



colorado.gov/hcpf

Provider Bulletin

Reference: B1400351

May 2014



Did you know...?

Mass adjustments made by the Department of Health Care Policy and Financing (the Department) can only be done if the original submitted charge on a claim is greater than the newly revised rate. Any claim on or after the date that new rates become effective, with a submitted charge lower than the corrected rate, must be adjusted by the provider. It is recommended that providers submit charges based on Usual & Customary rates, when applicable.

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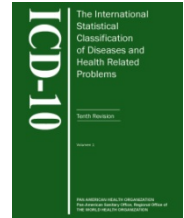
All Providers

International Classification of Diseases (ICD) - Version 10 Update

ICD-10 Implementation Delayed

On Monday, March 31, 2014 the U.S. Senate passed House Bill 4302, Protecting Access to the Medicare Act of 2014, which is a temporary “fix” to the Medicare sustainable growth rate (SGR) that postpones reduction in physicians’ Medicare rates and also delays implementation of ICD-10 until October 1, 2015. President Barack Obama signed the legislation on Tuesday, April 1, 2014 solidifying the delay of ICD-10 implementation date.

The bill prohibits the Centers for Medicare and Medicaid Services (CMS) from enforcing any mandate to switch to ICD-10 until at least October 1, 2015. The bill leaves CMS with many questions to answer; along with much of the provider community, the Department is awaiting answers. The Department’s ICD-10 Project Team will align, adjust, and share their implementation strategy as more information unfolds.



Below is general claim submission information:

- ICD-9 diagnosis and surgical procedure codes will be required on claims that contain Dates of Service (DOS) or Dates of Discharge (DOD) of September 30, 2015 and before.
- ICD-10 diagnosis and surgical procedure codes are required on claims that contain DOS or DOD of October 1, 2015 or after.
- Claims submitted with both ICD-9 and ICD-10 codes will not be processed. Providers will have to submit two different claims based on DOS or DOD.

ICD-10 and Dental Claims

The Colorado Medical Assistance Program does not currently require diagnosis codes on dental paper or electronic claims (837D) and will not require diagnosis codes with the implementation of ICD-10. Claims will not reject or deny if a valid diagnosis code(s) is submitted. The Current Dental Terminology (CDT) procedure codes are currently used to report services provided to clients and will continue to be used.

Please contact the Department’s fiscal agent, Xerox State Healthcare, at 1-800-237-0757 with questions.

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

Contacts

Billing and Bulletin Questions
1-800-237-0757

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

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

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

ColoradoPAR Program PARs
www.coloradopar.com

Financial Reporting System Transition

On July 1, 2014, the State of Colorado will replace its current payment financial system, the Colorado Financial Reporting System (COFRS), with a new system, the Colorado Operations Resource Engine (CORE). The new system is an enterprise-wide system that will be used by all three branches of Colorado government; it will provide new budgetary, procurement, and accounting functionality to the State, all which is integrated into one cohesive system.

The Department has been working with its vendor and other State staff to ensure all the existing interfaces between the Medicaid Management Information System (MMIS) and COFRS are updated accordingly. In testing the new interfaces, the Department does not anticipate any disruptions in payments to providers come July 1, 2014.

If a provider does encounter payment issues after July 1, 2014, please contact Tim Gaub at Tim.Gaub@state.co.us.

National Correct Coding Initiative (NCCI) Edits and Global Surgery Modifiers

The Department's policy staff has noticed an increase in improper use of Global Surgery Modifiers. Providers who bill these procedure codes should review the following information for the appropriate billing methods in order to avoid claim denials. Common billing issues include: incorrect modifiers, missing modifiers, or listing multiple incorrect modifiers on one procedure code.

The following modifiers are used by physicians and qualified healthcare professionals to indicate a billed service that is not part of a global surgical package and may be eligible for separate reimbursement:

24: Unrelated Evaluation and Management Service (E&M) by the same Physician during a Postoperative Period:

The physician may need to indicate that an E&M service was performed during a postoperative period for a reason(s) unrelated to the original procedure.

This circumstance may be reported by adding the modifier 24 to the appropriate level of E&M service. For example:

DOS: January 10, 2014

Diagnosis code: 171.2

Procedure code: 11606

Post-Operative period for 11606: 10 days

DOS: January 15, 2014

Diagnosis code: 692.0

Procedure code: 99212-24

In order for the E&M service to be payable in the post-operative period with the 24 modifier, the diagnosis code supporting the E&M service must be different from the diagnosis code reported for the previously performed surgery.

Modifier 24 should not be used for the medical management of a patient by the surgeon following surgery.



25: Significant, Separately Identifiable E&M Service by the same Physician on the Day of a Procedure or Other Service:

The provider should specify that on the date of the procedure, the patient's condition required

- a significant, separately identifiable E&M service above and beyond the primary service provided or
- services beyond the usual preoperative and postoperative care associated with the procedure that was performed.

A significant, separately identifiable E&M service is defined or verified by documentation that satisfies the relevant criteria for the reported E&M service. The E&M service may be a result of a symptom or condition for which the procedure and/or service was provided. Different diagnoses are not required for reporting of the E&M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E&M service. For example:

DOS: February 15, 2014

Diagnosis code 540.0

Procedure code – 44970

DOS: February 15, 2014

Diagnosis code 540.9

Procedure code 99223-25

Note: This modifier is not used to report an E&M service that resulted in a decision to perform major surgery. See modifier 57.

57: Decision for Surgery: An E&M service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

Evaluation and Management services on the day before or on the day of major surgery (90 day global period) which result in the initial decision to perform the surgery are not included in the global surgery payment. These E&M services may be billed separately and identified with the 57 modifier.

For example:

DOS: March 25, 2014

Diagnosis codes 812.42, E884.9

Procedure code – 24579 Post-Operative period for 24579 is 90 days

DOS: March 25, 2014

Diagnosis codes 812.42, E884.9

Procedure code - 99202-57

Modifier 57 should not be used for visits provided during the global period of minor procedures (0 or 10 day global period) unless the purpose of the visit is a decision for major surgery. This modifier is not used with minor surgeries because the global period for minor surgeries does not include the day prior to the surgery. When the decision to perform the minor procedure is typically done immediately before the service, it is considered a routine preoperative service and a visit or consultation is not billed in addition to the procedure.

Modifiers may be appended to Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes only if the clinical circumstances justify the use of the modifier. A modifier should not be appended to a HCPCS/CPT code solely to bypass an NCCI Procedure-to-Procedure (PTP) edit if the clinical circumstances do not justify its use.

Client Eligibility Verification Reminder

Why should eligibility be verified? 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 (DOS).



Since daily eligibility updates can occur, a provider can validate a client's status through one of the following methods:

- **Colorado Medical Assistance Web Portal (Web Portal)**
Providers may use the [Web Portal](#) to receive the most current, real-time, eligibility information for a client. Inquiries can be made for an individual client or in a batch. Using this method of verification gives the provider an eligibility guarantee number that can be used to demonstrate that a client had active eligibility at the time the inquiry was made.
- **FaxBack Eligibility Verification**
Providers have the ability to call a toll free number (1-800-493-0920) in order to obtain an individual client's eligibility information by phone. The client's pertinent information is needed to receive a hard-copy supporting document via fax machine.
- ❖ *Using the Web Portal or FaxBack options are preferred and are the most efficient means for verifying client eligibility. These two options also give the provider a hard-copy record of the eligibility verification; providers should retain and store these types of responses with their clients' records.*
- **Colorado Medical Assistance Program Eligibility Response System (CMERS) / Interactive Voice Response System (IVRS)**
Similar to the FaxBack option, excluding the hard-copy verification, providers can contact 1-800-237-0757, toll-free, to receive current eligibility information for individual clients.
- **Medical Identification Card (MIC)**
Medical Identification Cards include the client's name and State ID. The card by itself will not verify eligibility; providers must still verify eligibility with one of the other options mentioned above.

For further information about eligibility verification, providers are encouraged to review the [General Provider Information Manual](#).

Client Billing Permitted

Client Acknowledgement of Financial Responsibility

There are several scenarios in which a provider is permitted to bill a client related to services rendered to them. It is important to note, however, that if a service will not be covered by the Colorado Medical Assistance Program, the provider should have the client sign an acknowledgement of financial responsibility.



Clients' Unpaid Co-payment Obligation

Providers may not refuse services to a client that cannot pay a copayment at the time services are rendered; however, clients may be billed for unpaid copayments. In addition, providers may apply standard collection policies if the client fails to satisfy co-payment obligations.

Clients in a Nursing Facility

Clients in nursing facilities are responsible for patient payment amount when under Medicare Part A (skilled nursing) coverage. If a patient payment amount exceeds the Medicare Part A coinsurance due, the difference is refunded to the client.

Clients in a Managed Care Program

Clients that are part of a Managed Care Program must follow the rules of the Managed Care Organization (MCO). Clients who insist upon obtaining care outside of the MCO network may be charged for non-covered services.

Clients with Third Party Liability (TPL) or other Commercial Insurance

Clients who have commercial insurance coverage that require them to obtain services through a provider network must obtain all available services through the network.

Clients who insist upon obtaining managed care-covered services outside the network may be charged for such services.

For further information related to situations in which billing clients is permitted, as well as other general information, new and existing providers are encouraged to review the [General Provider Information Manual](#).

Memorial Day Holiday

Due to the Memorial Day holiday on Monday, May 26, 2014, claim payments will be processed on Thursday, May 22, 2014. The processing cycle includes claims accepted by Thursday before 6:00 p.m. Mountain Time (MT). The receipt of warrants may be delayed by one (1) or two (2) days. The State, the Department's fiscal agent, and the ColoradoPAR Program offices will all be closed on Monday, May 26, 2014. All offices will re-open for business on Tuesday, May 27, 2014.



Dental Providers

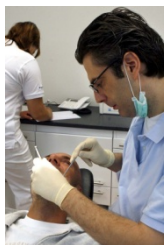
Dental Updates

Adult Dental Benefit

As of April 1, 2014 all clients age 21 years and older with Medicaid benefits are eligible for adult dental services; however, clients are subject to the limitations described in the April 2014 Provider Bulletin ([B1400350](#)) and the [Dental Billing Manual](#).

Note: Do not submit claims for adults, ages 21 and older, with DOS prior to April 1, 2014 for the services noted in the April 2014 bulletin. Claims submitted for reimbursement with earlier DOS are subjected to being audited and recovered to ensure the services provided are appropriate and that the proper documentation is maintained.

For additional billing information, please refer to the [Dental Billing Manual](#) located on the Department's website (colorado.gov/hcpf/Provider Services) → Billing Manuals → Dental.



Adult Dental Frequently Asked Questions (FAQs)

The Department recently updated the [Dental FAQs](#) and fee schedule on the [Provider Services](#) web page. Scroll down to the "Dental Providers" section and click on the updated documents.

The Department also updated the [Find a Provider](#) web page to help clients find both dentists and hygienists by name or by county. These provider directories list only those providers who have billed for Colorado Medicaid Services in the past 12 months.

These directories will be updated monthly and the Department reminds providers to update their contact information via the [Web Portal](#) or through the [Provider Enrollment Update Form](#). With Medicaid expansion, there are 178,000 'new patients' looking for providers to help them access their new benefits.

Pre-fabricated Crowns and Dental Benefits

Prefabricated stainless steel crowns are a benefit for both primary and permanent teeth. Prefabricated resin crowns, prefabricated stainless steel crowns with a resin window, and prefabricated esthetic coated stainless steel crowns are a benefit only for anterior primary teeth. When treating children under the age of 21, a maximum of five (5) crowns may be prepared and inserted on the same day of service in a non-hospital setting unless in-office sedation is provided.

Please contact Dawn McGlasson at Dawn.Mcglasson@state.co.us with questions.



Durable Medical Equipment (DME) Providers

DME - Oxygen Claim Edits

In compliance with NCCI, several procedure codes used for oxygen reimbursement have been denied based on PTP edits (edit 2021). The most affected procedure codes (E0441 and E0442) are the monthly oxygen contents procedure codes.

The Colorado Medical Assistance Program received approval from CMS for an exception to the edit for codes that prevented payment for oxygen contents when billed with either an oxygen concentrator or stationary oxygen system. The claims that were denied for the NCCI edit will be reprocessed by the Department's fiscal agent.

Please contact Richard Delaney at Richard.Delaney@state.co.us or 303-866-3436 with questions.

Federally Qualified Health Centers (FQHCs)

Rate Increases for the Federally Qualified Health Centers (FQHCs)

The Department is still awaiting CMS approval on the provider rate increases for the FQHCs. Once approved, the Department will retroactively adjust all claims with DOS on or after July 1, 2013 to reflect the new rates. Adjustments will be noted on future Provider Claim Reports (PCRs).

Please contact Greg Linster at Greg.Linster@state.co.us or 303-866-4370 with questions regarding FQHC rates.

Hospice Providers

Hospice Legislative Rate Increases Effective October 1, 2013

The Department has received approval for retroactive rate increases for hospice services. The Hospice rate increase of 8.26% has been applied to the following revenue codes:

| Revenue Code | Service Description |
|--------------|------------------------|
| 651 | Routine Home Care |
| 652 | Continuous Home Care |
| 655 | Inpatient Respite Care |
| 656 | General Inpatient Care |



Rates have been updated in the claims processing system and are effective for DOS on or after October 1, 2013. In order to receive the rate increase, providers need to adjust all hospice claims with a DOS on or after October 1, 2013. To adjust a claim through the [Web Portal](#), refer to the instructions on [How to Adjust a Claim through the Web Portal](#). The updated Hospice rate schedule is available on the [Billing Manuals](#) web page. The Department will provide additional instructions to hospice providers explaining the necessary steps for adjusting claims in the coming weeks.

Please contact Randie Wilson at Randie.Wilson@state.co.us with questions regarding Hospice rate increases,

Residential Child Care Facilities (RCCF)

National Correct Coding Initiative (NCCI) changes for RCCFs

Effective June 1, 2014, National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) editing will impact the following code pairings for RCCFs:

| | |
|---------------|---------------|
| 90791 / 90846 | 90791 / 90853 |
| 90791 / 90847 | 90853 / 90857 |

It is clinically appropriate to bill these code pairings together if distinct procedural services are delivered by the same provider on the same date of service. In addition, the appropriate PTP-associated modifier, 59, will bypass the edit. For specific guidance on the proper use of modifier 59, refer to the [CMS Modifier 59 Article](#).

Billing for Psychotherapy for Crisis

The Department has received approval from CMS allowing RCCFs to bill for psychotherapy for crisis effective June 1, 2014. Psychotherapy for crisis is an urgent assessment and history of a crisis state, mental status exam, and disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize trauma. The presenting problem is typically complex and/or life threatening and requires immediate attention to a patient in high distress.



In order to bill psychotherapy for crisis, procedure codes 90839 & 90840 are used to report the total duration of time face-to-face with patient and/or family.

- Procedure code 90839 should be used for the first 30-74 minutes of psychotherapy for crisis and can be billed one (1) unit per day.
- Procedure code 90840 should be used for additional blocks of time, up to 30 minutes beyond the first 74 minutes. 90840 can be billed at up to 2 units per day.

Note: When billing for psychotherapy for crisis, an RCCF can only bill Medicaid for psychotherapy for crisis, no other psychiatric codes should be billed on that date of service.

The [RCCF Billing Manual](#) will be updated to include the psychotherapy for crisis codes.

Please contact Meredith Henry at Meredith.Henry@state.co.us or 303-866-4538 with questions.

Pharmacy Providers

Drug Utilization Review Board (DUR) Meeting

Tuesday, May 20, 2014

6:00 p.m. - 7:00 p.m. Closed Session

7:00 p.m. - 9:00 p.m. Open Session

Skaggs School of Pharmacy

Anschutz Medical Campus

Seminar Room 1000, 1st Floor, Southeast Corner

12850 E. Montview Boulevard

Aurora, CO, 80045



Note: Attendees should park in the [Henderson Parking Garage](#).

Preferred Drug List (PDL) Update

Effective April 1, 2014, the following preferred products went into effect:

Insulins:



- Rapid acting duration: Humalog and Novolog pens and vials
- Short acting duration: Humulin R vial
- Intermediate acting duration: Humulin N pen and vial
- Long acting duration: Levemir pen and vial
 - Lantus is not preferred by the Colorado Medical Assistance Program. Clients will only be allowed to receive Lantus if they have tried and failed with Levemir.
- Insulin mixtures: All mixtures will be preferred including pens and vials

MS Agents:

- Copaxone 20mg injections are preferred
- Copaxone 40mg injections are not preferred
 - Copaxone 40mg will only be approved if the client has failed treatment with the 20mg formulation. Failure is defined as: lack of efficacy, allergy, or intolerable side effects

The complete PDL and criteria for non-preferred medications are available on the [PDL](#) web page.

May and June 2014 Provider Workshops

Provider Billing Workshop Sessions and Descriptions

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

The current and following month's workshop calendars are included in this bulletin.

Class descriptions and workshop calendars are also posted in the Provider Services [Training & Workshops](#) section of the Department's website.



Who Should Attend?

Staff who submit claims, are new to billing Colorado Medicaid services, need a billing refresher course, or administer accounts should consider attending one or more of the following Provider Billing Workshops. Courses are intended to teach, improve, and enhance knowledge of Colorado Medical Assistance Program claim submission.

May 2014

| Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
|--------|--------|--|---|--|---|----------|
| 4 | 5 | 6 Beginning Billing – CO -1500 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM *WebEx – Vision 1:00 PM-3:00 PM | 7 Beginning Billing – UB-04 9:00 AM-11:30 AM Web Portal 837I 11:45 AM-12:30 PM *WebEx – Nursing Facility 1:00 PM-3:00 PM | 8 DME/Supply 9:00 AM-11:30 AM FQHC/RHC 1:00 PM-3:00 PM | 9 *All WebEx: Beginning Billing – CO -1500 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM Provider Enrollment 1:00 PM-3:00 PM | 10 |
| 11 | 12 | 13 | 14 *WebEx – Dental 9:00 AM-11:00 AM | 15 | 16 | 17 |

June 2014

| Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
|--------|--------|--|--|--|--|----------|
| 8 | 9 | 10 Beginning Billing – CO -1500 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM *WebEx – Audiology 1:00 PM-3:00 PM | 11 Beginning Billing – UB-04 9:00 AM-11:30 AM Web Portal 837I 11:45 AM-12:30 PM *WebEx – Dialysis 1:00 PM-3:00 PM | 12 Provider Enrollment 9:00 AM-11:00 AM *WebEx – IP/OP Hospital 1:00 PM-3:00 PM | 13 Basic Billing Waiver 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM | 14 |

Reservations are required for all workshops

Email reservations to:

workshop.reservations@xerox.com

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

Or Call the Reservation hotline to make reservations:
1-800-237-0757, extension 5.

All the information noted above is necessary to process reservations successfully. Look for a confirmation e-mail within one week of making a reservation.

Reservations will only be accepted until 5:00 p.m. the Friday prior to the training workshop to ensure there is adequate space available.

If a confirmation has not been received at least two business days prior to the workshop, please contact the Department's fiscal agent and talk to a Provider Relations Representative.

Workshops presented in Denver are held at:

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

***Please note:** For WebEx training, a meeting notification containing the website, phone number, meeting number and password will be emailed or mailed to those who sign up.

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

Free parking is not provided and is limited in the downtown Denver area. Commercial parking lots are available throughout the downtown area. The daily rates range between \$5 and \$20. Carpooling and arriving early are recommended to secure parking. Whenever possible, public transportation is also recommended.

Some forms of public transportation include the following:

Light Rail – A Light Rail map is available at: http://www.rtd-denver.com/LightRail_Map.shtml.

Free MallRide – The MallRide stops are located on 16th St. at every intersection between the Civic Center Station and Union Station.

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

Xerox State Healthcare Provider Services at 1-800-237-0757.

Please remember to check the [Provider Services](#) section of the Department's website at colorado.gov/hcpf for the most recent information.

