COLORADO
Department of Health Care Policy & Financing

Provider Bulletin

Colorado.gov/hcpf

Reference: B1400360 **December 2014**

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...?

Medicaid members can log on to Colorado.gov/PEAK and print a copy of their Medicaid card to take to their appointments. Members who are enrolled in Medicaid can access their card at any time and do not have to wait for their card to be delivered by mail. The printable card looks just like the card a Medicaid member receives as if it were mailed. The Department strongly encourages providers to take the printed cards and to continue to follow the practice's business process for verifying Medicaid eligibility.

All Providers

Centers for Medicare and Medicaid Services 1500 (CMS 1500) Claim Form Transition

Currently, Colorado Medicaid providers submit professional claims electronically or via the Colorado 1500 (CO-1500) paper claim form. Effective December 1, 2014, the CO-1500 paper claim form will be replaced by the current CMS 1500 paper claim form [OMB-0938-1-1197 Form 1500 (rev. 02-12)]. The CMS 1500 form will not be processed before December 1, 2014. All CO-1500 claim forms received after December 1, 2014 will be denied, regardless of the date of service.

Per federal mandate, the Department of Health Care Policy and Financing (the Department) is required to institute ICD-10 diagnosis and procedure code sets throughout its systems and business processes for claims with dates of service on or after October 1, 2015. In preparation for this implementation, the Department is transitioning all professional paper claim submission to the CMS 1500 claim form.

As a result, the Department will also be updating the Adjustment Transmittal Form by removing the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and Professional Claim options, as they will no longer be needed when adjusting professional claims. Instead, the CMS 1500 form itself will be used for adjusting already-paid claims.

For further information, refer to the Frequently Asked Questions (FAQ) document that is available on the CMS 1500 section of Provider Implementations page of the Department's website (Colorado.gov/hcpf/provider-implementations).

The ColoradoPAR Program

CareWebQI (CWQI) Provider Messaging

Important messaging from the ColoradoPAR Program is communicated to providers via CWQI. The ColoradoPAR Program staff regularly communicates with providers about particular cases via the CWQI secure message feature.

Colorado Medicaid Fee Schedule

Providers may reference the Colorado Medicaid Fee Schedule to verify whether or not a code requires a prior authorization. The Fee Schedule is located on the Department's website under Provider Services.

Cancelling Approved Prior Authorization Requests (PARs)

A provider can stop a PAR already submitted by contacting the ColoradoPAR Program at 1-888-454-7686.

Continuous Positive Airway Pressure (CPAP) Prior Authorizations

- Use modifier RR for CPAP rentals
- Use modifier NU for CPAP purchases
- A PAR revision must be submitted for all CPAP purchases when the initial PAR was a rental, unless the following criteria applies:
  - The rental PAR has expired
  - The provider wants the purchase on a separate PAR and the compliance documentation is up to date
- CPAP PAR requests must include a minimum of 60 days of compliance data in order to qualify for purchase.

Clinical Indicators in CWQI

All clinical indicator boxes must be checked and the proper documentation attached for all CWQI submissions.

Colorado Medicaid Nurse Advice Line

The Nurse Advice Line is a free 24-hour access available to all Colorado Medicaid members. Medicaid members may call 1-800-283-3221 for medical advice and information and referral services. The Nurse Advice Line Frequently Asked Questions is a helpful resource that can be provided to Medicaid members and posted in clinics. Providers are encouraged to share Colorado Medicaid Nurse Advice Line information with Colorado Medicaid members.

International Classification of Diseases Version 10 (ICD-10)

Final Rule: October 1, 2015 - Transition date to ICD-10

On June 6, 2014, the U.S. Department of Health and Human Services (HHS) issued a rule, finalizing October 1, 2015, as the new compliance date for health care providers, health plans, and health care clearing houses to transition to ICD-10.

Ongoing Activities

The Department is finalizing the system and code conversion to ICD-10. The code mapping team will do another validation of the completed ICD-10 code sets when the all-inclusive list of codes are published by the Centers of Medicare and Medicaid Services (CMS) at the beginning of 2015.

Provider Outreach for External End-to-End Testing

As of September 2014, all State Medicaid Agencies (SMA) are required by CMS to complete end-to-end testing as part of meeting the October 1, 2015 deadline.

All SMA's will be required to complete testing of the five (5) critical success factors by the new deadline.

Below are the critical success factors outlined by CMS:

- Acceptance of electronic claims
- Accurate adjudication of claims and payments
- Payment (processing of 835's) and reimbursements

- Coordination of Benefits (COB)
- Submission of enhanced beneficiary, provider, claims, and encounter data via Transformed Medicaid Statistical Information System (T-MSIS)

By October 1, 2015, all testing of COB processes, claims exchange with partners, and Medicare must be completed by all SMA's.

In external end-to-end testing, business processes will be validated from start to finish with one (1) or more business partners. This testing will provide system validation to the State of Colorado, providers, clearinghouses, and other entities. External end-to-end testing will confirm that systems are integrated, operable, and ready to accept the new ICD-10 codes and formats.

External end-to-end testing will validate:

- Remediated business processes
- Payment Policies
- Claims adjudication rules and edits

External end-to-end testing will focus on the ability of providers and trading partners to exchange ICD-10 Medicaid transactions with the Medicaid Management Information System (MMIS). Participation will be required from the Colorado Medical Assistance Program providers, COB crossovers, clearinghouses, and billing agents.

The Department has started reaching out to providers to partner for external end-to-end testing. End-to-end testing is anticipated to start in March of 2015 and continue to the end of June of 2015.

To partner with the Department for ICD-10 External End-to-End testing, please contact one of the following:
Sienna Apis at Sienna.Apis@state.co.us or at 303-866-2252;

D'Anya Bierria at D'Anya.Bierria@state.co.us or at 303-866-3467;

Shawna Tye at Shawna.Tye@state.co.us or at 303-866-2347

National Correct Coding Initiative (NCCI) Notification of Quarterly Updates

Providers are encouraged to monitor CMS for updates to the NCCI rule
s and guidelines. The updates are completed quarterly with the next update available January 2015. A link to the CMS NCCI website is also available on the Providers Information section of the Department's website.

Eligibility Response Changes

Accountable Care Collaborative (ACC) Medicare-Medicaid Program Member Eligibility Responses

Providers that request eligibility information for members who are enrolled in the ACC Medicare-Medicaid Program will now be identified in the eligibility response and will state:

> "This is an Accountable Care Collaborative Medicaid client who also has Medicare and is enrolled in the Medicare-Medicaid Program."

This information appears in the Prepaid Health Plan section of the Web Portal response. All other member information currently provided in eligibility responses will continue to be provided.

Emergency Only: Emergency Only Eligibility Responses

When providers request eligibility information, for a member that is an undocumented non-citizen, the message appearing under the Health Plan Name has been updated. The new message states:

"Undocumented/Non-Citizen. Emergency Services Only.
Please Note: Eligibility Plan Coverage Does Not Apply."

The Co-Payment message for Dental Care for non-citizens has also been updated to:

"Emergency Services Only. Please See Provider Manual*."
This message appears in the Co-Payment area on the eligibility response.

*Please refer to the DentaQuest Office Reference Manual (ORM).

Dental Co-Payment: For all Eligibility Types except Emergency Only

The Dental Co-Payment message for Dental Care has been updated for all eligibility types. The new message states:

"Please see Provider Manual."

This message appears in the Co-Payment area in the eligibility response.

Accountable Care Collaborative (ACC)

When providers request eligibility information, members who are enrolled in the ACC will no longer have a unique box at the top of the eligibility inquiry from the Web Portal. The new message states:

"This Medicaid client is enrolled in a Regional Care Collaborative Organization that provides care coordination support. If no Primary Care Medical Provider is listed, please advise the client to call HealthColorado at 303-839-2120 or 1-888-367-6557 to select one."

If a provider encounters any issues or has questions concerning member eligibility, contact Colorado Medical Assistance Program Customer Service at 1-800-221-3943.

Affordable Care Act (ACA) Adult Medicaid Plan

When providers request eligibility information, for a member that is in the ACA Adult Medicaid Program (ACA), the message appearing under the Client Eligibility Details has been updated. The new message states:

"This Expansion Client receives the ACA-Adult Medicaid Plan."

Child Health Plan *Plus* – CHP *Plus*

When providers request eligibility information for a member that is in the Child Health Plan Plus, the message has been changed to:

"Not Medicaid Eligible. This client is enrolled in the CHP Plus program. Co-payment may be required. For eligibility and enrollment questions, please contact CHP Plus at the number provided in this Eligibility Response."

Client Over-Utilization Program (COUP)

The message appearing under the Services Restricted to Following Provider(s) has been updated for providers that request eligibility information for a member that is in COUP. The new message states:

"This client is enrolled in the Client Over-Utilization Program (COUP). All non-emergency services and/or referrals must first be approved by the client's Lock-In Primary Care Medical Provider(s). All medications must be filled by the client's Lock-In Pharmacy."

This response appears in the Services Restricted to Following Provider(s) area on the eligibility inquiry for the Web Portal.

Dental Administrative Services Only (ASO)

When providers request eligibility information, members who are enrolled in the Dental ASO Program will now be identified in the eligibility response. The response will be provided through the Web Portal, fax-back, or telephone and includes the Dental ASO provider, Dental Provider phone number and the following message:

"This client is eligible to receive standard Medicaid dental services.
All dental services should be coordinated through the Dental ASO vendor listed."

This response appears in the Prepaid Health Plan section of the Portal response.

Old Age Pension Program (OAP) - State Only

When providers request eligibility information, for a member that is in the Old Age Pension Program (OAP), the message appearing under the Client Eligibility Details has been updated. The new message states:

"This client is enrolled in the Old Age Pension Health and Medical Care Program.
Not Medicaid eligible. Benefits may be limited and payments may be reduced.
More information at Colorado.gov/hcpf."

This response appears in the Client Eligibility Details.

Standard Medicaid

When providers request eligibility information, for a member that is in the Standard Medicaid Program, the message appearing under the Eligibility Status has been updated. The new message states:

"This client receives the Standard Medicaid Benefit."

All of the above responses will be provided through the Web Portal, fax-back 1-800-493-0920, or CMERS/ AVRS 1-800-237-0757. All other member information currently provided in eligibility responses will continue to be provided. Please contact Colorado Medical Assistance Program Customer Service at 1-800-221-3943 with any issues or questions concerning member eligibility.

Increase in Payment for Office Visits and Vaccine Administration

Beginning January 1, 2015, Colorado Medicaid will reimburse covered office visit procedure codes and the vaccine administration procedure codes for all providers at a rate equal to 100% of the December 2014 Medicare reimbursement rate. The new rate will be available to all enrolled providers that submit fee schedule claims for office visits or vaccine administrations. The new reimbursement rate will remain in place through June 2016.

Primary Care Supplemental Payment Ending

The ACA program to pay attested primary care physicians a supplemental payment that increased reimbursement to Medicare rates will end December 31, 2014. Claims for services after December 31, 2014 will not be evaluated for supplemental payments to primary care physicians. There will be supplemental payments made in 2015 for services by attested physicians that were rendered in 2014. Although this ACA program is ending, Colorado Medicaid will begin reimbursements for office visits and vaccine administrations at 100% of the Medicare rate beginning January 2015.

Screening Medicaid Members for Depression

Colorado Medicaid covers depression screenings for individuals ages 11 and older, using a standardized, validated depression screening tool (e.g., PHQ-9, Edinburgh Postnatal Depression Scale,

Columbia Depression Scale, Beck Depression Inventory, Kutcher Adolescent Depression Scale, other). HealthTeamWorks notes in their online Depression in Adults: Diagnosis and Treatment Guideline Supplement that the PHQ2/PHQ-9 "can be effectively used to screen for depression with adolescents, adults, and seniors."

Providers cannot bill for more than one (1) screening per member per fiscal year.

Please reference the March 2014 (B1400349) and August 2014 (B1400355) Provider Bulletins for additional information on billing for these services and the online Healthy Living Addressing Depression in Primary Care Tool Kit for referral information.
Please contact Jerry Ware at Jerry.Ware@state.co.us with questions.

Coding Changes to the Medicaid Fee-for-Service Primary Care Depression Screening Benefit

Addendum to the March 2014 (B1400349) and August 2014 (B1400355) Provider Bulletin

Effective January 1, 2015, fee-for-service primary care providers are required to bill the following procedure codes to receive payment for Colorado Medicaid member depression screenings for dates of service on or after January 1, 2015: G8431 (positive screening) or G8510 (negative screening). Additional ICD-9 diagnosis codes are required. Current Procedural Terminology (CPT) code 99420 will not be accepted for dates of service on or after January 1, 2015.

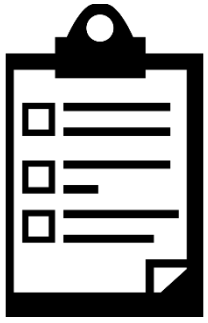
Postpartum depression screening counts as an annual depression screening and Medicaid primary care providers are encouraged to screen new mothers at a well-child visit using the mothers' Medicaid ID number. If a behavioral health need is identified after screening, the pediatric provider should assist with referring the mother to a Behavioral Health Organization (BHO) or Regional Care Collaborative Organization (RCCO) provider.

Important note: One (1) depression screening is allowed per member per fiscal year. Postpartum depression screening counts as an annual depression screening.

This benefit also requires providers to use a standardized, validated depression screening tool. Please review the online Healthy Living Addressing Depression in Primary Care Tool Kit for additional information.

Please contact Jerry Ware at Jerry.Ware@state.co.us with questions.

New Federal Provider Screening Regulations: Stakeholder Comments Sought



New federal regulations established by the CMS require enhanced screening and re-validation of providers enrolling with the Colorado Medical Assistance Program. These regulations are designed to reduce the potential for Medicaid fraud, waste, and abuse. Most providers will see very little change in their enrollment process, but some may be required to undergo additional screening before they can be enrolled or re-enrolled in Medicaid.
The Department is seeking feedback from providers and other stakeholders on a draft rule that will implement these federal regulations. The Department has limited flexibility in implementing the new federal regulations but is seeking feedback in a few key areas where the federal government has granted some flexibility.

More information, including a copy of the draft rule and instructions for submitting comments, can be found on the Department's website under the Federal Provider Screening Regulations section of Colorado.gov/hcpf/provider-implementations. Stakeholders may submit comments through December 1, 2014.

Tax Season and 1099s

Reminder: Please ensure all addresses (billing, location, and mail-to) on file with the Department's fiscal agent, Xerox State Healthcare, are current. 1099s returned for an incorrect address cause the account to be placed on hold, and **all** payments will be suspended, pending a current W-9. Payments that are held can be released once the W-9 is processed. Claims for payments not released are voided out of MMIS at two (2) different times during the year, once on June 30th and again on December 31st.

The Provider Enrollment Update Form or the Electronic Provider Enrollment Update Form can be used to update addresses, National Provider Identifiers (NPIs), licenses, and affiliations. In addition, an email address may be added or updated to receive electronic notifications. The form is available on the Department's website under Provider Services in the Update Forms section. With the exception of updating provider licenses and NPI information, the updates noted above may also be made through the Colorado Medical Assistance Web Portal (Web Portal) via the *MMIS Provider Data Maintenance* option. Please call 303-866-4090 if a provider does not receive a 1099.

December 2014 and January 2015 Holidays

Christmas Day Holiday

Due to Christmas Day holiday on Thursday, December 25, 2014, State, the ColoradoPAR Program, DentaQuest, and the Department's fiscal agent offices will be closed on Thursday, December 25, 2014. The Department's fiscal agent offices will close at 12:00 p.m. on Wednesday, December 24, 2014. The receipt of warrants and Electronic Funds Transfers (EFTs) may potentially be delayed due to the processing of the United States Postal Service (USPS) or providers' individual banks.

New Year's Day Holiday

Due to the New Year's Day holiday on Thursday, January 1, 2015, State, the ColoradoPAR Program, DentaQuest, and the Department's fiscal agent offices will be closed on Thursday, January 1, 2015. The Department's fiscal agent offices will close at 3:00 p.m. on Wednesday December 31, 2014. The receipt of warrants and Electronic Funds Transfers (EFTs) may potentially be delayed due to the processing of the United States Postal Service (USPS) or providers' individual banks.

Martin Luther King Day Holiday

Due to the Martin Luther King Day holiday on Monday, January 19, 2015, State, the ColoradoPAR Program, and DentaQuest offices will be closed on Monday, January 19, 2015. The Department's fiscal agent office will be open during regular business hours. The receipt of warrants and Electronic Funds Transfers (EFTs) may potentially be delayed due to the processing of the United States Postal Service (USPS) or providers' individual banks.

Ambulatory Surgery Center (ASC)

Pilot Reimbursement

Effective November 1, 2014, Colorado Medical Assistance Program conducted a change in reimbursement for professional fees and ASC facility fees for targeted procedures with the goal of moving targeted procedures from hospitals to ASCs. The following targeted procedures are for: hernia repair and knee arthroscopies. The pilot reimbursement program will continue until June 30, 2015. The utilization for these procedures in all settings will be analyzed to evaluate any change in utilization. The results of the analysis will be used to plan future professional and facility rates for hernia repair and knee arthroscopies and similar services in the ASC setting. The Department conducted a similar pilot three (3) years ago and the pilot resulted in increased reimbursement for one (1) procedure code.

For the procedure codes identified in the table below, the Colorado Medical Assistance program has changed the grouper assignment for the ASC facility fee to the grouper reimbursement that is closest to the Medicare rate without exceeding the Medicare rate.

	Hernia Repair	From Grouper	To Grouper	To Grouper Rate
49500	RPR 1ST INGUN HRNA AGE 6 MO-5 YRS REDUCIBLE	4	9	$1,046.48
49505	RPR 1ST INGUN HRNA AGE 5 YRS/GT REDUCIBLE	4	9	$1,046.48
49507	RPR 1ST INGUN HRNA AGE 5 YRS/GT INCARCERATED	9	9	$1,046.48
49585	RPR UMBILICAL HRNA 5 YRS/GT REDUCIBLE	4	9	$1,046.48
49587	RPR UMBILICAL HRNIA AGE 5 YRS/GT INCARCERATED	9	9	$1,046.48
49650	LAPS SURG RPR INITIAL INGUINAL HRNA	4	10	$1,735.75
49651	LAPS SURG RPR RECURRENT INGUINAL HRNA	7	10	$1,735.75

	Knee Arthroscopy	From Grouper	To Grouper	To Grouper Rate
29877	ARTHRS KNEE DEBRIDEMENT/SHAVING ARTCLR CRTLG	4	6	$645.55
29879	ARTHRS KNEE ABRASION ARTHRP/MLT DRLG/MICROFX	3	6	$645.55
29880	ARTHRS KNEE W/MENISCECTOMY MED and LAT W/SHAVING	4	6	$645.55
29881	ARTHRS KNEE SURG W/MENISCECTOMY MED/LAT W/SHVG	4	6	$645.55
29888	ARTHRS AIDED ANT CRUCIATE LIGM RPR/AGMNTJ/RCNSTJ	3	6	$645.55

The professional fee for the procedures identified in the table below will be reimbursed at Medicare rates when the service is rendered in an ASC. To identify that the professional service was done at an ASC, the line item on the claim must use the SG modifier. The SG modifier for professional services should only be used when a hernia repair or a knee arthroscopy is done in an ASC. The professional service rates for the targeted procedures in any other setting will not be changed.

	Hernia Repair	Modifier	Rate
49500	RPR 1ST INGUN HRNA AGE 6 MO-5 YRS REDUCIBLE	SG	$422.97

49505	RPR 1ST INGUN HRNA AGE 5 YRS/GT REDUCIBLE	SG	$578.50
49507	RPR 1ST INGUN HRNA AGE 5 YRS/GT INCARCERATED	SG	$651.25
49585	RPR UMBILICAL HRNA 5 YRS/GT REDUCIBLE	SG	$494.01
49587	RPR UMBILICAL HRNA AGE 5 YRS/GT INCARCERATED	SG	$528.85
49650	LAPS SURG RPR INITIAL INGUINAL HRNA	SG	$476.38
49651	LAPS SURG RPR RECURRENT INGUINAL HRNA	SG	$619.67

	Knee Arthroscopy	Modifier	Rate
29877	ARTHRS KNEE DEBRIDEMENT/SHAVING ARTCLR CRTLG	SG	$697.57
29879	ARTHRS KNEE ABRASION ARTHRP/MLT DRLG/MICROFX	SG	$742.97
29880	ARTHRS KNEE W/MENISCECTOMY MED and LAT W/SHAVING	SG	$630.96
29881	ARTHRS KNEE SURG W/MENISCECTOMY MED/LAT W/SHVG	SG	$606.69
29888	ARTHRS AIDED ANT CRUCIATE LIGM RPR/AGMNTJ/RCNSTJ	SG	$1,108.72

Dental Providers

Billing and Program Updates from DentaQuest

The latest edition, Vol. 2 – October Revised 2014, of the *Colorado Summit* has updates on the Colorado Medicaid 2% provider rate increase, an overview of scaling & root planing criteria, a dental sedation/deep sedation overview and clarification on payment, and claims reports for July through September 2014. Please contact DentaQuest Provider Services at 1-855-225-1731 for more information.

Dental Services for Presumptive Eligible (PE) Children

Presumptive eligibility is temporary coverage of medical benefits until eligibility for the Medicaid Program is determined. The Department would like to assure the dental provider community and members that PE Medicaid children qualify for access to dental services under the Children's Dental Program, as mandated by the federal Early Periodic Screening, Diagnosis and Testing (EPSDT) program.

Presumptive Eligible Children have been updated in the DentaQuest eligibility system as of November 29, 2014.

If a dental claim was billed while a child was presumptively eligible, and the claim was denied due to eligibility edits for a date of service on or after July 1, 2014, the Department has coordinated the necessary claims processing solution with DentaQuest. The incorrectly denied claims may be resubmitted to DentaQuest for claims processing as of December 1, 2014.

Please contact DentaQuest Provider Services at 1-855-225-1731 with questions.

Dental Program Benefits – Rules and Regulations Update

Adult Dental

The Department plans to take the Adult Dental Services rule to the Medical Services Board (MSB) hearing on January 9, 2015. The rule will include revisions based on provider and stakeholder feedback that has been received since the adult dental benefit was implemented in July 1, 2014.

The Department will share a draft copy of the proposed changes to the rule for stakeholder feedback at the Public Rule Review meeting on Monday, December 22, 2014, at 9:00 a.m. at 225 E. 16th Avenue in the 1st floor conference room, Denver, Colorado, 80203.

Durable Medical Equipment (DME) Providers

Complex Rehabilitation Technology (CRT) Supplier Enrollment

Effective January 1, 2015, House Bill 14-1211 will require the Department to recognize CRT as a unique category of service under Medicaid. CRT includes individually configured manual and power wheelchair systems, adaptive seating systems, alternative positioning systems, standing frames, gait trainers, and specially designated options and accessories that qualify as Durable Medical Equipment (DME).

To comply with the bill, the Department is adopting CRT supplier standards and will be restricting the reimbursement of CRT to only suppliers meeting these standards. Starting January 1, 2015 to qualify as a CRT supplier, a provider must meet the following requirements:

1. Be accredited by a recognized accrediting organization as a supplier of CRT;
2. Meet the supplier and quality standards established for DME suppliers under Medicare or the Medical Assistance Program;
3. Employ at least one (1) CRT Professional (i.e. an assistive technology professional) at each physical location;
4. Maintain a reasonable supply of parts, adequate physical facilities, and qualified and adequate service or repair technicians to provide members with prompt service and repair of all CRT it sells or supplies; and
5. Provide the member with written information at the time of sale on how to access service and repair.

Existing Colorado Medicaid DME providers that want to enroll as a CRT supplier, please contact Carrie Smith at Carrie.Smith@state.co.us, and request a letter of intent to enroll as a CRT supplier. Suppliers with multiple Medicaid provider ID numbers will need to submit a letter of intent for each provider ID number that bills CRT to Medicaid.

New Colorado Medicaid providers that want to enroll as a CRT supplier can follow the Provider Enrollment process. Please select CRT as a provider type when applying.

Please contact Eskedar Makonnen at Eskedar.Makonnen@state.co.us or 303-866-4079 with questions.

DME Billing Manual Update

A CRT section will be added to the DME and Supply billing manual in January 2015. The new CRT section will include information on covered CRT benefits, CRT codes, eligible providers, and prior authorization. Please contact Eskedar Makonnen at Eskedar.Makonnen@state.co.us or 303-866-4079 with questions.

Prior Authorization Clarification for Continuous Positive Airway Pressure (CPAP) Machines

A Home Sleep Study is an approved alternative to a Polysomnography (PSG), provided that it demonstrates obstructive sleep apnea, documents the AHI index, and has been completed within one (1) year of the authorization request date.

Federally Qualified Health Centers (FQHC) Providers

Approval of FQHC Rates

The Department recently received CMS approval of the FQHC rate increases effective July 1, 2014. Currently, the FQHC encounter rates are being loaded in the MMIS. Once the rates are loaded, the Department will retroactively adjust claims with dates of service on or after July 1, 2014 to reflect the rate increase. Adjustments will be reflected on future Provider Claim Reports (PCRs).
Please contact Marguerite Richardson at Marguerite.Richardson@state.co.us with questions.

Freestanding Birth Center Providers

Overview

Effective for claims with dates of service on or after July 1, 2014, Colorado Medicaid will pay licensed freestanding birth centers a birth center payment (facility payment) when a Medicaid member delivers a baby at a center. Payment is also available for cases when a member must be transferred to a hospital prior to delivery.

Provider Enrollment

Reimbursement for birth centers is only available to licensed freestanding birth centers that enroll with the Colorado Medical Assistance Program as a Medicaid provider for services rendered to Medicaid-eligible members. Practitioners, such as certified nurse midwives, providing services at birth centers must also be enrolled as Medicaid provider and affiliate with the birthing center under which claims are submitted. Currently, licensed freestanding birth centers enroll as non-physician practitioner groups with the Colorado Medical Assistance Program and affiliated certified nurse midwives enroll as certified nurse midwives.

Billing Requirements

All birth center claims should be submitted electronically through the Web Portal. Freestanding birth centers should submit usual and customary charges for all services rendered. Claims will be submitted using the 837 Professional (837P) transaction for practitioner claims. Birth centers in Colorado must notify the Department prior to submitting the first claim for reimbursement to ensure correct payment.

The following table illustrates the coding that must be used for the facility payment.

Description	CPT Code(s)	Modifier	Reimbursement
Birth center payment	59899	HD	$2,185.05

The modifier included in the tables above and below are required for the claim to pay correctly. If HD (women's program/service) is not included in the 1st modifier position, the claim will pay incorrectly.

Occasionally, members are unable to deliver at the birth center and need to be transferred to a hospital. In these cases, a reduced birth center payment is available as is reimbursement for time spent with the member.

Description	CPT Code(s)	Modifier 1	Modifier 2	Reimbursement
Transfer payment: Payment for costs incurred prior to transporting a member to a hospital	59899	HD	52	$1,092.53

In addition to the payment made for members who transfer, claims can be submitted for the time a midwife spends with the member prior to transfer and for antepartum care.

Description	CPT Code(s)	Reimbursement
Office or outpatient visit; up to 40 minutes of time (99215)	99215	Payment is based upon Colorado Medicaid's fee schedule.
Office or outpatient visit; 41 minute to 121 minutes (99354)	99215 + 99354	Payment is based upon Colorado Medicaid's fee schedule.
Office or outpatient visit; each 30 minutes after 121 minutes (99355)	99215 + 99354 + 99355 (1 unit of 99355 per each additional 30 minutes)	Payment is based upon Colorado Medicaid's fee schedule.

Other Covered Services and Payment Information

Birth centers can provide a range of antepartum, delivery, and postpartum care to Medicaid members. For more information related to obstetrical care, refer to the Obstetrical Care Billing Manual.

The following is not an exhaustive list of billable CPT codes, but it demonstrates the Colorado Medical Assistance Program's coding requirements for some of the services provided by a birth center. Billing agents should use published billing manuals and the CPT/HCPC coding books for specific information.

Description	Code	Reimbursement
Global obstetrical care: includes antepartum care, labor and vaginal delivery, and postpartum care. (Requires a minimum of 4 antepartum visits.)	59400	Payment is based upon Colorado Medicaid's fee schedule.
Newborn care	99463	Payment is based upon Colorado Medicaid's fee schedule.
Antepartum care, 4-6 visits	59425	Payment is based upon Colorado Medicaid's fee schedule.
Antepartum care, 7 or more visits	59426	Payment is based upon Colorado Medicaid's fee schedule.

Please refer to the Code of Colorado Regulation 10 C.C.R. 2505-10 §8.012.2.C. Providers may not collect or attempt to collect payments from Medicaid members for covered services. This specifically prohibits Medicaid providers from charging Medicaid members for any unreimbursed costs for covered services. As an example, if a birth center bills Medicaid $5,000 for the obstetrical care and Medicaid pays $2,000, the member cannot be charged the $3,000 difference. Pregnant women are exempt from all co-payments while they are pregnant and through 60 days postpartum.

Payment for Services Rendered between July 1, 2014 and December 2014

Licensed birth centers can submit claims for a facility payment or transfer payment for claims with dates of service on or after July 1, 2014 through present day. If the claim is more than 120 days old, contact Kirstin Michel at Kirstin.Michel@state.co.us prior to submission. A late bill override date (LBOD) will be provided and is required on the claim.

Please contact Kirstin Michel at Kirstin.Michel@state.co.us or 303-866-2844 for more information about enrolling as a licensed freestanding birth center or with other questions.

Hospital Providers

Inpatient and Outpatient Rate Increase Update

The Department recently received CMS approval to increase rates for fee-for-service inpatient and outpatient hospital services. The hospital facility inpatient base rates and the updated outpatient Medicaid percentage of costs are in the process of being loaded in the MMIS. Once the rates are loaded, the Department will retroactively adjust claims with dates of service on or after July 1, 2014 to reflect the rate increase. Adjustments will be reflected on future Provider Claim Reports (PCRs).

Please contact Marguerite Richardson at Marguerite.Richardson@state.co.us with questions.

Non-Covered Days for Inpatient Claims

Hospital providers have been using Occurrence Code 81 to report any non-covered days. As of January 1, 2014, the Department added the new Occurrence Span 74 which would allow providers to report the exact date span for the non-covered days. Due to a system error, both Occurrence Codes cannot be correctly recognized simultaneously, inadvertently positing "Edit 0183- Invalid Non-covered Days," which in turn denies the claim. Until further notice, providers should continue using Value Code 81 to report non-covered days and not use the Occurrence Span 74 at this time.

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

Billing Vxx.xx Diagnosis Codes as Other Diagnosis

The Department has identified that certain Vxx.xx diagnosis codes that are not covered as primary diagnosis have been leading to denials for entire inpatient claims if the diagnosis was reported as an Other Diagnosis. The Department has completed updating all of the Vxx.xx diagnosis codes, and the claims will no longer deny for the diagnosis not covered when a Vxx.xx is reported. Please note, that claims may still deny if these codes are reported as the primary diagnosis. Hospital providers may contact Ana Lucaci at Ana.Lucaci@state.co.us for a LBOD if claims continue to deny for Vxx.xx diagnosis codes not covered.

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

Updates to Outpatient Cost-to-Charge Ratios

The Department is in the process of updating all hospitals' outpatient cost-to-charge ratios. Outpatient laboratory, occupational therapy, physical therapy, and hospital-based transportation claim lines are reimbursed based on the Medicaid Fee Schedule located on the Rates & Fee Schedule web page. Outpatient hospital services not reimbursed according to the Department's fee schedule are reimbursed on an interim basis at actual billed charges multiplied by:

1. The most recent Medicare cost-to-charge ratio that has been sent to the Department.
2. 71.6 percent (%) in Fiscal Year 2014-2015.

The Department conducts a periodic cost audit, and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 71.6% or billed charges less 71.6%.

It is the hospital's responsibility to notify the Department of changes to their Medicare outpatient cost-to-charge ratio.

Effective January 1, 2015, all Hospital Cost-to-Charge Ratios will be updated

If a hospital fails to provide the Department with updated information by December 15, 2014, the Department will institute a default reduction in the hospital's cost-to-charge ratio as needed with the goal of reducing the magnitude of future cost settlement amounts. Providers who have already provided the most recent cost-to-charge ratio to the Department may disregard this message.

Please contact Marguerite Richardson at Marguerite.Richardson@state.co.us or 303-866-3839 with questions about the process or to submit the Medicare outpatient cost-to-charge ratios for the facility. Note: Faxes may be sent to 303-866-4411.

Physical and Occupational Therapy Providers

PAR Required

All physical and occupational therapy services, including CPT code 97150, require a PAR after the first 24 units of therapy have been used in order for proper reimbursement.

Members cannot be charged for covered services due to provider failure to request a PAR.

Please refer to the Code of Colorado Regulation 10 CCR 2505-10 8.012, "Providers Prohibited from Collecting Payment from Recipients" for further information.

Waiver Providers

Changes to Financial Management Services (FMS) for Consumer Directed Attendant Support Services (CDASS) Members

The Department is making changes to Financial Management Services (FMS) for CDASS members. Effective January 1, 2015, CDASS members will have a choice between three (3) FMS vendors and two (2) employer models: Agency with Choice (AwC) and Fiscal/Employer Agent (F/EA). Additionally, the Department will contract with a CDASS training and operations vendor to provide training and customer service support for participant directed service delivery models available within Colorado.

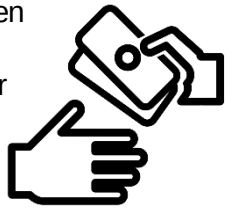
The three (3) FMS contractors are as follows:

- ACES$ Financial Management Services: MyCIL.org
- Morning Star Financial Services: morningstarfs.com
- Public Partnerships, LLC: publicpartnerships.com

The CDASS training and operational support will be provided by a separate training and operations vendor (more information is forthcoming).

Please contact Kelly Jepson at Kelly.Jepson@state.co.us with questions.

Alternative Care Facility (ACF) PARs and Payment



The Department was recently informed of payment issues for categorically eligible members receiving ACF services. The payment issues are the result of a Department error and have since been corrected. The payment issue affected claims for categorically eligible members only. For providers who received incorrect payment for ACF services for dates of services on or after July 1, 2014, action may need to be taken to receive the correct payment for services. For providers whose usual and customary charges are greater than the current ACF rate of $50.95, no action is required, and claims will be mass adjusted by the Department. For providers whose usual and customary charges are less than the current ACF rate of

$50.95, will have to submit adjustments to the claims to ensure correct payment is received. Please refer to the following instructions on How to Adjust a Claim through the Web Portal.

Please contact Randie Wilson at Randie.Wilson@state.co.us for rates questions.

Please contact Jennifer Martinez at Jennifer.Martinez@state.co.us for policy questions.

Pharmacy Providers

Prior Authorization Process for Harvoni® and other New Hepatitis C Treatment Agents

The Department looks to its Drug Utilization Review (DUR) Board to advise and provide recommendations regarding issues of drug utilization, provider education interventions, and application of standards. Hepatitis C drugs were reviewed by the DUR Board in August 2014 and as such, they are not scheduled to be reviewed again until August 2015. Currently, the DUR Board can make recommendations to the Department regarding coverage criteria on existing and new Hepatitis C agents. The Department will continue to evaluate the drug class to determine whether it will request the DUR Board to review these drugs before August 2015. The Department manually reviews each request for new agents for medical necessity. Consideration for new agents requires a letter of medical necessity. The Colorado Medical Assistance Program still offers available pharmaceutical options for the treatment of Hepatitis C.

Please see the Preferred Drug List (PDL) on the Forms web page.

Preferred Drug List (PDL) Update

Effective January 1, 2015, these are the preferred medications in the following categories:

Anti-Emetic
Ondansetron tablets, ODT, and oral solution

New Generation Antidepressants
Citalopram, venlafaxine IR tablets, venlafaxine XR capsules, paroxetine, fluoxetine, mirtazapine, sertraline, bupropion IR, bupropion SR, bupropion XL, and escitalopram

Anti-herpetic
Acyclovir

Oral Antiplatelet
Clopidogrel, Aggrenox, ticlodipine, and Effient

Fluoroquinolone
Brand name Cipro oral suspension, levofloxacin tab and ciprofloxacin tab

Pancreatic Enzyme
Creon and Zenpep

Proton Pump Inhibitor
Nexium capsules and packets, Prevacid solutab, lansoprazole capsules, omeprazole, and pantoprazole tablets

Pulmonary Hypertension Agents
Sildenafil (generic Revatio), Letairis, and epoprostenol (generic Flolan)

Targeted Immunmodulators
Enbrel and Humira

Triptan
Sumatriptan tablet, brand name only Imitrex injection and nasal spray, naratriptan, rizatriptan MLT, and brand name only Relpax

Prior Authorization Changes/Reminder

Effective January 1, 2015, the pegylated interferon and ribavirin products used in combination to treat Hepatitis C will require a prior authorization. By requiring these products to be prior authorized, it ensures members only receive the products as part of a combination therapy regimen.

Pharmacies should only dispense a medication that requires a prior authorization after obtaining the prior authorization. In an emergency, if a PAR cannot be obtained in time to fill the prescription, pharmacies may dispense a 72-hour supply (three days) of covered outpatient prescription drugs to an eligible member by calling the Department's PA Helpdesk for approval at 1-800-365-4944. An emergency situation is any condition that is life threatening or requires immediate medical intervention.

Pharmacy and Therapeutics (P&T) Committee Openings

The Colorado P&T Committee has several openings with terms beginning January 2015 through December 2016. Currently there are openings for:

- Two (2) pharmacists,
- One (1) physician specializing in pediatrics,
- One (1) physician specializing in psychiatry or the treatment of disabilities, and
- One (1) physician that is of any medical specialty.

The Committee serves as an advisory committee to the Department, reviewing the safety and efficacy of drugs in the classes on the PDL. The P&T Committee meets quarterly in January, April, July, and October. More information regarding the Committee can be found on the Pharmacy and Therapeutics (P&T) Committee's webpage.

Please contact Swaniee Grubb at Swaniee.Grubb@state.co.us or 303-866-3614 with questions about the committee positions.

If interested in serving on the committee, please submit a resume/CV and conflict of interest form to:

Swaniee Grubb
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203
Fax: 303-866-3590
Swaniee.Grubb@state.co.us

December 2014 and January 2015 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 Training section of the Department's website.

Who Should Attend?

Staff who submit claims, are new to billing Colorado Medical Assistance Program services, need a billing refresher course, or administer accounts should consider attending one (1) or more of the following Provider Billing Workshops. Courses are intended to teach, improve, and enhance knowledge of Colorado Medical Assistance Program claim submission. Reservations are required for all workshops.

December 2014

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
7	8	9 CMS 1500 9:00AM-11:30AM Web Portal 837P 11:45AM-12:30PM **WebEx*** OT/PT/ST 1:00PM-3:00PM	10 ***All WebEx*** UB-04 9:00AM-11:30AM Web Portal 837I 11:45AM-12:30PM IP/OP Hospital 1:00PM-3:00PM	11 Provider Enrollment 9:00AM-11:00AM Audiology 1:00PM-3:00PM	12 ***All WebEx*** CMS 1500 Waiver 9:00AM-11:30AM Web Portal 837P 11:45AM-12:30PM	13
14	15	16 Beginning Billing CMS 1500 Waiver 9:00AM-11:00AM Beginning Billing CMS 1500 1:00PM-3:00PM	17 Beginning Billing CMS 1500 Waiver 9:00AM-11:00AM	18 Beginning Billing CMS 1500 9:00AM-11:00AM	19	20

January 2015

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
11	12	13 CMS 1500 9:00AM-11:30AM Web Portal 837P 11:45AM-12:30PM Audiology 1:00PM-3:00PM	14 UB- 04 9:00AM-11:30AM Web Portal 837I 11:45AM-12:30PM ***WebEx*** Hospice 1:00PM-3:00PM	15 Beginning Billing Waiver 9:00AM-11:30AM Web Portal 837P 11:45AM-12:30PM Personal Care 1:00PM-2:30PM Web Portal 837P 2:45PM-3:30PM	16 ***All WebEx*** CMS 1500 9:00AM-11:30AM Web Portal 837P 11:45AM-12:30PM	17

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 (1) 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 (2) 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.

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