Provider Bulletin

Reference: B0900272 **November 2009**

colorado.gov/hcpf

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

ACS Contacts

Billing and Bulletin Questions
303-534-0146
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

Did you know...?

The fiscal agent is not able to help clients or answer client questions. If clients have Medicaid questions, they should be referred to their county social services office or to the Department's call center at 303-866-35131(Denver-Metro area) or 800-221-3943 (Outside the Denver-Metro area).

All Providers

H1N1 Vaccine

The vaccine to protect against H1N1 influenza will be made available at no cost to providers; therefore, Medicaid will pay for the administration of the vaccine but not for the vaccine itself. Providers interested in providing the H1N1 vaccine may obtain information by calling the Colorado Immunization Program at 303-692-2650 or visiting www.cdphe.state.co.us/epr/h1n1.html. All Medicaid clients are eligible to receive the vaccine.

For each administration of the H1N1 vaccine, report one unit of the new CPT code 90470 - "*H1N1 immunization administration (intramuscular, intranasal), including counseling when performed*" with the ICD-9-CM diagnosis code V04.8 - *need for prophylactic vaccination and inoculation against certain viral diseases, influenza*. Reimbursement for 90470 is $6.50 and is limited to a one-time administration fee. The revised CPT code 90663 - "*influenza virus vaccine, pandemic formulation, H1N1*" should be used for billing the vaccine (for tracking purposes) even though there is no reimbursement because the vaccine is available at no cost to providers. An evaluation and management (E/M) code should not be reported when the only purpose of the office visit is to administer the H1N1 vaccine.

Preparation checklists, toolkits, and guidelines that will assist healthcare providers and service organizations in planning for a pandemic outbreak can be found at http://pandemicflu.gov/professional/hospital/.

Please contact Marcy Bonnett at marcy.bonnett@state.co.us or 303-866-3604 with questions.

Synagis® Immune Globulin

Effective November 1, 2009, the following protocols for Synagis® (Palivizumab) replace those listed in the Immunization Benefit Update (B0900262 - 01/09) Provider Bulletin. The new policy is based on the American Academy of Pediatrics (AAP) 2009 and the Colorado Chapter of the AAP recommendations for Respiratory Syncytial Virus (RSV) prophylactic therapy.

Synagis® is used to prevent serious lower respiratory tract disease caused by RSV in pediatric patients at high risk for RSV disease. Synagis® is administered by intramuscular injections, at 15 mg per kg of body weight, once a month during expected periods of RSV frequency in the community.

When Synagis® is administered in a Provider's Office or Outpatient Hospital:

Prior Authorization is not required if:

The client is under age 2 at the start of the current RSV season or at the time of the first injection for the current RSV season, who meets all of the following:

- Diagnosis of Chronic Lung Disease (CLD) AND having one for more of the following clinical needs during the previous 6 months:
  - o Supplemental oxygen;
  - o Regular use of inhaled or oral bronchodilators;
  - o Recent use of corticosteroid therapy; or
  - o Regular or intermittent use of diuretics to treat pulmonary disease.

  ***A maximum of five monthly doses is recommended.**
- Diagnosis of Interstitial Lung Disease and/or Neuromuscular disease which impacts pulmonary function

  ***A maximum of five monthly doses is recommended.**
- Any infant or child under the age of 2 who has a diagnosis of congenital heart disease and meets any of the following criteria:
  a. Receiving medication to control congestive heart failure (diuretics, antihypertensives);
  b. Suffer moderate to severe pulmonary hypertension; or
  c. Suffer Cyanotic Heart Disease.

  ***A maximum of five monthly doses is recommended.**
- Any infant up to 6 months of age, born 29 to less than 32 weeks gestation

  ***A maximum of five monthly doses is recommended.**
- Any infant up to 12 months of age, born at 28 weeks or less gestation

  ***A maximum of five monthly doses is recommended.**
- Any infant younger than 3 months of age at the start of the RSV season, born at 32 to less than 35 weeks gestation and meets one of the following risk factors:
  a. Currently attends day care;
  b. Has a sibling younger than 5 years of age;
  c. Congenital abnormalities of the airway; or
  d. A neuromuscular condition that compromises handling of respiratory secretions.

  ***A maximum of three monthly doses is recommended for patients in this category, or until the child reaches 3 months of age.**
- Infants up to 2 years of age with hemodynamically significant heart disease defined as having one or more of the following:
  a. Infants receiving medication to control congestive heart failure;
  b. Infants with moderate to severe pulmonary hypertension; or
  c. Infants with cyanotic heart disease.

  ***A maximum of five monthly doses is recommended.**

Prior authorization is required for:

- Children ages 2 or older at the start of each RSV season but whose physician believes that they require Synagis® and writes a letter of medical necessity with a prior authorization request.

Providers administering Synagis® in the office must furnish the immune globulin and must use CPT code 90378 to bill Synagis® on the Colorado 1500 paper claim form or as an 837 Professional (837P) transaction. Bill one unit per 50 mg vial; limit six units per day.

Providers may not ask clients to obtain Synagis® from a pharmacy and bring it to the practitioner's office for administration.

Outpatient hospitals should bill using the appropriate revenue code.

Prior Authorization Requests (PARs) should be sent to:

PARs
P.O. Box 30
Denver, CO 80201-0030

Providers may contact the fiscal agent's prior authorization line at 303-534-0279 or 1-800-237-7647 with questions.

Synagis® may be a pharmacy benefit if the medication is administered in the client's home or long-term care facility. The prior authorization request criteria for approval are the same as those listed above.

Pharmacy prior authorizations may be requested by calling or faxing the Pharmacy Prior Authorization Help desk at:

- Phone: 1-800-365-4944
- Fax: 1-888-772-9696

For additional questions, please contact Marcy Bonnett at marcy.bonnett@state.co.us or 303-866-3604. You may also contact Gina Robinson at gina.robinson@state.co.us or 303-866-6167.

Provider Load Letters

What is a Load Letter? A Load Letter permits providers to submit a paper claim for services rendered past the 120 days of the date of service (DOS). A Load Letter can only be issued when the provider has verified the client's eligibility and receives an *Eligibility Status* of "**Eligible**" through the Colorado Medical Assistance Program Secure Web Portal (Web Portal), FaxBack, or CMERS. Upon receiving the request from providers, the Department of Health Care Policy and Financing (Department) will generate a Load Letter as long as the request meets **all** of the following criteria:

- Client/patient was eligible when services were rendered;
- Client/patient was showing as ineligible at the time of claims submission;
- Eligibility was recently reinstated retroactively, but the claim is out of timely filing; and
- Client is currently showing as eligible.

All requests should be faxed to the Department at 303-866-4517, Attention: Tracy Vallejos or emailed to loadletterrequests@hcpf.state.co.us. Use **Client's State ID, Load Letter Request** as the subject. Please remember to take all necessary precautions when faxing or emailing client information to the Department, as some of the following information is considered protected health information under HIPAA, and subject to federal privacy protections.

Each request must contain the following information:

- Client 's State ID
- Dates of Service
- Provider's Name
- Provider's Address
- Provider's Contact Phone and Fax Number

The Department will review and research each request to determine if the client was eligible during the (DOS). If the client is found eligible on the DOS, Department staff will issue and send a Load Letter to the provider by fax or mail. Once the Load Letter is issued, the provider can submit a paper claim along with the Load Letter to the Department's fiscal agent, ACS for processing. If the claim is submitted outside of 120 days from the DOS, the "load date" is required on the claim as the late bill override date (LBOD).

Please note this is an alternate method for providers. County Departments of Social/Human Services can still issue a Load Letter upon request from a provider. Please contact Tracy Vallejos at 303-866-6103 with any questions.

Add-A-Baby Requests

On October 1, 2009, the Department began accepting all Add-A-Baby requests for processing. Although the eligibility sites will continue to be able to add babies to Medicaid upon request, the Department is giving providers an alternative means to making babies eligible within five business days of the form request being received.

Providers can submit the Add-A-Baby form to the Department in three different ways:

1) An email submission can be sent by completing the Add-A-Baby Form (Fill-in) located under "Other Forms" in the Provider Services Forms section and emailing it as an attachment to add-a-baby@hcpf.state.co.us.

   The email must be encrypted for security purposes, please follow the instructions below:

   How to encrypt the Add-A-Baby form:

   a. In Microsoft Word, select the **Tools** option from the menu bar
   b. Select **Options…** from the drop down menu
   c. Click on the Security tab and enter "hcpf" in the **Password to open:** field located in the **File encryption options for this document** section
   d. Click OK

2) Submit the completed form by fax to the Department at 303-866-4517, Attention: Shawna Moreno or mail the completed form to Health Care Policy and Financing, 1570 Grant Street, Denver CO, 80203, Attn: Shawna Moreno. The standardized Add-A-Baby Form (Print and Fax/Mail) is available under "Other Forms" in the Provider Services Forms section and as Attachment A of this bulletin.

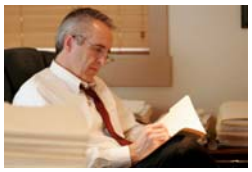
3) An online form is available through the **Clients & Applicants** section of the Department's Web site. Click on Report the birth of a Medicaid or CHP+ baby online under the "**I am a Medicaid/CHP+ client, how can I report the birth of my newborn?**" question.

Please note that the Department will only accept the official form for Add-A-Baby requests. We ask that providers do not alter the form in any way, since all of the information on the form is needed to process the requests.

Please contact Shawna Moreno at shawna.moreno@state.co.us or 303-866-4456 if you have any questions.

Providers Are Required to Screen for Excluded Employees and Contractors

On January 16, 2009, the Centers for Medicare and Medicaid published and issued a letter to State Medicaid Directors to strengthen the integrity of the Medicaid program and to help states reduce improper payments to providers. The letter advises states of their obligation to direct providers to screen their own employees and contractors for excluded persons. For easy reference, the letter may be found at http://www.cms.hhs.gov/SMDL/downloads/SMD011609.pdf.



In direct response to this State Medicaid Director's Letter, the Department proposed a Medicaid program rule revision to declare the Department's expectation for compliance to federal requirements. The Medical Services Board promulgated a rule revision to provider participation in 10 CCR 2505-10, Section 8.130.35, titled *Screening for Excluded Employees and Contractors*, with an effective date of July 1, 2009.

These changes will affect all providers enrolled in the Medicaid program. Providers will benefit from the rule revision as the rule outlines the steps a provider can take to avoid the risk of federal civil monetary penalties for employing individuals or contractors who have been excluded from participation in Medicaid by the U.S. Department of Health and Human Services Office of the Inspector General (HHS-OIG).

The Department acknowledges that this process adds extra duties for provider staff but the risk of losing state and federal funding for the medical assistance program far outweighs the challenges to implement a new monthly exclusion validation process. Please note that the Department conducts a monthly exclusion validation process of all enrolled Medicaid providers. Any excluded provider that matches the exclusion database is terminated from Medicaid participation and recovery of any state and federal funds is implemented. The Department is mandated to report to the HHS-OIG any instances where excluded individuals or entities are participating in the Medicaid program.

It is strongly advised that providers become familiar with all Medicaid rules, provider bulletins, billing manuals and instructions.

If you have any questions, please contact Nancy Downes, Program Integrity Manager, at nancy.downes@state.co.us or 303-866-5421.

Tax Season and 1099s

Please don't forget to update your current provider enrollment information with the fiscal agent. By using the Provider Enrollment Update Form, you can update your address, NPI, license, email address, affiliations, and receive electronic bulletin notifications. The form is available in Enrollment for Existing Providers in the Provider Services Enrollment section of the Web site.

With the exception of provider license information, the above updates may also be made through the Web Portal. Updated provider license information must be made using the Provider Enrollment Update form.

November and December Holidays

The Veterans Day holiday on Wednesday, November 11, 2009 and the Thanksgiving Day holiday on Thursday, November 26, 2009 will delay the receipt of warrants and EFTs by one or two days.

Due to the Christmas Day holiday on Friday, December 25, 2009, the claims processing cycle will include electronic claims accepted before 6:00 P.M. Mountain Time on Thursday, December 24, 2009. The receipt of warrants and EFTs will also be delayed by one or two days.

State Furlough Day

All Colorado State offices will be closed on Friday, November 27, 2009 due to statewide furlough day. ACS Government Solutions and the Provider Services Call Center will be open for business.

Please contact ACS Provider Services at 303-534-0146 or 1-800-237-0757 with questions.

Dental Providers

Dental Hygiene Providers

Effective November 1, 2009, dental hygiene providers should no longer submit claims to Medicaid for D0999*, unspecified diagnostic procedure, by report.* Unsupervised* hygienists may now submit claims for D0120*, periodic oral evaluation - established patient*, OR D0145, *oral evaluation for a client under three years of age and counseling with primary caregiver*, in lieu of D0999. Dental hygiene services are limited to Medicaid-enrolled clients ages 20 and under. Dental preventive procedures that can be independently provided and billed by an unsupervised dental hygienist for Medicaid enrolled children include:

D0145 - o*ral evaluation for a patient* ***under three years*** *of age and counseling with primary caregiver*

D0120 - *periodic oral evaluation-established patient*

D1110 - *prophylaxis – adult* (age 20 and under when appropriate)

D1120 - *prophylaxis – child*

D1203 - *topical application of fluoride-child*, ages 6 and older

D1204 - *topical application of fluoride*-adult, ages 12 and older

D1206 - *topical fluoride varnish; therapeutic application for moderate to high caries risk patients,* ages 0 through 20. Fluoride varnish is the only acceptable fluoride treatment that will be reimbursed by Medicaid for clients under age 6.

D1330 - *Oral hygiene instructions*, ages 3 through 20

D1351 - *Sealant (per tooth)*-benefit only for the occlusal surface of permanent molar teeth 2, 3, 14, 15, 18, 19, 30, 31

Two evaluation codes should not be billed for the same client on the same date of service by the same provider.

*Unsupervised dental hygiene as defined by the Colorado Department of Regulatory Agencies (DORA).

Please call Marcy Bonnett at 303-866-3604 or email at marcy.bonnett@state.co.us with any questions.

HCBS Providers

People with Developmental Disabilities (HCBS-DD) Waiver

In January 2009, the Home and Community Based Services for People with Developmental Disabilities (HCBS-DD) Waiver was amended and subsequently renewed July 1, 2009. As part of the amendment and renewal, skilled nursing duties were included in the Residential Habilitation Services and Supports (RHSS) definition as well as factored into the residential rate for all residential settings including Group Residential Services and Supports (GRSS) and Individual Residential Services and Supports (IRSS), including Host Homes and Personal Care Alternative (PCA) homes.

The Department will be implementing these changes as they will impact the delivery of Long Term Home Health (LTHH) services to clients enrolled in the HCBS-DD Waiver.
The Department is amending the current Home Health rule (10CCR 25.10 Section 8.528.14.B.1-2), which will require that all RHSS providers be responsible for providing and/or reimbursing for all LTHH.
Therefore, until such time that the rule is amended and approved, the Community Centered Boards (CCBs) will continue to review and process LTHH Prior Authorization Requests (PARs) for clients enrolled in the HCBS-DD Waiver according to the rules as set forth in Medicaid Program Rule 10 CCR 25.10 Section 8.527. If the client resides in a GRSS setting, the PAR shall be denied. The case manager shall send a Long Term Care (LTC) 803 Notice of Action form to the client, citing the current Medicaid Home Health rule. If the client resides in an IRSS setting (Host Home or PCA), the case manager shall review the PAR according to the current rules (10 CCR Section 8.527). However, the case manager shall only certify the PAR for 90 days, rather than for the requested annual certification period.
Please contact Amy Beccera at amy.beccera@state.co.us or 303-866-3011 if you have any questions.

DME Providers

Clarification of Equipment, Supply, Orthotic & Prosthetic Rate Change

In July and September 2009, the Department implemented two rate reductions for durable medical equipment and supplies. The reductions had incorrect calculations. The rates have been corrected and claim adjustments are being made. Corrections are as follows:
Equipment, supply, oxygen, orthotics, and prosthetics shall be reimbursed at the lower of the following:

1. Submitted charges; or
2. Fee schedule for durable medical equipment and supplies as determined by the Department.

Durable medical equipment and supplies that require manual pricing shall be reimbursed at the lower of the following rates for dates of service on or after July 1, 2009:

1. Submitted charges;
2. Manufacturer's suggested retail price (MSRP) less 19.62 percent; or
3. Actual invoiced acquisition cost plus 17.64 percent when no MSRP is available.

Durable medical equipment and supplies that require manual pricing shall be reimbursed at the lower of the following rates for dates of service on or after September 1, 2009:

1. Submitted charges;
2. Manufacturer's suggested retail price (MSRP) less 20.82 percent; or
3. Actual invoiced acquisition cost plus 15.87 percent when no MSRP is available.

Reimbursement rates for dates of service on or after July 1, 2009, and dates of service on or after September 1, 2009, for these services can be found by accessing the Medicaid Fee Schedule on the Provider Services home page.
Please contact Doug van Hee at doug.vanhee@state.co.us or 303-866-4986 if you have any questions.

Nursing Facility Providers

Post-Eligibility Treatment of Income (PETI) Fee Schedule 2009 Update

The Nursing Facility (NF) PETI fee schedule has been updated to reflect dates of service on or after

November 1, 2009 (see Attachment B of this bulletin). The fee schedule lists dental, hearing, and vision services by procedure code. It includes the reimbursable fee amount and notes whether or not the service is an adult Medicaid benefit. The NF PETI fee schedule is not all-inclusive, nor does the inclusion of any code imply that the service is a routinely approved request. Medical necessity and the absence of other payment sources are two criteria that must be met to justify the use of PETI funds.

A notation of 'MP' under the PETI Fee column indicates the procedure is manually priced by the Department. The nursing facility must submit a PETI request to the Department for all such MP codes even when the billing amount is below the first $400 PETI expense for the year. For all procedures that are a potential adult Medicaid benefit, a Medicaid provider must determine whether a client meets the Medicaid criteria to qualify for the benefit. If a valid Medicaid claim is submitted and then denied reimbursement, the nursing facility may submit a PETI request to the Department with a copy of the denial notice. A provider is not required to submit a claim to Medicaid if the service is not a Medicaid benefit.

Providers are reimbursed the same amount whether or not they are enrolled in the Medicaid program. A Medicaid provider may not ordinarily collect more from the beneficiary than the allowable PETI fee established by the NF PETI fee schedule. A service that is not listed on the fee schedule may be submitted to the Department for NF PETI consideration.

The Department reserves the right to request additional verification of medical necessity for any proposed procedure. Failure to provide such documentation will result in the denial of the NF PETI request.

Please contact Rose-Marie Nelson at rose-marie.nelson@state.co.us or 303-866-3167 if you have any questions.

Pharmacy Providers

H1N1 Vaccine

On October 21, 2009, the Department began reimbursing pharmacy providers for the administration of the H1N1 vaccine. The administration fee is the established dispensing fee of $4.00. As previously noted, the Department will only reimburse the administration fee and not the vaccine itself since the vaccine is available at no cost. The seasonal flu vaccine and other vaccines are not a covered pharmacy benefit.

The Department will only be able to reimburse for H1N1 vaccines that are rebateable. The current rebateable NDCs are 49281-0640-15, 49281-0650-10, 49281-0650-50 and 49281-0650-90. A drug's rebate status can change so be sure to submit claims through the point of sale system to verify coverage.

If you have any questions, please contact Kim Eggert at kimberly.eggert@state.co.us or 303-866-3176.

Preferred Drug List (PDL) Update

Effective November 1, 2009, the Department will cover generic Adderall XR without prior authorization for clients 6 years of age and older. Please contact Jim Leonard at jim.leonard@state.co.us or 303-866-3502 with questions.

Smoking Cessation Benefit

Effective September 1, 2009, all fee-for-service Medicaid clients are eligible for two courses (up to 180 days) of smoking cessation pharmacotherapy each year. This is a significant increase from the old benefit that only allowed for one 90-day course of pharmacotherapy treatment in a client's lifetime. Prior authorization approval will still be necessary to receive this benefit, since enrollment in a behavioral modification program is still required.

Please contact Beth MacKenzie at beth.mackenzie@state.co.us or 303-866-6342 with questions.

Increased Access for Prenatal Vitamins and Folic Acid

As of November 1, 2009, women no longer need prior authorization to receive Prenatal Vitamins or Folic Acid 1 mg. The pharmacy will still need to use Medical Certification/Prior Authorization Type Code of 4 to make sure that pregnant clients aren't charged a co-payment.

The Department has made this change because this combination of supplements is not only healthy for women preparing to give birth, but also aids in maintaining overall health and well being for all women. Specifically, the folic acid found in prenatal vitamins is helpful in the prevention of serious birth defects to the fetus' developing spinal cord and brain, called the neural tube. Defects to the neural tube most commonly occur during the first 28 days after conception, before most women know they are pregnant. Studies have shown that including folic acid in the diet before and during pregnancy significantly reduces the prospect of damage to the neural tube, thus decreases the likelihood of a birth defect.

Please contact Beth MacKenzie at beth.mackenzie@state.co.us or 303-866-6342 if you have any questions.

November and December 2009 Provider Billing Workshops

Denver Provider Billing Workshops

Provider billing workshops include both Colorado Medical Assistance Program billing instructions and a review of Colorado Medical Assistance Program billing procedures.
The November and December 2009 workshop calendars are included in this bulletin and are posted in the Provider Services Training & Workshops section of the Web site.

Should You Attend?

New and experienced receptionists, front desk personnel, admission personnel, office managers, billing services, and other billers should consider attending the appropriate workshops.

Reservations are required

Reservations are necessary for ***all workshops***.

Email reservations to:
workshop.reservations@acs-inc.com

Or

Call Provider Services to make reservations:
1-800-237-0757 or 303-534-0146

Press "**5**" to make your workshop reservation. You must 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

Without all of the requested information, your reservation will not be processed successfully. Your confirmation will be mailed to you within one (1) week of making your reservation.
If you do not receive a confirmation within one (1) week, please contact Provider Services and talk to a Provider Relations Representative.

All Workshops held in Denver are located at:

ACS
Denver Club Building
518 17th Street, 4th floor
Denver, Colorado 80202

Beginning Billing Class Description

These classes are for new billers, billers who would like a refresher, and billers who would like to network with other billers about the Colorado Medical Assistance Program. Currently the class covers in-depth information on resources, eligibility, timely filing, reconciling remittance statements and paper claim completion for the UB-04 and the Colorado 1500. *These classes do **not** cover any specialty billing information.* The fiscal agent provides specialty training throughout the year in their Denver office.

The classes do not include any hands-on computer training.

October and November Specialty Workshop Class Descriptions

Dental

The class is for billers using the 2006 ADA/837D claim format. The class covers billing procedures, claim formats, common billing issues and guidelines specifically for the following provider types: Dentists, Dental Hygienists

HCBS-BI

This class is for billers using the Colorado 1500/837P claim format for the following services: adult day care, non-medical transportation, home electronics, home modifications and personal care. The class covers billing procedures, common billing issues and guidelines specifically for HCBS-BI providers.

HCBS-EBD

This class is for billers using the Colorado 1500/837P claim format for the following services: adult day care, non-medical transportation, home electronics, home modifications and personal care. The class covers billing procedures, common billing issues and guidelines specifically for the following waivers:
HCBS-EBD HCBS-PLWA HCBS-MI

HCBS-DD

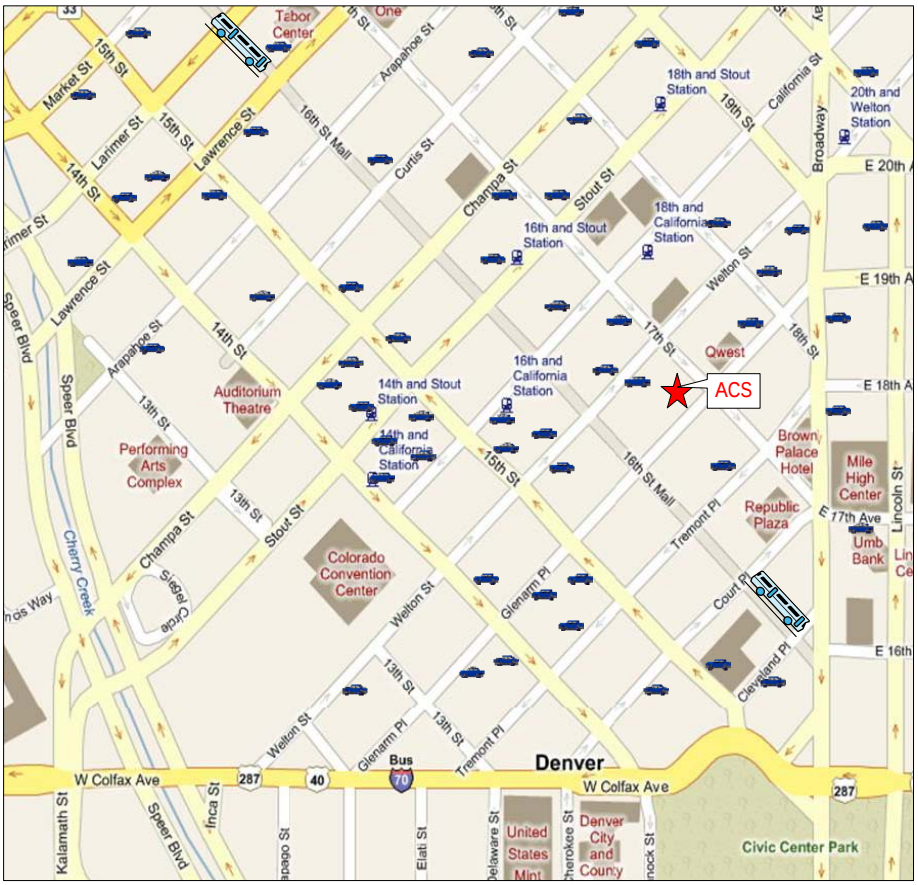
This class is for billers who bill on the CO1500 claim format for the following: Comprehensive Services (HCBS-DD), Supported Living Services (SLS), Children's Extensive Support (CES), Children's Residential Habilitation Program (CHRP) and Targeted Case Management (TCM). The class covers billing procedures, common billing issues and guidelines for HCBS-DD providers.

Transportation
This class is for transportation providers billing on the CO1500/837P and/or UB-04/837I format. The class covers billing procedures, common billing issues and guidelines primarily for non-emergency Transportation providers.

Provider Enrollment
This workshop focuses on the importance of correctly completing the Colorado Medical Assistance Program Provider Enrollment Application. Newly enrolling providers, persons with the responsibility for enrolling providers within their groups, association representatives, and anyone who wants to better understand the Colorado Medical Assistance Program enrollment requirements should attend.
This class focuses on completing the PAR correctly and avoiding common mistakes. This class is for DME/Supply providers who bill procedures requiring prior authorization. *(This class is not for Dental, HCBS, Nursing Facility, Pharmacy or Pediatric Home Health Providers)*

Driving directions to ACS, Denver Club Building, 518 17th Street, 4th floor, Denver, CO:
Take I-25 toward **Denver**
Take exit **210A** to merge onto **W Colfax Ave (40 E),** 1.1 miles
Turn **left** at **Kalamath St,** 456 ft.
Continue on **Stout St,** 0.6 miles
Turn **right** at **17th St,** 0.2 miles
ACS is located in the Denver Club Building on the west side of Glenarm Place at 17th Street (Glenarm is a two-way street).

Parking: Parking is not provided by ACS and is limited in the Downtown Denver area.
Providers attending workshops are urged to carpool and arrive early to secure parking or use public transportation.
= Light Rail Station: A Light Rail map is available at: http://www.rtd-denver.com/LightRail_Map.shtml
Free MallRide: MallRide stops are located at every intersection between Civic Center Station and Union Station.
Commercial parking lots: Lots are available throughout the downtown area. The daily rates are between $5 and $20.



Please direct questions about Colorado Medical Assistance Program billing or the information in this bulletin to
ACS Provider Services at 303-534-0146 or 1-800-237-0757 (toll free).
Please remember to check the Provider Services section of the Department's Web site at colorado.gov/hcpf.

November 2009 Workshop Calendar

.Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	2	3	4	5	6	7
8	9	**10** Beginning Billing – CO -1500 and 837P (Web Portal) 9:00 am – 2:00pm	**11** Provider Enrollment 9:00am – 12:00pm *Veterans Day*	**12** Beginning Billing – UB-04 and 837I (Web Portal) 9:00 am-2:00 pm	**13** HCBS BI 9:00am – 11:00 am HCBS EBD 1:00 pm – 3:00pm	14
15	16	17	18	19	20	21
22	23	24	25	26 *Thanksgiving Day*	27 *State Furlough Day*	28
29	30					

December 2009 Workshop Calendar

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		1	2	3	4	5
6	**7** Beginning Billing – CO- 1500 9:00am-2:00pm Transportation – 3:00pm-4:30pm	**8** Beginning Billing – UB-04 9:00am-2:00pm Developmental Disabilities – 3:00pm-4:30pm	9	10	**11** Dental Billing – 2006 ADA 9:00am-12:00pm	12
13	14	15	16	17	18	19
20	21	22	23	24	25 *Christmas Day*	26
27	28	29	30	31 *State Furlough Day*		

Add-A-Baby Request Form (Effective February 20, 2009)

Instructions: Please print legibly. If we are unable to read the information, it will be returned.

Fax this form to the Department of Health Care Policy and Financing, Attn: Shawna Moreno at 303-866-4517. Or you can mail the form to: Health Care Policy and Financing, 1570 Grant Street, Denver CO 80203, Attn: Shawna Moreno. Your request will be processed within five business days of receipt. You may also email this form to add-a-baby@hcpf.state.co.us, but it must be encrypted. Please see the encrypting instructions noted in this bulletin.

NOTE: All forms missing the required information will be sent back to the requestor which will cause a delay in this request. If you have any questions, please contact Shawna at 303-866-4456.

Please return form to: **Today's Date**: _____

Name: _____

Practice Name: _____

Phone: _____ **Fax:** _____

Information about Mother of Child: [REQUIRED INFORMATION]

Case Number: _____ **State ID:** _____

Social Security Number: _____ **Date of Birth:** _____

Last Name: _____ **First Name:** _____

Address: _____

Phone: _____ **County of Residence:** _____

Information about the Baby: [REQUIRED INFORMATION]

NOTE: Baby's information must be the same as it appears on the birth certificate.

Name (first, middle, last): _____

Date of Birth: _____ **Gender (circle one): Male Female**

Name (first, middle, last): _____

Date of Birth: _____ **Gender (circle one): Male Female**

Child's Doctor or HMO: _____ **Report taken by:** _____

Medicaid Tech and Date Reported to DHS office: _____

EPSDT Children's Medicaid Navigator: _____

PETI Dental Fee Schedule Effective November 1, 2009			
Procedure Code	**Cost Per Unit**	**Medicaid Benefit**	**Procedure Description per ADA-CDT**
D0120	$20.49	No	Periodic oral evaluation. Exam for a patient of record - a periodic scheduled check up or recall
D0140	$30.73	Yes	Limited oral evaluation - problem focused.
D0150	$35.34	Yes	Comprehensive oral evaluation - new or established patient
D0160	$64.03	Yes	Detailed and extensive oral evaluation - problem focused by report
D0170	$28.17	No	Re-evaluation - limited, problem focused. (Established patient; not post-operative visit)
D0180	$38.42	Yes	Comprehensive periodontal evaluation
D0210	$52.24	Yes	Intraoral - complete series (including bitewings). Full mouth set of x-rays - X-rays of all the teeth
D0220	$12.29	Yes	Intraoral - periapical - first film. X-ray showing all of a tooth.
D0230	$10.24	Yes	Intraoral - periapical - each additional film. X-ray showing all of the tooth
D0240	$17.93	Yes	Intraoral - occlusal film. A larger x-ray of several teeth in the upper or lower jaw
D0250	$25.61	Yes	Extraoral - first film. X-ray of the head or face
D0260	$21.00	Yes	Extraoral - each additional film. X-ray of the head or face. After the first x-ray in a series
D0270	$11.78	Yes	Bitewing - first film. One x-ray of the upper and lower teeth closed together
D0272	$18.95	Yes	Bitewings - two films
D0274	$26.63	Yes	Bitewings - four films. Four x-rays of the upper and lower teeth closed together
D0277	$39.44	Yes	Vertical bitewings – 7 to 8 films
D0330	$47.12	Yes	Panoramic film. Large single x-ray showing all the teeth and both jaws.
D0460	$24.07	Yes	Pulp vitality tests. Use of testing methods to find out if the nerve of a tooth is alive or dead
D0999	$15.23	No	Unspecified diagnostic procedure as performed by an unsupervised dental hygienist in unsupervised practice for a dental screening
D1110	$37.63	No	Prophylaxis - adult (hygienists)
D1110	$37.63	No	Prophylaxis - adult (DDS or under dentist's license)
D1204	$15.37	No	Topical application of fluoride - Adult
D1351	$23.05	No	Sealant - per tooth
D2140	$55.32	No	Amalgam - one surface - primary or permanent
D2150	$70.68	No	Amalgam - two surfaces - primary or permanent
D2160	$84.76	No	Amalgam - three surfaces - primary or permanent
D2161	$99.37	No	Amalgam - four or more surfaces - primary or permanent
D2330	$66.07	No	Resin-based composite - one surface anterior
D2331	$81.95	No	Resin-based composite - two surfaces anterior
D2332	$97.32	No	Resin-based composite - three surfaces anterior
D2335	$121.90	No	Resin-based composite - four or more surfaces anterior
D2391	$55.32	No	Resin-based composite - one surface posterior
D2392	$70.68	No	Resin-based composite - two surfaces posterior
D2393	$83.49	No	Resin-based composite - three surfaces posterior
D2394	$99.37	No	Resin-based composite - four or more surfaces posterior
D2710	MP	No	Crown - Resin Based Composite

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Procedure Code	**Cost Per Unit**	**Medicaid Benefit**	**Procedure Description per ADA-CDT**
D2720	$172.48	No	Crown - Resin Composites with high noble metal.
D2721	MP	No	Crown - Resin Composites with predominantly base metal
D2791	$70.68	No	Crown - Full cast base metal for tooth # 1, 2, 3, 14, 15, 16, 17, 18, 19, 30, 31, 32
D2910	$44.56	No	Re-cement inlay – onlay - Partial coverage restoration.
D2920	$45.59	No	Re-cement crown
D2932	$143.42	No	Pre-fabricated resin crown
D2933	$148.03	No	Pre-fabricated stainless steel crown with resin window
D2940	$47.12	No	Sedative filling
D2950	$115.25	No	Core build-up including any pins
D2951	$28.17	No	Pin retention
D2952	$176.71	No	Cast post and core in addition to crown Indirectly fabricated
D2953	$120.88	No	Each additional indirectly fabricated cast post-same tooth
D2954	$140.34	No	Pre-fabricated post and core in addition to crown
D2955	$120.88	No	Post Removal (not in conjunction with endodontic treatment
D2957	$68.12	No	Each additional pre-fabricated post-same tooth
D2980	$116.27	No	Crown repair, by report
D2999	MP	No	Unspecified restorative procedure by report
D3110	$33.81	No	Pulp cap direct (excluding final restoration)
D3120	$33.81	No	Pulp cap - indirect (excluding final restoration).
D3220	$79.39	No	Therapeutic pulpotomy (excluding final restoration)
D3221	$96.62	No	This is a type of emergency partial root canal therapy done to relieve pain and infection
D3310	$297.08	No	Endodontic therapy, Anterior tooth (excluding final restoration)
D3320	$351.88	No	Endodontic therapy, Bicuspid tooth (excluding final restoration)
D3330	$423.59	No	Endodontic therapy, Molar (excluding final restoration)
D3351	$169.84	No	Apexification/recalcification - initial visit (apical closure/calcific repair of perforation - root resorption, etc.
D3352	$104.49	No	Apexification/recalcification - interim medication replacement
D3353	$212.56	No	Apexification/recalcification - final visit (includes completed root canal therapy)
D3410	$273.00	No	Apicoectomy/periradicular surgery - anterior
D3421	$307.83	No	Apicoectomy/periradicular surgery - bicuspid (first root)
D3425	$358.54	No	Apicoectomy/periradicular surgery - molar (first root)
D3426	$147.51	No	Apicoectomy/periradicular surgery (each additional root)
D3430	$112.68	No	Retrograde filling - per root
D3450	$223.74	No	Root amputation - per root
D3470	$332.93	No	Intentional replantation (including necessary splinting)
D3920	$190.03	No	Hemisection (including any root removal), not including root canal therapy
D3950	$103.46	No	Canal preparation and fitting of preformed dowel or post
D3999	MP	No	Used for a procedure that is not adequately described by a code. Describe procedure.

PETI Dental Fee Schedule Effective November 1, 2009			
Procedure Code	**Cost Per Unit**	**Medicaid Benefit**	**Procedure Description per ADA-CDT**
D4210	$256.10	Yes	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant
D4211	$97.83	Yes	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant
D4240	$303.22	Yes	Gingival flap procedure, including root planing--four or more contiguous teeth or tooth bounded spaces per quadrant
D4245	$353.93	No	Apically positioned flap
D4274	$284.27	No	Distal or proximal wedge
D4320	$208.98	No	Provisional splinting - intracoronal
D4321	$189.51	Yes	Provisional splinting - extracoronal
D4341	$103.98	Yes	Periodontal scaling and root planning - four teeth per quadrant
D4342	MP	No	Periodontal scaling and root planning - one to three teeth per quadrant
D4355	$76.83	Yes	Full mouth debridement to enable comprehensive evaluation and diagnosis
D4381	$72.21	Yes	Localized delivery of antimicrobial agents into diseased crevicular tissue - per tooth
D4910	MP	No	Periodontal maintenance
D5110	$800.00	No	Complete denture - maxillary
D5120	$800.00	No	Complete denture - mandibular
D5130	$750.00	No	Immediate denture - maxillary
D5140	$750.00	No	Immediate denture - mandibular
D5211	$499.40	No	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)
D5212	$501.96	No	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)
D5213	$777.00	No	Maxillary partial denture - cast metal framework with resin denture base. (including clasps, rests, etc.)
D5214	$777.00	No	Mandibular partial denture - cast metal framework with resin denture base. (incl. claps, rests and teeth)
D5281	$426.13	No	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)
D5410	$37.90	No	Adjust complete denture - maxillary
D5411	$37.90	No	Adjust complete denture - mandibular
D5421	$37.90	No	Adjust partial denture - maxillary
D5422	$37.90	No	Adjust partial denture - mandibular
D5510	$72.21	No	Repair broken complete denture base
D5520	$75.81	No	Repair missing broken teeth - complete denture (each tooth)
D5610	$86.56	No	Repair resin denture base
D5620	$121.90	No	Repair cast framework
D5630	$110.64	No	Repair or replace broken clasp
D5640	$76.83	No	Replace broken teeth - per tooth
D5650	$68.14	No	Add tooth to existing partial denture
D5660	$115.25	No	Add clasp to existing partial denture
D5710	$240.73	No	Rebase complete maxillary denture
D5711	$241.76	No	Rebase complete mandibular denture

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Procedure Code	**Cost Per Unit**	**Medicaid Benefit**	**Procedure Description per ADA-CDT**
D5720	$231.00	No	Rebase maxillary partial denture
D5721	$231.00	No	Rebase mandibular partial denture
D5730	$153.66	No	Reline complete maxillary denture (chairside)
D5731	$153.66	No	Reline complete mandibular denture (chairside)
D5740	$151.61	No	Reline maxillary partial denture (chairside)
D5741	$153.15	No	Reline mandibular partial denture (chairside)
D5750	$250.00	No	Reline complete maxillary denture (laboratory)
D5751	$250.00	No	Reline complete mandibular denture (laboratory)
D5760	$193.10	No	Reline maxillary partial denture (laboratory)
D5761	$193.10	No	Reline mandibular partial denture (laboratory)
D5810	$340.10	No	Interim complete denture (maxillary)
D5811	$340.61	No	Interim complete denture (mandibular)
D5820	$281.71	No	Interim partial denture (maxillary)
D5821	$281.71	No	Interim partial denture (mandibular)
D5850	$84.00	No	Tissue conditioning maxillary
D5851	$84.00	No	Tissue conditioning mandibular
D5860	$822.08	No	Overdenture - complete
D5861	$819.52	No	Overdenture – partial
D5862	$281.71	No	Precision attachment
D5867	$135.73	No	Replacement of replaceable part of semi-precision or precision attachment. (male or female component)
D6210	MP	No	Pontic - Cast high noble metal
D6211	$410.78	No	Pontic - cast predominantly base metal
D6240	MP	No	Pontic - porcelain fused to high noble metal
D6241	$422.57	No	Pontic - porcelain fused to predominantly base metal
D6242	MP	No	Pontic - porcelain fused noble metal
D6545	$317.56	No	Retainer - cast metal for resin bonded fixed prosthesis
D6720	MP	No	Crown - resin with high noble metal
D6721	MP	No	Crown - resin with predominantly base metal
D6722	MP	No	Crown - resin with noble metal
D6750	MP	No	Crown - porcelain fused to high noble metal
D6751	$420.00	No	Crown - porcelain fused to predominantly base metal
D6752	MP	No	Crown - porcelain fused to noble metal
D6791	$412.32	No	Crown - full cast predominantly base metal
D6920	$410.78	No	Connector bar
D6930	$68.63	No	Re-cement fixed partial denture
D6940	$174.15	No	Stress breaker
D6950	$268.39	No	Precision attachment
D6970	$182.34	No	Cast post and core in addition to fixed partial denture retainer
D6971	MP	No	Cast post and core as part of fixed partial denture
D6972	$142.39	No	Prefab post and core in addition to fixed partial denture retainer
D6973	$117.29	No	Core build up for retainer including any pins
D6975	$299.12	No	Coping – metal

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Procedure Code	**Cost Per Unit**	**Medicaid Benefit**	**Procedure Description per ADA-CDT**
D6976	$117.81	No	Each additional cast post - same tooth
D6977	$75.29	No	Each additional prefabricated post - same tooth
D6980	$158.78	No	Fixed partial denture repair
D6999	MP	No	Unspecified fixed prosthodontic procedure
D7140	$67.10	Yes	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	$115.25	Yes	Extraction - surgical removal of erupted tooth
D7220	$130.61	Yes	Extraction - removal of impacted tooth – soft tissue
D7230	$166.98	Yes	Extraction - removal of impacted tooth – partially bony
D7240	$204.88	Yes	Extraction - removal of impacted tooth – completely bony
D7241	$243.30	No	Extraction - removal of completely bony - with unusual surgical complications
D7250	$126.00	Yes	Extraction - surgical removal of residual tooth roots - cutting procedure
D7260	$323.20	Yes	Oroantral fistula closure
D7261	$405.56	Yes	Primary closure of sinus perforation
D7270	$224.34	No	Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth
D7272	$365.76	No	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization
D7280	$196.68	No	Surgical access of an unerupted tooth
D7290	$197.20	No	Surgical repositioning of teeth
D7310	$118.32	No	Alveoloplasty in conjunction with extractions-four or more teeth or tooth spaces per quadrant usually in preparation for a prosthesis
D7320	$174.15	No	Alveoloplasty not in conjunction with extractions-four or more teeth or tooth spaces per quadrant no extractions performed in an edentulous area
D7471	$256.10	No	Removal of lateral exostosis
D7510	$93.22	Yes	Incision and drainage of abscess – intraoral soft tissue
D7520	$159.29	Yes	Incision and drainage of abscess – extraoral soft tissue
D7530	$143.93	Yes	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue
D7540	$297.05	Yes	Removal of reaction-producing foreign bodies - musculoskeletal system
D7999	MP	Yes	Unspecified oral surgery procedure
D9110	$48.66	Yes	Palliative (emergency) treatment of dental pain - minor procedures
D9220	$183.06	Yes	Deep sedation/general anesthesia-first 30 minutes
D9221	$64.54	Yes	Deep sedation/general anesthesia each additional 15 minutes
D9230	$28.68	No	Analgesia – anxiolysis - inhalation of nitrous oxide
D9241	$154.68	Yes	Intravenous conscious sedation/analgesia - first 30 minutes
D9242	$60.44	Yes	Intravenous conscious sedation/analgesia - each additional 15 minutes
D9248	$128.05	No	Non-intravenous conscious sedation
D9310	$48.66	Yes	Consultation (diagnostic services provided by dentist or physician other than the treating practitioner)
D9410	$90.00	No	House/extended care facility call - Dentist
D9410	$20.00	No	House/extended care - Independent Hygienists
D9420	$102.44	Yes	Hospital call-dentist

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Procedure Code	**Cost Per Unit**	**Medicaid Benefit**	**Procedure Description per ADA-CDT**
D9911	$31.76	No	Application of desensitizing resin for cervical and/or root surface - per tooth
D9940	$243.81	No	Occlusal guard to reduce unnatural wear on teeth from grinding, bruxisum, bruxing
D9951	$71.20	No	Occlusal adjustment - limited - Used to adjust some permanent teeth 1-32, on a per visit basis
D9952	$202.39	No	Occlusal adjustment - complete
D9999	MP	No	Unspecified adjunctive procedures

Audiology NF PETI Fee Schedule Effective November 1, 2009 until further Notice		
Procedure Code	**NF PETI Fee Amount**	**Product or Service Description**
V5008	$20.00	Hearing service-cerumen removal per ear limited to 2x/year or as ordered by MD-copy of order must be submitted
V5010	$53.68	Hearing Aid Evaluation test
V5011	$60.00	Fitting/Orientation/Checking of Hearing Aid*
	$30.00	Checking of hearing aid by audiologist other than dispensing audiologist
V5014	MP	Hearing Aid repair/modification following warranty period
V5130	$860.00	Hearing Aid-ITE. Pricing is all inclusive for one hearing aid. Two year warranty required
V5140	$1,022.03	Hearing Aid-BTE. Pricing is all inclusive for one hearing aid. Two year warranty required
V5247	$1045.18 per unit	Hearing Aid, digitally programmable analog BTE - pricing is all inclusive for one hearing aid. Two year warranty required.
V5250	$1045.18 per unit	Hearing Aid, digitally programmable analog --CIC-- pricing is all inclusive per one hearing aid. Two year warranty required.
V5251	$1045.18 per unit	Hearing aid, digitally programmable analog, ITE -pricing is all inclusive per one hearing aid. Two year warranty required.
V5256	$1358.73 per unit	Hearing aid, digital, ITE-all inclusive for one hearing aid. Two year warranty required.
V5257	$1358.73 per unit	Hearing aid, digital, BTE-all inclusive for one hearing aid. Two year warranty required
V5258	$1358.73 per unit	Hearing aid, digital, CIC-all inclusive for one hearing aid. Two year warranty required.
V5264	$65 per unit	Ear mold/insert, not disposable, any type
V5266	MP	Batteries
	MP	Assistive listening device
	$125.00	Hearing aid comprehensive service warranty--Annual coverage for replacement or repair of one hearing aid. Protection for loss, damage or component failure.
	$10.00	Safety chain to prevent loss
	$20.00	Nursing facility visit
*Dispensing fee includes initial office visit, ear mold impressions and fittings of the proper hearing aid, the first five post fitting follow-up visits as necessary for adjustments and hearing aid orientation. New hearing aids must be provided with batteries for one year.		

Vision Services PETI Fee Schedule Effective November 1, 2009 until further Notice		
Procedure Code	**NF PETI Fee Amount**	**Product or Service Description**
	$50.00	Eye exam--exams are generally paid by Medicare and Medicaid and should be appropriately billed to them prior to submitting a request for payment to NF PETI
	$50.00	Glasses frames-client may elect more expensive frames but must make private arrangement to pay for the excess cost of the preferred frames
	MP	Lenses by prescription
	MP	Tinted sun glasses only when prescribed for client as medically necessary
	MP	UV lenses only when prescribed for client as medically necessary
	MP	Safety cord to prevent loss