Provider Bulletin

colorado.gov/hcpf

Reference: B1200326 **September 2012**

Did you know...?

When submitting W9 & banking updates to hcpfar@hcpf.state.co.us, please do not include Protected Health Information (PHI) as the email address is not secured or staffed to respond to claim inquiries. The email address should be used only to submit W9s and update banking information.

In this issue:

All Providers 1
Proof of Eligibility Letter....1
Safeguarding Medical Identity Toolkit 1
Colorado Choice Transition....2
Fee Schedule 2
PAR Submission to the ColoradoPAR Program....2
Client Over-Utilization Program (COUP).... 3
ACC Program Referral Requirement....4
ACC Payment Reform Initiative....4
Dual Eligibles....4
Record Retention....5
September & October Holidays....5
Dental and Orthodontic Providers....5
PAR Procedures Update 5
DME/Supply Providers....6
Special PAR Submission Requirements.... 6
Federally Qualified Health Centers 6
Provider Identification Number 6
HCBS Waiver Providers....6
What is PERM? 6
Home Health Providers.... 7
PAR Submission....7
Hospital Providers....7
Inpatient Medicaid Base Rates effective July 1, 2012 7
ICD-9-CM Codes Crosswalk 7
Nursing Facility Providers....8
What is PERM? 8
PT/OT Providers 8
Daily Unit Limit Changes 8
Pharmacy Providers....9
Next P&T Committee Meeting 9
Appendix P 9
COBManager....9
Medicare Part D Updates 9
PPI....9
PDL Update 10
September & October 2012 Workshops.. 10
Proof of Medicaid Eligibility Letter. A-1

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

Contacts

Billing and Bulletin Questions
1-800-237-0757 or 1-800-237-0044

Claims and PARs Submission
P.O. Box 30
Denver, CO 80201

Correspondence, Inquiries, and Adjustments
P.O. Box 90
Denver, CO 80201

Enrollment, Changes, Signature Authorization and Claim Requisitions
P.O. Box 1100 Denver, CO 80201

ColoradoPAR Program PARs
www.coloradopar.com

All Providers

Proof of Medicaid Eligibility Letter

Some Medicaid clients' eligibility cannot be electronically verified due to system issues. System edits take time to implement and in some cases, client eligibility updates may not be available at the time of service. The Department of Health Care Policy and Financing (the Department) is requesting providers' cooperation to ensure clients receive the medical services required.

In the past, affected clients were issued a letter known as a "**Notice of Action (NOA)**". The NOA has been replaced with a "**Proof of Medicaid Eligibility**" letter. The letter allows Medicaid providers to receive payment for services for *eligible* clients when eligibility cannot be verified electronically. Providers must attach the Proof of Medicaid Eligibility letter and submit paper claims to the Department's fiscal agent, Xerox State Healthcare, for Medicaid-covered charges. Please refer to Attachment A of this bulletin for a current sample of the letter.

For the Provider:

Whenever a client's eligibility inquiry shows as ineligible for benefits via the Colorado Medical Assistance Program Web Portal (Web Portal), CMERS, or Fax-Back eligibility systems, direct the client to their Medicaid eligibility worker for assistance. The worker will initiate a request that a Proof of Medicaid Eligibility letter be sent to the client and/or directly to the provider.

The letter will provide official confirmation of the client's eligibility status and provide detailed instructions about how to file the claim.

It is important to remember the following:

- Always keep a copy of the letter in the client's file(s) and suggest the client do the same;
- Note the client's status in billing records – clients may not be billed for charges covered by Medicaid;
- Preserve timely filing status: Submit the initial claim (paper claim and attachments) within 120 days of the date of service and resubmit within 60 days thereafter if there are deficiencies, etc.

Please email medicaid.eligibility@hcpf.state.co.us for more information, additional questions, and concerns.

New Provider Toolkit: Safeguarding Medical Identity

The Centers for Medicare and Medicaid Services (CMS) and the Education Medicaid Integrity Contractor are disseminating new provider education material on medical identity theft.

"Safeguarding Your Medical Identity" provides Continuing Medical Education (CME) credit at no cost and serves as enduring resource material.

After completing this training, providers will be able to describe the associated problems, recognize the associated risks, learn strategies for mitigating vulnerability, and identify resources for reporting medical identity theft. This material will provide recommendations to help providers protect their practice and help Medicaid patients avoid fraud, waste, and abuse.

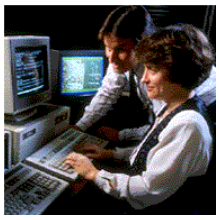
To access this toolkit, visit the Medicare Learning Network® (MLN) Web site:

Medicare Learning Network

Thank you in advance for your interest and support.

Colorado Choice Transition Update

The Department continues to experience delays associated with procedure codes and changes to the care management software, which will manage the Colorado Choice Transitions (CCT) services and benefits. In the meantime, work is continuing on creating a CCT provider billing manual, Prior Authorization Request (PAR) forms, and a provider enrollment application. At this time, there is no timeframe for when the Department will begin enrolling providers, but ask for continued patience as the work continues to implement this important program.



Once the procedure codes have been finalized and the appropriate systems changes have been made, existing provider enrollment materials will become available, including policy guidance and provider qualifications for CCT benefits and services. Materials will be distributed using a provider distribution list as well as posted on the Department's CCT Web page. More information will be forthcoming as it becomes available.

For questions or comments about the CCT program, or to add an organization to the provider distribution list, please contact Nicole Storm, Project Manager, at Nicole.Storm@state.co.us or 303-866-2858.

Fee Schedule

The 2012 Colorado Medicaid fee schedule and instructions have been updated and are available on the Provider Services home page of the Department's Web site. The fee schedule contains general code information, pricing, and PAR requirements.

For questions, please call Xerox State Healthcare Provider Services at 1-800-237-0757 or 1-800-237-0044.

Prior Authorization Request (PAR) Submission to the ColoradoPAR Program

The ColoradoPAR Program continues to process PARs for the following benefits:

- Audiology
- Dental and Orthodontics
- Durable Medical Equipment (DME)/Supply- All (including repairs)
- Diagnostic imaging– limited to non-emergency Computed Tomography (CT) Scans and Magnetic Resonance Imaging (MRI), and all Positron Emission Tomography (PET) Scans
- Medical/surgical services
- Reconstructive surgery
- EBI Bone Stimulator
- Second surgical opinions
- Physical and occupational therapy services
- Transportation
- Out-of-state non-emergency surgical services
- Organ transplantation
- EPSDT Extraordinary Home Health
- Private Duty Nursing
- Vision, including contact lenses
- Long Term Home Health for clients 20 and under

Questions can be directed to the ColoradoPAR Program at 1-888-454-7686.

Online PAR Processing with CareWebQI (CWQI)

Please continue to use the CWQI online portal to submit PARs to the ColoradoPAR Program. PARs submitted through this portal have faster processing times and allow for greater continuity of care. Submitting PARs through CWQI allows the medical review staff to see medical documentation quickly and provide a decision faster than those PARs submitted by fax. All PARs will continue to be processed in a timely manner regardless of the submission method.

Submitting Clinical Documentation with CWQI

Clinical information is imperative for PAR review. Be sure to answer the clinical questions in CWQI when submitting a PAR and attach relevant clinical information needed for PAR determinations. Submit all relevant supporting documentation with the PAR so that the medical review can be completed in a timely fashion. It is the responsibility of the provider who submits the PAR to provide all relevant information. If clinical information is missing or inadequate, a message will be sent to providers via the CWQI message system. Please stay current with these messages in order to keep the PAR moving through the process. Missing or inadequate clinical information will result in a lack of information (LOI) denial. PAR submitters will have 24 hours to respond to requests for more information before a LOI denial is issued.

Training on CWQI

If training is needed for CWQI, visit coloradopar.com for more information, including updated trainings and schedules. The ColoradoPAR Program offers CWQI training the second Wednesday of the month at 1:00 p.m. mountain standard time (MST). The ColoradoPAR Program also offers training to providers who would like on-site training. If interested, please email the ColoradoPAR Program at RES_ColoradoPAR@apsealthcare.com.

For WebEx trainings, please be sure to log on prior to the scheduled time for online training to make sure the correct software is available for viewing the presentation. If technical assistance is needed with using the WebEx, please call 1-866-863-3910 *OR* see https://www.webex.com/login/attend-a-meeting for more information.

Client Over-Utilization Program (COUP)

A reminder to all providers that the Colorado Medical Assistance Program has a COUP in place. The COUP is a statewide utilization control program that safeguards against unnecessary or inappropriate use of care or services. This program provides a post-payment review process allowing for the review of Medicaid client utilization profiles. It identifies excessive patterns of utilization in order to rectify over-utilization practices of clients. The COUP will restrict clients to one designated pharmacy and primary care physician when there is documented evidence of abuse or over-utilization of allowable medical benefits.

Medicaid clients that meet any one of the following criteria during a three-month period may be placed in the COUP:

- Use of sixteen or more prescriptions;
- Use of three or more pharmacies;
- Use of three or more drugs in the same therapeutic category, i.e., Oxycodone, Oxycontin, Hydrocodone;
- Has excessive Emergency Room (ER) and physician visits; OR
- A referral or analysis indicates possible over utilization.

Exceptions can be made when use of services is determined to be medically necessary.

Roles and Responsibilities of Client Over-Utilization Primary Care Provider/Primary Pharmacy

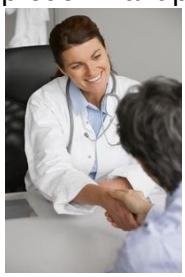
1. The COUP primary care provider will serve as the case manager for the client. The COUP primary care provider shall authorize and monitor services rendered to the client by any other health care provider and/or pharmacy.
2. COUP primary care providers will be responsible for member referral to any specialist provider(s) determined necessary by primary care provider. In addition, the primary care provider is responsible for approval of all prescriptions.
   Some exceptions may be made in the case of a pain specialist working with the client that is not also the primary care provider.

3. COUP primary care providers (primary care physician or primary pharmacy) may terminate their participation in the COUP by notifying the COUP Coordinator at 1-888-454-7686, option 2. The COUP Coordinator shall notify the recipient immediately to select another primary care provider (physician/pharmacy). The COUP primary care provider will be asked to continue as the primary care provider for 45-post notification date while a new COUP provider is assigned.

The Department is looking for COUP Providers. If interested, please contact Sarah Kennedy at skennedy@apshealthcare.com.

The Department's Position Statement on the Accountable Care Collaborative (ACC) Program

After one year of operation, the Department remains committed to the ACC Program as the predominant program that will lead Colorado into the future of better health care. The primary goals of the ACC Program are to improve clients' health and reduce costs. The initial results of this program are promising; costs, utilization and client experience are trending in the right direction. Department staff will continue to analyze program outcome and cost data on a monthly basis and will adjust the program as necessary. On November 1, 2012, a response to the legislative request will be submitted for information concerning the ACC. The response will include initial program results such as utilization and costs.



Following are the next steps for expansion:

- In August 2012, the Department began to work with the Regional Care Collaborative Organizations (RCCOs) to develop an expansion timeline and to ensure that administrative costs for the program remain budget neutral.
- Beginning in October 2012, the Department will remove the limit on the number of children enrolled in the program. The Department will prioritize the enrollment of children who can be linked to a Primary Care Medical Provider (PCMP).
- Beginning in November 2012, the Department will enroll the clients of the Comprehensive Primary Care Initiative (CPCI) practices into the ACC Program.
- By spring of 2013, the Department will begin to enroll clients who are dually eligible for both Medicaid and Medicare into the ACC Program.

This statement only addresses the immediate next steps for ACC Program expansion. The Department is developing a broader vision for payment reform within the ACC Program and integration across the various delivery systems. The Department will have a robust stakeholder process as this larger vision is developed.

Contact Marceil Case at Marceil.Case@state.co.us or 303-866-3054 with questions.

ACC Payment Reform Initiative-1281

The ACC Payment Reform Initiative (ACC PRI) allows the Department to accept proposals for innovative payment reforms that will demonstrate new ways of paying for improved client health outcomes while reducing costs. The Department has now released three initial documents which inform the stakeholder community about the ACC PRI and invite RCCOs and their partners to submit abstracts. Abstracts will assist the Department in developing the proposal evaluation criteria for the ACC PRI.

More information can be found through the following references:

- For the initiative, its process and a preliminary timeline, refer to the fact sheet.
- Frequently asked questions (FAQs).
- The invitation for abstracts.

For other inquiries, please visit the Department's ACC PRI Web page.

Dual Eligibles

Providers are reminded that Medicaid is always the payer of last resort; therefore, services for dual-eligible clients - those with coverage from Medicare and Medicaid - must be billed first to Medicare. Please refer to the July 2011 Provider Bulletin (B1100303) for an example of exceptions for Home Health services. Providers must be able to show evidence that claims for dual-eligible clients, where appropriate, have been denied by Medicare prior to submission to the Colorado Medical Assistance Program.

Per the Provider Participation Agreement, this evidence must be retained for six years following the Medicare denial. The Colorado Medical Assistance Program requires that a copy of the Medicare Standard Paper Remit (SPR) accompany any paper claims for dual-eligible clients which are submitted for reimbursement.

Please contact Xerox State Healthcare Provider Services at 1-800-237-0757 or 1-800-237-0044 with questions.

Record Retention

Providers must maintain records that fully disclose the nature and extent of services provided. Upon request, providers must furnish information about payments claimed for Colorado Medical Assistance Program services. Records must substantiate submitted claim information. Such records include but are not limited to:

- Treatment plans
- Prior Authorization Requests (PARs)
- Medical records and service reports
- Records and original invoices for items, including drugs that are prescribed, ordered, or furnished
- Claims, billings, and records of Colorado Medical Assistance Program payments and amounts received from other payers

Each medical record entry must be signed and dated by the person ordering and providing the service. Computerized signatures and dates may be applied if the electronic record keeping system meets Colorado Medical Assistance Program security requirements.

Records must be retained for at least six years or longer if required by regulation or a specific contract between the provider and the Colorado Medical Assistance Program.

September and October 2012 Holidays

Labor Day Holiday

Due to the Labor Day holiday on Monday, September 3, 2012, the claims processing cycle included electronic claims accepted before 6:00 p.m. MST on Thursday, August 30, 2012. The receipt of warrants will be delayed by one or two days. State, the Department's fiscal agent, and ColoradoPAR Program offices will be closed on September 3, 2012. Offices will re-open during regular business hours on Tuesday, September 4, 2012.

Columbus Day

Due to Columbus Day Holiday on Monday, October 8, 2012, the claims processing cycle will include electronic claims accepted before 6:00 p.m. MST on Thursday, October 4, 2012. The receipt of warrants may be delayed by one or two days. State and the ColoradoPAR Program offices will be closed on Monday, October 8, 2012. The Department's fiscal agent offices will be open during regular business hours.

Dental and Orthodontia Providers

PAR Processing Update

On June 25, 2012, the Department transitioned reviews of dental and orthodontia PARs to the ColoradoPAR Program.

The ColoadoPAR Program currently has a backlog of dental and orthodontia PARs, and providers are experiencing delays with PAR processing. The Department is working closely with the ColoradoPAR Program to address delays and plans to have the backlog resolved within the next few weeks. Department staff would like to apologize for any difficulties this backlog has caused.

Please contact the ColoradoPAR Program at 1-888-454-7686 with questions or concerns about the new PAR process, status of a PAR or to confirm the PAR has been received. If unable to obtain information about a PAR from the ColoradoPAR Program, please contact Chris Acker at Chris.Acker@state.co.us or 303-866-3920.

Durable Medical Equipment (DME)/Supply Providers

Special PAR Submission Requirements

On July 2, 2012, the PAR process for certain DME codes changed. In an effort to increase efficiency and timely access to services, the ColoradoPAR Program is no longer doing a clinical review for selected codes. Please see the **revised** special provider bulletin, B1200323, for the list of codes. Providers are still required to submit a "notification" into CWQI in order to provide these services, and the notification will then be auto-authorized. The notification process is the same as the PAR process in CWQI, except providers will no longer have to provide the clinical indications for the codes listed in the special bulletin. Although providers will have auto-authorization, a PAR ID must still be obtained in order to provide services and is still required when submitting claims to the Colorado Medical Assistance Program.

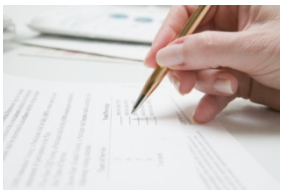
It is the provider's responsibility to maintain clinical documentation to support services provided in the client's file in the event of an audit or retroactive review. Suggested documents include, but are not limited to, the history and physical reviews of the client, progress notes, office notes, lab results and medications being taken. As with all PARs and notifications, an auto-authorized service is not a guarantee of payment.

PLEASE NOTE: Services may be audited after being rendered to ensure services provided are appropriate and that all appropriate documentation is maintained. For any questions please contact the ColoradoPAR Program at 1-888-454-7686.

Federally Qualified Health Centers (FQHCs)

Provider Identification (ID) Number

The Colorado Medical Assistance Program is adopting the policy of Medicare (42 CFR 491.5(a)(3)(iii)) in requiring each site of a FQHC to enroll and use a separate provider ID for reimbursement. Several FQHCs have already obtained a separate provider ID for each location. Beginning in September 2012, the Department will work with FQHCs applying for provider IDs for each of their sites. Mobile units of an FQHC are not required to be separately enrolled in the Colorado Medical Assistance Program, but are treated as part of the FQHC. By December 2013, every FQHC site in Colorado must have a separate provider ID.



Applications for enrollment as an FQHC provider type should include the Health Resources and Services Administration Notice of Award of a Section 330 grant covering the site unless the provider is an FQHC Look-Alike. Applications for enrollment as an FQHC provider type by an FQHC Look-Alike organization should include a verification from the Health Resources and Services Administration that the applying organization meets the appropriate requirements.

As part of the requirement to use a provider ID for each location, a current provider ID held by an FQHC that is for a clinic provider type (except Substance Abuse specialty clinics) will be deactivated. Generally, all claims for services by an FQHC can be submitted using the same provider ID for both Institutional and Professional claims. For centers with a Family Planning provider ID, the decision on deactivating that ID will be made on an individual basis by working with the FQHC.

Contact Richard Delaney at Richard.Delaney@state.co.us or 303-866-3436 for more information.

Home and Community Based Service (HCBS) Waiver Providers

What is Payment Error Rate Measurement (PERM)?

PERM is a federally-mandated audit that occurs once every three years. The purpose of this program is to review claims payments and examine eligibility determinations made for the Medicaid and Child Health Plan *Plus* (CHP+) programs for accuracy and to ensure that states only pay for appropriate claims.

Providers are required by section 1902(a)(27) of the Social Security Act and 10 CCR 2505-10, Sec.8.130.2.A to:

- submit records to the federal and state government upon request;
- retain records necessary to disclose the nature and extent of services provided to recipients;
- maintain records which fully substantiate or verify claims submitted for payment.

The collection and review of protected health information contained in individual-level medical records for payment review purposes is permissible by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and implementing regulations at 45 Code of Federal Regulations, parts 160 and 164.

2010 PERM Errors

Errors for the 2010 PERM cycle for Day Habilitation and Waiver Programs, Adult Day Care, and Foster Care were due to:

- unsigned timesheets;
- missing documentation;
- submitted timesheets and other documents not supporting billed units of service.

2013 PERM Cycle

The Department will participate in the 2013 PERM cycle. CMS contractors may contact providers who provide Medicaid and CHP+ services to request copies of medical records with October 2012 to September 2013 dates of service for the PERM review. Providers have 75 business days to provide documentation to the CMS contractor. If additional documentation is requested, providers have 15 business days to provide additional documentation. If documentation is not provided, the provider's claim(s) will be considered an error, and the Department will recover the money associated with the claim from the provider, regardless of whether or not the service was provided.

More Information

Providers can participate in provider education calls to learn more about PERM and provider responsibilities. CMS will host provider education calls on September 25 and October 24, 2012. More information may be found at CMS → Provider Education Calls.

Additional information may be obtained at CMS or by contacting the Department's PERM Program Manager, Matt Ivy, at Matt.Ivy@state.co.us or 303-866-2706.

Home Health Providers

Prior Authorization Request (PAR) Submission

On August 24, 2012, Long Term Home Health PARs for clients 20 and under started to be processed by the ColoradoPAR Program. The Department and the ColoradoPAR Program will be offering trainings regarding the PAR process via webinar, and there will be a separate communication regarding the upcoming training schedule.

Please contact ColoradoPAR with any questions at 1-888-454-7686.

Hospital Providers

Inpatient Medicaid Base Rates effective July 1, 2012

The hospital-specific Medicaid inpatient base rates effective July 1, 2012 have been finalized and are now pending approval from CMS. The hospital-specific base rates which are still effective as of July 1, 2011 will remain in place until CMS approval is received. Once approved, the Department will update each hospital inpatient base rate and mass adjust the affected claims. Information regarding each facility's July 1, 2012 hospital-specific inpatient base rate was mailed on July 6, 2012, using the most current information on file. Additional copies of this letter may be requested by contacting Elizabeth Lopez at Elizabeth.Lopez@state.co.us.

New International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Diagnosis and Procedure Codes Crosswalk

Updates to the Diagnosis-Related Group (DRG) System

The Department is in the process of implementing new ICD-9-CM codes which became effective October 1, 2011. Every year the Department maps the new codes to pre-existing codes used by the CMS-DRG version 24 grouper (crosswalk) so that DRGs are assigned and reimbursed correctly by the grouper. The October 1, 2011 crosswalk table is located on the Department's Web site in the Provider Services DRG Relative Weights section.

As stated in the October 2011 provider Bulletin (B1100306), claims that included these new ICD-9 codes will be mass adjusted without the need of further actions from providers.

The mass adjustment may be completed a month after the crosswalk implementation date. Providers will notice payment adjustments to their inpatient claims due to this crosswalk implementation throughout the month of September 2012. Please contact Dana Batey at Dana.Batey@state.co.us or 303-866-3852 with questions related to the crosswalk implementation and claim adjustments.

Nursing Facility Providers

What is Payment Error Rate Measurement (PERM)?

PERM is a federally-mandated audit that occurs once every three years. The purpose of this program is to review claims payments and examine eligibility determinations made for the Medicaid and Child Health Plan *Plus* (CHP+) programs for accuracy and to ensure that states only pay for appropriate claims.

Providers are required by section 1902(a)(27) of the Social Security Act and 10 CCR 2505-10, Sec.8.130.2.A to:

- Submit records to the federal and state government upon request.
- Retain records necessary to disclose the nature and extent of services provided to recipients.
- Maintain records which fully substantiate or verify claims submitted for payment.

The collection and review of protected health information contained in individual-level medical records for payment review purposes is permissible by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and implementing regulations at 45 Code of Federal Regulations, parts 160 and 164.

2010 PERM Errors

Errors for the 2010 PERM cycle for Nursing Facilities, Chronic Care services, and Intermediate Care Facilities were due to missing or unsigned physician progress notes.

2013 PERM Cycle

The Department of Health Care Policy and Financing (the Department) will participate in the 2013 PERM cycle. The Centers for Medicare and Medicaid Services (CMS) contractors may contact providers who provide Medicaid and CHP+ services to request copies of medical records for October 2012 to September 2013 dates of service for the PERM review. Providers have 75 business days to provide documentation to the CMS contractor. If additional documentation is requested, providers have 15 business days to provide additional documentation. If documentation is not provided, the provider's claim(s) will be considered an error, and the Department will recover the money associated with the claim from the provider, regardless of whether or not the service was provided.

More Information

Providers can participate in provider education calls to learn more about PERM and provider responsibilities. CMS will host provider education calls on September 25 and October 24, 2012. More information may be found at CMS → Provider Education Calls.

Additional information may be obtained at CMS or by contacting the Department's PERM Program Manager, Matt Ivy, at Matt.Ivy@state.co.us or 303-866-2706.

Physical Therapy and Occupational Therapy (PT/OT) Providers

Daily Unit Limit Changes for PT/OT Procedure Codes

On July 1, 2012, new daily unit limits for PT/OT procedure codes listed below were implemented in the Medicaid Management Information System (MMIS). The new daily unit limits were inadvertently omitted from the July 2012 Provider Bulletin.

Because providers were not notified prior to implementation, the Department will take the following steps to address this error for services already rendered:

- For services rendered between July 1, and August 31, 2012, claims that have already been submitted, as well as claims submitted by September 30, 2012, will be *automatically* adjusted by the Department (providers do not need to resubmit these denied claims). Denied units on those claims that were over the new maximum but within the old maximum will be reimbursed following the automatic adjustment at the end of September 2012. Claims submitted after September 30, 2012 for dates of service between July 1 and August 31, 2012 will not be adjusted.

- Services rendered on or after September 1, 2012 will be subject to the new daily unit limits as outlined in the chart below for each individual code. Units in excess of the new daily unit limits for each code below will not be reimbursed for dates of service on or after the date of this notice.

Please note that the overall, combined daily unit limit of five units of any combination of the PT/OT procedure codes still applies.

Procedure Code	New Unit Limit		Procedure Code	New Unit Limit		Procedure Code	New Unit Limit
97012	1		97113	2		97535	4
97014	1		97116	3		97537	4
97016	1		97139	3		97542	4
97024	1		97140	2		97760	4
97026	1		97150	1		97761	4
97028	1		97530	3		97762	4
97039	1		97532	3		97799	1
97110	4		97533	4			

Please contact Amanda Belles at Amanda.Belles@state.co.us or 303-866-2830 with questions.

Pharmacy Providers

Pharmacy & Therapeutics (P&T) Committee Meeting

Tuesday, October 2, 2012
1:00 p.m. - 5:00 p.m.
225 E. 16th Avenue
Denver, CO 80203
1st Floor Conference Room

Appendix P

Appendix P has been updated pending the recent Pharmacy & Therapeutics (P&T) Committee and Drug Utilization Review (DUR) Board recommendations.

Additions include criteria for Belviq, Qsymia and Truvada.

Coordination of Benefits (COB) Manager

The latest information from the vendor implementing this program is available on the Department's Pharmacy Web page.

Medicare Part D Updates

Due to updates in the Affordable Care Act, coverage policies will soon be changing for clients eligible for both Medicare and Medicaid. Currently, both benzodiazepines and barbiturates have been covered through the Medicaid pharmacy benefit for dual eligible clients. After January 1, 2013, coverage will move to Medicare Part D for most indications. Please see the Pharmacy Web page for updates.

Proton Pump Inhibitors (PPI)

Please see the prior authorization criteria listed on the Preferred Drug List (PDL) under the PPI class for significant updates.

The pharmacy claims system will be sending a message to pharmacies reminding them of the upcoming changes which began in August 2012. The actual criteria will become effective September 15, 2012, and most clients will be limited to 60 days of PPI therapy per year unless certain criteria are met.

For questions contact Jim Leonard at Jim.Leonard@state.co.us.

Preferred Drug List (PDL) Update

Effective October 1, 2012, the following will be preferred agents on the Medicaid PDL and will be covered without a prior authorization:

Bisphosponates: Alendronate (generic) 5mg, 10mg, 35mg, and 70mg tablets

Biguanides: Metformin generic 500mg, 850mg, and 1000mg tablets; metformin XR 500mg tablets (this does not include generic equivalents of Fortamet)

Hypoglycemic Combinations: None

- Providers will need to utilize the separate products starting on October 1, 2012

Meglitinides: None

TZDs: None

- Patients stabilized on Actos will continue to be able to receive the drug, however, a PAR will be required for new starts or interruptions in therapy

Newer Diabetic Agents: Byetta, Januvia and Tradjenta

Erythropoiesis Stimulating Agents: Procrit

Overactive Bladder Agents: oxybutynin, oxybutynin ER and Toviaz

Protease Inhibitors for Hepatitis C: Victrelis

- Patients taking Victrelis will be subject to meeting clinical requirements

Stimulants and ADHD: mixed amphetamine salts IR, Adderall XR (brand), dexmethylphenidate, Focalin XR (brand), methylphenidate (generic Ritalin), methylphenidate SR (generic Ritalin SR), methylphenidate ER (generic Concerta), Strattera, Vyvanse

The complete PDL and prior authorization criteria for non-preferred drugs are posted on the PDL Web page.

Other PDL News

- The generic formulation for Detrol will be a non-preferred product.
- The generic formulation for Fortamet will be a non-preferred product.
- The protease inhibitors for hepatitis C are a new addition to the PDL beginning October 1, 2012. The preferred agent will be Victrelis.

September and October 2012 Provider Billing Workshops

Provider Billing Workshop Sessions

Provider billing workshops include both Colorado Medical Assistance Program billing instructions and a review of Colorado Medical Assistance Program billing procedures.

The September and October 2012 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 for all workshops

Email reservations to:
workshop.reservations@xerox.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 to ensure there is space available.

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:

Xerox State Healthcare
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.

Provider Enrollment Application Workshop

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.

September and October 2012 Specialty Workshop Class Descriptions

Dialysis

This class is for billers who bill for Dialysis services on the UB-04/837I and/or Colorado 1500/837P claim formats. The class covers billing procedures, common billing issues and guidelines specifically for dialysis providers. *(This is not the class for Hospitals – please refer to the Hospital Class.)*

Home Health

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

Nursing Facility

This class is for billers using the UB-04/837I claim format. The class covers billing procedures, common billing issues, PETI, Medicare Crossovers, and guidelines specifically for Nursing Facility 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.)*

Practitioner

This class is for providers using the Colorado 1500/837P format. The class covers billing procedures, common billing issues and guidelines specifically for the following provider types:

Ambulance	Family Planning	Independent Radiologists	Physician Assistant
Anesthesiologists	Independent Labs	Nurse Practitioner	Physicians, Surgeons

Transportation

This class is for emergency transportation providers billing on the Colorado 1500/837P and/or UB-04/837I formats. The class covers billing procedures, common billing issues, and guidelines specifically for Transportation providers.

Beginning Billing for Waiver Programs

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

Vision
This class is for ophthalmologists, optometrists, and opticians billing on the Colorado 1500/837P claim format. The class covers billing procedures, common billing issues, and guidelines specifically for practitioners providing vision services.

Web Portal
Web Portal classes provide an overview of the Colorado Medical Assistance Program Web Portal, a description of its functions and contact and support information.

Driving directions to 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.

The fiscal agent's office is located in the Denver Club Building on the west side of Glenarm Place at 17th Street (Glenarm is a two-way street).

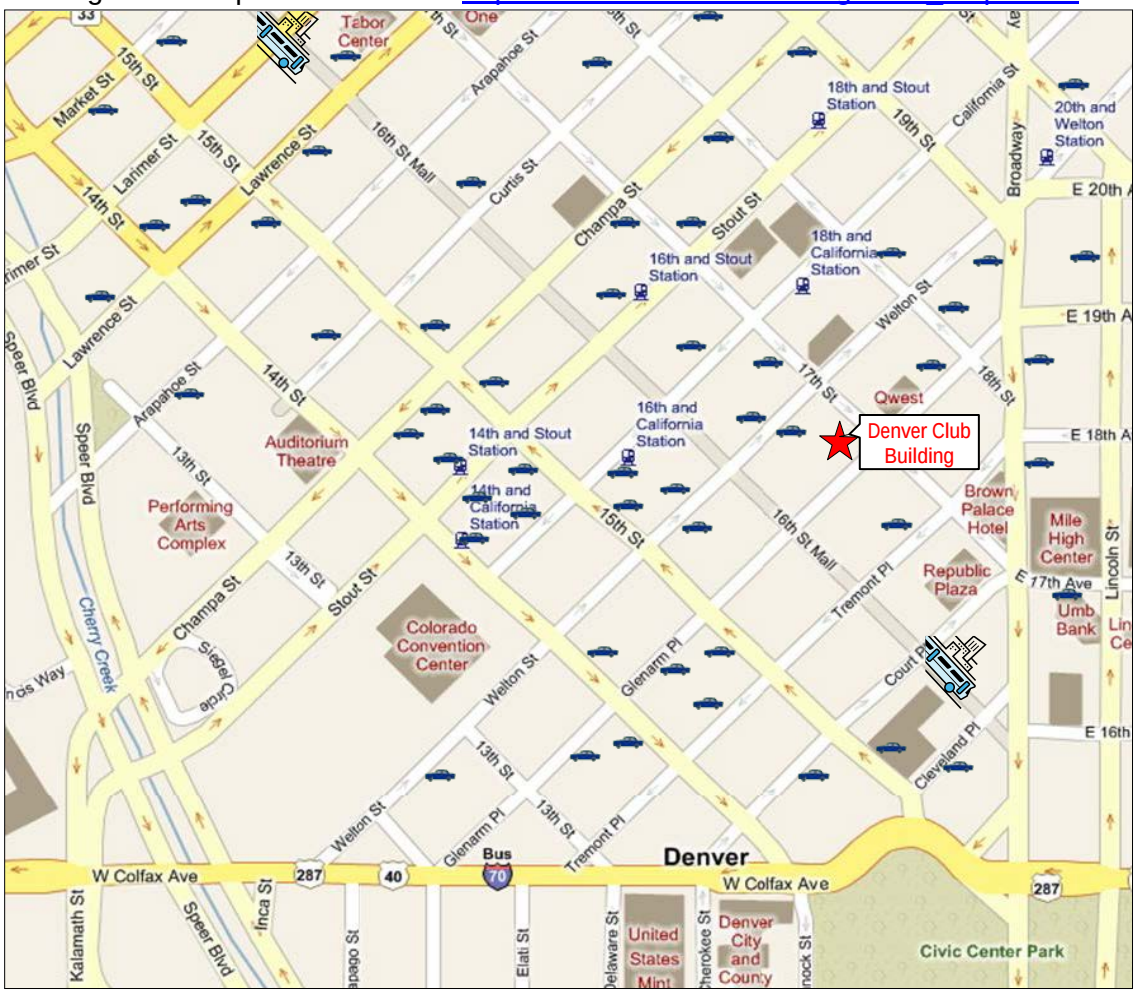
Parking is not provided and is limited in the downtown Denver area.

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@xerox.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.

September 2012

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						1
2	3 *Labor Day*	4	5	6	7	8
9	10	11 Beginning Billing – CO -1500 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM Transportation 1:00 PM-3:00 PM	12 Beginning Billing – UB-04 9:00 AM-11:30 AM Web Portal 837I 11:45 AM-12:30 PM Dialysis 1:00 PM-3:00 PM	13 Provider Enrollment 9:00 AM-11:00 AM Pharmacy 2:00 PM-3:00 PM WebEx - Practitioner 1:00 PM-4:00 PM	14 WebEx - Basic Bill for Waiver Providers 9:00 AM-11:30 AM Web Portal 837I 11:45 AM-12:30 PM Home Health 3:00 PM-4:30 PM	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

October 2012

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	1	2	3	4	5	6
7	8 *Columbus Day*	9 Beginning Billing – CO -1500 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM Vision 1:00 PM-3:00 PM	10 Beginning Billing – UB-04 9:00 AM-11:30 AM Web Portal 837I 11:45 AM-12:30 PM Nursing Facility 1:00 PM-3:00 PM	11 Dental 9:00 AM-11:00 AM Web Portal 837P 11:15 AM-12:00 PM WebEx - Inpatient/Outpatient 1:00 PM-3:00 PM	12 Basic Billing for Waiver Providers 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 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

Xerox State Healthcare 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

COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

1570 Grant Street, Denver, CO 80203-1818 • (303) 866-2993 • (303) 866-4411 Fax • (303) 866-3883 TTY

John W. Hickenlooper, Governor • Susan E. Birch MBA, BSN, RN, Executive Director

PROOF OF MEDICAID ELIGIBILITY

IMPORTANT INFORMATION - DO NOT THROW THIS AWAY

Date

Client info

This notice proves that you are eligible for Medicaid.

Your benefits cannot be verified electronically. Take this notice with you to medical appointments and pharmacies until your eligibility can be verified through the automated verification systems.

PROVIDERS AND PHARMACIES

PAYMENT FOR MEDICAID SERVICES IS GUARANTEED WITH THIS LETTER FOR THE EFFECTIVE DATES BELOW. PLEASE SEE BILLING INSTRUCTIONS ON THE BACK OF THIS NOTICE.

The following person is eligible for Medicaid Benefits:

Name:

State ID:

Effective: thru

Authorizing Eligibility Site: CBMS Case Number:

APPROVED ASSISTANCE:

☐ **Full Medicaid** ☐ **Medicaid-No prescription assistance**

AUTHORIZED SIGNATURE _____ **TEL:** 303-866-____

We are here to help during normal business hours (Monday-Friday from 8:00 am to 5:00 pm). If you have any questions regarding this notice, please call the person listed above for assistance.

Sample

Medicaid Provider Instructions:

You must bill Medicaid for charges incurred for this Medicaid-eligible client in accordance with Colorado state law, C.R.S. 25.5-4-301. You may not bill the client for charges covered by Medicaid.

1. **Make two copies of this letter and return the original to the client.**
2. **Keep one copy for your records as proof of eligibility verification.**
3. **Attach the second copy to a paper claim and submit both sheets to be adjudicated by the fiscal agent, Xerox State Healthcare.**
4. **Use the eligibility information printed on this notice to fill in the paper claim.**

Medicaid eligibility is guaranteed with this letter for the client and effective dates provided on this notice. The client's eligibility cannot currently be verified through the eligibility verification system. If you have billing questions, please call Xerox State Healthcare Provider Services at 1-800-237-0757. If you have questions about this letter, please contact the person listed on the front of this notice during business hours.

Pharmacy Instructions:

You must bill Medicaid for charges incurred for this Medicaid-eligible client in accordance with Colorado state law, C.R.S. 25.5-4-301. You may not bill the client for charges covered by Medicaid.

1. **Check for current Medicaid eligibility for the client in the pharmacy eligibility system. If the client shows as Medicaid eligible, bill Medicaid for the charges. If the client does not show as Medicaid eligible, proceed to #2.**
2. **Contact the person listed on the front of this letter. Help is available during normal business hours. Medicaid spans in the pharmacy system may be reopened in most cases.**
3. **If you cannot verify current eligibility and it is outside of normal business hours, please distribute a 72 hour supply of emergency medication to the client, as needed, and contact us during business hours to arrange for payment by Medicaid.**

Medicaid eligibility is guaranteed with this letter for the client and effective dates provided on this notice. The client's eligibility cannot currently be verified through the eligibility verification system. If you have billing questions, please call Xerox State Healthcare Provider Services at 1-800-237-0757. If you have questions about this letter, please contact the person listed on the front of this notice during business hours.