Provider Bulletin

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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...?

Rendering providers enrolled under their Social Security Number (SSN) that are affiliated with a billing provider and do not want to receive direct payment from the Colorado Medical Assistance Program, can have their enrollment status changed to an active non billable status. Changing this status will prevent accidental billing and IRS reporting of payments on the individual's SSN. Please submit a letter to ACS Provider Enrollment requesting the change and include the provider ID.

All Providers

Delay in Implementation of New Provider Rates for FY 2011-12

FY 2011-12 provider rates will be reduced beginning July 1, 2011 to help balance the state budget. This reduction was announced in the June 2011 Provider Bulletin. Although the effective date is July 1, 2011, we need to wait for an official approval from the Centers for Medicare and Medicaid Services (CMS), to implement the change for all reductions, except for Home and Community Based Services. The new rates for services delivered on or after July 1, 2011 will be retroactively applied once approval is granted. Until approval is received, providers will be paid at the FY 2010-11 rates. For Home and Community Based Services, the rate reductions will be applied beginning July 1, 2011.

We apologize for any administrative difficulties this presents. You can be assured that we are working as quickly as possible with CMS to implement the new rates. Please contact Jeanine Draut at Jeanine.Draut@state.co.us or 303-866-5942 if you have any questions.

Eligibility Verification

The Department of Health Care Policy and Financing (the Department) would like to remind providers to always verify eligibility before rendering services. After obtaining the birth date and State ID or SSN, the provider can conduct an eligibility request to determine the client's eligibility status. The provider who checks a client's eligibility on the day of service and finds the client eligible receives an eligibility guarantee number. If eligibility has changed when the claim is submitted, the guarantee number exempts those claims from eligibility edits for that date of service. Following this process today can help avoid problems later.

Providers can verify eligibility through one the following:

Colorado Medical Assistance Program Web Portal (Web Portal) - Batch or Interactive:

X12N 270 – Eligibility Inquiry

FaxBack: 1-800-493-0920 Toll-free

Provides fax responses to client eligibility requests

Colorado Medicaid Eligibility Response System (CMERS)/Automatic Voice Response System (AVRS): 1-800-237-0044 Toll free

CMERS is an automated voice response system that furnishes providers with information ranging from client eligibility to provider warrant and claim status information.

How Will Internal Classification of Diseases (ICD-10) Change Your Practice?

The ICD-10 transition affects everyone covered by the Health Insurance Portability and Accountability Act (HIPAA), even those who do not submit Medicaid claims. Anyone covered by HIPAA must use ICD-10 diagnosis codes for services provided on or after October 1, 2013. To be prepared for this transition, you should begin planning now if you haven't done so already.

Here are a few of the many areas where the transition to ICD-10 will affect your practice:

- More robust codes. Codes will grow from 17,000 to 140,000. Code books and styles will completely change.
- Updated policies and procedures. Any office policy or procedure tied to a diagnosis code, disease management, tracking, or Prior Authorization Request (PAR) must be changed**.**
- Medical record documentation. ICD-10 codes will better reflect the specificity already inherent in the patient's medical record. Physicians will need to continue to document the patient's plan of care to include laterality, stages of healing, weeks in pregnancy, episodes of care, etc. Other health care professionals will also need to continue to document patient information with specificity. The Health Care Policy and Financing Department (the Department) is strongly recommending all providers review their documentation. To prepare providers can determine where ICD-9 codes currently appear in your systems and business processes. Consider budgeting for training, re-printing of superbills, evaluating all vendor and payer contacts and developing an ICD-10 timeline.

Keep Up to Date on ICD-10.

The Centers for Medicare and Medicaid have a web site that includes factsheets, timelines, and additional resources to assist you with the transition to ICD-10 codes. Please visit cms.gov/icd10 for the latest news and resources to help you **prepare!**

Developmental, Depression and Autism Screens Policy

Effective for dates of service on or after August 1, 2011, the Department has issued the following policy for developmental and depression screens, and set the following rates for CPT codes 96110 and 99420. The Colorado Medical Assistance Program will reimburse developmental screening code, 96110, at $17.00 and depression screening code, 99420, at $10.08.

Developmental Screening

The Colorado Medical Assistance Program covers developmental screening for children ages 0 – 4, using a standardized, validated developmental screening tool (e.g., PEDS, Ages and Stages) at the child's periodic visits. In the absence of established risk factors or parental or provider concerns, the American Academy of Pediatrics (AAP) recommends developmental screens at the 9th, 18th, and 30th month, and 3 and 4 year well-child visit.

Limitations:

- Three (3) screens per year for children aged 0 – 24 months
- Two (2) screens per year for children aged 25 – 59 months

Providers should report CPT code 96110, "Developmental testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report," when providing developmental screens.

To report a positive screen:

- Use a valid diagnosis code within category 315, "Specific Delays in Development," category 313, "Disturbance of Emotions Specific to Childhood and Adolescence," category 314, "Hyperkinetic Syndrome of Childhood," for specific delays in mental development.
- Use a valid diagnosis code within category 783 (using 4th and 5th digits when needed), "Symptoms Concerning Nutrition, Metabolism, and Development," for physiological delays.

To report a negative screen:

- Use code V20.2, "Routine Infant or Child Health Check."

Providers should report CPT code 96111, "Developmental testing; extended (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instrument) with interpretation and report," when a limited developmental screening suggests an abnormality in a particular area of development and more extensive formal testing is needed to evaluate the concern.

Depression Screening

The Colorado Medical Assistance Program covers developmental screening for adolescents aged 11 – 20, using a standardized, validated depression screening tool (i.e., PHQ-9, Columbia Depression Scale, Beck Depression Inventory, Kutcher Adolescent Depression Scale, etc.) at the child's periodic visits.

Limitations:

- One (1) screen per year for adolescents aged 11 – 20 years
  - Post-Partum Depression Screening: providers may choose to screen adolescent clients for post-partum depression as part of the client's annual depression screen. However, post-partum depression screening is a non-covered benefit for Medicaid clients aged 21 and over.

Providers should report CPT code 99420, "Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)," when providing depression screens.

To report a positive screen**, use diagnosis code V40.9**

To report a negative screen, **use diagnosis code V79.8**

Autism Screening

Colorado Medicaid covers autism screening for children aged 18- and 24-months, using a standardized, validated depression screening tool (i.e., M-CHAT) at the child's periodic visits.

Limitations:

- Two (2) screens per year for children aged 18 – 24 months

Providers should report CPT code 96110, "Developmental testing; limited (i.e., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report," when providing autism screens.

- To report a positive screen:
  - Use a valid diagnosis code within category 299 (using 4th and 5th digits when needed), "Pervasive Developmental Disorders."
- To report a negative screen:
  - Use code V20.2, "Routine Infant or Child Health Check."

Screening Tools:

The Colorado Medical Assistance Program does not require the use of a specific developmental screening tool, but providers must use a validated, standardized developmental screening tool.

The Colorado Medical Assistance Program recommends the use of PHQ-9 depression screening tool, but other validated, standardized depression screening tools are also acceptable.

Referrals to Care:

If a behavioral health need is identified, the primary care clinician must offer to either:

Provide the necessary services; or

Refer the patient to a specialist.

Primary care providers who choose to refer a client to a specialist must assist with the referral process.

For more information on which Behavioral Health Organization (BHO) to refer pediatric clients, visit the BHO section of the Department's Web site at colorado.gov/hcpf.

For additional information, please refer to the Developmental/Depression Screening Policy Statement by visiting the Boards & Committees section of the Department's Web site and choose the Benefits Collaborative option. Please contact Sheeba Ibidunni at Sheeba.Ibidunni@state.co.us or 303-866-3510 with any questions.

Mental Health First Aid

The Division of Behavioral Health recently informed the Department about an educational opportunity for providers. The Mental Health First Aid Program is a behavioral health public education, prevention, and early intervention program. This program is designed to advance the mental health literacy of the general public and to train citizens in how to identify, provide initial help, and guide individuals displaying mental health and substance use problems to professional treatment. Please contact Deb Hutson, LCSW, LAC Prevention Program Manager at Deb.Hutson@state.co.us or 303-866-7494 to attend training.

Rx Review Program

The Rx Review Program is a voluntary participatory medication review for Medicaid clients who are high drug-utilizers (five or more drugs each month for three consecutive months).

Statewide consultations will be conducted by contracted pharmacists beginning in late August or early September 2011 with providers and patients receiving a recommendation letter from the pharmacist. Evaluations include educating the patient and a review of all prescription medications as well as over-the-counter drugs and nutritional supplements, identifying drug-drug interactions, drug duplication or use of multiple providers as well as conformity with the Preferred Drug List (PDL). Your initial promotion of the program will help ease your patients' apprehension to participate once Medicaid and the pharmacist contact them. Since patient participation is voluntary, their pharmacy benefits will not be affected in any way.

If you are a pharmacist interested in participating in the program, would like to see the qualifications, and/or submit an application, please contact Tammie Ruiz at Tammie.Ruiz@state.co.us or visit the Pharmacist Resources section of the Department's Web site.

Independence Day Holiday

Due to the Independence Day holiday on Monday, July 4, 2011, claims were processed on Thursday, June 30, 2011. The processing cycle included claims accepted on or before Thursday at 6:00 P.M. Mountain Time (MT). The receipt of warrants will be delayed by one or two days.

The State and fiscal agent offices will be closed on Monday, July 4, 2011.

Ambulatory Surgery Centers (ASCs)

Procedure Migration Project

Effective August 1, 2011, the Department will begin a provisional project with ASCs to evaluate the potential for budget savings in Colorado Medical Assistance Program. The project will increase reimbursement for six procedure codes, and open a new procedure code for ASCs. The project will be used to determine if the Department would realize budget savings through the migration of the selected procedures from higher cost outpatient settings to lower cost ASC settings.

These new rates are temporary in nature and will be re-evaluated periodically throughout the project.

Due to the increased reimbursement and the newly added code, there will be three additional ASC reimbursement groups created for this pilot project. ASC Group 10 will reimburse at $921.30, ASC Group 11 will reimburse at $672.00, and ASC Group 12 will reimburse at $1,668.35.

The following codes will be included in the following groups:

ASC Group 10

42820- Tonsillectomy and Adenoidectomy; younger than age 12

42821- Tonsillectomy and Adenoidectomy; age 12 or over

42825- Tonsillectomy, Primary or Secondary; younger than age 12

42826-Tonsillectomy, Primary or Secondary; age 12 or over

42830-Adenoidectomy, Primary; younger than age 12

ASC Group 11

69436-Tympanostomy General Anesthesia

ASC Group 12

47562-Laparoscopic Cholecystectomy

The project will be closely monitored to track whether the migration is occurring at a reasonable rate, and if the program should be continued. At the conclusion of the project, information will be used to inform providers of any changes to the permanent ASC rate methodology.

Please contact Dana Batey at Dana.Batey@state.co.us or 303-866-3852 with any questions.

Durable Medical Equipment (DME) and Supply Providers

Updated Supplies and DME Billing Manual

The Supplies and DME billing manual has been separated from the CO-1500 Specialty Billing Information manual and is now available in the Provider Services Billing Manuals section of the Department's Web site. The new manual clarifies benefits and billing instructions for DME and Supply services.

Home Health Providers

Billing for Dually Eligible Clients

For dates of service on or after May 14, 2011, home health agencies may bill the Colorado Medical Assistance Program without billing Medicare if the services below are the only services on the claim:

- Pre-pouring of medications for acute and long term care;
- Certified Home Health Aide services for acute and long term care;
- Occupational Therapy when provided as acute home health service; or
- Routine Laboratory Draw which is included in the nursing visit services for acute and long term care.

For dates of service on or after May 14, 2011, the home health agency may bill the Colorado Medical Assistance Program at the time of service delivery (before receiving a Medicare service denial) for services that Medicare does not cover, if the conditions below apply:

- The client is stable;
- The client is not experiencing an acute episode; and
- The client routinely leaves the home without taxing effort and unassisted for social, recreational, educational, or employment purposes.

In these cases, the claim must also be submitted to Medicare so that the denial, when received, is part of the client's file. **The Medicare denial MUST be a non-covered service denial. The home health provider may not bill Medicaid when the Medicare denial is for a technical or medical necessity reason.**

Home health agencies must maintain clear documentation in the client's record of the conditions and services that are billed to the Colorado Medical Assistance Program without billing Medicare first. Claims submitted by paper must include a copy of the Standard Paper Remit (SPR). Agencies must still complete a Home Health Advance Beneficiary Notice (HHABN), even if it bills the Colorado Medical Assistance Program first.

Please contact Guinevere Blodgett at Guinevere.Blodgett@state.co.us or 303-866-5927 for additional information.

Billing for Insulin Administration and Other Uncomplicated Visits

The Colorado Medical Assistance Program covers insulin administration to home health clients only if the client or caregiver is not able to administer the insulin to the client.

In these cases, the home health agency may administer the insulin. As this is a skilled nursing service, home health agencies must bill Medicare first for dually eligible clients (clients who receive both Medicare and Medicaid) who require this service except when the client is not homebound.

If the client receives Medicaid only, uncomplicated home health visits that are required multiple times per day (such as insulin administration) must be billed to the Colorado Medical Assistance Program as Brief Visits.

Please contact Guinevere Blodgett at Guinevere.Blodgett@state.co.us or 303-866-5927 for additional information.

Items to Include in the Home Health Plan of Care

Home Health agencies must describe the following in a client's Home Health Plan of Care (also called the "485" document):

- Whether the client is homebound, and
- The services or care activities the client or caregiver cannot perform, and therefore require the home health agency to perform the service (e.g., bathing a child or administering insulin). The 485 must include the reasons that the client or caregiver cannot do these tasks themselves. If the task falls within the usual and customary role of a caregiver or parent, the Plan of Care must contain reason that a skilled caregiver is required to perform the task.

Please contact Guinevere Blodgett at Guinevere.Blodgett@state.co.us or 303-866-5927 for additional information.

Telehealth

In the upcoming months, the Colorado Medical Assistance Program plans to make Home Health Telehealth services a reimbursed service. Telehealth is defined as:

- The collection of patient data in the home setting and the transmission of such data between a patient and the home health care agency,
- The clinical assessment of the transferred data, and
- A response by the agency as needed.

The purpose of providing Telehealth services is to assist in the effective management and monitoring of clients whose medical needs can be appropriately and cost-effectively met at home through the monitoring of data and early intervention.

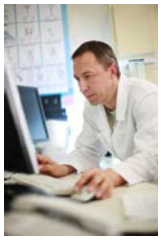
Program rules are scheduled to be presented in the July 2011 Medical Services Board meeting.

Client Eligibility

Home Health Telehealth will be a reimbursed service for home health clients who need frequent and ongoing monitoring of their health care status, as determined by a service approval process.

The following criteria must be met:

- Services must be authorized on a plan of care prescribed by a physician.
- Client must be treated by a home health agency for one or more of the following diagnoses for receipt of services:
  - Congestive Heart Failure
  - Chronic Obstructive Pulmonary Disease
  - Hypertension
  - Diabetes
- Client must have been hospitalized two or more times in the last 12 months for symptoms/diseases related to qualifying diagnoses. If the client has received services from the home health agency for less than six months, the client must have been hospitalized at least once in the last three months.
- Client or caregiver must be willing and able to comply with the monitoring equipment instructions and home health agency direction.
- Client's home environment must be compatible for the use of the equipment.
- Client or caregiver must be willing to comply with the monitoring schedule.
- Home health agencies will assess clients prior to the submission of a prior authorization, using a tool developed by the home health agency. The clients will be assessed for their potential for disease management, their ability and willingness for service participation, and the suitability of the home environment relative to the installation of equipment. Clients will sign their assessment form, as well as a Patient Agreement.



Clients must be receiving services from a home health care agency that is Medicare certified, and has the equipment and the staff available to provide Telehealth services.

Reimbursement – Department Service Approval Required

- Home Health Telehealth services must be approved by an entity designated by the Department. This process uses a Service Approval Form - it is a different form and process than the usual home health authorization.
  Service Approval Forms must be submitted prior to admission to Home Health Telehealth services, and thereafter on a schedule designated by the Department. The form will be made available on the Department web site so look for updates.
- The unit of reimbursement for Home Health Telehealth shall be one day and is only reimbursed for those days on which the client information is reviewed and responded to as needed.
- The initial visit to install the equipment and train the client may be billed as a set-up visit. Only one (1) set-up visit may be billed per client.
- Payment for approved Home Health Telehealth services is based on the established fee schedule, unless a lower amount is billed.
- The Department will only reimburse for services provided by a Registered Nurse, consistent with state law.
- The purchase and maintenance of the equipment is the responsibility of the home health agency. The agency must ensure that the equipment is Food and Drug Administration (FDA) certified or Underwriter Laboratories (UL) listed/certified.
- Claims must include another home health service to be paid.

Description/Service	Revenue Code	Procedure Code	Reimbursement	Units of Service
Acute Home Health Telehealth	583	98969	Rate is pending CMS Approval	1 unit = 1 day limited to 31 units/month
Long-Term Home Health Telehealth	780	98969	Rate is pending CMS Approval	1 unit = 1 day limited to 31 units/month
Initial Set Up – Acute Home Health	583	98969 plus TG modifier	Rate is pending CMS Approval	May only be billed one time per patient per agency
Initial Set-Up – Long-Term Home Health	780	98969 plus TG modifier	Rate is pending CMS Approval	May only be billed one time per patient per agency

Please contact Guinevere Blodgett at Guinevere.Blodgett@state.co.us or 303-866-5927 for additional information.

Hospital Providers

Groupers Used to Process Medicaid Inpatient Hospital Claims

The following versions of the CMS Grouper are being used to process Medicaid inpatient hospital claims:

Discharge Date	Grouper
On or after October 1, 2006	Version 24.0
October 1, 2005 to September 30, 2006	Version 23.0
October 1, 2004 to September 30, 2005	Version 22.0
October 1, 2003 to September 30, 2004	Version 21.0
October 1, 2002 to September 30, 2003	Version 20.0

Effective for discharge dates on or after July 1, 2011, the weight for Diagnosis Related Group (DRG) 317 (Admit for Renal Dialysis) will be adjusted from 0.8513 to 0.628.

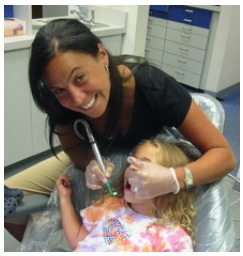
Please contact Jeremy Tipton at Jeremy.Tipton@state.co.us or at 303-866-5466 with any questions.

Practitioners

Fluoride Treatments for Children by Medical Personnel

Allowable Services

Trained medical personnel (see qualifications below) may administer fluoride varnish to Medicaid children ages 0 through 4 (until the day before their fifth birthday) with moderate to high caries risk. A fluoride varnish may be administered only after a risk assessment is completed, and must be administered together with an oral evaluation with counseling by a primary caregiver, or a screening. Risk assessment forms may be found either at cavityfreeatthree.org under Provider Materials or in the Provider Services Forms section of the Department's Web site. Documentation of risk must be part of the client's medical record.



The maximum allowable benefit per eligible and high risk child is 3 times per fiscal year. Dental and medical providers are encouraged to communicate with one another to avoid duplication and nonpayment of services. Medical personnel who may bill directly for these services include MDs, DOs, and nurse practitioners.

Trained medical personnel employed through qualified physician offices or clinics may provide these services and bill using the physician's or nurse practitioner's Medicaid provider number.

In order to provide this benefit and receive reimbursement, the medical provider must have:

- Participated in on-site training from the "Cavity Free at Three" team or

- Have completed Module 2 (child oral health) and Module 6 (fluoride varnish) at the Smiles for Life curriculum at smilesforlifeoralhealth.org.

Medical personnel who complete the training must save the documentation for this training in the event of an audit.

Billing procedures

For children ages 0-2 (until the day before their third birthday):

Private practices: D1206 (topical fluoride varnish) and D0145 (oral evaluation for a patient under three years of age and counseling with primary caregiver) must be billed on a Colorado1500 paper claim form or electronically as an 837 Professional (837P) transaction.

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs): D1206 and D0145 must be itemized on the claim with a well child visit, but reimbursement will be at the current encounter rate.

The diagnosis V72.2 should be used as a secondary diagnosis. Billing is on the UB-04 paper claim form or electronically as an 837 Institutional (837I) transaction.

For children ages 3 and 4 (from their third birthday until the day before their fifth birthday):

Private practices: D1206 and D0999 (dental screening) must be billed on a Colorado 1500 paper claim form or electronically as an 837P transaction.

FQHCs and RHCs: D1206 and D0999 must be itemized on the claim with a well child visit but reimbursement will be at the current encounter rate. The diagnosis V72.2 should be used as a secondary diagnosis. Billing is on the UB-04 paper claim form or electronically as an 837I transaction.

Primary care physicians can consult the InsureKidsNow.gov Web site for a list of Colorado Medical Assistance Program enrolled dental providers.

Procedure	Procedure Code	CO Medicaid Fees (as of 1/1/11)	Criteria
Topical fluoride varnish (risk assessment must be included)	D1206	$15.07	Children ages 0-4 who are mod-high caries risk
Oral evaluation for children ages <3 years & counseling with primary caregiver	D0145	$28.62	Children ages 0-2
Unspecified diagnostic procedure	D0999	$14.96	Children ages 3-4

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

Pediatric Immunization Codes 90460 and 90461 Billing Clarification

In the January 2011 Immunization Bulletin (B1100293), the Department published instructions on how to bill the new pediatric immunization codes 90460 and 90461. Since that bulletin, the Department has received numerous inquiries on how to properly bill these new codes and is now issuing the following clarification.

The pediatric immunization administration codes 90460 and 90461 are component based and replace deleted codes 90465- 90468. These new codes allow the provider to bill for each vaccine component separately. As defined by the 2011 CPT, a vaccine component is each antigen in the vaccine that prevents disease(s) caused by one (1) organism.

CPT codes 90460 and 90461 reflect the administration of one component vaccines, which provide protection for a single disease, and multiple component vaccines (combination vaccines), which provide protection for multiple diseases. These codes must be reported for Medicaid clients aged 0-18 and when a physician or qualified health care professional provides face-to-face counseling to the patient and family during the administration of a vaccine.

Note: Providers are **not** to bill CPT codes 90471-90474 for children aged 0-18 for whom counseling was given. CPT Codes 90471-90474 must only be billed for adults (aged 19 and over) or children aged 0-18 for whom no counseling was given.

Billing Guidelines

Providers should bill CPT code 90460 for the first component and 90461 for each additional component in a given vaccine when counseling to a Medicaid client aged 0-18 is provided.

The following chart identifies the number of components in some of the common pediatric vaccines, and how to report the pediatric immunization administration codes for each vaccine:

Table 1

Vaccine	# of Components	Which Codes to Report?
HPV	1	90460
Influenza	1	90460
Meningococcal	1	90460
Pneumococcal	1	90460
Td	2	90460, 90461
DTaP or Tdap	3	90460, 90461, 90461
MMR	3	90460, 90461, 90461
DTaP-Hib-IPV	5	90460, 90461, 90461, 90461, 90461
DTaP-HepB-IPV	5	90460, 90461, 90461, 90461, 90461
DTaP-IPV	4	90460, 90461, 90461, 90461
MMRV	4	90460, 90461, 90461, 90461
DTaP-Hib	4	90460, 90461, 90461, 90461
HepB-Hib	2	90460, 90461
Rotavirus	1	90460
IPV	1	90460
Hib	1	90460

Source: American Academy of Pediatrics "FAQ Fact Sheet for the 2011 Pediatric Immunization Administration Codes"

To submit claims for immunizations, providers must "roll up/bundle" the total unit count of the immunization administration codes.

- If you bill immunization administration codes for each vaccine that was given during the visit as its own line item, each subsequent line item billed using 90460 after the initial 90460 line item will be denied as a duplicate claim.

Example 1:

The following example, demonstrates how to bill for the administration of Hep A, DTaP-HIB-IPV, and MMR vaccines.

Component Calculation and which codes to report (Using Table 1):

Table 2

Vaccine	# of Components	Which Codes to Report?
Hep A	1	90460
DTaP-HIB-IPV	5	90460, 90461, 90461, 90461, 90461
MMR	3	90460, 90461, 90461

How to Bill:

Table 3

Line #	CPT Descriptor	CPT Code	Units
Line 1	First Vaccine Component	90460	3
Line 2	Additional Vaccine Component	90461	6
Line 3	Hep A	90633	1
Line 4	DTaP-HIB-IPV	90698	1
Line 5	MMR	90707	1

- CPT code 90460 is billed for 3 units because it was reported once for each vaccine that was administered.
- CPT code 90461 is billed for 6 units because it was reported 6 times – 4 times for the DTaP-HIB-IPV vaccine and twice for the MMR vaccine.

For further clarification on billing pediatric immunization codes, please reference the American Academy of Pediatrics (AAP) practice guidelines or the CPT Changes 2011 – An Insider's View.

Should you have any billing questions, please contact the Department's fiscal agent, ACS, at 1-800-237-0757 or 1-800-237-0044. For all other inquiries, please contact Sheeba Ibidunni at Sheeba.Ibidunni@state.co.us or 303-866-3510, or Amanda Belles at Amanda.Belles@state.co.us or 303-866-2830.

Provider Referrals

The Department's mission is to improve access to cost-effective and quality health care services for Coloradans.

Are there any Specialists, Home Health Agencies, or other providers that you commonly refer your patients to for commercial insurance who are not currently Medicaid or CHP+ Providers?

If so, we need your help. Please ask those providers to contact one of the following for more information about becoming a provider:

Adult referrals
Amy Brown, Provider Recruiter
Department of Health Care Policy and Financing
303-866-2412
1-800-221-3943missing a digit
Amy.Brown@state.co.us

Child referrals
Lisa Foster, Provider Recruiter
Family Voices of Colorado
303-995-3758
1-800-881-8272
lfoster8@hotmail.com

Thank you for your continued support and participation in Colorado Medical Assistance Program and CHP+ Programs.

Pharmacy

Pharmacy Record Keeping

Providers are required to maintain prescription records as a condition of participating in the Colorado Medical Assistance Program. Maintaining proper prescription records is important because it supports patient safety and provides an official record of a patient encounter. The State Board of Pharmacy requires an exact duplicate of the original prescription to be available in a reproducible format. The Department's rules stipulate that the pharmacist shall be responsible for assuring that reasonable efforts have been made to obtain, record and maintain client information from the client or his/her apparent agent for each new prescription and these records must be stored for six years. Providers can view the rules regarding Prescription Record Requirements at 10 C.C.R 2505-10, Section 8.800.11.

Override Codes

In order to reduce the number of calls received regarding the use of permitted Dispense As Written (DAW) codes, the Department would like to remind pharmacies of the following policy:

DAW 1
DAW 1 is only to be used when the prescriber requests brand name drugs to be provided. This code is required for brand name products that have a generic equivalent to override Federal Upper Limit (FUL) reimbursement. A prior authorization may also be necessary if the drug is not excluded from the generic mandate.

DAW 2
DAW 2 should never be used. The Department discontinued the use of DAW 2 as of December 2007.

Next Pharmacy and Therapeutics (P&T) Committee Meeting

Tuesday, July 12, 2011, 1:00 P.M. - 5:00 P.M.
The meeting will be held at 225 E. 16th Avenue, Denver, Colorado 80203
1st floor conference room

Therapeutic classes up for review include: Oral Bisphosphonates; Diabetes Management Classes; Erythropoiesis Stimulating Agents; Overactive Bladder Agents and Stimulants/ADHD Treatments. Public comment should be submitted to Jim.Leonard@state.co.us or pdl@state.co.us on or before July 8, 2011 for consideration.

Preferred Drug List (PDL) Update

Effective July 1, 2011, the following medications will be preferred agents on the Medicaid PDL and will be covered without a prior authorization:

Antihistamines (newer generation):
cetirizine and loratadine generic dosage forms

Angiotensin Receptor Blockers, Combinations and Renin Inhibitors:
Avapro, Diovan, losartan, Avalide, Diovan-HCT, losartan/HCTZ generic products

Anticholinergic Inhalants:
ipratropium nebulizer solution, Atrovent HFA and Spiriva

Anticholinergic and Short Acting Beta-2 Agonist Combinations:
albuterol/ipratropium nebulizer solution and Combivent inhaler

Corticosteroid Inhalants:
Asmanex, budesonide nebulizer solution, Flovent HFA and diskus and Qvar inhaler

Corticosteroid and Long-Acting Beta-2 Agonist Combinations:
Advair diskus, Dulera and Symbicort Inhaler

Short-acting Beta-2 Agonists:
albuterol nebulizer solution, ProAir HFA and Ventolin HFA

Long-acting Oral Opiates:
1st line: methadone and morphine ER; 2nd line: fentanyl patches

Skeletal Muscle Relaxants:
baclofen, tizanidine and cyclobenzaprine

Topical Immunomodulators:
Elidel and Protopic for clients age 2 years and older.

The complete PDL and prior authorization criteria for non-preferred drugs are posted in the Pharmacy Preferred Drug List (PDL) section of the Department's Web site.

New Prior Authorization Policies

Based upon recommendation from the Drug Utilization Review (DUR) Board at their May 17, 2011 meeting in Denver, the following new policies will be implemented starting July 1, 2011:

Makena (hydroxyprogesterone caproate) will now require prior authorization as an outpatient pharmacy benefit. Makena will be approved if the following conditions are met:

- The drug is administered in the home (or in a long-term care facility) by a healthcare professional;
- The client has a singleton pregnancy and a history of singleton spontaneous pre-term birth;
- Therapy is initiated between 16 weeks and 20 weeks, 6 days gestation; and
- Compounded hydroxyprogesterone products are contraindicated.

Newly approved drugs: Newly marketed drugs may be subject to prior authorization for a minimum of nine months following FDA marketing approval. Initial approval criteria will include non-preferred criteria for PDL drug classes and FDA approved indications, ages and doses for non-PDL drugs. Please see Appendix P for more information.

DUR Board Updates

The DUR Board currently has an opening for one non-voting pharmaceutical industry representative. Interested parties should submit a CV to the Department for consideration. Please contact Jim Leonard for more information at Jim.Leonard@state.co.us or 303-866-3502.

Vision and Eyewear Providers

Vision and Eyewear Billing Manual

The Vision and Eyewear billing manual has been separated from the CO-1500 Specialty Billing Information manual and is now available in the Provider Services Billing Manuals section of the Department's Web site. The new manual clarifies benefits and billing instructions for Vision and Eyewear services.

July and August 2011 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 July and August 2011 workshop calendars are included in this bulletin and are also posted in the Provider Services Training & Workshops section of the Department's Web site.

Who Should 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 1-800-237-0044

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

All this information is necessary to process your reservation successfully. Look for your confirmation by mail within one week of making your reservation.

Reservations will only be accepted until the Friday before the training workshop. This will ensure that there is space available and enough training materials.

If you have not received a confirmation within at least two business days prior to the workshop, please contact Provider Services and talk to a Provider Relations Representative.

All Workshops presented in Denver are held 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 completion of the UB-04 and the Colorado 1500 paper claim forms.

The Beginning Billing classes do not cover any specialty billing information.

The fiscal agent provides specialty training throughout the year in their Denver office.

Classes do not include any hands-on computer training.

July and August 2011 Specialty Workshop Class Descriptions

Audiology

This class is for billers using the Colorado 1500/837P format for audiology services. The class covers billing procedures, common billing issues and guidelines specifically for Audiologists.

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.

FQHC/RHC

This class is for billers using the UB-04/837I and Colorado 1500/837P format. The class covers billing procedures, Encounter Payments, common billing issues and guidelines specifically for FQHC/RHC providers.

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 provider types:
HCBS-EBD HCBS-PLWA HCBS-MI

HCBS-DD
This class is for billers who bill on the Colorado 1500/837P 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.

Hospice
This class is for billers using the UB-04/837I format. The class covers billing procedures, common billing issues and guidelines specifically for Hospice providers.

IP/OP Hospital
This class is for billers using the UB-04/837I format. The class covers billing procedures, common billing issues and guidelines specifically for In-patient Hospital and Out-patient Hospital providers.

Pharmacy
This class is for billers using the Pharmacy claim format/Point of Sale and/or PCF Format. The class covers billing procedures, common billing issues and guidelines specifically for Pharmacies. *(This is not the class for DME/ Supply Providers – please refer to DME/ Supply Provider Class.)*

Supply/DME

This class is for billers using the Colorado 1500/837P claim format. The class covers billing procedures, common billing issues and guidelines specifically for Supply/DME providers.

Supply/DME PAR
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 **Welton St.**, 0.5 miles.
Turn **right** at **17th St.**, 0.2 miles.
The Denver Club Building will be on the right.

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 - The 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 note: Email all WebEx training reservations to workshop.reservations@acs-inc.com.

A meeting notification containing the Web site, phone number, meeting number, and password will be emailed or mailed to providers who sign up for WebEx.

July 2011

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
					1	2
3	4 *Independence Day*	5	6	7	8	9
10	11	12 Beginning Billing – CO -1500 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM Audiology 1:00 PM-3:00 PM	13 Beginning Billing – UB-04 9:00 AM-11:30 AM Web Portal 837I 11:45 AM-12:30 PM IP/OP Hospital 1:00 PM-3:00 PM	14 Dental 9:00 AM-11:00 AM	15 Beginning Billing for Waiver Providers 9:00 AM-11:30 AM Web Portal 837P 12:00 PM-12:45 PM	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

August 2011

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	1	2	3	4	5	6
7	8	9 Beginning Billing – CO -1500 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM	10 Beginning Billing – UB-04 9:00 AM-11:30 AM Web Portal 837I 11:45 AM-12:30 PM Hospice 1:00 PM-3:00 PM	11 DME/Supply 9:00 AM-11:00 AM DME PAR 11:30 AM-1:30 PM Pharmacy 2:00 PM-3:00 PM	12 (WebEx) CO-1500 9:00 AM-12:00 PM (WebEx) FQHC/RHC 1:00 PM-4:00 PM	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

Please direct questions about Colorado Medical Assistance Program billing or the information in this bulletin to

ACS Provider Services at 1-800-237-0757 or 1-800-237-0044.

Please remember to check the Provider Services section of the Department's Web site at colorado.gov/hcpf.