Provider Bulletin

COLORADO
Department of Health Care
Policy & Financing

colorado.gov/hcpf

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**Xerox State Healthcare
Denver Club Building
518 17th Street, 4th floor
Denver, CO 80202**
Contacts
Billing and Bulletin Questions
800-237-0757
Claims and PARs Submission
P.O. Box 30
Denver, CO 80201
**Correspondence, Inquiries, and
Adjustments**
P.O. Box 90
Denver, CO 80201
**Enrollment, Changes, Signature
Authorization and Claim
Requisitions**
P.O. Box 1100 Denver, CO 80201
ColoradoPAR Program PARs
www.coloradopar.com

Did you know...?

If you are a provider in one (1) of the following counties: Denver, Douglas, or Jefferson, revalidation and enrollment begins Friday, January 1, 2016. Providers may utilize the new Online Provider Enrollment (OPE) tool. Please refer to the revalidation and enrollment wave schedule to find your county's assigned wave.

All Providers

Federal Tax Document IRS Form 1095-B Coming in January 2016

Under the Affordable Care Act (ACA), most individuals are required to have qualifying health coverage, known as minimum essential coverage (MEC), or pay an Internal Revenue Service (IRS) federal tax penalty called the Individual Shared Responsibility Payment.

Child Health Plan *Plus* (CHP+) and nearly all Medicaid programs count as MEC.

Federal law requires the Colorado Department of Health Care Policy and Financing (the Department) to send IRS Form **1095-B: Health Coverage** to almost all individuals who were enrolled in Medicaid or CHP+. This form is proof that members had MEC during the month(s) they were enrolled in Medicaid or CHP+.

The Department will start mailing IRS Form 1095-B in mid-January 2016. All 1095-B forms are scheduled to be mailed by February 1, 2016.

There is an introductory webinar and fact sheet posted on Colorado.gov/HCPF/eligibility-partners under FAQs & Training, IRS Form 1095-B: Health Coverage subsection.

For Medicaid and CHP+ member information, go to COHealthInfo.com/IRSForm1095B.

The Department will be posting more resources for stakeholders and members as they become available.

For more information, please contact Nina Schwartz at Nina.Schwartz@state.co.us

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Physician Office Data Collection Study

The Department is preparing for the 2016 Healthcare Effectiveness Data and Information Set (HEDIS®)* data collection study. The Department contracted with Health Services Advisory Group, Inc. (HSAG) to conduct this study.

Beginning in February 2016, Guardian Angel Consulting will be contacting providers to collect necessary medical records. **It is critical to the success of the study that providers respond with the requested information as soon as possible.**

Obtaining a signed release form from the member is not necessary; by signing the member's Medicaid application, the member has already agreed to medical record access. In addition, the provider contract/agreement with the Department contains a statement allowing the Department and its designees access to the medical records of Medicaid members. The Code of Colorado Regulations (CCR) allows the Department or its designees to obtain copies of medical records "at the expense of the provider"; therefore, reimbursement to the provider or to vendors photocopying medical records is not offered. If you receive a medical record request, you must send your charts to Guardian Angel Consulting **prior to the May 12, 2016 deadline**. Please do not send charts to Guardian Angel Consulting after this date, as those records will not be included in the study. Thank you for your cooperation towards the success of this project.

*HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Please contact Roxzana Santacruz, HSAG administrative assistant, at RSantacruz@hsag.com or 303-755-1912 with any questions about the 2016 HEDIS data collection study.

Fiscal Year (FY) 2015 Fee-for-Service (FFS) Depression Screening Summary

The FFS depression screening count for fiscal year 2015 has been completed, and the Department would like to recognize Primary Care Providers (PCPs) for their help in increasing depression screening and follow up care for our Medicaid members. Claims data shows that more than 22,000 adult and adolescent depression screenings were completed in FY 2015. More than 12,300 of the total screenings completed were for female members, and more than 9,600 of the total screenings completed were for male members. The majority of depression screenings completed for FY 2015 were completed on adolescent members. The total number equaled a 3% increase in adolescent depression screenings compared to the previous year.

The Department maintains a depression screening tool kit online to assist FFS PCPs with screenings and follow up care. Please contact Jerry Ware at Jerry.Ware@state.co.us or 303-866-2335 with questions.

2016 Health Care Procedural Coding System (HCPCS) Codes Annual Update

The Department is updating the Medicaid Management Information System (MMIS) with 2016 HCPCS billing codes. Once the updates are completed, notification will be provided in future communications. Please contact the Department's fiscal agent, Xerox State Healthcare at 800-237-0757 with questions.

ColoradoPAR

Active Billable Provider ID Required on Prior Authorization Requests (PARs)

As a reminder, providers submitting a PAR must have an active billable provider ID. The billing provider ID on the PAR must match the billing provider ID on the claim to ensure claim payment. Any PARs submitted without an active billable provider ID will be denied. These PARs may be resubmitted once an active billable provider ID is included. **Please contact eQHealth Solutions Customer Service at 888-801-9355 with questions.**

eQSuite® Enhancement to Allow Ordering Providers to Submit PARs

eQSuite® is now programmed to accept PARs from both the billing provider and the ordering provider's office. The requestor will simply answer "Are you the Billing Provider?" prior to continuing with review.

- If yes, the Provider ID and name will populate in the Billing Provider field.
- If no, the requestor will type in the Billing Provider's ID. The system will display the service/setting types set up for the Billing Provider. The requestor will select the service/setting and continue the request as usual.

eQSuite® PAR Submission

Effective **January 1, 2016**, all PARs reviewed under the ColoradoPAR Program must be submitted via eQSuite®. Faxed PARs will **not** be accepted by eQHealth Solutions unless an exception has been previously granted.

Exceptions will be granted under the following circumstances:

- The provider is visually impaired, or
- The provider is out-of-state or the request is for an out-of-area service, or
- The provider submits, on average, five (5) or fewer PARs per month and would prefer to submit PARs by fax.

Please fill out the eQSuite® Exception Request Form located on www.ColoradoPAR.com, under Provider Resources → Forms and Instructions. An email confirmation will be sent to the requesting provider.

Lack of Information (LOI) Denial

A Lack of Information (LOI) denial will occur when eQHealth Solutions does not receive the necessary documentation needed to complete a PAR review within four (4) days of notification. This will occur if: a) the status remains at Awaiting Required Attachments, or b) clinical reviewers pend the review, but the additional information requested is not submitted within four (4) days. The requesting provider will need to resubmit the PAR if a LOI denial is issued.

Visit www.ColoradoPAR.com for additional information and instructions under the Provider Resources tab.

Successful Launch of Synagis®

All Synagis® (Palivizumab) requests require a PAR. Providers will need to complete the Medical Synagis® PAR Request Form, which can be found at www.ColoradoPAR.com under Provider Education/Training tab. The PAR form may be used to submit information to eQHealth Solutions in two (2) ways:

1. Fill out the PAR form with the required information, then call 813-397-1879 for an immediate PAR determination. **NOTE: Providers should utilize this process when the client is in the office, and an expedited PAR determination is needed.**
2. Fax the completed form to 813-397-1783.

Home Health Speech/Language Therapy (SLT) PARs

When submitting Home Health SLT PARs:

- Include all related diagnoses on the 485 Plan of Care and PAR.
- Ensure compliance with Colorado Medicaid's SLT guidelines described in the Long-Term Home Health Benefit Coverage Standard.
    - As stated on page 37, "Treatment of speech and language delays is only covered when they are associated with a chronic medical condition, neurological disorder, acute illness, injury, or congenital issue."

ACC Phase II January 2016

Accountable Care Collaborative Phase II: New Resource

The Department is looking to consult with stakeholders on the future of the Accountable Care Collaborative (ACC). The ACC is the Department's delivery system for health care services, and it is critical to supporting the health of our members. Learn more about the ACC.

The Department has developed a new resource for stakeholders that highlights the key concepts in the ACC Phase II Concept Paper. Check out our two (2) page Key Concepts Fact Sheet available at Colorado.gov/HCPF/ACCPhase2.

The current ACC Phase II Concept Paper was shaped by the information provided to the Department through the Request for Information (RFI) process. We encourage you to review the RFI documents available on our site.

Stay informed by joining our newsletter.

New Desk Aid for Eligibility Notice of Action (NOA)

Earlier this month, the Department released a NOA Desk Aid.

This desk aid is designed to help assistors understand and explain to members one of the most important pieces of correspondence - the Notice of Action. Members will receive the NOA in the mail when they apply for or receive Public Assistance, and any decision or change is made to their case. This desk aid explains the various components of the NOA.

Please contact Medicaid.Eligibility@state.co.us for questions about specific cases or about this document.

Continuous Eligibility FAQ Now Available

Continuous eligibility provides children up to 12 months of Medicaid or CHP+ coverage, regardless of changes in the family's circumstances, with some exceptions. In March 2014, the Department implemented this policy for the majority of children – specifically those who qualified for Modified Adjusted Gross Income (MAGI) Medicaid or CHP+. Effective October 18, 2015, the Department extended continuous eligibility for up to 12 months to all Medicaid children, regardless of the Medicaid program for which they qualify.

Please review the Continuous Eligibility FAQ document for more information or contact Ana Bordallo at Ana.Bordallo@state.co.us with questions.

# Coming in January: Enhancements to PEAKHealth Mobile App

The PEAK*Health* mobile app gives Medicaid and CHP+ members a simple way to keep information up-to-date and access important health information right from their phone. The PEAK*Health* app is for current Medicaid and CHP+ members. Users must have a Colorado.gov/PEAK account to sign on. PEAK*Health* is not for people who want to apply for benefits.

PEAK*Health* helps Medicaid and CHP+ members search for providers, view medical cards, update income and contact information, view benefit information, make payments, and access health and wellness resources. **Beginning in January, PEAK*Health's* provider search will have an improved layout.**

PEAK*Health* is available free in the Apple iTunes Store and the Android/Google Play App Store.

For more information about PEAK*Health* see the January 2015 Provider Bulletin (B1500361). For more information on the PEAK*Health* mobile app, check out our Partner resource Page at Colorado.gov/HCPF/PEAKHealth-Stakeholders and view this video tour.

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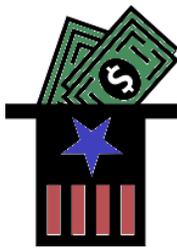
Reminder: Please ensure all addresses (billing, location, and mail-to) on file with the Department's fiscal agent, Xerox State Healthcare, are current. 1099s returned for an incorrect address cause the account to be placed on hold and **all** payments to be suspended, pending a current W-9. Payments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

The 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 in the Provider Forms section of the Department's website under the Update Forms section. With the exception of 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. If a provider does not receive a 1099, please call the State Controller's office at 303-866-4090 for assistance.

January and February 2016 Holidays

New Year's Day Holiday

Due to the New Year's Day holiday on **Friday, January 1, 2016**, State offices, Xerox State Healthcare, DentaQuest, and the ColoradoPAR Program offices will be closed. The receipt of warrants and Electronic Funds Transfers (EFTs) may potentially be delayed due to the processing at the United States Postal Service or providers' individual banks. Additionally, Xerox State Healthcare will have limited business hours on Thursday, December 31, 2015 and will be closing at 3:00 p.m. MT.

Martin Luther King, Jr. Day Holiday

Due to the Martin Luther King Day holiday on **Monday, January 18, 2016**, State offices, DentaQuest, and the ColoradoPAR Program offices will be closed. Xerox State Healthcare is conducting business during regular business hours. The receipt of warrants and EFTs may potentially be delayed due to the processing at the United States Postal Service or providers' individual banks.

Presidents' Day Holiday

Due to the Presidents' Day holiday on **Monday, February 15, 2016**, State offices, DentaQuest, and the ColoradoPAR Program offices will be closed. Xerox State Healthcare is conducting business during regular business hours. The receipt of warrants and EFTs may potentially be delayed due to the processing at the United States Postal Service or providers' individual banks.

<u>Family Planning Providers</u>

Long-Acting Reversible Intrauterine Contraceptive Methods: Newly Assigned Healthcare Common Procedure Coding System (HCPCS) Codes

Two (2) 52mg levonorgestrel-releasing intrauterine systems (IUS) are currently on the market and available for coverage by Medicaid. Liletta is FDA-approved for three (3) years of contraceptive coverage, while Mirena is approved for a five (5) year coverage period. Effective January 1, 2016, both of these intrauterine devices were assigned new HCPCS codes that are available for Medicaid billing.

To bill for provision of:

- Liletta (3-year), use the new HCPCS code **J7297** (previously billed using the miscellaneous drug code **J3490**)
- Mirena (5-year), use the new HCPCS code **J7298** (previously billed using **J7302**, this code will be closed effective January 1, 2016)

When billing for any intrauterine contraceptive device and associated procedures, continue to use the appropriate family planning diagnosis codes and the family planning modifier (FP) when the **intent** of the device and procedure is to delay or prevent a pregnancy. Additionally, include the appropriate national drug code (NDC) number associated with each contraceptive device.

To bill for the other two (2) FDA-approved intrauterine devices (listed below) continue to use their previously assigned HCPCS codes.

- Paragard (**Cu380T**), use **J7300**
- Skyla (13.5mg levonorgestrel-releasing system) use **J7301**

For additional information regarding reimbursement rates, please review the [Provider Rates & Fee Schedule](#) website.

If you are purchasing any of these products through the [Federal 340B Drug Pricing Program](#), you must bill Medicaid the actual acquisition cost plus shipping and handling.

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

Federally Qualified Health Center (FQHC) Providers

Reimbursement for Group Services at FQHCs

Effective December 30, 2015, the following changes (in italics) to rule 10 CCR 2505-10 8.700.1 will be active:

> "Visit means a *one-on-one*, face-to-face encounter between a center client and physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, clinical psychologist, podiatrist or clinical social worker providing the services set forth in 8.700.3. *Group sessions do not generate a billable encounter for any FQHC services.*"

Federally Qualified Health Centers will be reimbursed for Medicaid-covered group services according to the following logic. The costs for group services rendered by one (1) of the eligible providers named in the rule above should be included in the cost report for incorporation into the FQHC's encounter rate.

For group services not rendered by an eligible provider, the FQHC may either:

1. Include the costs of providing the group services into the cost report for incorporation of the FQHC's encounter rate; or
2. Adjust the costs of providing the group services out of the cost report and be reimbursed for the group services from the fee schedule.

Please contact Zabrina Perry at Zabrina.Perry@state.co.us or 303-866-4370 with questions.

Immunization Providers

New and Updated Immunization Current Procedural Terminology (CPT) Codes

Several new immunization CPT codes have been added or updated in the Colorado Medicaid claims system (MMIS). These codes were created or updated to use for new vaccines that have been released this year.

Providers may now use the following immunization codes:

90620: Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B, 2 dose schedule, for intramuscular use. Code became effective March 1, 2015.

90621: Meningococcal recombinant lipoprotein vaccine, Serogroup B, 2 or 3 dose schedule, for intramuscular use. Code became effective March 1, 2015.

90630: Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use. Code became effective January 1, 2015.

90648: Hemophilus influenza B vaccine (HIB), PRP-T Conjugate, 4 dose schedule, for intramuscular use. Code became effective January 1, 2015.

90651: Human Papillomavirus 9-valent vaccine, recombinant, 3 dose schedule, for intramuscular use. Code became effective March 1, 2015.

Providers who billed these codes after their effective dates but before they were loaded into the claims system have received payment adjustments to fully reimburse those claims retroactively.

<u>Hospice Providers</u>

Medicaid Hospice Reimbursement Effective January 1, 2016

Hospice providers may be reimbursed for one (1) unit of Routine Home Care (RHC), revenue code **0650** or **0651**, per day regardless of provider visit duration. Effective for Dates of Service (DOS) on or after January 1, 2016, RHC will be reimbursed on a two (2) tiered rate, with a RHC "high" rate for the first 60 days of hospice care and a RHC "low" rate for days 61 and beyond.

For a hospice patient who is discharged and readmitted to hospice within 60 days of that discharge, his/her prior hospice days will count toward his/her patient days for receiving hospice in the determination of whether receiving hospice may be paid at the "high" or "low" RHC rate upon hospice election. For a hospice patient who has been discharged from hospice care for more than 60 days, a new election to hospice will initiate a reset of the patient's 60 day window paid at the RHC "high" rate upon the new hospice election.

Additionally, a Service Intensity Add-on (SIA) may be billed and reimbursed at a rate equal to the Continuous Home Care (CHC) rate, if the day is a RHC level of care day in addition to the RHC billed for that day. The SIA is to be billed in one (1) hour increments and may total a maximum of four (4) hours per day. The SIA reimbursable visits include those conducted by a registered nurse (RN) or social worker during the last seven (7) days of a beneficiary's life (and the beneficiary is discharged deceased). The SIA must be provided in-person. The SIA payment will apply to beneficiaries receiving RHC in the home or nursing facility setting.

Detailed guidance and instruction for billing the two (2) tiered routine home care rate and SIA has been communicated to Medicaid hospice providers through email, and a training is scheduled for January 11, 2016 at 2:00 p.m. Training conference call information is listed below:

<div align="center">

Toll: 720-279-0026

Toll Free: 877-820-7831

Participant Passcode: 610450#

</div>

Rates for the following hospice services will be loaded for billing on January 1, 2016:

- Hospice services provided between October 1, 2015 and December 31, 2015 under revenue codes **0651**, **0652**, **0655**, and **0656**.
- Hospice services provided on and after January 1, 2016 under revenue codes **0650**, **0651**, **0652**, and **0656**.

After January 1, 2016				
Rev Code	**Description**	**Care Days**	**CMS Daily Rate / Hourly Rate**	**CO HCPF Daily Rate / Hourly Rate[αβ]**
0650	Routine Home Care	1-60	187.08	207.62
0651	Routine Home Care	60+	147.02	163.16
0652	Continuous Home Care		945.16	1,048.94
	hourly*		39.38	43.70
0652	Service Intensity Add-on	last 7 days	945.16	1,048.94

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			last 7 days	39.38	43.71
		hourly*			
	0655	Inpatient Respite Care		176.26	195.61
	0656	General Inpatient Care		720.11	799.18
*		The Department reimburses Continuous Home Care and Service Intensity Add-on in units of one (1) hour			
α		Individual provider rates may vary due to the CMS wage index applied to the wage portion of each rate before the CO rate increase percentage is applied			
β		FY2015-16 hospice rates reimbursed at 10.98% above CMS rates per Colorado State Plan Amendment (SPA) # CO-15-0014			

Hospice rates were updated in the Hospice FFS Fee Schedule for rates effective 10/01/2015 through 09/30/2016 and 01/01/2016 through 09/30/2016. For additional information, please refer to the Hospice Policy and Rate Changes Effective January 1, 2016 PowerPoint presentation on the Provider Training website. Please contact Jay Davenport at James.Davenport@state.co.us for rates questions. Please contact Alexandra Koloskus at Alexandra.Koloskus@state.co.us for policy questions.

Hospital Providers

All Patient Refined-Diagnosis Related Group (APR-DRG) and Immediate Post-Partum Long-Acting Reversible Contraception (PP-LARC) Update

All Patient Refined-Diagnosis Related Group

In January 2014, the APR-DRG system replaced the CMS-DRG system previously used by the Department. The APR-DRG provided the more sophisticated system needed to reflect the diverse Medicaid population and the complexity of services provided – such as insertion of immediate post-partum LARCs. The APR-DRG payments consider multiple factors including:

- severity of illness,
- mortality risk,
- complexity, and
- resource utilization.

By applying these factors, the APR-DRG system more accurately reimburses inpatient hospital services. Because of APR-DRG's additional capabilities, documentation to ensure accurate DRG identification is critical to ensuring full reimbursement. Documentation requires:

- reason(s) for admission,
- all secondary diagnoses that affect care within the current episode,
- cause of diagnoses, and
- full details of all procedures.

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Carve-Out

Prior to implementation of the APR-DRG, the Department identified payment as a barrier to provision of PP-LARCs in hospitals. A short-term process to "carve out" PP-LARC reimbursement from the obstetrical global code was created to remove the cost barrier until APR-DRG took effect January 1, 2014. This was communicated in the November 2013 provider bulletin (B1300344). Once the APR-DRG took effect, placement of a PP-LARC was built into the new reimbursement system, and additional payment was made for this service of higher complexity. The Department relies on hospitals to provide full DRG documentation, as outlined above, to receive full and accurate reimbursement.

Currently, all hospitals should receive the increased APR-DRG reimbursement when PP-LARCs are placed, and proper documentation is provided. Although the APR-DRG improves compensation over the previous CMS-DRG system, the Department recognizes that the increase may not fully cover the cost of PP-LARC devices. For this reason, the Department is exploring a long-term "carve out" for PP-LARC device costs from the hospital's global obstetric rate. This proposal will require federal approval by the Centers for Medicare and Medicaid Services (CMS). The Department recognizes the value of PP-LARC provision and is working diligently to support it.

Please contact the Department's fiscal agent at 800-237-0757 with APR-DRG claims questions.

Pharmacy Providers

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

Clarification on Shipped Supplies

This is not a policy change, only a clarification

Medicaid's policy regarding shipping supplies is consistent with Medicare's policy. Supplies cannot be automatically shipped to members on a predetermined regular basis (i.e., no auto refills/the supplier may not initiate a refill). Providers must have contact with the member/caregiver prior to every shipment to ensure that the member's information is correct, there have been no changes to the prescription, and supplies/additional supplies are needed. Member contact consists of either a specific request from the member/caregiver that supplies are needed or a member/caregiver's response to an inquiry by the DMEPOS provider that supplies are needed.

Morphine Equivalent Limitations Update

Effective February 1, 2016, the Department will implement a limit on total daily morphine equivalents to 300 milligrams (mg) to align with the Governor's initiative to decrease the misuse and abuse of prescription opioids. This includes opioid-containing products where conversion calculations are applied. Prescriptions that cause the member's drug regimen to exceed the maximum daily limit of 300mg of morphine equivalents (MME) 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.

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Prior authorizations will be granted to allow for tapering. Periodically, the Department anticipates decreasing the limit until a daily limit of 120MME is reached. Ample notice will be provided before any changes are made to the limit. Doses greater than 120MME have been associated with a higher risk of opioid overdose death. This is in agreement with the Policy for Prescribing and Dispensing Opioids published by the Colorado Department of Regulatory Agencies.

The PA Help Desk can be reached at 800-365-4944.

Criteria:

- Diagnosis of sickle cell anemia will receive a preemptive PA for lifetime.
- A one (1) year PA will be granted for admission to or diagnosis of hospice or end of life care.
- A one (1) year PA will be granted for diagnoses of pain from metastatic cancer, bone cancer, and pain from recent cancer treatment.
- Medicaid provides guidance on the treatment of pain, including tapering, on our Pain Management Resources and Opioid Use website.
- **Only one** (1) long-acting oral opioid agent (including different strengths) and one (1) short-acting opioid agent (including different strengths) will be considered for a prior authorization.

Member should be counseled not to take opioids and drink alcohol concurrently. Also, concomitant use of benzodiazepines and opiates has been associated with a higher incidence of opioid-related overdose.

Functional and pain assessments should be performed during patient visits. If a member has not shown clinically meaningful improvement, then continued opioid use is not considered appropriate care in most cases. Thirty percent improvement from baseline assessment or at the time of dose change is considered clinically meaningful.

January Preferred Drug List (PDL) Announcement

Effective January 1, 2016, the following will be preferred agents on the PDL and will be covered without a prior authorization (unless otherwise indicated with an *):

Oral Fluoroquinolones: ciprofloxacin tablets, levofloxacin tablets, Cipro suspension (for members under the age of five (5))

Oral Antiherpetic Agents: acyclovir tablets, capsules and suspension

Pancreatic Enzymes: Creon and Zenpep

Antiplatelets: Aggrenox, clopidogrel, and Brilinta

Targeted Immune Modulators (self-administered): Humira and Enbrel

Antidepressants: buproprion IR, SR and XL, citalopram, escitalopram, fluoxetine, mirtazipine, paroxetine, sertraline, venlafaxine IR tablets and XR capsules

PDE-5 Inhibitors: sildenafil

Endothelin Antagonists: Letairis

Prostanoids: generic epoprostenol and Ventavis

Antiemetics: ondansetron tablets, ondansetron ODT tablets, ondansetron suspension (for members under five (5) years), Diclegis

PPIs: Nexium (capsules and packets), omeprazole generic capsules, pantoprazole tablets, Prevacid solutabs (for members under two (2) years)

Triptans and Combinations: Imitrex nasal spray and injection, sumatriptan tablets, rizatriptan MLT tablets, naratriptan tablets, Relpax

Omega-3-Acid Ethyl Esters for Cardiovascular Protection

Effective January 1, 2016, Omega-3-acid ethyl esters will be approved for members that have a confirmed diagnosis of hypertriglyceridemia, defined as TG ≥ 500 mg/dL. This will require a diagnosis in the patient's medical history or indication on the claim submitted by the pharmacy.

A PA can be requested by calling the PA Help Desk at 800-365-4944.

Hepatitis C Medication Prior Authorization Process

Effective January 1, 2016, all PARs for Hepatitis C medications will be faxed to the PA Help Desk at 888-772-9696.

Prior Authorization Reminder

As a reminder, pharmacies should only dispense medication that requires a prior authorization after obtaining the prior authorization. In an emergency, when a PAR cannot be obtained in time to fill the prescription, pharmacies may dispense a 72-hour supply (3 days) of covered outpatient prescription drugs to an eligible member by calling the Department's PA Helpdesk for approval at 800-365-4944. An emergency situation is any condition that is life threatening or requires immediate medical intervention.

Psychiatric Consultation for Children

The Department is pleased to share with all providers a valuable service to help providers manage psychiatric medications for children. Our Drug Utilization Review (DUR) provider, the University of Colorado Skaggs School of Pharmacy and Pharmaceutical Sciences, in collaboration with Colorado Behavioral Health Systems, specifically the Colorado Psychiatric Access and Consultation for Kids (C-PACK) program, has child psychiatrists available to provide consultation to Medicaid providers. The service includes phone or email consultations to optimize pharmacotherapy. For additional information or to be connected with a child psychiatrist, please contact Nila Mahyari, PharmD, DUR Clinical Specialist at Nila.Mahyari@state.co.us. Child psychiatrist responses are usually provided within a few days of the initial request. Care coordination is not a service provided by DUR.

Speech Therapy Providers

Outpatient Speech Therapists

Pursuant to the ACA requirements that State Medicaid Agencies ensure correct ordering, prescribing, and referring (OPR) National Provider Identification (NPI) numbers be on the claim form (42 CFR §455.440), the following changes to the Speech Therapy benefit will be made:

1. Effective April 1, 2016, all Outpatient Speech Therapy claims must contain the valid NPI number of the ordering, prescribing, or referring physician, physician assistant, nurse practitioner, or provider associated with an Individualized Family Service Plan (IFSP), in accordance with Program Rule 8.125.8.A.

2. All physicians, physician assistants, nurse practitioners, or providers associated with an IFSP who order, prescribe, or refer Outpatient Speech Therapy services for Medicaid members must be enrolled in Colorado Medicaid (42 CFR §455.410), in accordance with Program Rule 8.125.7.D. An OPR provider may enroll on the Colorado Medicaid Provider Resources website.

   a. The new enrollment requirement for OPR providers does not include a requirement to see Medicaid members or to be listed as a Medicaid provider for patient assignments or referrals.

   b. Physicians or other eligible professionals who are already enrolled in Colorado Medicaid as participating providers and who submit claims to Colorado Medicaid are not required to enroll separately as OPR providers.

Technical Details

1. Only licensed or certified otolaryngologists and speech-language pathologists and supervised speech-language pathology assistants and clinical fellows may render speech therapy services to Medicaid members, in accordance with Program Rule 8.200.3.D.

2. The term "valid OPR NPI number" means the registered NPI number of the provider that legitimately orders, prescribes, or refers the outpatient speech therapy service being rendered, as indicated by the procedure code on the claim.

3. Claims without a valid OPR NPI number that are paid will then be subject to recovery.

4. Medical documentation must be kept on file to substantiate the order, prescription, or referral for outpatient speech therapy. Claims lacking such documentation on file will be subject to recovery.

5. Colorado Medicaid recognizes that outpatient speech therapy ordered in conjunction with an approved IFSP for early intervention may not necessarily have an ordering provider. Under this circumstance alone, the rendering provider must use their own NPI number as the OPR NPI number.

   a. Early intervention outpatient speech therapy claims must have modifier "TL" attached on the procedure line item for Colorado Medicaid to identify that the services rendered were associated with an approved IFSP.

   b. Any claim with modifier "TL" attached must be for a service ordered by an approved IFSP and delivered within the time span noted in the IFSP.

   c. If the OPR NPI on the claim is that of the rendering provider, and the claim does not have modifier "TL" attached, the claim is subject to recovery.

Refer to the Outpatient Speech Therapy billing manual for further details.

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

Waiver Providers

Community Transition Services (CTS) Rate Increase

Effective January 1, 2016, rates for Community Transition Services (CTS) offered on the Colorado Choice Transitions (CCT) grant program will be increased. The rate applies to the demonstration service of the CCT grant program only. Reimbursement for the qualified waiver service offered on the Home and Community Based Services (HCBS) waiver for Persons who are Elderly, Blind, and Disabled has not changed.
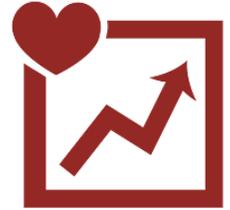
Transition coordination service rates will increase. These are activities provided by transition coordination agencies (TCAs) through provider agreements. These services are provided to transition residents of nursing facilities and intermediate care facilities for Individuals with Intellectual Disabilities (ICF-IIDs) who desire to live in a less restricted setting.

The following codes will be affected by the rate increase.

Code	Code Description	Current Rate	New Rate	Reimbursement Unit
T2038 UC	Community Transition Services Coordinator – CCT	$2,000.00	$3,800.00	Per Transition
A9900 UC	Community Transition Services Purchase – CCT	$1,500	$1,500	Purchase

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January and February 2016 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.

January 2016

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
10	11	12 CMS 1500 9:00 a.m.-11:30 a.m. Web Portal 837P 11:45 a.m.-12:30 p.m. Audiology 1:00 p.m.-3:00 p.m.	13 UB-04 9:00 a.m.-11:30 a.m. Web Portal 837I 11:45 a.m.-12:30 p.m.	14 Waiver 9:00 a.m.-11:30 a.m. Web Portal 837P 11:45 a.m.-12:30 p.m. Personal Care 1:00 p.m.-3:30 p.m. Web Portal 837P 3:45 p.m.-4:30 p.m.	15 ***WebEx*** CMS 1500 9:00 a.m.-11:30 a.m. Web Portal 837P 11:45 a.m.-12:30 p.m. ***WebEx*** Hospice 1:00 p.m.-3:00 p.m.	16

February 2016

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
7	8	9 ***WebEx*** CMS 1500 9:00 a.m.-11:30 a.m. Web Portal 837P 11:45 a.m.-12:30 p.m. ***WebEx*** Vision 1:00 p.m.-3:00 p.m.	10 ***WebEx*** UB 04 9:00 a.m.-11:30 a.m. Web Portal 837I 11:45 a.m.-12:30 p.m. ***WebEx*** FQHC 1:00 p.m.-3:00 p.m.	11 ***WebEx*** DME/Supply 9:00 a.m.-11:00 a.m. ***WebEx*** Practitioner 1:00 p.m.-3:00 p.m.	12 ***WebEx*** Home Health 9:00 a.m.-11:00 a.m. Dialysis 1:00 p.m.-3:00 p.m.	13

Reservations are required for all workshops
Email reservations to:
workshop.reservations@xerox.com

Or   Call the Reservation hotline to make reservations:
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:

<div align="center">

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

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*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.

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Please direct questions about Colorado Medical Assistance Program billing or the information in this bulletin to
Xerox State Healthcare Provider Services at 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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