependence as documented by appropriate drug screens and counseled about the importance of refraining from drug and/or alcohol abuse. Routine substance/alcohol/opioid screens must be conducted monthly for members that have a history (within the past 2 years) of drug or alcohol abuse.
9. Member must have a baseline HCV RNA level within 30 days of anticipated start date
10. Member is not receiving concomitant treatment with a hepatitis protease inhibitor (e.g. telaprevir or boceprevir).
11. All approvals will initially be for a 8 week time period, with further approvals dependent on the submission of the HCV RNA level at 4, at week 12, and week 24 to rational drug therapy (see discontinuation criteria).
12. If the week 4 HCV RNA is detectable while on sofobuvir therapy, HCV RNA will be reassessed in 2 weeks. If the repeated HCV RNA level has increased (i.e., >1 log10 IU/ml from nadir) all treatment will be discontinued unless documentation is provided to support continuation of therapy.
13. Must be in accordance to approved regimens and duration (see Table 1).
14. Must be adherent to treatment regimen (see discontinuation criteria).
15. Must be Sofosbuvir naïve.

Note*:* Once treated, the Department will only cover a once per lifetime treatment with Sofosbuvir.

Sovaldi (Sofosbuvir) Discontinuation Criteria:

- Patients receiving a Sofosbuvir based regimen should have HCV RNA levels assessed at weeks, 4, 6 (if applicable), and 12 (if applicable); if the HCV RNA is above the lower limit of quantification by a validated test at any of these time points, all treatment will be discontinued.
- The department will prospectively evaluate medication adherence based on prescription fills. If a patient documents non-adherence to filling their Sofosbuvir prescription (e.g. within 7 days), all treatment will be discontinued.

Quantity and Refill Limits:
Quantity Limit: one 400mg tablet per day (28 tablets/28days)
Length of authorization: Based on HCV subtype
Refills: Should be reauthorized in order to continue the appropriate treatment plan. The member must receive refills within one week of completing the previous fill.

Table 1. Recommended Regimens and Treatment Duration for Sofosbuvir

HCV Genotype and Comorbidities (Mono-infected and HCV/HIV-Co-infected)	Treatment	Duration
Patients with genotype 1 or 4 HCV with or without compensated cirrhosis	Sofosbuvir + peginterferon alfa + ribavirin	12 weeks

HCV Genotype and Comorbidities (Mono-infected and HCV/HIV-Co-infected)	Treatment	Duration
(including those with hepatocellular carcinoma) if interferon eligible		
Patients with genotype 1 with or without compensated cirrhosis (including those with hepatocellular carcinoma) if interferon ineligible	Sofosbuvir + ribavirin	24 weeks
Patients with genotype 2 HCV with or without compensated cirrhosis (including those with hepatocellular carcinoma)	Sofosbuvir + ribavirin	12 weeks
Post-transplant patients (genotypes 1,2, and 4) with or without compensated cirrhosis (including those with hepatocellular carcinoma) if interferon eligible	Sofosbuvir + peginterferon alfa+ ribavirin	12 weeks
Post-transplant patients (genotypes 1,2, and 4) with or without compensated cirrhosis (including those with hepatocellular carcinoma) if interferon ineligible	Sofosbuvir + ribavirin	24 weeks

Interferon Alpha Ineligible defined:

- Platelet count <75,000mm3
- Decompensated liver cirrhosis (CTP Class B or C or CTP score ≥ 7).
- Documented history of depression or mood disorder, which are not stable on current drug regimen.
- Autoimmune hepatitis and another autoimmune disorder
- Inability to complete a prior treatment course due to a documented interferon-related adverse event.

Short-Acting Opioids (dosing limits) – Beginning August 1, 2014

- All short-acting opioids products will be limited to a quantity of 120 units in 30 days.
- Butalbital combination products are limited to 180 units in 30 days.
- Members with a diagnosis of a terminal illness or sickle cell anemia are excluded from quantity limits. This will require a prior authorization.

Protopic

Beginning July 1, 2014, when a pharmacy submits a prescription for Protopic, anew rejection code will appear at the point-of-sale. The NCPDP edit that will appear at the point-of-sale is “R6” and will include

text indicating that Protopic is non-preferred. Please also note that the claim will be adjudicated and denied. On the Pharmacy Provider Claim Report (PCR), this denial will appear as edit PBR6.

July and August 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.

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 –** Basic Billing Waiver 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM Practitioner 1:00 PM-3:00 PM	19

August 2014

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
3	4	5 Beginning Billing – CO -1500 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM ***WebEx –** OT/PT/ST 1:00 PM-3:00 PM	6 **All *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	7 **All *WebEx –** DME/Supply 9:00 AM-11:00 AM Provider Enrollment 1:00 PM-3:00 PM	8 **All *WebEx –** Basic Billing Waiver 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM FQHC/RHC 1:00 PM-3:00 PM	9

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, 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 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

Fiscal Year 2013-2014 Payment Adjustment Factor by Provider

Name	FY 2013-2014 OP Payment Adjustment Factor
Animas Surgical Hospital	124.08%
Arkansas Valley Regional Medical Center	29.00%
Aspen Valley Hospital	31.81%
Boulder Community Hospital	22.27%
Centura Health - Avista Adventist Hospital	20.91%
Centura Health - Littleton Adventist Hospital	20.91%
Centura Health - Parker Adventist Hospital	20.91%
Centura Health - Penrose -St. Francis Health Services	20.91%
Centura Health - Porter Adventist Hospital	20.91%
Centura Health - Saint Anthony Central Hospital	20.91%
Centura Health - Saint Anthony North Hospital	20.91%
Centura Health - Saint Anthony Summit Hospital	29.87%
Centura Health - St. Mary-Corwin Medical Center	20.91%
Centura Health - St. Thomas More Hospital	29.87%
Children's Hospital Colorado	23.86%
Colorado Plains Medical Center	31.14%
Community Hospital	44.66%
Conejos County Hospital	212.86%
Craig Hospital	11.56%
Delta County Memorial Hospital	167.03%
Denver Health Medical Center	19.88%
East Morgan County Hospital	31.81%
Estes Park Medical Center	159.07%
Exempla Good Samaritan Medical Center	22.27%
Exempla Lutheran Medical Center	22.27%
Exempla Saint Joseph Hospital	22.27%
Family Health West Hospital	237.02%
Grand River Medical Center	39.77%
Gunnison Valley Hospital	31.81%
Haxtun Hospital	377.80%

Name	FY 2013-2014 OP Payment Adjustment Factor
HealthOne Medical Center of Aurora	22.27%
HealthOne North Suburban Medical Center	22.27%
HealthOne Presbyterian/St. Luke's Medical Center	21.35%
HealthOne Rose Medical Center	22.27%
HealthOne Sky Ridge Medical Center	20.91%
HealthOne Spalding Rehabilitation Hospital	11.68%
HealthOne Swedish Medical Center	21.57%
HealthSouth Rehabilitation Hospital - Colorado Springs	11.93%
Heart of the Rockies Regional Medical Center	31.81%
Keefe Memorial Hospital	119.30%
Kit Carson County Memorial Hospital	79.54%
Lincoln Community Hospital and Nursing Home	159.07%
Longmont United Hospital	22.27%
McKee Medical Center	22.27%
Medical Center of the Rockies	22.27%
Melissa Memorial Hospital	258.49%
Memorial Hospital	22.27%
Mercy Medical Center	29.87%
Middle Park Medical Center	31.81%
Montrose Memorial Hospital	31.81%
Mount San Rafael Hospital	31.81%
National Jewish Health	89.62%
North Colorado Medical Center	22.27%
Northern Colorado Rehabilitation Hospital	11.93%
Pagosa Mountain Hospital	79.54%
Parkview Medical Center	11.20%
Pikes Peak Regional Hospital	132.83%
Pioneers Hospital	159.07%
Platte Valley Medical Center	32.61%
Poudre Valley Hospital	22.27%
Prowers Medical Center	31.81%
Rangely District Hospital	278.38%
Rio Grande Hospital	261.67%
San Luis Valley Regional Medical Center	29.87%

Name	FY 2013-2014 OP Payment Adjustment Factor
Sedgwick County Memorial Hospital	79.54%
Southeast Colorado Hospital	198.84%
Southwest Memorial Hospital	31.81%
Spanish Peaks Regional Health Center	79.54%
St. Mary's Hospital and Medical Center	22.27%
St. Vincent General Hospital District	198.84%
Sterling Regional MedCenter	31.81%
The Memorial Hospital	31.81%
University of Colorado Hospital	29.87%
Vail Valley Medical Center	62.29%
Valley View Hospital	31.81%
Vibra Long Term Acute Care Hospital	11.93%
Weisbrod Memorial County Hospital	198.84%
Wray Community District Hospital	99.42%
Yampa Valley Medical Center	30.81%
Yuma District Hospital	79.54%

Attachment B

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

Code	Description
93970	EXTREMITY STUDY
93975	VASCULAR STUDY
93976	VASCULAR STUDY
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