COLORADO
Department of Health Care Policy & Financing

# Provider Bulletin

**Reference: B1600381** **April 2016**

colorado.gov/hcpf

## In this issue:



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**Denver Club Building**
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**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 30
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…?**

All claims delayed by third party insurers that are submitted over 365 days from the date of service must be denied per state and federal regulations. (42 C.F.R. § 447.45(d), 10 CCR 2505-10 8.043.01 and .02 A.)

# All Providers

## Rendering, Referring, and Prescribing Providers

### Attention Practitioners & Pharmacies

Pursuant to federal requirements that State Medicaid Agencies must ensure correct rendering, referring, and prescribing National Provider Identifier (NPI) numbers be included on the claim form, the following changes will be made:

- Effective May 1, 2016, all pharmacy claims (when submitting with NPI) must contain a valid NPI number for the prescribing provider. The NPI will be validated in order for the claim to pay.
- All practitioner claims must continue to contain a valid NPI number for the rendering or referring provider. The NPI will be validated in order for the claim to pay.
- The term "valid NPI number" means the NPI number registered to the provider is in the National Plan & Provider Enumeration System (NPPES). If you do not currently have an NPI, please visit the NPPES website to apply.
- Claims without a valid NPI number may be subject to denial or recovery.

### Technical Details:

#### CMS 1500

Electronic claims:

- Must enter the rendering NPI in 2420A loop and segment with Qualifier **XX** in NM108 and the NPI in NM109.
- Must enter the referring NPI in 2310A loop and segment with Qualifier **XX** in NM108 and the NPI in NM109.

Paper claims:

- Must enter the rendering NPI in field #24J in addition to the eight-digit Medicaid Provider ID in field #24J.
- When applicable, enter the referring NPI in field #17B in addition to the eight-digit Medicaid Provider ID in field #17A.

**Pharmacy**

Electronic Claims:

- Prescriber's ID field (411-DB) must be completed with a valid NPI, State License Number, or Drug Enforcement Administration (DEA) number.
- Prescriber's ID Qualifier field (466-EZ) must be completed with one of the following:

  **01** = NPI
  **08** = State License #
  **12** = DEA#

Paper Claims:

- Prescriber's ID field must be completed with a valid NPI, State License Number, or Drug Enforcement Administration (DEA) number.
- Prescriber's ID Qualifier field must be completed with one of the following:

  **01** = NPI
  **08** = State License #
  **12** = DEA#

Please contact Provider Services at 800-237-0757 with further questions.

## Medicaid Provider Revalidation Update

Although the Centers for Medicare & Medicaid Services (CMS) has extended its deadline for states to complete provider revalidation, it is important that Colorado providers **complete revalidation and/or enrollment as soon as possible**. By completing the revalidation and enrollment process as soon as possible through the Online Provider Enrollment (OPE) tool, providers will not experience any delay in payment. The Department is launching its new enrollment and claims management system, the Colorado interChange, on **October 31, 2016**. Starting on that date, claims and encounters submitted by providers who have not enrolled and/or revalidated will be denied.

Please **do not** begin the application before reviewing all of the training resources available online. An incorrect or incomplete application requires additional review, which may add **weeks** to processing time. Revalidation and Enrollment Instructions are available online. Be sure to review the Information by Provider Type before you begin the online training, as it will help you select the correct training. Please contact Provider.Questions@state.co.us with questions, but please be patient as response times may take 10-14 business days.

# ACC Phase II Update: Behavioral Health Reimbursement Framework & FAQs

The Department is committed to creating a high-performance, cost-effective Medicaid system that delivers quality services and improves the health of Coloradans. The next iteration (Phase II) of the Accountable Care Collaborative (ACC) seeks to leverage the proven successes of Colorado Medicaid's programs to enhance the Medicaid member and provider experience. Learn more about ACC Phase II.

## Behavioral Health Reimbursement Framework

The Department has developed a high-level model further defining the February 2016 program decision regarding the reimbursement of behavioral health services in ACC Phase II. The Department will retain a capitation payment to support the full continuum of behavioral health services from outpatient therapy to alternative community services to crisis response and hospitalization. One significant change from the current capitation will be limiting the use of the covered diagnosis requirements, where possible, in order to improve access to care.

In addition to the capitation, the Department will be reimbursing more behavioral health services delivered within primary care settings for low acuity and brief episodic conditions. To support integrated care, the Department will define a new set of services for behavioral health providers who work as members of primary care teams.

Additional details on these reimbursement strategies will be made available as they are finalized through the draft Request for Proposal for ACC Phase II. Read more about the behavioral health framework here.

## February 9 Webinar: FAQs Now Available

On February 9, Medicaid Director Gretchen Hammer and Deputy Medicaid Director Laurel Karabatsos hosted a call and webinar with stakeholders to discuss the ACC Phase II procurement timeline and behavioral health reimbursement program decision. FAQs are now available online.

## Opportunities for Engagement & Staying Informed

The ACC Phase II Team will continue to utilize the scheduled ACC Program Improvement and Advisory Committee (PIAC) and Subcommittees to solicit feedback. These meetings are open to the public and have a call in option for participation. Notes will be available online following the meetings.

We encourage all interested parties to sign up for the ACC Phase II Stakeholder Updates list. The Department will use this list and our ACC Phase II website as the primary vehicles to announce feedback opportunities and Phase II developments. Stakeholders can also find previously published stakeholder updates on the ACC Phase II website.

## Questions & Feedback

The Department welcomes input on the future of the ACC and encourages stakeholders to use the ACC Phase II Question Submission form for questions regarding Phase II development. We will use your questions to shape future communications regarding Phase II. **We are unable to guarantee individual responses to all questions received**.

To request a presentation, please use this form. Unfortunately, **we are unable to accommodate all requests for presentations at this time** and strongly encourage you to participate in the stakeholder opportunities.

## Free Screening, Brief Intervention, and Referral to Treatment (SBIRT) Training for Medicaid Providers

The Department offers free SBIRT training for Colorado health professionals who provide care to members enrolled in Medicaid through our partnership with Peer Assistance Services (PAS). Training on substance abuse screening and brief intervention aids in assessing members. The process serves as a quick and easy way to identify and intervene with members whose substance use puts them at risk for health issues.

Upcoming training sessions are conducted at the PAS Training Center.

**Peer Assistance Services**

2170 South Parker Road

Suite 229

Denver, Colorado 80231

Interested providers may register for one of the training sessions or contact Kevin Hughes at khughes@peerassist.org or 303-369-0039 ext. 226 to schedule an onsite training.

## Person and Family Centered Approach: Creating a Culture of Collaboration with Members

The Department hosted a town hall-style meeting and webinar in February to share the successes and challenges of our person-centered efforts and get stakeholder feedback on the next phase of this work. In early March 2016, the Department was awarded a renewal grant from The Colorado Health Foundation for Phase II of this project. This grant will help us fully implement our Strategic Plan and begin to extend person-centered principles to selected vendors, contractors, and providers. It will also help us incorporate the person-centered approach into our vendor contract language.

Stakeholder feedback on Phase II is still needed. A recorded webinar version of the meeting, along with meeting materials, is available on the Person and Family Centeredness Advisory Council's website. Feedback can be provided through an online survey.

## 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 April 2016. Please find more information on the CMS NCCI website.

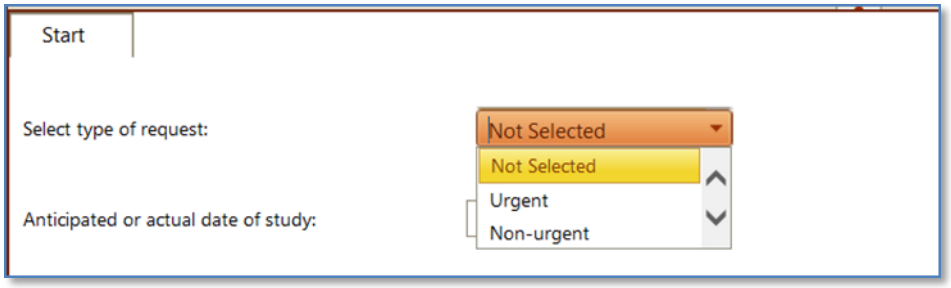
# ColoradoPAR Program Updates

## Urgent Prior Authorization Requirements

An urgent prior authorization request (PAR) should be submitted for expedited review when a delay:

- Could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function, or
- Based on physician assessment of the member's medical condition, would subject the member to severe pain and the medical condition cannot be adequately managed without the requested care or treatment.

Please choose "Non-urgent" in eQSuite®, unless the ordering provider has determined that the member meets the criteria mentioned above. Requesting an urgent request when the member does not meet the criteria may delay the prior authorization process.




## Change of Provider Reminder

The Change of Provider Form should be completed when a member has an approved PAR from another provider for the same service or supply during the same or overlapping timeframe.

- **Diagnostic Imaging Exception:** Please submit an online helpline ticket for all change of provider requests.

Follow the steps below to ensure the proper transition of PARs from one provider to another:

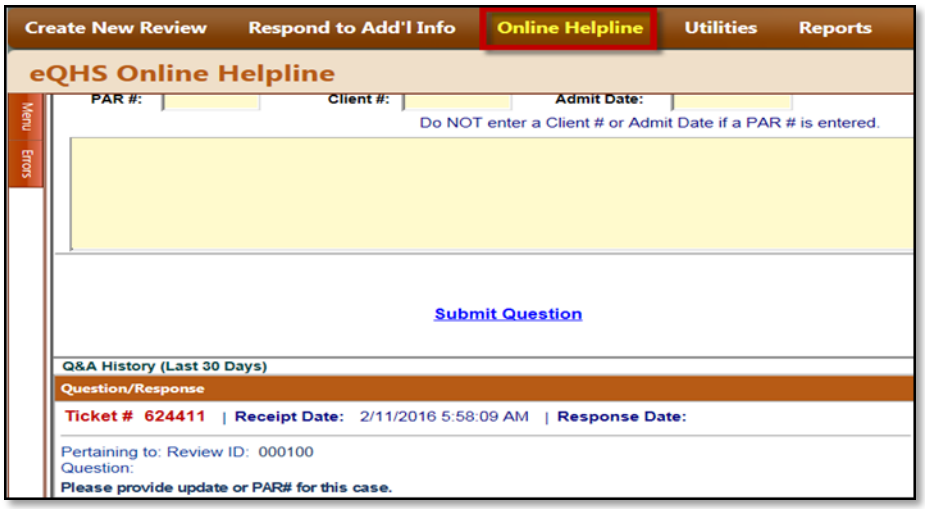
- Print and fill out the Change of Provider Form.
- Assist the member in signing the form.
  - **The member must sign the form for eQHealth to process the request.**
- Fax the signed form to eQHealth Solutions at 866-940-4288. Please allow three business days for processing, **OR**
- Submit a new PAR by selecting "admission" in eQSuite and uploading all required supporting documents, including a copy of the signed Change of Provider Form.

## Change of Rendering/Billing Provider Information

An online helpline ticket should be submitted to eQHealth Solutions if the ordering physician is incorrectly listed as the rendering/billing provider. Please log on to eQSuite® and click the Online Helpline tab to submit a ticket. A ticket number and receipt date will appear with your question in the Q&A History section.

- Please allow three days for Helpline ticket processing.
- You will receive an email notice when eQHealth has addressed the question.
- The answer will appear in the Q&A History next to your question.

*Note: If you are exempt from using eQSuite®, please call eQHealth Solutions Customer Service Line at 888-801-9355 to submit a Helpline ticket.*




## eQSuite® PAR Edits

New edits in eQSuite® are in place to assist users with PAR requirements, coverage limitations, and other information necessary for accurate and complete requests. Please note some of the following edits by service type:

**Outpatient Therapies:**

**Habilitative Services**

- Habilitative therapy services are not permitted in schools or nursing facilities.
- Appropriate modifiers for habilitative services: **GO** and **HB** or **GP** and **HB**.

**Early Intervention Services**

- The Early Intervention and Individual Family Service Plan (IFSP) questions must be answered if the member is less than four (4) years old.
- Appropriate modifiers for Early Intervention service: **GO** and **TL** or **GP** and **TL**.

**Diagnostic Imaging (Radiology):**

- PAR duration cannot exceed 90 calendar days.

**Surgical/Non-Surgical:**

- PAR duration cannot exceed 90 calendar days (excluding transplants).

**Durable Medical Equipment:**

- If the time requirement is not met, the purchase modifier, **NU**, cannot be used.

For important guidelines and rules by service type, please refer to the Billing Manuals web page.

## Billing Provider ID Reminder

Many provider accounts were adjusted with the recent HCPF revalidation enrollment. When creating a new PAR request in eQSuite®, the requestor must use a billing provider ID that is currently active in the MMIS Payer System. As a reminder:

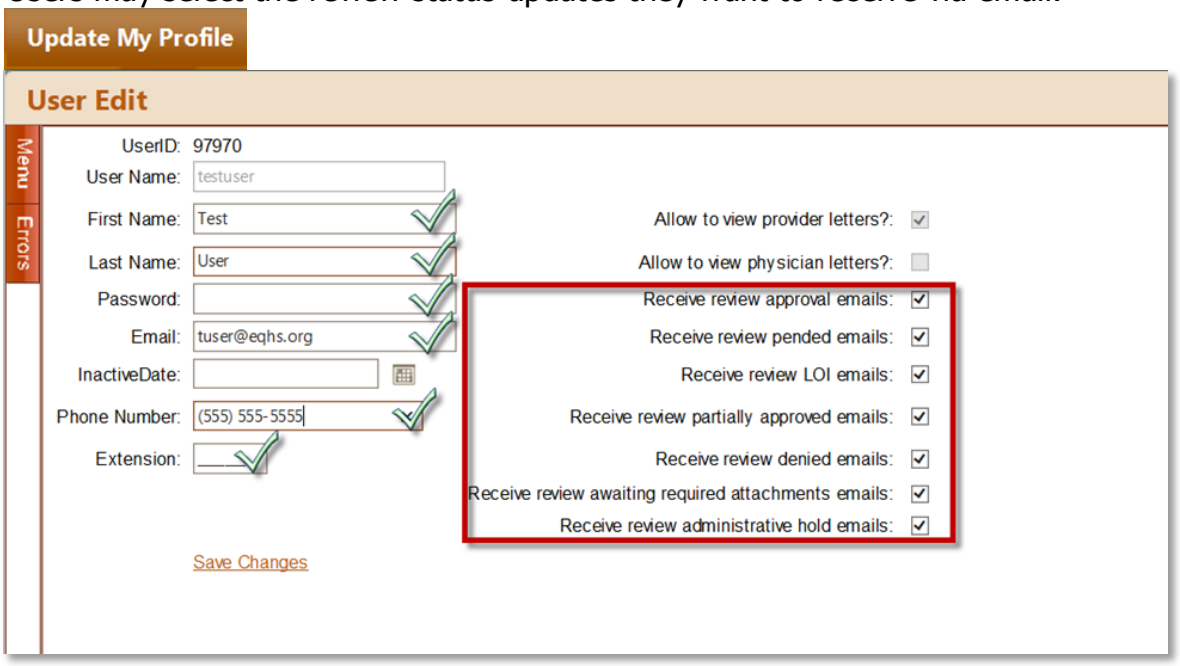
- If the Billing Provider ID you entered is not valid, you will receive a message on the screen "Please enter active billing provider ID."

- Check with your billing department to ensure you are using the correct facility or practice Medicaid Billing ID.

## Provider Communications

To ensure timely communication during the PAR process, it is important to have updated contact information on file in eQSuite®. All users can easily update their contact information and email notifications by clicking "Update My Profile" on the menu bar.

- Users may update the following account fields:
  - First or last name
  - Password
  - Email
  - Phone number or extension
- Users may select the review status updates they want to receive via email.




Please contact eQHealth Solutions Customer Service at 888-801-9355 with questions.

## Discontinued Codes

| | | |
|---|---|---|
| 01999 | 36299 | 64999 |
| 17999 | 38999 | 69399 |
| 20999 | 42299 | 69799 |
| 23929 | 43499 | 76499 |
| 26989 | 43999 | 78099 |
| 27599 | 46999 | 78399 |
| 27899 | 47379 | 78499 |
| 28899 | 47579 | 87999 |
| 29799 | 49999 | 93799 |
| 30999 | 51999 | 94799 |
| 31599 | 58578 | 96379 |
| 31899 | 58679 | 99199 |
| 33999 | 58999 | 99499 |

**Please note:** Effective May 1, 2016, the procedure codes listed in the table above will no longer be covered services under Colorado Medicaid. These rarely used procedure codes are for nonspecific services. Please contact Richard.Delaney@state.co.us with questions.

## 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 updated W-9 is processed. Claims for payments not released are voided out of the Medicaid Management Information System (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 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. Providers who do not receive a 1099 should call the State Controller's office at 303-866-4090 for assistance.

# Family Planning Service Providers

## Food and Drug Administration (FDA) Update on Essure: Female Sterilization Method

The Department would like to **encourage** all Essure providers to review the updated FDA information prior to offering Essure to members seeking permanent sterilization by this method. The information reported below comes from recent FDA reports.

Essure is a permanent non-surgical birth control method for female sterilization. Over the past several years this device and procedure has been associated with an increased number of adverse-event reports. Some FDA reported adverse events include:

- Persistent pain
- Perforation of the uterus and/or fallopian tubes
- Intra-abdominal or pelvic device migration
- Abnormal or irregular bleeding
- Allergy or hypersensitivity reactions.
- Other associated adverse outcomes such as Essure failure and, in some cases, incomplete patient follow-up have resulted in unintended pregnancies.

On September 24, 2015, the FDA convened a meeting of the Obstetrics and Gynecology Devices Panel of the Medical Devices Advisory Committee to hear expert scientific and clinical opinions, as well as patients' experiences regarding the benefits and risks of Essure.

Following careful review of this information, the FDA:

1. Ordered Bayer to conduct a post market surveillance study to obtain more data about Essure's benefits and risks;

2. Intends to require that a boxed warning and Patient Decision Checklist be added to the product labeling to help ensure that women receive and understand information regarding the benefits and risks of this type of device. In addition, the FDA issued the draft guidance, "Labeling for Permanent Hysteroscopically-Placed Tubal Implants Intended for Sterilization" to provide the public an opportunity to comment on the proposed language to be included in these warnings;
3. Is in the process of completing its evaluation of the trade complaint.

Below are links for additional FDA information.

- Advisory Committee meeting summary and panel transcript
- FDA website on Essure Permanent Birth Control
- FDA website on status of FDA's evaluation of the Essure System

Please contact the Department's fiscal agent at 800-237-0757 with claims questions. Please contact Melanie.Reece@state.co.us or 303-866-3693 with policy questions.

# Hospital Providers

## Inpatient Claims for Members Fewer than 29 Days Old

The Department has identified an error in processing inpatient claims for members who are fewer than 29 days old (neonates) at the date of admission under the APR-DRG methodology implemented January 1, 2014. The error causes an incorrect DRG to be assigned that is not appropriate to the age of the member on both the date of admission and date of discharge.

The Department identified the claims containing this issue with a paid date within calendar year (CY) 2014, and hospitals should have received a letter the week of March 7, 2016 with guidance specific to their situation.

Impacted hospitals would either have:

- **A net underpayment for CY2014**: a transaction dated 2/25/2016 was deposited into the appropriate account in settlement for the affected claims.
- **A net overpayment for CY2014**: repayment of the identified amount is due to the Medicaid Program by April 3, 2016 (within 30 days of the mailing of the notice).

Adjustments for claims in calendar year 2015 and the remainder of 2016 are pending a system fix. The Department will notify all affected hospitals once a timeline is established.

Please contact Diana.Lambe@state.co.us or 303-866-5526 with questions.

# Pharmacy Providers

## Preferred Drug List (PDL) Update

Effective April 1, 2016, these are the following drug classes and preferred agents:

**Alzheimer's Agents:** donepezil 5mg and 10mg, donepezil ODT 5mg and 10mg, galantamine and galantamine ER, memantine.

**Atypical Antipsychotics:** Abilify, Abilify ODT, aripiprazole oral solution, clozapine, Clozaril, Geodon, Latuda, olanzapine, quetiapine IR, risperidone, risperidone ODT, Risperdal, Risperdal M-tab, Seroquel IR, ziprasidone, Zyprexa

**Growth Hormones:** Genotropin and Norditropin

**Insulins:**

- Rapid acting: Novolog vial and pen
- Short acting: Humulin R vial and pen
- Intermediate acting: Humulin N vial and pen
- **Long acting: Levemir vial and pen**
  - **Lantus will be second line treatment**
  - **All other long-acting insulins will require a failure of Levemir and Lantus**
- Mixtures: Humulin 70/30 vial/ pen, Humalog Mix 50/50 vial/ pen, Humalog Mix 75/25 vial/ pen, Novolog Mix 70/30 vial/ pen

**Intranasal Corticosteroids:** fluticasone, Nasonex

**Leukotriene Modifiers:** montelukast tablet and chewable tablet

**MS Agents:** Copaxone 20mg, Avonex, Betaseron and Rebif will be preferred.

- All other agents will be subject to prior authorization

**Ophthalmic Allergy Agents:** cromolyn, olopatadine 0.1% (generic Patanol), Pataday, Pazeo and Zaditor

**Sedative-Hypnotics (non-benzo):** eszopiclone, zaleplon, zolpidem

**Statins/Statin Combinations:** Crestor, atorvastatin, pravastatin, simvastatin

The April 1, 2016 PDL is posted on the Department's website. This can be found on the Provider Forms website in the Pharmacy section. Please refer to the latest PDL for detailed prior authorization criteria.

## Hepatitis C

**Effective March 1, 2016**, the prior authorization (PA) criteria for Hepatitis C was updated. Please refer to the PDL for updated criteria sets, and utilize the new consolidated prior authorization form for these agents. This form should be used for all submissions after March 1, 2016 and is available on the Provider Forms website in the Pharmacy section.

## Morphine Equivalent Limitations Update

**Effective February 17, 2016**, the Department implemented 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 a member's drug regimen to exceed the maximum daily limit of 300 mg 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.

Prior authorizations for six (6) months will initially be granted to allow for tapering.

The Prior Authorization (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 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.

Members 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 member visits. If a member has not shown clinically meaningful improvement, then continuing opioids is not considered appropriate care in most cases. Thirty percent improvement from the baseline assessment or at the time of dose change is considered clinically meaningful.

## Drug Utilization Review (DUR) Board Update

The DUR board has openings for physicians and pharmacists. The physician and pharmacist board members shall serve in staggered two (2) year terms, so that new Board members are appointed each year and may be re-appointed to two-year terms.

If you are interested in serving or know someone who is qualified, please submit a curriculum vitae (CV) or resume by emailing:

Robert.Lodge@state.co.us

Or mail to:
Colorado Department of Health Care Policy and Financing
Attn: Robert Lodge
1570 Grant Street
Denver, CO 80203

Or fax to: 303-866-3590.

**The deadline for this submission is April 29, 2016.** The next DUR Board meeting will be in May, and the specific date will be decided in the middle of April.

# Speech Therapy Providers

## Attention Outpatient Speech Therapists

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

1. Effective April 1, 2016, all Outpatient Speech Therapy claims must contain the valid NPI number of the OPR 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. The OPR NPI must be present on both institutional (UB-04) and practitioner (CMS 1500) claim types.
    a. Electronic CMS 1500 claims must have the OPR NPI in field #17.b.
    b. Electronic UB-04 claims may indicate the attending provider as the OPR provider in field #76.
    c. Electronic UB-04 claims without an attending provider as the OPR provider must have the OPR NPI in field #78.

2. Only licensed or certified otolaryngologists and speech-language pathologists or 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.
3. 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.
4. Claims without a valid OPR NPI number that are paid will then be subject to recovery.
5. Medical documentation must be kept on file to substantiate the order, prescription, or referral for outpatient speech therapy. This is in addition to other required documentation (notes detailing member progress and what was performed on that date) about the speech therapy service performed. Claims lacking such documentation on file will be subject to recovery.
6. 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.

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

# Waiver Providers

## Home and Community Based Services (HCBS) Waiver Providers

The HCBS Waiver for Persons with Spinal Cord Injury (HCBS-SCI) has been approved for a five-year renewal. The following changes are effective March 21, 2016.

### Unduplicated Member Count

The unduplicated member count on the SCI waiver has been increased from 67 individuals to 120 individuals. The current waitlist for this waiver will be eliminated with this increase.

### Complementary and Integrative Health Provider Model

- The new provider model allows for individual acupuncturists, chiropractors, and massage therapists to enroll as Complementary and Integrative Health service providers for SCI members.
- The new provider model also allows for members to receive Complementary and Integrative Health services in their home.

### Hospital Level of Care

Hospital level of care has been added to the eligibility criteria for the SCI waiver.

### Home Modification Increase

The overall lifetime maximum for the Home Modification benefit has been increased from $10,000 to $14,000.

### In-Home Support Services (IHSS)

- IHSS may be provided in the community.
- The member, or the member's authorized representative, is responsible for directing their care, including scheduling, managing, and supervising attendants.
- The member, or the member's authorized representative, may work with the IHSS agency to determine the amount of oversight by a licensed health care professional.
- IHSS agencies may provide support necessary for members who do not have an authorized representative to participate in IHSS.
- A spouse is now an eligible family member who may act as an attendant providing IHSS.
- The 444 hour per year family member reimbursement limit for personal care has been removed and replaced with a 40 hour per week family member reimbursement limit for IHSS personal care.

### Targeted Rate Increases

The following services received a Targeted Rate Increase during the 2015-2016 Legislative Session. These increases went into effect for the HCBS-SCI waiver on March 21, 2016.

| Approved Targeted Rate Increases: **Procedure Code** | **Service Description** | **Approved TRI** | **Unit** |
|---|---|---|---|
| **S5130** | Homemaker | $4.25/unit | 15 Minutes |
| **S5130** | IHSS Homemaker | $4.25/unit | 15 Minutes |
| **S5150** | In-Home Respite Services | $4.87/unit | 15 Minutes |
| **T1019** | Personal Care | $4.25/unit | 15 Minutes |
| **T1019** | Personal Care-Relative | $4.25/unit | 15 Minutes |
| **T1019** | IHSS Personal Care | $4.25/unit | 15 Minutes |
| **T1019** | IHSS Personal Care Relative | $4.25/unit | 15 Minutes |
| **S5165** | Home Modifications | $14,000.00 Lifetime Maximum | Per Modification |
| **98942** | Chiropractic Care | $23.20/unit | 15 Minutes |

The Department will perform mass adjustments on all claims with these procedure codes to ensure correct payment on or after March 21, 2016.

**Please note:** Mass adjustments made by the Department can only be performed if the originally submitted charge on a claim is greater than the newly revised rate. Any claim on or after the date that the new rates become effective 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 & Customary rates when applicable.

Please refer to the Provider Rates & Fee Schedule website for the most current fee schedules or the Billing Manuals website for the appropriate rate and fee schedule.

Please contact Samantha.Saxe@state.co.us with questions.

# In-Home Support Services (IHSS)

## Public Notice

The Department revised the IHSS Physician Attestation form. This form is available on the Department's Participant-Directed Programs website in the IHSS Forms section and on the Consumer Direct Colorado website. In-Home Support Service providers are encouraged to routinely review forms on the Department's website to ensure they are utilizing the most recently updated forms.

Please contact Rhyann.Lubitz@state.co.us or 303-866-3641 with questions.

# April and May 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.

## April 2016

| Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
|---|---|---|---|---|---|---|
| 10 | 11 | 12<br>***WebEx***<br>CMS 1500<br>9:00 a.m.-11:30 a.m.<br><br>Web Portal 837P<br>11:45 a.m.-12:30 p.m. | 13<br>***WebEx***<br>UB-04<br>9:00 a.m.-11:30 a.m.<br><br>Web Portal 837I<br>11:45 a.m.-12:30 p.m.<br><br>***WebEx***<br>NHVP<br>1:00 p.m.-3:00 p.m. | 14<br>***WebEx***<br>Pharmacy<br>9:00 a.m.-11:00 a.m.<br><br>Practitioner<br>1:00 p.m.-3:00 p.m. | 15<br>Hospice<br>9:00 a.m.-11:00 a.m.<br><br>Transportation<br>1:00 p.m.-3:00 p.m. | 16 |

## May 2016

| Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
|---|---|---|---|---|---|---|
| 8 | 9 | 10<br>CMS 1500<br>9:00 a.m.-11:30 a.m.<br><br>Web Portal 837P<br>11:45 a.m.-12:30 p.m.<br><br>***WebEx***<br>Vision<br>1:00 p.m.-3:00 p.m. | 11<br>UB-04<br>9:00 a.m.-11:30 a.m.<br><br>Web Portal 837I<br>11:45 a.m.-12:30 p.m.<br><br>FQHC<br>1:00 p.m.-3:00 p.m. | 12<br>Waiver<br>9:00 a.m.-11:30 a.m.<br><br>Web Portal 837P<br>11:45 a.m.-12:30 p.m.<br><br>Personal Care<br>1:00 p.m.-3:30 p.m.<br><br>Web Portal 837I<br>3:45 p.m.-4:30 p.m. | 13<br>***WebEx***<br>CMS 1500<br>9:00 a.m.-11:30 a.m.<br><br>Web Portal 837P<br>11:45 a.m.-12:30 p.m.<br><br>DME/Supply<br>1:00 p.m.-3:00 p.m. | 14 |

**Reservations are required for all workshops by:**

Emailing reservations to: workshop.reservations@xerox.com

Or

Calling the Reservation hotline to make reservations: 800-237-0757, extension 6, option 4.

**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 email 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 a Provider Relations Representative at 800-237-0757.

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:

Light Rail

Free MallRide

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 for the most recent information.*

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