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Did you know...?

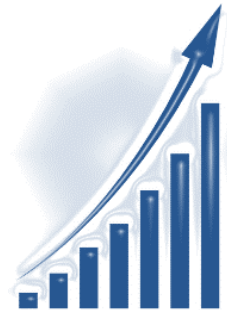
The Colorado Medicaid Nurse Advice Line provides Medicaid members free around-the-clock access to medical information and advice by calling 800-283-3221. The Nurse Advice line is available free of charge, 24 hours a day, 7 days a week, 365 days a year.

Nurses will answer medical questions, provide care advice and help Medicaid members determine if they should see a doctor right away. They can also help with medical conditions, such as diabetes or asthma, as well as provide advice on the type of doctor that may be right for a member's medical condition.

All Providers

Medicaid Provider Rate Increase Update

Effective July 1, 2015, targeted rate increases on certain high value services take effect for fiscal year 2016. The fee schedule is being updated to reflect these increases; however, the new rates cannot be paid to providers until federal approval is received from the Centers for Medicare and Medicaid Services (CMS). The Department of Health Care Policy and Financing (the Department) is working to obtain approval from CMS in order to implement the rates on July 1, 2015, but it is likely that implementation of some rates will be delayed beyond that date. Rate increases will be loaded into the Medicaid Management Information System (MMIS) within a few weeks after federal approval.



After the new rates are approved and loaded, providers will be reimbursed for claims submitted after July 1, 2015 that were not paid at the new rates. Providers should submit charges based on Usual and Customary rates (UCR), when applicable, to ensure that rate adjustments occur correctly in the system once the new rates are loaded.

The Department will provide monthly updates on implementation of the targeted rate increases. Please refer to the online [Rate Increase Fact Sheet](#) and [Rate Increase FAQ](#) for more information.

Please contact Colin Laughlin at Colin.Laughlin@state.co.us for questions related to Home and Community Based Service Waivers. Please contact Tess Ellis at Teresa.Ellis@state.co.us for questions about all other services.

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

International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10) Update

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

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

Current Activities: End-to-End Testing Wrap-up

The Department processed the remaining provider test claims, with user acceptance testing (UAT) completed on June 17, 2015. User acceptance testing efforts were very successful, with nearly all test claim issues relating to data entry errors in the x12. The successful testing means the Department will be ready to accept and process ICD-10 claims on October 1, 2015.

End-to-End Testing: Critical Success Factors

As of September 2014, the Department is required to meet five (5) critical success factors outlined by CMS in order to complete end-to-end testing as part of meeting the October 1, 2015 deadline.

Below are the critical success factors outlined by CMS:

- Acceptance of ICD-10 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)

As external end-to-end testing comes to a close, the Department would like to thank the trading partners who have exchanged ICD-10 Medicaid test transactions with the MMIS. Participation with various Colorado Medical Assistance Program providers, COB crossovers, clearinghouses, and billing agents has been very successful. External end-to-end testing has confirmed that Department systems are integrated, operable, and ready to accept the new ICD-10 codes and formats on October 1, 2015.

Please contact Sean Gagnon at Sean.Gagnon@state.co.us or at 303-866-3467, or Shawna Tye at Shawna.Tye@state.co.us or at 303-866-2347 with questions.

Parking Placards for Persons with a Disability

During the first three (3) weeks of June, the Department conducted a marketing campaign aimed at raising awareness about the inappropriate use of parking spaces that are reserved for persons with a disability. The campaign included ads on local radio, information on certain websites, and signs on buses as seen below:



The Department is working with the [Colorado Academy of Family Physicians](#) to make this topic a continuing education credit and is developing a “physician-to-physician” letter to help inform and influence providers about when it is and isn’t appropriate to issue the applications allowing a member access to a placard. The letter includes the following:

Medical colleagues: We are asking for your help. You are our first line of defense to help stop abuse. If you have applications in your office, as I do, please note that this year they have changed and be sure that you have a copy dated 1/1/15 or later. Also:

- Please make sure the applications are distributed only to persons who meet the specific criteria on the form.
- Each disabled family/person should get one form.
- The DMV will distribute two (2) plates, placards or one (1) of each.
- Please sign for the shortest span needed – 90 day forms can be renewed for one additional 90 day span.

Again, protect yourself and your patients. Know what you are signing. If knowingly misused or falsely signed, you can be fined up to \$500,000 for a class 4 felony, or \$1,000 for a class 1 misdemeanor. The bottom line is many people who are truly disabled are going home without groceries, prescriptions, or are late to medical appointments because they cannot find a parking spot for someone with a disability. Hence, people with disabilities are even further inconvenienced. We are making a statewide effort to help with education. We are hoping to educate those that park in disabled spots unlawfully, so that our population with disabilities has the same access as people without disabilities. This is not only about parking, but access to services, which is a **civil right**.

Please visit the [Colorado Disability Council](#) website to learn more or contact Gina Robinson at Gina.Robinson@state.co.us or by phone at 303-866-6167. Thanks so much for your participation in spreading the word!

Coming in 2016: Colorado Medicaid is Changing its Name!

The Department will be introducing a new look and name for the Medicaid program in May 2016.

The new name and logo, shown here, reflect the Department’s commitment to customer service, fully engaging our members in their health care and working collaboratively with partners and stakeholders.



Over the next few months, Department representatives will be meeting with contractors, stakeholders, and other partners to help them plan for this exciting change.

Please contact Debbie Fimple at Debbie.Fimple@state.co.us with questions.

Provider Conflict of Interest: Interpreter Services

Recently, the Department became aware of instances where Home and Community Based Services (HCBS) providers were acting as interpreters. This type of occurrence could be perceived as a conflict of interest. In order to mitigate this type of situation, the Department respectfully requests all service providers not perform interpreter functions unless directed to do so by the local Single Entry Point Agency (SEP).

Per the SEP contract, the SEP shall provide interpreter services when a need is identified by the member or case manager. Please contact Christopher Scofield at Christopher.Scofield@state.co.us or 303-866-4065 with questions.

Vaccine Administration Rate Increase Update

Effective January 1, 2015, the General Assembly approved an increase to the rate for vaccine administration. The new rate is 100% of the maximum rate for Colorado, set by DHHS.

The rate for vaccine administration codes **90460**, **90471**, and **90473** is now \$21.68, an increase of more than 300% from the previous rate of \$6.59.

The federal law creating the [Vaccines for Children Program](#) also mandated that DHHS cap fees for vaccine administration. Each state has a different cap. Colorado's fee cap is \$21.68.

Medicaid received federal approval from CMS on March 11, 2015. The new rates have been loaded into the MMIS and the new rate is operational.

Providers will receive the new rate through a mass adjustment, unless their submitted charge is less than the new rate, \$21.68. Any claim with a submitted charge lower than the revised rate must be adjusted by the provider. It is recommended that providers submit charges based on Usual and Customary rates, when applicable.



Non-Invasive Prenatal Testing for Fetal Aneuploidy



Non-Invasive Prenatal Testing (NIPT) for Fetal Aneuploidy, available **only** for a diagnoses of Trisomy 13, 18 or 21, will be reimbursed by the Colorado Medical Assistance Program when billed by Medicaid enrolled providers. This service is only covered for the previously mentioned conditions, when clinically indicated, and when the clinical indication is clearly documented in the member record.

Non-invasive diagnostic testing is available for women carrying a singleton gestation who meet one (1) or more of the following conditions:

- Maternal age 35 years or older at delivery
- Fetal ultrasonographic findings indicated an increased risk of aneuploidy
- History of a prior pregnancy with a trisomy
- Positive test result for aneuploidy, including first trimester, sequential, or integrated screen, or a quadruple screen
- Parental balanced robertsonian translocation with increased risk of fetal trisomy 13 or 21

The following codes should be used to bill non-invasive prenatal screening tests.

CPT Code	Specific NIPT for Trisomy 13, 18 or 21
81420	Panorama NIPT
81507	Harmony NIPT
81479*	Verify NIPT
81479*	MaterniT21 NIPT

* **81479** needs to be billed on the CMS 1500 claim form, and documentation (stating the testing is provided for non-invasive prenatal testing) needs to be included with the claim. If

requested documentation is not attached, or if the claim is submitted electronically, the claim will be denied.

Please contact Melanie Reece at Melanie.Reece@state.co.us or 303-866-3693 with any questions.

National Correct Coding Initiative (NCCI) Notification of Quarterly Updates

Providers are encouraged to monitor CMS for updates to NCCI rules and guidelines. Updates to the procedure-to-procedure (PTP) and medically unlikely edit (MUE) files are completed quarterly with the next file update available July 2015. Please find more information on the [CMS NCCI](#) website.

Diabetes Self-Management Education (DSME) Coverage

Effective July 1, 2015, services for accredited DSME to Medicaid members under certain conditions is a covered benefit. Two (2) new procedure codes are being added to the benefits of Colorado Medicaid:

- **G0108** (individual classes)
- **G0109** (group classes)



Facilities providing DSME can bill using revenue code **0942** and identify the appropriate procedure codes on the claim. Individual providers that render DSME can bill the procedure codes.

This benefit provides the following:

Up to 10 hours of diabetes-related training within a consecutive 12-month period following the submission of the first claim for the benefit which includes:

- One (1) hour for either a group or individual assessment
- Nine (9) hours for group-only diabetes education
- Up to two (2) hours of follow-up training each year after the initial 12-month period
- The training can be performed in any combination of 30 minute increments

Eligibility

Members that have a diagnosis of type 1, type 2, or gestational diabetes.

Diagnostic Criteria

According to national coding and diagnostic standards, diabetes is defined as a condition of abnormal blood glucose metabolism using the following diagnostic criteria:

- A1C > 6.5% OR
- Fasting glucose > 126 mg/dL on two (2) or more occasions OR
- Two (2)-hour post glucose challenge > 200 mg/dL on two (2) or more occasions OR
- A random glucose test > 200 mg/dL for a person with symptoms of uncontrolled diabetes (16)

NOTE: Diabetes Self-Management Education and Medical Nutrition Therapy (MNT) cannot be billed on the same day. Diabetes Self-Management Education and MNT are complementary services and cannot be billed on the same service date.

Accreditation

A healthcare provider or entity interested in obtaining Medicaid reimbursement for DSME must become an accredited program provider. There are two (2) accrediting organizations recognized by CMS: the American Diabetes Association's (ADA) [Education Recognition Program \(ERP\)](#) and the American Association of Diabetes Educators' (AADE) [Diabetes Education Accreditation Program \(DEAP\)](#). Colorado Medicaid follows the CMS policy of requiring accreditation from one of these programs.

For further information about each of these organizations, please contact ADA or AADE directly at:

[American Diabetes Association](#)

www.diabetes.org

800-DIABETES

[American Association of Diabetes Educators](#)

www.diabeteseducator.org

800-338-3633

A number of Colorado programs are accredited by the [ADA](#) and [AADE](#) and can be found utilizing each websites search function.

The recognized facilities or billing providers must be enrolled in Medicaid to be reimbursed. When DSME is provided in the ambulatory setting, the rendering provider (or supervisor of the rendering provider) must also be enrolled in Medicaid.

Once a provider or entity achieves accreditation or recognition, Colorado Medicaid must be informed of the accreditation/recognition certificate from ADA or AADE for valid reimbursement. The accreditation/recognition certificate information must be submitted along with the Medicaid Provider Identification and National Provider Identification Number (NPI) by completing the information on the [DSME Accreditation Registration](#) website. Once this information is received, the provider or entity will be officially recognized by Medicaid to conduct a DSME program.

Medicaid Billing Detail



Initial education must be provided in a continuous 12-month period starting with the first date the DSME benefit is provided and is reflected on the claim. It is available to members who have not previously received any services billed under codes **G0108** or **G0109**. In the initial year, the total number of hours billed cannot exceed 10 hours and must be delivered in no less than 30 minute increments. The member is eligible for one (1) hour of individual training and nine (9) hours in a group setting.

After the initial 12-month period, a maximum of two (2) hours of follow-up education are available as either individual or group education.

To bill for DSME, a number of key elements must be in place. The beneficiary must have:

- A diabetes diagnosis
- A written referral for DSME, provided by a physician provider or qualified non-physician provider

The DSME program must have:

- Accreditation from either AADE or ADA

- A Medicaid provider who is able to bill
- A program for maintaining documentation of the beneficiary's diabetes diagnosis in his or her medical record

Federally Qualified Health Centers (FQHCs)

In order to be reimbursed for the DSME services, the program at an FQHC must be recognized by the AADE or ADA. If the program at the FQHC is recognized, they can include the costs of diabetes self-management in the cost report and generate an encounter when there is a face-to-face visit with a listed provider (diabetes educators are not listed as eligible to generate an encounter). Even if the visit does not include a provider type that can generate an encounter, the costs associated with a recognized DSME program can be included in the calculations that determine reimbursement amount.

If the FQHC does not have a DSME program recognized by the AADE or ADA, the FQHC must refer the member to a recognized DSME provider for reimbursed diabetes education.

Summary

The procedure codes for this newly covered service are Healthcare Common Procedure Coding System (HCPCS) code **G0108** (30 minute units, two (2) units per day) for each individual counseling and code **G0109** (30 minute units, two (2) units per day) for group counseling. Medicaid members are only allowed 20 combined units of DSME per year (up to two (2) combined units of **G0108** and up to 18 combined units of G0109). Fee schedule reimbursement for the procedure codes are:

G0108 - \$40.22

G0109 - \$11.04

For More Information:

Please contact ADA at ERP@diabetes.org or 888-232-0822 with ADA questions.

Please contact AADE at DEAP@aadenet.org or 800-338-3633 with AADE questions.

Please contact Christine Fallabel at Christine.Fallabel@state.co.us or 303-866-5186 or Kelly McCracken at Kelly.McCracken@state.co.us or call 303-692-2512 with general questions.

Please contact Colorado Medicaid at 303-866-2993 for additional general inquiries, or for billing questions, call Medicaid Provider Services at 800-237-0757.

ColoradoPAR New Vendor Notification

[eQHealth Solutions](#) was selected by the Department to provide utilization management services, which include review and authorization of prior authorization requests (PARs), for the [ColoradoPAR Program](#) beginning September 1, 2015. eQHealth Solutions is a not-for-profit population health management corporation with 28 years of utilization and quality management, information technology development, data analytics, and provider education and outreach experience.



Providers should continue to submit online PARs using the current provider portal, CareWebQI ([CWQI](#)). eQHealth Solutions will perform provider outreach and communication, including face-to-face meetings with providers and other stakeholders, beginning July 2015. A series of webinars to train providers on the new online PAR provider portal, eQSuite, will be scheduled during the month of August.

Please continue to look for updates regarding this transition in future [Provider Bulletins](#), on [CWQI](#), [ColoradoPAR.com](#), and the Department's [Prior Authorization Request Program](#) website.

Colorado Medicaid and CHP+ Provider Revalidation & Enrollment Begins September 15, 2015

New federal regulations established by CMS require enhanced screening and revalidation of **all** Medicare, Medicaid, and CHP+ providers.

Beginning September 15, 2015, all Colorado providers who want to continue, or begin, providing services to Medicaid and CHP+ members after March 31, 2016 will be required to enroll and revalidate their licensure and business information under new federal enrollment screening criteria.



Based on CMS [provider type and risk designation](#), this process may include a criminal background check, fingerprinting, and unannounced site visits – including pre-enrollment site visits for some providers. Providers who fail to revalidate and enroll by March 31, 2016 may have their claims suspended or denied.

Timeline

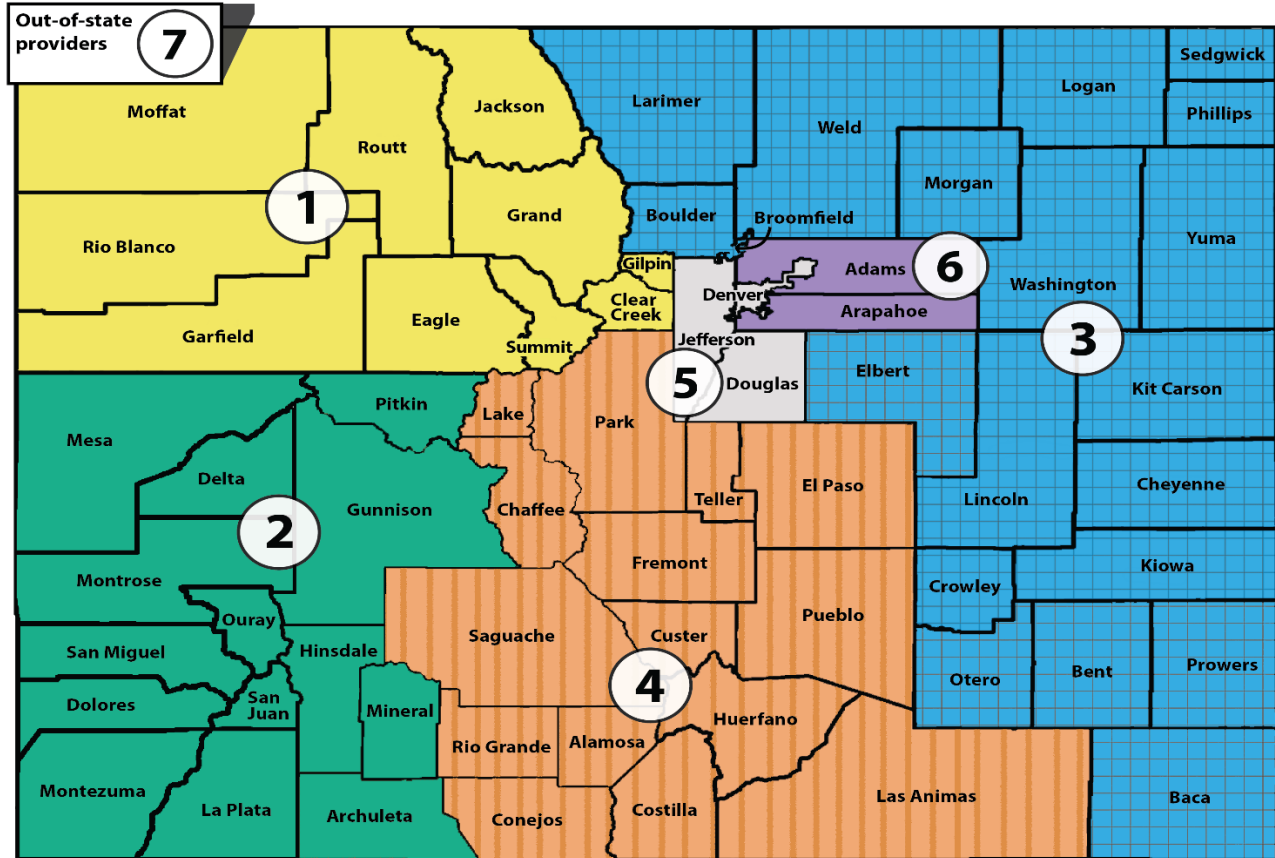
Existing Colorado Medicaid and CHP+ providers will begin revalidation/enrollment on September 15, 2015. To help all existing providers meet the March 31, 2016 deadline, the Department has grouped counties together and will initiate a series of revalidation/enrollment 'waves' by county. The map showing the county waves/groups and a schedule of when each wave can begin their revalidation/enrollment can be found on the next page.

Providers are strongly encouraged to start preparing now by gathering documentation that will be needed to begin the revalidation/enrollment process:

- Obtain your NPI.
 - If you do not have an NPI, you may request one through the [National Plan & Provider Enumeration System](#) (NPPES) website.
- Make electronic copies of certifications and licensures.

The Department has created a general [Provider Enrollment Checklist](#) that lists information providers will need to have ready. The checklist and a number of helpful FAQs can be found on the [Provider Resources](#) website. Providers are encouraged to visit the website often, as this information is updated frequently.

2015-2016 Provider Revalidation and Enrollment Wave Schedule



Wave 1:

Begins 9/15/15

Ends 10/15/15

- Clear Creek
- Eagle
- Garfield
- Gilpin
- Grand
- Jackson
- Moffat
- Rio Blanco
- Routt
- Summit

Wave 2:

Begins 10/1/15

Ends 10/31/15

- Archuleta
- Delta

- Dolores
- Gunnison
- Hinsdale
- La Plata
- Mesa
- Mineral
- Montezuma
- Montrose
- Ouray
- Pitkin
- San Juan
- San Miguel

Wave 3:

Begins 11/1/15

Ends 11/30/15

- Baca
- Bent
- Boulder

- Broomfield
- Cheyenne
- Crowley
- Elbert
- Kiowa
- Kit Carson
- Larimer
- Lincoln
- Logan
- Morgan
- Otero
- Phillips
- Prowers
- Sedgwick
- Washington
- Weld
- Yuma

Wave 4:

Begins 12/1/15

Ends 12/31/15

- Alamosa
- Conejos
- Costilla
- Chaffee
- Custer
- El Paso
- Fremont
- Huerfano
- Lake
- Las Animas
- Park
- Pueblo
- Rio Grande
- Saguache
- Teller

Wave 5:

Begins 1/1/16

Ends 1/31/16

- Denver
- Douglas
- Jefferson

Wave 6:

Begins 2/1/16

Ends 2/29/16

- Adams
- Arapahoe

Wave 7:

Begins 3/1/16

Ends 3/31/16

- Out-of-state Medicaid & CHP+ Providers

New Medicaid ID Cards Coming

New Medicaid ID Cards in July

Some changes are being made to Medicaid ID cards issued after July 1, 2015. New cards will look very similar to the current cards, but will be made out of sturdy paper stock and will no longer contain a magnetic strip.

Current Medicaid ID cards are still valid; Medicaid members do not need to request new cards.

As a reminder, Medicaid members are only required to furnish their photo ID at appointments. Medicaid ID cards are not required to receive services. Providers should verify member identity and eligibility at each appointment. For additional information on how to verify a member's eligibility, see pages 22-24 of the [General Provider Information Billing Manual](#).

Independence Day Holiday

Due to the Independence Day holiday on Saturday, July 4, 2015, State offices, DentaQuest, the Department's fiscal agent, and the ColoradoPAR Program offices will be closed on Friday, July 3, 2015. The receipt of warrants and Electronic Funds Transfers (EFTs) may potentially be delayed due to the processing at the United States Postal Service (USPS) or providers' individual banks.



Audiology Providers

Newborn Hearing Screening Reimbursement Policy

1. For inpatient hospital deliveries, reimbursement for newborn hearing screening is included in the hospital Diagnosis Related Group (DRG) for the delivery. Current Procedural Terminology (CPT)/HCPCS codes for hearing screening cannot be billed for dates on or during the date span of the delivery hospital stay.
 - o Hospitals are responsible for newborn hearing screening. Therefore, Medicaid will not provide reimbursement in addition to the DRG rate for services rendered in the inpatient hospital setting, including newborn nurseries or NICU.
2. For freestanding birth center deliveries or home births, reimbursement for newborn hearing screening may be billed using CPT/HCPCS codes for hearing screening. These codes may be billed for dates on or during the date span of the delivery.
3. Follow-up screening for newborns who fail their initial hearing screening may be billed using CPT/HCPCS codes. Follow-up screenings may be billed only if they occur on dates of service outside of the date span for the delivery hospital admission.

Newborn hearing screenings are a Preventive Service, but that designation does not supersede the reimbursement policies listed above.

For more information on Audiology services, please reference the [Audiology Billing Manual](#) on the Department's [Billing Manuals](#) web page in the CMS 1500 section.

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

Dental Providers

Dental Program – Benefits and Administrative Updates

Effective July 1, 2015, DentaQuest begins its administration of dental benefits for members enrolled in the Colorado Medicaid Division of Intellectual and Developmental Disabilities (DIDD) Waivers Program. On July 1, 2015, the DIDD Waivers Program and DentaQuest will begin processing all PARs and claims for services rendered on or after July 1, 2015 for this group. For more information and resources on this transition, DIDD dental providers can refer to the [DIDD/Community Centered Board DentaQuest](#) website.



Effective July 1, 2015, there is a minor change in billing guidelines for assistant surgeons who bill dental claims directly to DentaQuest. Dental claims filed through DentaQuest for dental surgical assistants should include the keyword "LARK" in Box 35 of the American Dental Association (ADA) claim form for reimbursement. These updated billing instructions can also be found in the [Colorado Medicaid DentaQuest Office Reference Manual](#), located on the [DentaQuest Colorado Providers](#) website under the DentaQuest Resources header.

"Take 5" Pay for Performance Program – Details Coming Soon!

The Colorado Medical Assistance Program is pleased to announce it recently received the required federal approval from CMS needed to secure the state funds allocated for the program by the Legislature for state fiscal year 2014-15 and successfully extended into the 2015-16 fiscal year. The Department secured an additional year for the program's overall duration, which will allow providers more time to schedule and treat additional new Medicaid members. The evaluation period to see a new member twice will now be extended to 15-months and run from October 1, 2014 through December 31, 2015. Payments will be made to providers starting in July 2015, and payments will continue through June 2016.



The Department is working closely with DentaQuest to finalize the program's logistical details and is looking forward to sharing this information with providers and community partners soon!

Dental Program – Rate Increases Coming July 1, 2015

The dental program received federal approval from CMS for the 0.5% across-the-board increase in addition to the targeted rate increases as approved by the Legislature for the dental fee schedule. This means the dental rate increases will be effective and implemented on July 1, 2015. The dental program still encourages dental providers to check their billing procedures to ensure they are billing at their Usual and Customary Rates, or at minimum, using the increased rates on the dental fee schedule for all services rendered on or after July 1, 2015. The dental fee schedule (effective July 1, 2015) is posted on the [DentaQuest Colorado Providers](#) website and reflects both the across-the-board increase and the targeted rate increases effective on July 1, 2015.

Additional details regarding the Medicaid dental rate increases can be found in the Department's June 2015 Provider Bulletin ([B1500367](#)). Please contact DentaQuest Provider Services at 855-225-1731 for more information.

Durable Medical Equipment (DME), Prosthetics, Orthotics and Supplies (DMEPOS) Providers

Policy Changes and Updates

The methodology for determining the maximum allowable **rental** price for manually priced codes has changed from “Per PAR” to “MSRP or Invoice Pricing”. Claims will no longer pay based on the price on the PAR. Items that require manual pricing for rental, excluding oxygen, will be reimbursed using the manufacturer suggested retail price (MSRP) or invoice methodologies, divided by 13, for one (1) month of rental. If for a partial month rental, divide again by 30 for a daily rental price. Total rental reimbursement cannot exceed the maximum allowable purchase price. Please reference the below examples for how to calculate the manually priced rental reimbursement rate:

MSRP: \$1000	Invoice: \$1000
*19.46% → \$194.60	*17.85% → \$178.50
$\$1000 - \$194.60 = \$805.40 \div 13 = \61.95	$\$1000 + \$178.50 = \$1178.50 \div 13 = \90.65
If a partial month rental is needed, divide again by 30. i.e. $\$61.95 \div 30 = \2.07	

*The percentages are subject to change. Please reference [10 CCR 2505-10, § 8.590.7.I](#) for current pricing.

Beds and Mattresses

Miscellaneous code **E1399**, when used for beds and/or mattresses, must be rented for six (6) to nine (9) months before purchase will be considered if the MSRP or actual acquisition cost is above the following dollar amounts:

Beds: \$2,700 Mattress: \$6,500

Additional information can be found on the [DME Billing Manual](#) in the comments section of the codes.



Manual Wheelchair Codes K0009 (other) and K0008 (custom)

Following Medicare practices, the code **K0009** has been closed and replaced with **K0008**. **K0009** has a notation on the [DME Billing Manual](#) that it has been deleted and **K0008** has been included with the Pure CRT codes and is only billable by CRT Providers.

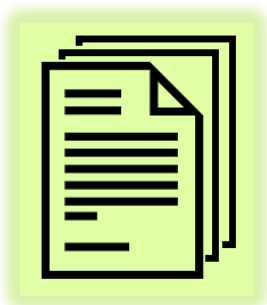
Augmentative and Alternative Communication Device (AACD) Tablet Computers

The reimbursement rate for tablet computers used as AACD devices has been increased! It was previously manually priced with a cap of \$600 but has been changed to a rate of \$850. As the code used for tablets is a miscellaneous code, the rate will not be present on the Fee Schedule; however, it is noted in the comments section of the [DME Billing Manual](#). Additionally, the software code used with the tablets, **E2511**, has received a rate increase. Previously priced at \$283.45, it is now at \$325.

Please contact Carrie Smith at HCPF_DME@state.co.us with questions regarding supplying tablets as AACDs or for Speech-Language Pathologists looking for providers to supply them.

Family Planning Clinics and Other Providers of Family Planning Services

Medical Record Documentation for Intent of Service



Family Planning Services are defined as those services provided to individuals of child-bearing age, including sexually active minors, with the intent to delay, prevent, or plan for a pregnancy. Family Planning Services may include physical examinations, diagnoses, treatments, counseling, supplies (including all FDA-approved contraceptives, with the exception of spermicides and female condoms), prescriptions, and follow-up services.

Federal regulations require that the **intent** of Family Planning Services be documented in the member's medical record. If the intent of the service does not relate to planning, delaying, or preventing a pregnancy, the provider should document the intent in the medical record but not use the Family Planning (FP) modifier when billing for that service.

For example, if the intent of prescribing an oral contraceptive pill (OCP) is to prevent pregnancy, document the intent of the prescription as pregnancy prevention in the medical record and bill with the 'FP' modifier. If the intent of the OCP is to treat acne, a bleeding disorder, or other non-pregnancy related conditions, document this intent, and do not use the 'FP' modifier with that service procedure code.

Please contact Melanie Reece at Melanie.Reece@state.co.us or 303-866-3693 with questions.

Liletta – New Long-Acting Reversible Intrauterine Contraceptive Method

Liletta is a new long-acting reversible contraceptive method that came on the market in April 2015. Liletta is a three (3) year levonorgestrel-releasing, intrauterine system and is a covered Medicaid benefit. To bill for provision of Liletta, as of April 1, 2015, providers should use the miscellaneous HCPCS code **J3490**, the appropriate family planning diagnosis codes, and the family planning modifier (FP) to receive reimbursement until an assigned code is available.

All claims must include an invoice and be submitted on paper. If you are purchasing this product through the federal [340B Drug Pricing Program](#), you must bill Medicaid the actual acquisition cost plus shipping and handling. All other providers must bill their Usual and Customary charge for this item. Additionally, providers must include the following NDC# for Liletta on all claims: 52544003554.

Note: When submitting claims for insertion of the device, use the 'FP' modifier in addition to the appropriate CPT code.

Please contact Melanie Reece at Melanie.Reece@state.co.us or 303-866-3693 with questions.

Hospital Providers

All Patient Refined Diagnosis Related Group (APR-DRG) Version Update

Effective January 1, 2014, APR-DRG version 30 became a reimbursement methodology for all claims with dates of discharge on or after January 1, 2014. The Department has since updated the payment methodology to APR-DRG version 32. All claims sent in after June 1, 2015 and with dates of service on or after January 1, 2014 will process payment through version 32. Claims that have already been submitted with discharge dates after January 1, 2014 will not be reprocessed through the new grouper version.

Inpatient hospital claims will be processed based on discharge date using the following grouper versions:

Discharge Date	Grouper
January 1, 2014 – current	APR-DRG Version 32
October 1, 2006 to December 31, 2013	CMS Version 24.0 + annual crosswalks
October 1, 2005 to September 30, 2006	CMS Version 23.0
October 1, 2004 to September 30, 2005	CMS Version 22.0
October 1, 2003 to September 30, 2004	CMS Version 21.0
October 1, 2002 to September 30, 2003	CMS Version 20.0

The payment policies (outlier days, transfers, interim payment, well baby/sick baby, and mother's discharge) remain the same. More information can be found in the [IP/OP Hospital Billing Manual](#) located on the Department's [Billing Manuals](#) web page located under the UB-04 section. The Department is expecting minimal impact with the implementation of this new version. Please contact the Department's fiscal agent at 800-237-0757 with questions.

Imaging and Radiology Providers

Preventive Lung Cancer Screening is a Covered Benefit

The [United States Preventive Services Task Force](#) recommends annual screening for lung cancer with low-dose computed tomography for adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.



Effective July 1, 2015, the following coding guidelines take effect:

- HCPCS code **S8032** should be used for preventive lung cancer screening services
- Requires Prior Authorization
- Limited to one (1) screening (one (1) unit of service) per state fiscal year (July 1 – June 30)

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

Laboratory Providers

Current Procedural Terminology (CPT) Code 80300-80377 Update

The Department has approved coverage of CPT codes **80300-80377**. Claims for the new CPT codes **80300-80377**, which have been suspended for payment since January 1, 2015, will be processed in July 2015 once rates for the codes are loaded into the MMIS. For providers who delayed sending in claims for these codes, the 120 day timely filing claim policy will be waived.

This bulletin serves as a mass late bill override date authorization when the claim has all of the following conditions:

- Only for hospital, laboratory, and clinic providers
- Only for CPT codes **80300-80377**
- Only for dates of service between 1/1/2015 and 6/30/2015

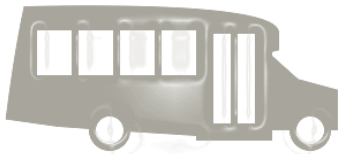
With the addition of codes **80300-80377**, the HCPCS codes **G0431** and **G0434** for drug screening will be closed effective 6/30/2015.

Please contact the Department's Fiscal Agent at 800-237-0757 for claims inquiries.

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

Transportation Providers

Approved Non-Emergent Medical Transportation (NEMT) Rates



The Department received CMS approval for NEMT rate increases effective July 1, 2014. These NEMT rates are being loaded in MMIS. Once the rate upload is complete, the Department will retroactively adjust claims with dates of service on or after July 1, 2014.

Note: Fiscal Year 2014 mass adjustments made by the Department can only be done if the original submitted charge on a claim is greater than the Fiscal Year 2013 rate. Any claim on or after July 1, 2014 at or below the Fiscal Year 2013 rate must be adjusted and resubmitted by the provider to receive the Fiscal Year 2014 rate. It is recommended that providers submit changes based on Usual and Customary charges, when applicable.

Please contact Doug van Hee at Doug.vanHee@state.co.us with questions.

Pharmacy Providers

Pharmacy Cost of Dispensing Survey

The Department has contracted with Mercer Health & Benefits LLC (Mercer) to conduct a cost of dispensing survey. Mercer will distribute survey packets to all pharmacy providers on July 13, 2015. Survey responses will be due to Mercer on August 7, 2015. The Department encourages all pharmacy providers to fully participate in this survey as the responses will be a significant factor in determining the dispensing fees paid to pharmacies. Please contact Colorado.SMAC@state.co.us with questions related to the survey.



Preferred Drug List (PDL) Update

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

Testosterone products will require a PAR; however, the preferred products will be Androgel 1.62%, Androderm, and brand or generic Depo-Testosterone.

Newer generation antihistamines and combination preferred products will be cetirizine and loratadine. All combination products will require a PAR.

Angiotensin Receptor blockers preferred products will be irbesartan, Benicar, Diovan, and losartan. Combination preferred products will be Benicar-HCT, Diovan-HCT, and losartan/HCTZ.

Fibromyalgia agent preferred products will be Lyrica and duloxetine (generic Cymbalta).

Long Acting Oral Opioid preferred products will be methadone, morphine sulfate ER, fentanyl patches, and tramadol ER. If a member has tried and failed **one** (1) of these preferred products, he or she may request a PAR for Butrans patches.

Inhaled anticholinergics and combinations preferred products will be albuterol/ipratropium, ipratropium, Atrovent HFA, Combivent Respimat, and Spiriva Handihaler.

Inhaled beta 2 agonist preferred products will be albuterol solutions and Proair HFA inhaler.

Long acting inhaled beta 2 agonists will not have a preferred product.

Inhaled corticosteroids preferred products will be budesonide nebulers, 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 PAR but the preferred product will be Elidel.

Other Preferred Drug List (PDL) Update Effective August 1, 2015:

Brand name Abilify will be preferred over generic aripiprazole.

Pharmacy and Therapeutics (P&T) Meeting:

Tuesday, July 7, 2015

1:00-5:00 p.m.

303 E 17th Street

Denver, CO 80203

11th floor conference room



Drug Utilization Review (DUR) Board Open Position

The Department is currently accepting curriculum vitae (CV) for the following position:

- One (1) non-voting representative from the pharmaceutical industry

This position will serve a one (1) year term from August 2015 – July 2016. If interested in serving or know someone who would that is qualified, please submit a CV to:

Colorado Department of Health Care Policy and Financing

Attn: Robert Lodge

1570 Grant Street

Denver, CO 80203

Fax: 303-866-3590

Robert.Lodge@state.co.us

The deadline for submissions will be July 31, 2015.

Reminder: Tobacco Cessation

Effective July 1, 2015, the Department made adjustments to the policy regarding Tobacco Cessation products. The changes are seen below in bold.

“Medicaid will cover only one (1) tobacco cessation product at one (1) time, **except in the case of the Nicotine Replacement Therapy (NRT) Patch and NRT gum/lozenge co-administration.**

Member must receive a prescription (prescriber must be a Medicaid enrolled provider) and a PAR (the Department), **except for the first fill of NRT gum/lozenge.”**

Morphine Equivalent Limitations

The Department is developing a policy for opioid-containing products and methadone that will apply a limit on the total daily milligrams of opioids and methadone that can be dispensed using morphine equivalents conversion calculations. The Department currently plans for this rule to go into effect in September 2015. Under this new policy, the daily milligrams of morphine equivalents for each opioid containing agent (including both long-acting and short-acting) and methadone that a member is currently taking will be added together. Prescriptions that exceed the maximum daily limit will be denied. In addition, the current policy that limits short-acting opioids to four (4) per day, except for acute pain situations, will continue to be in effect. More details will be provided in future announcements.

Waiver Providers

Children with Autism Waiver Billing Changes

Procedure code **H2000** (Initial/Ongoing Treatment Evaluation and Post Service Evaluation) on the Children with Autism Waiver, will have an updated unit limitation as of July 1, 2015. Due to unit limits implemented by the National Correct Coding Initiative (NCCI), billing **H2000** for more than one (1) unit will be denied by Medicaid. The Department will change the unit limitation in the MMIS from a maximum of six (6) 15-minute units to a new maximum of one (1) 90-minute unit per procedure and modifier combination. Providers will be limited to two (2) 90-minute assessments in a single fiscal year. This change will provide a transition from single 15-minute units with a maximum of six (6) possible units to a single 90-minute assessment unit. Effective 1/1/2015, this will be the updated rate, and claims will be mass adjusted by the Department.

For providers whose Usual and Customary charges are greater than the current rate of \$120.48, no action is required by the providers, and claims will be corrected automatically by the Department. For providers whose Usual and Customary charges are less than the current rate of \$120.48, providers will have to submit adjustments to the claims to ensure correct payment is received. Please click on the link for [instructions](#) on how to adjust a claim.

Please contact Victoria Montoya at Victoria.Montoya@state.co.us for rates questions.

Please contact Candace Bailey at Candace.Bailey@state.co.us for policy questions.



July and August 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 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 2015

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
12	13	14 CMS 1500 9:00AM-11:30AM Web Portal 837P 11:45AM-12:30PM *WebEx* Audiology 1:00PM-3:00PM	15 UB-04 9:00AM-11:30AM Web Portal 837I 11:45AM-12:30PM *WebEx* FQHC 1:00PM-3:00PM	16 *All Classes WebEx* Waiver 9:00AM-11:30AM Web Portal 837P 11:45AM-12:30PM Web Portal 837P 3:45PM-4:30PM	17 *All Classes WebEx* CMS 1500 9:00AM-11:30AM Web Portal 837P 11:45AM-12:30PM Transportation 1:00PM-3:00PM	18

August 2015

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
9	10	11 CMS 1500 9:00AM-11:30AM Web Portal 837P 11:45AM-12:30PM *WebEx* Vision 1:00PM-3:00PM	12 *All Classes WebEx* UB-04 9:00AM-11:30AM Web Portal 837I 11:45AM-12:30PM Hospice 1:00PM-3:00PM	13 *WebEx* DME/Supply 9:00AM-11:00AM CMS 1500 1:00PM-2:30PM Web Portal 837P 2:45PM-3:30PM	14 *WebEx* Practitioner 9:00AM-11:00AM OT / PT / ST 1:00PM-3:00PM	15

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: 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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