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Did you know...?

For claims with dates of service on or after January 1, 2016, outpatient hospital providers submitting on a CMS 1500 claim form may begin utilizing place of service code 19 for Outpatient Hospital Off-Campus claims processing. Note: Place of service code 22 should be utilized for Outpatient Hospital On-Campus claims.

All Providers

Attention Colorado Medicaid and CHP+ Providers – Coming Soon! Big Changes to the Provider Portal, Medicaid Management Information System (MMIS), and Pharmacy Benefits Management System (PBMS)

As part of the Colorado Medicaid Management Innovation and Transformation (COMMIT) project, the Department will be launching several new provider-facing systems on October 31, 2016. Two of these new systems will affect the way providers submit claims and receive payment. These are:

1. The Colorado interChange - a new claims processing and eligibility verification system
2. The PBMS - a new pharmacy point of sale system



Over the next several months, we will be working to inform and prepare our provider network for these changes.

What's changing?

The Department procured two completely new systems for processing claims, prescriptions, and verifying member eligibility. Both systems are powered by leading technologies that promise to increase access to information and improve provider satisfaction.

Who's changing?

The Department has teamed up with industry leading companies to assist in the design, build, implementation, and operation of these new Health Care Enterprise systems. Hewlett Packard Enterprise (HPE) will replace Xerox State Healthcare as the Department's fiscal agent. The new PBMS and contract will be taken over by Magellan Healthcare.

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

Contacts

Billing and Bulletin Questions
800-237-0757

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

**Correspondence, Inquiries, and
Adjustments**
P.O. Box 30
Denver, CO 80201

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

ColoradoPAR Program PARs
www.coloradopar.com

How will you stay informed?

The Department will continue to keep providers informed and help prepare you for these coming changes. Look for future updates posted in the Provider Bulletins, At a Glance, Provider Claim Reports, and on the Department's website.

Get updates that matter to you! [Sign-up](#) for our email distribution list today and you will receive information **specific to your provider type or business**, straight to your email inbox.

Long Bill Has Been Signed: Outlines Funding for Fiscal Year 2017

The "Long Bill," or the legislation that authorizes funding for the next fiscal year, has been signed into law. Several other bills were signed as part of the Long Bill package. [HB16-1408](#), Cash Fund Allocations For Health-related Programs, was signed into law on May 4, 2016. The bill includes *temporary* funding for rate enhancements for codes related to primary office visits, preventative medicine visits, counseling and health risk assessments, immunization administration, health screening services, and newborn care.

Pending federal approval, these *temporary* rate enhancements will be in effect from July 1, 2016 through June 30, 2017. More information to come in the July 2016 provider bulletin.

Medicaid Provider Revalidation Update

Many Colorado Medicaid providers **have not yet begun** the Provider Revalidation process. Although the Centers for Medicare & Medicaid Services (CMS) extended the deadline for states to complete provider revalidation, **it is important that providers complete enrollment and/or revalidation as soon as possible.** By completing the enrollment/revalidation process now through the [Online Provider Enrollment \(OPE\) tool](#), providers will not experience delays in payment when the new enrollment and claims management system, Colorado interChange, launches on October 31, 2016. **Starting on October 31, 2016, claims and encounters submitted by providers who have not enrolled and/or revalidated will be denied.**



Please **do not** begin the application before reviewing all of the training resources available online. An incorrect or incomplete application requires additional review, which may add weeks to your application's processing time. [Enrollment and Revalidation Instructions](#) are available online. Be sure to review the [Information by Provider Type](#) before you begin the online training, as it will help you select the correct training. The [Provider Enrollment Manual](#) also includes valuable information to help providers complete applications correctly.

Got Enrollment or Revalidation Questions? We've Got Answers

To aid providers with enrollment and revalidation questions, the Department has partnered with Xerox State Healthcare (Xerox), the current Fiscal Agent, to open the **Colorado Medicaid Enrollment and Revalidation Information Center!** Whether you have general enrollment questions, questions about the status of your application, or simply want help getting started, provider enrollment specialists are here to help. Effective May 1, 2016, providers may call:

Colorado Medicaid Enrollment and Revalidation Information Center

800-237-0757, option 5

Available Monday through Friday from 8:00 a.m. - 5:00 p.m.

Closed between 12:00 p.m. - 1:00 p.m.

The Center gives providers the added ability to speak with a live provider enrollment specialist. If a specialist is unavailable, providers may leave a voicemail with their name, a brief message, application tracking number, and a phone number so that a specialist may promptly call back to address questions. Questions may still be submitted to the Provider.Questions@state.co.us email. Email response times are between two to three business days.

Electronic Funds Transfer (EFT) Setup for New Provider Enrollments

New providers who enroll through the Online Provider Enrollment tool before October 31, 2016 must take an additional step to set up EFT payments. In order to set up EFT, a provider must **mail** the following documents directly to Xerox:

1. A copy of their W-9
2. The [Electronic Funds Transfer](#) form
3. A Voided Check or Bank Letter

These documents may be mailed to Provider Enrollment at:

Xerox Provider Enrollment
PO Box 1100
Denver, CO 80201

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

ACC: Access KP Payment Reform Initiative



ACC: Access KP is a new payment reform initiative within Colorado's Accountable Care Collaborative (ACC). ACC: Access KP is a partnership between the Department, Colorado Access, and Kaiser Permanente (KP). The initiative provides a limited benefit, capitated primary care model designed to pilot an alternative to the current fee-for-service payment mechanism.

Who will be enrolled in the initiative?

All ACC Region 3 (Adams, Arapahoe, and Douglas Counties) Medicaid members who are currently attributed to KP as their Primary Care Medical Provider (PCMP) as of May 1, 2016 will be passively enrolled into the new ACC: Access KP initiative. The initial enrollment is estimated to include about 26,000 Medicaid members.

Members outside ACC Region 3 will not be eligible for ACC: Access KP.

ACC: Medicare Medicaid Program (ACC: MMP) members will not be enrolled in ACC: Access KP, but will be able to keep KP as their PCMP.

Members who have health coverage in addition to Medicaid (e.g. Medicare, commercial insurance) will not be enrolled in the program.

When will the initiative begin?

ACC: Access KP will begin July 1, 2016.

Will this have an impact on provider billing?

Yes. Depending on the services being provided to the member, providers outside of the KP network will have to bill either the Department or KP. The Department will publish additional guidance on billing as soon as possible.

How will providers identify members enrolled in ACC: Access KP?

Members enrolled in ACC: Access KP will have a KP member ID card and a unique identification within the Department’s provider portal.



How can I learn more about ACC: Access KP?

Join us for one of six webinar opportunities to learn more about The ACC: Access KP program.

This webinar will:

- Provide an overview of the ACC: Access KP program
- Identify who will be enrolled in the ACC: Access KP program
- Review the Medicaid benefits that are covered in the ACC: Access KP program, and the benefits that are considered wrap around benefits
- Review how to bill for patients enrolled in the ACC: Access KP program
- Provide you with ACC: Access KP resources that will support your staff and patients

Dates and registration information are below. We hope you join us!

DATE AND TIME	WEBINAR AUDIENCE	REGISTRATION LINK
June 16 12 p.m. – 1 p.m.	Community & Advocacy Partners	June 16 Webinar Registration
June 21 12 p.m. – 1 p.m.	Medicaid Providers and Office Staff	June 21 Webinar Registration
June 23 12 p.m. – 1 p.m.	Medicaid Providers and Office Staff	June 23 Webinar Registration
June 28 12 p.m. – 1 p.m.	Medicaid Providers and Office Staff	June 28 Webinar Registration
July 19 12 p.m. – 1 p.m.	Medicaid providers: FQHCS & SBHCs	July 19 Webinar Registration

Additional information for non-KP Providers can be found on the [non-KP Providers](#) website.

Please contact Matthew.Lanphier@state.co.us with questions.

2016 Payment Error Rate Measurement (PERM) Audit

Starting this summer, CMS will begin its 2016 PERM audit on the Medicaid and Child Health Plan Plus (CHP+) programs. CMS will randomly select a set number of paid and denied claims from October 1, 2015 to September 30, 2016 for review.

CMS has contracted with Chickasaw Nation Industries (CNI) Advantage who will contact providers by phone and letter to request medical records that support the claims providers submitted for payment. CNI Advantage will review the medical records to determine if the payment for the corresponding claim was justified. Providers will have 75 calendar days to provide medical record documentation to CNI Advantage.



If the initially submitted medical record documentation is not sufficient, CNI Advantage will contact the provider to request additional documentation. Providers then have 15 calendar days

to provide additional documentation. If documentation is not provided or is insufficient, the provider's claim(s) will be considered in error, and the Department will initiate recovery for the monies associated with the claim from the provider. The Department will also investigate the reasons why the provider did not submit proper documentation.

Provider Education Calls

CMS will host Provider Education Sessions on June 21, June 29, July 19, and July 27 to give providers an opportunity to learn more about PERM, provider responsibilities, and best practices. Please review the [CMS flyer](#) for more information on the Provider Education Sessions. Providers may also visit the [CMS PERM](#) website and the [Department PERM](#) website for more information.

What is Payment Error Rate Measurement (PERM)?

The PERM is a federally mandated audit that occurs once every three years. This is a review of claim payments and eligibility determination decisions made for the Medicaid and CHP+ programs for accuracy and to ensure that states only pay for appropriate claims. The collection and review of protected health information contained in medical records for payment review purposes is authorized by U.S. Department of Health and Human Services regulations at [45 C.F.R. 164.512\(d\)](#), as a disclosure authorized to carry out health oversight activities, pursuant to the [Health Insurance Portability and Accountability Act of 1996 \(HIPAA\)](#); CMS PERM Review Contractor activities are performed under this regulation.

Please contact CMS at PERMProviders@cms.hhs.gov or Matt.Ivy@state.co.us or 303-866-2706 with questions.

ColoradoPAR Program Updates

eQSuite® Training Opportunities

June 2016 ColoradoPAR Training Webinars include:

- Habilitative Speech Therapy Overview
- Prior Authorization Request (PAR) Revisions Training
- eQSuite® New User Training



Find more information and complete [training registration](#) by clicking the Provider Education/Training tab on www.ColoradoPAR.com.

Ordering Physician Reminder

- When submitting a PAR, the requestor must use an ordering provider ID that is currently active in the Medicaid Management Information System (MMIS).
- In order to obtain a prior authorization, the requesting, ordering, referring, or prescribing provider must be enrolled with an active 8-digit Colorado Medicaid provider identification number.
- The provider must have an active status code and be approved as one of the following provider types with the Department:
 - Dentist, MD, DO, Physician Assistant, Nurse Practitioner, CRNA, Nurse Midwife, Podiatrist, Optometrist, Audiologist, Speech Therapist, Occupational Therapist, Physical Therapist, Psychologist, MA Psychologist, Non-physician practitioner, or Rehabilitation Agency.

- If the ordering provider ID is invalid, an eQSuite® “**Error 12013**” message will be generated.
- eQHealth Solutions cannot make system changes to allow PAR submission if the provider does not meet these requirements.
- Check with your billing department to request an active ordering provider ID if needed.

PAR Turnaround Time

The four business day turnaround time for PAR determinations continues to be met or exceeded. As a reminder:

- The PAR determination process begins when eQHealth Solutions receives **all** required information and documentation.
- Please do not start PARs in eQSuite if all required information is not ready to be entered. These PARs will be denied for lack of information after three days with no response from the user.

Customer Satisfaction Survey

eQHealth Solutions is committed to providing excellent customer service to Colorado providers. Each month, a subgroup of providers will receive an email from eQHealth Solutions to complete a short Customer Satisfaction Survey. Provider feedback will offer valuable insight into areas of strength and opportunities for improvement. Your time and feedback is appreciated.



eQHealth Solutions Provider Relations Resources

eQHealth Solutions has dedicated provider relations and outreach staff to address provider questions and provide assistance. They are available to assist providers one-on-one or provide webinars and in-person trainings. The locally based team is committed to developing and strengthening relationships with all Colorado Medicaid providers through quality interactions and educational opportunities.

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

National Correct Coding Initiative (NCCI) Notification of Quarterly Updates

Providers are encouraged to monitor CMS for updates to NCCI rules and guidelines. Updates to the procedure-to-procedure (PTP) and medically unlikely edit (MUE) files are completed quarterly, with the next file update available July 2016. Please find more information on the [CMS NCCI](#) website.

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



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

Upcoming [training sessions](#) are conducted at the PAS Training Center.

Peer Assistance Services

2170 South Parker Road
Suite 229
Denver, Colorado 80231

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

Accredited Diabetes Self-Management Education (DSME) Providers and Program Staff: We Want to Hear from You!

The Colorado Department of Health Care Policy and Financing, the Department of Public Health and Environment (CDPHE), and Telligen are hosting a **series of three calls** to elicit feedback about the newly opened DSME codes that are now reimbursable by Colorado Medicaid. We will use your feedback to coordinate and further develop resources you need.

Providers and Program Staff are strongly encouraged to join one of our 30 minute calls to discuss:

- What are your successes and challenges with referrals and enrollment of DSME programs?
- Do you have any feedback for how to make the program and benefit better?
- What is the most impactful benefit of DSME to the member population?
- How can we help?

Join us for a 30 minute call on Thursday, June 23, 2016 at either:

8:30 a.m.
12:00 p.m.
4:30 p.m.

Please [register to attend](#) one of the feedback sessions mentioned above.

July 2016 Holiday

Independence Day Holiday

Due to the Independence Day holiday on **Monday, July 4, 2016**, State offices, Xerox State Healthcare, DentaQuest, and the ColoradoPAR Program will be closed. The receipt of warrants and Electronic Funds Transfers (EFTs) may be delayed due to the processing at the United States Postal Service or providers' individual banks.



Dental Providers

Billing and Program Updates from DentaQuest

The latest DentaQuest quarterly e-newsletter (the Colorado Summit), [Vol. 8 - March 2016](#), is available on the [DentaQuest Colorado Providers](#) website.

"Take 5" Pay for Performance Program Update



DentaQuest will continue to process provider payments for the "Take 5" Pay for Performance Program through June 2016, when the program sunsets. As a reminder, the approved qualifying time frame for providers to have seen new members twice was from October 1, 2014 to December 31, 2015. Payments will be made by DentaQuest via paper checks and will be mailed to the billing entities on behalf of the rendering providers. Please contact your DentaQuest provider relations representative or DentaQuest Provider Services at 855-225-1731 with questions.

Hospital Providers

All Patient Refined Diagnosis Related Group (APR-DRG) Version Update

All Patient Refined Diagnosis Related Group (APR-DRG) version 32 has been in effect since June 1, 2015 and has been the reimbursement methodology for all inpatient hospital claims with dates of discharge on or after January 1, 2014. The Department is planning to update the payment methodology to APR-DRG version 33. The update should be completed by July 1, 2016. At that time, all claims with dates of discharge on or after October 1, 2015 will process payment through version 33. The Department will reprocess claims that have already been submitted with discharge dates on or after October 1, 2015 to utilize APR-DRG version 33.

The differences between APR-DRG Version 32 and 33 are minimal and unlikely to impact many claims. After version 33 is implemented, inpatient hospital claims will be processed using the following grouper versions:

Discharge Date	Grouper
October 1, 2015 – current	APR-DRG Version 33
January 1, 2014 – September 30, 2015	APR-DRG Version 32
October 1, 2006 – December 31, 2013	CMS-DRG Version 24.0 + Annual Crosswalks
October 1, 2005 – September 30, 2006	CMS-DRG Version 23.0
October 1, 2004 – September 30, 2005	CMS-DRG Version 22.0
October 1, 2003 – September 30, 2004	CMS-DRG Version 21.0
October 1, 2002 – September 30, 2003	CMS-DRG Version 20.0

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

Outpatient Physical and Occupational Therapy Providers

Attention Outpatient Physical and Occupational Therapists

Effective July 1, 2016, the Department will be changing the claim payment system to align with the policies outlined in the Medicaid State Plan, which affects the following benefit limitations:

	Children (ages 0 – 20)	Adults (ages 21+)
Rehabilitative Benefit Limit	No limit	48 units per 12-month period
Habilitative Benefit Limit	Covered for all children. See billing manual for details.	48 units per 12-month period covered for certain adult members only. See billing manual for details.
Prior Authorization Required	Yes, for units exceeding the initial 48 units per 12-month period. Habilitative services always require a prior authorization request.	Not required for Rehabilitative benefits. Always required for Habilitative benefits.
Billing Cycle	Claims for services beyond 48 units per 12-months that do not have prior authorization will be denied.	Claims for rehabilitative services beyond 48 units per 12-month period will be automatically denied. Claims for Habilitative services that do not have prior authorization will be denied.

Further Policy Guidance

- Existing approved prior authorizations that span or exceed a member's 21st birthday will be not be affected. Providers may still bill for services for which prior authorization has already been obtained regardless of the member's age.
- Future prior authorization requests submitted on or after July 1, 2016 for children nearing their 21st birthday will be automatically end-dated to the last day of their 20th year of age.
- At this time, the Department does not have the technological capability to display, for providers or members, the remaining benefit unit-amount a member has for physical and/or occupational therapy. The Department is working to program this capability for 2017. It is therefore recommended (but not required) that providers always seek prior authorization for children to avoid rendering services that cannot be paid because a prior authorization is not on file. Providers of adult services are advised to closely monitor the number of units they have billed and to inform the client when their benefit is nearing exhaustion.
- The Department posted the adult benefit limitation on the [Member Benefits and Services Overview](#) page; however, providers are encouraged to remind the adult member of this limitation at the onset of services.



Benefit coverage information detailing this policy can be found in the [Physical and Occupational Therapy Benefit Coverage Standard](#).

Further billing information is located in the [Outpatient Physical and Occupational Therapy Billing Manual](#).

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

Pharmacy Providers

Preferred Drug List (PDL) Update

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

Newer generation antihistamines and combinations: Preferred products will be cetirizine (generic OTC Zyrtec) (tab, chew tab, syrup), loratadine (generic OTC Claritin) (tab, syrup)

Angiotensin Receptor Blockers and combinations: Preferred products will be Benicar, irbesartan, losartan, valsartan, Benicar-HCT, Diovan-HCT, losartan/HCTZ

Renin Inhibitors and Combinations: No preferred products

Fibromyalgia agents: Lyrica, duloxetine

Inhaled Anticholinergics and Combinations: Albuterol/ipratropium, ipratropium, Atrovent HFA, Combivent Respimat, Spiriva Handihaler

Short-acting Inhaled Beta 2 agonists: Albuterol solution, Proair HFA inhaler

Long-acting Inhaled Beta 2 agonists: Serevent but will still require a PA

Inhaled Corticosteroids and Combinations: Budesonide nebulas (0.25mg and 0.5mg), Pulmicort nebulas (1mg) Asmanex Twisthaler, Flovent HFA and Diskus, QVAR, Advair Diskus, Dulera

Long Acting Oral Opioids: Methadone, fentanyl patches, morphine sulfate ER, tramadol ER

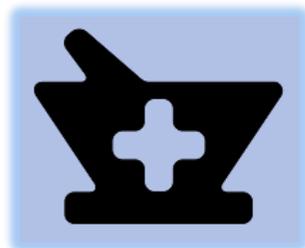
- Butrans patch with single step edit

Skeletal muscle relaxants: Baclofen, cyclobenzaprine, tizanidine

Testosterone: Androgel 1.62%, Androderm, Depo-Testosterone (brand and generic)

Topical Immunomodulators: Elidel

The July 1, 2016 PDL is posted on the Department's website. This can be found on the [Provider Forms](#) web page in the Pharmacy Section. Please refer to the latest PDL for detailed prior authorization criteria.



Pharmacy and Therapeutics Committee Meeting

Tuesday, July 5, 2016

1:00 p.m. – 5:00 p.m.

303 E 17th Avenue

11th floor Conference Rooms

Drug Utilization Review (DUR) Board Update

The DUR board has openings for a physician and an industry representative. The physician board member shall serve a two-year term. The industry position is a one-year term, non-voting position.

If you are interested in serving, please submit curriculum vitae (CV) or resume by emailing:

Robert.Lodge@state.co.us

Or mail to:

Colorado Department of Health Care Policy and Financing



Attn: Robert Lodge
1570 Grant St
Denver, CO 80203

Or fax to:

303-866-3590.

The deadline for this submission is **July 22, 2016**.

Inhaled Corticosteroid Combinations

Effective July 1, 2016, Advair HFA Inhaler will **no longer** be a preferred product. Please prepare Medicaid members to switch to one of the preferred products (Advair Diskus or Dulera).

New Vendor for Setting Average Acquisition Cost (AAC) Rates

Effective July 1, 2016, Myers and Stauffer will take over as the Department's new pharmacy AAC rate-setting vendor. As a result, the contact information for submitting AAC price inquiries and pharmacy acquisition cost data will change.

All AAC price inquiries should be emailed to:

copharmacy@mslc.com or faxed to 317-571-8481

Pharmacy acquisition cost data should be emailed to:

pharmacy@mslc.com

Attn: Colorado Survey

The data may also be mailed to:

Myers and Stauffer
9265 Counselors Row
Suite 100
Indianapolis, IN 46240

Please contact Myers and Stauffer help desk line at 800-591-1183 for questions concerning the AAC price inquiries or the submission of acquisition cost data.

Rx Review Program Upcoming Cycle

The Department would like to thank all the pharmacists who participated in the latest Rx Review Cycle. There was a good mix of returning and new pharmacists who participated, and everyone did a great job. Our members were very appreciative!

The next cycle will begin on July 1, 2016 and run through September 18, 2016. The Department is accepting applications for pharmacists interested in participating in this program.

Current reimbursement rates for Rx Review Consultations are:

\$150 for Face-to-Face consultation.

\$90 for Phone consultation.

The Department prefers that consultations are face-to-face; however, there are circumstances where a face-to-face meeting is not possible.

If you or a pharmacist you know is interested in supporting the Colorado Medicaid community, please contact Sara.Haynes@state.co.us for more information or to apply.

Speech Therapy Providers

Attention Speech-Language Pathology Providers

Habilitative speech therapy is a covered benefit for all children and for adults on the Affordable Care Act (ACA) Medicaid Expansion benefit plan. Prior authorization is not required for children, but it is required for adults. Providers may view a member’s benefit plan by querying their eligibility status through the provider web portal.

	Children ages 20 and under	Adults ages 21+
Habilitative speech therapy covered	Yes	Only adults on the ACA Medicaid Expansion benefit plan
Prior Authorization Required	No	Yes

Prior authorization is attained through the ColoradoPAR program. Please visit the [ColoradoPAR](#) website to begin the PAR process.

Please reference the [Speech Therapy Billing Manual](#) in the CMS1500 section of the Provider Billing Manuals web page for billing and policy details.

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

Waiver Providers

Home and Community Based Services (HCBS) Providers Post-Payment Review Audit Announcement

Purpose: To inform all Provider Agencies and Community Centered Boards (CCBs) that a post-payment waiver claim review, as required by the waiver agreement, is being performed on a sampling of waiver claims for the Home and Community Based Services Elderly, Blind, and Disabled (EBD) Waivers, Home and Community Based Services Brain Injury (BI), Home and Community Based Services Community Mental Health Supports (CMHS), Home and Community Based Services Spinal Cord Injury (SCI), Children’s Home and Community Based Services (CHCBS), Home and Community Based Services Children with Autism (CWA), Home and Community Based Services Children with Life Limiting Illness (CLLI), Home and Community Based Services for Persons with a Developmental Disability (HCBS-DD), Home and Community Based Services Supported Living Services (HCBS-SLS), and the Home and Community Based Services Children’s Extensive Support (HCBS-CES) Waivers.



Background: In order to operate the HCBS waivers for children and adults with intellectual and/or developmental disabilities, and receive federal financial participation for these services, the Department enters into waiver agreements with the federal Centers for Medicare & Medicaid Services (CMS). As a part of these agreements, the Department provides assurances of financial accountability for HCBS services, which may include documentation substantiating claims billed to and paid by the Department’s Medicaid Management Information System (MMIS). The Department is conducting this post-payment review to provide CMS with required assurances regarding financial accountability and programmatic oversight.

Providers agree to the following when signing the Department's Provider Participation Agreement (the Agreement), which is necessary to serve members on HCBS Medicaid waivers:

- Maintain records that fully and accurately disclose the nature and extent of benefits provided to eligible members for a minimum of six years.
- Disclose ownership and provision of access to medical records and billing information to the Department, or its designees.
- Agree that the Department or its designees have the right to audit any claim documentation records, to include original source documentation.

Procedure or Information: The Department is contracting with Myers and Stauffer, LLC (the contractor) to perform a post-payment review of a randomly selected, representative sample of Medicaid Waiver claims for the HCBS waivers serving children and adults. The time period for this review is FY 2014-15.

The contractor will be sending formal requests to Community Centered Boards and Service Agencies for information confirming that the services that were billed were rendered. Required information includes, but may not be limited to:

- Employee timesheets
- Supervisory visit notes
- Invoices for products and services
- Email from members, case managers, or other contacts substantiating service delivery
- Other documents supporting service delivery

The contractor will be contacting agencies in writing to request documentation. The request for information will include all necessary identifying claim information to ensure that agencies can identify and produce the requested information.

The contractor will communicate all timeframes and deadlines for agencies to provide the requested information. Further, the contractor will define how the requested information is to be returned to the contractor.

Please contact the Waiver Administrator, Cassandra.Keller@state.co.us, with questions.

June and July 2016 Provider Workshops

Provider Billing Workshop Sessions and Descriptions

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

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

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



Who Should Attend?

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

June 2016

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
12	13	<p>*WebEx* CMS 1500 9:00 a.m.-11:30 a.m.</p> <p>Web Portal 837P 11:45 a.m.-12:30 p.m.</p> <p>*WebEx* Audiology 1:00 p.m.-3:00 p.m.</p>	<p>*WebEx* UB-04 9:00 a.m.-11:30 a.m.</p> <p>Web Portal 837I 11:45 a.m.-12:30 p.m.</p> <p>*WebEx* IP/OP 1:00 p.m.-3:00 p.m.</p>	<p>*WebEx* Dialysis 9:00 a.m.-11:00 a.m.</p>	<p>Home Health 9:00 a.m.-11:00 a.m.</p> <p>*WebEx* Nursing Facility 1:00 p.m.-3:00 p.m.</p>	18

July 2016

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
10	11	<p>CMS 1500 9:00 a.m.-11:30 a.m.</p> <p>Web Portal 837P 11:45 a.m.-12:30 p.m.</p> <p>PT/OT/ST 1:00 p.m.-3:00 p.m.</p>	<p>UB-04 9:00 a.m.-11:30 a.m.</p> <p>Web Portal 837I 11:45 a.m.-12:30 p.m.</p>	14	<p>*WebEx* CMS 1500 9:00 a.m.-11:30 a.m.</p> <p>Web Portal 837P 11:45 a.m.-12:30 p.m.</p>	16	
17	18	19	20	<p>*All Classes WebEx* Waiver 9:00 a.m.-11:30 a.m.</p> <p>Web Portal 837P 11:45 a.m.-12:30 p.m.</p> <p>Personal Care 1:00 p.m.-3:30 p.m.</p> <p>Web Portal 837I 3:45 p.m.-4:30 p.m.</p>	21	22	23

Reservations are required for all workshops by:

Emailing reservations to: workshop.reservations@xerox.com Or Calling the Reservation hotline to make reservations: 800-237-0757, extension 6, option 4.

Leave the following information:

- Colorado Medical Assistance Program provider billing number
- The date and time of the workshop
- The number of people attending and their names
- Contact name, address and phone number

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

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

If a confirmation has not been received at least two business days prior to the workshop, please contact a Provider Relations Representative at 800-237-0757.

Workshops presented in Denver are held at:

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

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

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

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

Some forms of public transportation include:

[Light Rail](#)

[Free MallRide](#)

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

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

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

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