



colorado.gov/hcpf

Provider Bulletin

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October 2014

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Did you know...?

Mass adjustments made by the Department of Health Care Policy and Financing (the Department) can only be processed correctly if the original submitted charge on a claim is greater than or equal to 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.

All Providers

Centers for Medicare & Medicaid Services 1500 (CMS 1500) Claim Form Transition

Currently, Colorado Medicaid providers submit professional claims electronically or via the Colorado 1500 (CO-1500) paper claim form. Effective December 1, 2014, the CO-1500 paper claim form will be replaced by the current CMS 1500 paper claim form [OMB-0938-1-1197 Form 1500 (rev. 02-12)].

Per federal mandate, the Department is required to institute ICD-10 diagnosis and procedure code sets throughout its systems and business processes for claims with dates of service on or after October 1, 2015. In preparation for this implementation, the Department is transitioning all professional paper claim submission to the CMS 1500 claim form.

As a result of this transition, the Department will also be updating the Adjustment Transmittal Form by removing the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and Professional claim options, as it will no longer be needed when adjusting professional claims. Instead, the CMS 1500 form itself will be used for adjusting already-paid claims.

For further information, refer to the Frequently Asked Questions (FAQ) document that is available on the Provider Implementations web page of the Department's website (colorado.gov/hcpf/provider-implementations).

Financial Reporting System Processing Schedule

Addendum to the January 2014 Provider Bulletin (B1400346)

Due to the upgrade from the state's previous financial reporting system to the current one effective July 1, 2014, the 2014 processing schedule, originally published in the January 2014 Provider Bulletin ([B1400346](http://colorado.gov/hcpf/provider-implementations)), must also be updated. The state's new financial reporting system no longer requires early processing due to state holidays. The receipt of warrants and Electronic Funds Transfers (EFTs), however, may potentially be delayed due to the processing of the United States Postal Service (USPS) or providers' individual banks.

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

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

Additional Payment for Meeting Enhanced Primary Care Medical Providers (PCMP) Standards

Primary Care Medical Providers within the Accountable Care Collaborative (ACC) are now eligible to receive an additional \$0.50 Per Member Per Month (PMPM) payment for providing enhanced primary care services to their ACC members. To be eligible for the additional payment, PCMPs must meet at least five (5) of the nine (9) following Enhanced Primary Care Factors:

1	The PCMP has regularly scheduled appointments (at least one time per month) on a weekend and/or on a weekday outside of typical workday hours.
2	The PCMP provides timely clinical advice by telephone or secure electronic message both during and after office hours. Members and families are clearly informed about these procedures.
3	The PCMP uses available data (e.g., SDAC, clinical information) to identify special patient populations who may require extra services and support for medical and/or social reasons. The Practice has procedures to proactively address the identified health needs.
4	The PCMP provides on-site access to behavioral health care providers.
5	The PCMP collects and regularly updates a behavioral health screening (including substance use) for adults and adolescents and/or developmental screening for children (newborn to five years of age) using a Medicaid-approved tool. In addition, the practice has documented procedures to address positive screens and has established relationships with providers to accept referred patients or utilize the standard referral and release form created by the Behavioral Health Organizations.
6	The PCMP generates lists of members actively receiving care coordination.
7	The PCMP tracks the status of referrals to specialty care providers and provides the clinical reason for the referral along with member clinical information.
8	The PCMP will accept new Medicaid members for the majority of the year.
9	The PCMP and member/family/caregiver collaborate to develop and update an individual care plan.

Each Regional Care Collaborative Organization (RCCO) will be responsible for certifying practices within their region that meet the criteria for receiving the additional payment. The additional payment will be based on the total number of months that are attributed to a member's enrollment in a PCMP for State fiscal year 2014-2015 (July 1, 2014 – June 30, 2015), retroactive to July 1, 2014 or the date that the PCMP first met the minimum number of required factors, whichever comes first. The additional payment will be made as a one-time, lump-sum distribution to each certified practice, on or before August 31, 2015.

A detailed description of the nine (9) Enhanced Primary Care Factors can be found on the Medicaid [Primary Care Providers](#) page of the Department's website.

Please contact the local RCCO or Marty Janssen at Marty.Janssen@state.co.us or 303-866-4095.

October and November Holidays

Columbus Day

Due to the Columbus Day Holiday on Monday, October 13, 2013 State, the ColoradoPAR Program, and DentaQuest offices will be closed. The Department's fiscal agent offices will be open during regular business hours.

Veterans Day

Due to the Veterans Day Holiday on Tuesday, November 11, 2014 State, the ColoradoPAR Program, and DentaQuest offices will be closed. The Department's fiscal agent offices will be open during regular business hours.



Thanksgiving Day

Due to the Thanksgiving Day Holiday on Thursday, November 27, 2014 State, the ColoradoPAR Program, DentaQuest, and the Department's fiscal agent will be closed.

Dental Providers

Colorado Medicaid Adult and Children's Dental Benefit Administration Transition to DentaQuest – Updates Billing and Program Updates from DentaQuest

The most recent version of the [Colorado Summit](#), the DentaQuest e-newsletter for Colorado's Medicaid dental providers, is available on the [DentaQuest Colorado Providers](#) website. The latest publication of the *Colorado Summit* contains updates on receiving payments, understanding DentaQuest's provider portal, claim denials and reprocessing, and ways DentaQuest can help the dental provider community on behalf of the Department. Providers should regularly check this publication for the latest news and updates about the Colorado Medicaid Dental Program from DentaQuest.



Dental providers may contact DentaQuest Provider Services at 1-855-225-1731 with questions.

Non-Citizen Immigrants and Emergency Dental Services

When rendering covered emergency dental services for non-citizen immigrants, the Department would like to remind providers to reference the Non-Citizen Immigrant code table in the Dental Billing Manual (pages 52-55) located on the Department's website (colorado.gov/hcpf/billing-manuals). Providers should continue to submit these claims through the Colorado Medical Assistance Web Portal ([Web Portal](#)) and not through DentaQuest as these members do not qualify for the Medicaid Dental Program. A non-citizen member is eligible for emergency treatment if the member presents with an acute oral cavity condition that requires hospitalization and/or immediate surgical care. Only the most limited service(s) needed to correct the emergency oral cavity condition(s) are allowed.

Member Eligibility in the DentaQuest Web Portal

An accurate Date of Birth (DOB) and a member ID is needed to search for a member in the DentaQuest web portal. Alternatively, a guarantee number generated on the Date of Service (DOS) through an Eligibility Response from the Department's [Web Portal](#) can also be used to confirm eligibility in cases where the DentaQuest web portal cannot find an eligible member.

Dental Benefit – Rules and Regulations

The Children's Dental Rule passed its first reading at the [Medical Services Board](#) (MSB) hearing on August 8, 2014. A large volume of input has been received throughout the process over the past ten (10) months and this has led to many changes made in collaboration with dental providers, community members, and advocates. The Department is scheduled to present the Children's Dental Rule for its second reading and permanent adoption at the next MSB meeting, which will be held on Friday, October 10, 2014. The earliest possible effective date for this rule will be November 30, 2014.

Also on October 10, 2014, The Department will present an emergency rule change to how oral surgeons can bill for medical and dental services they render to Medicaid members. The Department will share a draft copy of the proposed changes to this rule language with stakeholders via email in the near future and would welcome feedback from any interested parties.



Dialysis Providers Dialysis Treatment Centers

The Department has received approval from CMS to update the rate methodology for Dialysis treatment in Dialysis Treatment Centers. Rates will be made effective retroactively to July 1, 2014. The updated methodology utilizes current pricing information and relies on the CMS index for county wage adjustments. For the majority of providers, this will result in an overall rate increase above the 2% increase previously approved.

Providers were sent notification of this change in August 2014, and will be sent an additional, individual letter explaining the changes in detail in the coming weeks. Note: For providers who billed usual and customary charges higher than the new rates, no action is required to receive the rate increase. However, providers who billed charges less than the new rate will need to adjust the claims with dates of service on or after July 1, 2014 to receive the new rate. Detailed instructions will be sent with the individual letter to facilitate any needed adjustments to claims. Instructions for making adjustments via the Web Portal can also be found on the Department's website (colorado.gov/hcpf/web-portal).



For the Dialysis Clinic rates by County Fee Schedule, providers may visit the Department's website (colorado.gov/hcpf/provider-rates-fee-schedule).

If a provider has not received previous notification, or does not receive an individual rate letter from the Department by October 17, 2014, please contact Randie Wilson at Randie.Wilson@state.co.us. For policy questions, please contact Ana Lucaci at Ana.Lucaci@state.co.us.

Durable Medical Equipment (DME) Providers

Complex Rehabilitation Technology (CRT) Supplier Enrollment

Effective January 1, 2015, House Bill 14-1211 will require the Department to recognize CRT as a unique category of service under Medicaid. Complex Rehabilitation Technology includes individually configured manual and power wheelchair systems, adaptive seating systems, alternative positioning systems, standing frames, gait trainers, and specially-designated options and accessories that qualify as DME.

To comply with this bill, the Department is adopting CRT supplier standards and will be restricting the reimbursement of CRT only to suppliers meeting these standards. Starting January 1, 2015, to qualify as a CRT supplier, a provider must meet the following requirements:

1. Be accredited by a recognized accrediting organization as a supplier of CRT;
2. Meet the supplier and quality standards established for DME suppliers under Medicare or the Medical Assistance Program;
3. Employ at least one CRT Professional (i.e., an assistive technology professional) at each physical location;
4. Maintain a reasonable supply of parts, adequate physical facilities, and qualified and adequate service or repair technicians to provide members with prompt service and repair of all CRT it sells or supplies; and
5. Provide members with written information at the time of sale on how to access service and repair.

More information on how to enroll as a CRT supplier will be provided in future Provider Bulletins.

Please contact Eskedar Makonnen at Eskedar.Makonnen@state.co.us or 303-866-4079 with questions.

Billing Reminder for LT and RT Modifiers

Providers are reminded that, when submitting claims, modifiers LT and RT should **not** be used on the same line together as this can cause claims to be suspended or denied. Providers must bill the Healthcare Common Procedure Coding System (HCPCS) procedure codes on two separate claim lines; using modifier RT with the appropriate units on one claim line, and modifier LT with the appropriate units on a separate claim line.



Home and Community Based Services (HCBS) Providers

Division of Intellectual and Developmental Disabilities (DIDD) Providers Targeted Case Management (TCM)

Division of Intellectual and Developmental Disabilities providers offering TCM services were incorrectly paid at the previous year's rate for claims submitted with July 2014 dates of service. The Department has since corrected the issue and will mass adjust all claims for TCM services provided during July 2014. Note: For providers who bill usual and customary charges higher than the current rates, no action is

required to receive the adjustment. However, providers who billed charges less than the current rate will need to adjust the claims with dates of service on or after July 1, 2014 to receive the adjustment. Instructions for making adjustments via the Web Portal can be found on the Department's website (colorado.gov/hcpf/web-portal).

Please contact Nancy Fritchell at Nancy.Fritchell@state.co.us with questions.

Homemaker Services

Division of Intellectual and Developmental Disabilities providers offering Homemaker services (procedure code S5130) were paid at the incorrect rate for July, August, and September 2014 dates of service. The Department has since corrected the issue and will be mass adjusting all claims for Homemaker services rendered during July, August, and September 2014. However, providers who continued billing the incorrect Medicaid rate of \$6.02 must adjust their claims to receive the correct rate. For providers who bill usual and customary charges higher than the current rate, no action is required to receive the correct rate. The Department apologizes for any inconvenience these issues may have caused.

Please contact Nancy Fritchell at Nancy.Fritchell@state.co.us with questions.

Statewide Change in the Options Counseling Process

The Department is contracting with Aging and Disability Resources for Colorado (ADRC) sites to provide counseling to people residing in nursing facilities who are interested in learning about their options for living and receiving long-term services and supports within the community. The anticipated start date of the ADRC Options Counseling contract will be forthcoming. These sites will then become the local agencies across the State to provide options counseling services to nursing facility residents.

Referrals for options counseling may come from many different sources, including, but not limited to, nursing facility residents, nursing facility staff, family members, ombudsmen, and others. Options counseling referrals will also result from the Minimum Data Set (MDS) assessment. The MDS is an assessment provided to all residents in a Medicare and/or Medicaid-certified long-term care facility and is used to help determine functional capabilities and identify health problems among residents. In 2010, Section Q was added to the MDS that asks residents if they would like to speak with someone about their options for returning to the community. If a resident answers "yes" to the Section Q question, the nursing facility will contact the ADRC in their region to make a referral for options counseling.



To learn more about ADRC Options Counseling or to find the ADRC locations throughout the State, refer to the ADRC training section of the [Provider Training](#) web page of the Department's website. Additional details will be forthcoming via various communications from the Department. Supplemental information about the MDS can also be found on the [MDS](#) web page on the CMS website.

Nursing Facility Providers

Skilled Nursing Facility Provider Contact Information

The Department is working to implement a Fair Rental Value (FRV) improvement process. This process will involve the scheduling of appraisal appointments by National Valuation Consultants (NVC) to ensure all necessary Nursing Facility staff are on hand and providers have adequate time to prepare documentation. National Valuation Consultants will also provide an appraisal preparation communication alerting providers to the required documentation and which staff are necessary for the audit.



In addition, this process will allow providers a 30-day period to comment on completion of the initial appraisal. Following the 30-day comment period, NVC may adjust the appraisal components related to the comments received from the provider. Once the final appraisal is sent to providers, they will have an additional opportunity to address the outcome, if the appraisal still causes concern. Providers may file for Informal Dispute Resolution (IDR)

following the 30-day comment period and final appraisal. All informal reconsideration and appeal processes will be maintained.

In order to ensure all necessary tasks can take place, the Department is requesting that all providers send the following contact information:

1	Facility Name and Provider Number
2	Mailing Address (for where the appraisal is to be sent)
3	Email Address
4	Fax Number
5	Indicate preference for receiving appraisal (Mail, Email, Fax)
6	Provide three (3) contacts and contact information that will receive all appraisal information
7	Identify one (1) primary contact and contact information, who will be responsible for all necessary actions regarding the appraisal
8	Identify one (1) backup contact as the primary contact
9	Any additional information the Department may need to ensure the FRV process is smooth and efficient

Please send all information to hcpf.snffrv@state.co.us no later than October 15, 2014.

Physical, Occupational, & Speech Therapy (PT/OT/ST) Providers **Assistive Technology Assessments**

Current Procedural Terminology (CPT) Procedure Code 97755

Effective October 1, 2014, the following billing policy changes were made to CPT procedure code 97755 to accommodate House Bill 14-1211. The bill requires that all Medicaid members seeking complex rehabilitation technology have an initial Assistive Technology Assessment (complex rehabilitative technology evaluation/assessment) prior to receiving complex rehabilitation technology and any follow-up assessments as needed. Only qualified health care professionals, including but not limited to licensed PT/OT/ST providers may provide these types of specialty evaluations.

All providers billing procedure code 97755 must follow these guidelines. The Department recognizes that only a portion of Assistive Technology Assessments will be used for complex rehabilitation technology evaluation/assessment.

Policy Change	Notes
Complex rehabilitation technology evaluations / assessments are billed using only procedure code 97755.	Combinations of procedure codes, including procedure code 97542, for the purposes of complex rehabilitation technology evaluation / assessment are not allowed.
Procedure code 97755 always requires a Prior Authorization Request (PAR).	Prior Authorization Requests must be submitted electronically using ColoradoPAR via CareWebQI (CWQI). Details are found on the ColoradoPAR Program's website.
Member daily limit for procedure code 97755 is 20 units.	Up to five (5) hours of assessment is allowed per date of service.
Member yearly limit for procedure code 97755 is 60 units.	Members may have up to 60 units of procedure code 97755 per State Fiscal Year (SFY) July 1 – June 30. This limit will reset with the start of each new SFY.

Prior Authorization Requests for procedure code 97755 must comply with the following policies:

- Current prescription/referral for an Assistive Technology Assessment from the member's primary care physician is required.
- May indicate up to a one (1) year duration.
- May indicate initial/new assessments or follow-up assessment visits.
- Only one active PAR for procedure code 97755 is allowed per member, per span of time. Overlapping PARs will be denied.
- Initial PT/OT evaluation services, such as procedure code 97001, are not required prior to requesting a PAR for procedure code 97755.
- Procedure code 97755 is separate from PT/OT PARs and is not part of a member's PT/OT benefit limitation.
- PARs for procedure code 97755 should be submitted independently from other services. The Medical PAR type should be selected for procedure code 97755 in [CWQI](#).



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

Substance Use Disorder (SUD) Providers **Enrollment with Behavioral Health Organizations (BHO's)**

Effective January 1, 2014, SUD (formerly known as "Substance Abuse") providers must enroll with a BHO in order to provide outpatient SUD services to Medicaid members. This policy applies to both existing **and** new SUD Medicaid providers. Please refer to the Community Behavioral Health Services program located on the Department's website (colorado.gov/hcpf/behavioral-health-organizations), which contains BHO contact information and program details.

Substance Use Disorder treatment services are considered to be any claim with the following criteria:

1. Contains any procedure code found under the "Covered Procedure Codes" section of Appendix T; and
2. Contains any diagnosis of a substance use disorder found under the "Covered SUD Diagnosis Codes (ICD-9)" section of Appendix T located in the billing manuals section of the Department's website (colorado.gov/hcpf/billing-manuals).

Substance Use Disorder providers must send their claims to the BHO for reimbursement per the billing guidelines found in Appendix T. Substance Use Disorder providers are prohibited from submitting Fee-For-Service (FFS) claims through the Web Portal unless either:

1. The Medicaid member they are treating is not enrolled in the Community Behavioral Health Services program, and the BHO has first denied their claim **solely** on this basis, or
2. The SUD provider has received documented authorization from the Department's Rehabilitation Benefits Policy Specialist allowing them to send SUD claims as FFS for a limited, specified period of time.

Behavioral Health Organizations may have prior-authorization policies that require provider compliance. Failing to obtain a prior-authorization for SUD services does not permit a provider to bill FFS as an alternative, or extension, to BHO covered services. Any SUD provider that submits claims as FFS outside of these guidelines will be contacted and may be subject to corrective action and/or recoupments.

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



Transportation Providers

Non-Emergent Medical Transportation (NEMT) Broker

The Department will be transitioning from its current NEMT broker, First Transit, to its new NEMT broker, Total Transit. Total Transit will be serving Colorado Medicaid members residing in Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson, Larimer and Weld counties.



The new NEMT broker contract with Total Transit will be effective November 1, 2014 and will maintain several key provisions of the previous contract:

- Member support materials – web site access, toll-free number for scheduling trips, and trip forms will remain the same;
- Enhanced vehicle safety requirements, such as having a safety expert inspect all transportation vehicles;
- Strict driver requirements, including ongoing driver training and safety monitoring;
- The use of a clinical specialist to help advise on the most appropriate mode of transportation for the elderly and members with disabilities;
- Trip booking available 48 hours or more prior to the appointment time;
- Trip scheduling 24 hours per day, 7 days a week; and
- Use of a computer monitoring system to assist transportation providers with last-minute routing and scheduling changes to ensure clients are delivered to their appointments on time.

In an effort to provide a seamless transition for providers and members, the new broker will be transitioning a number of key personnel from the previous contractor. Additionally, the Department will send letters to approximately 19,000 members who have used NEMT services within the past year, informing them of the change in broker while reinforcing that the contact phone number and website remain the same.



This new NEMT contract continues to simplify transportation for Medicaid members travelling to and from their medical appointments, thereby reducing members' use of hospital emergency rooms for their primary health care needs.

Please contact Doug Van Hee at Doug.Vanhee@state.co.us or 303-866-4986 with questions.

Reduction of Usage for Four NEMT Procedure Codes

For calendar year 2014, NEMT codes were evaluated and restrictions placed on the number of trips that a transportation provider could offer a member per day. As a result of feedback from the community, the Department has received approval from the CMS to eliminate restrictions on the following four (4) procedure codes:

Procedure Code	Description
A0100	Nonemergency transportation; taxi
A0110	Nonemergency transportation and bus, intra – interstate carrier
A0130	Nonemergency transportation: wheelchair van
A0425	Ground mileage, per statute mile, no longer has any maximum unit restrictions.

- Claims with dates of service between January 1, 2014 and June 30, 2014 will be mass adjusted and payments sent to the billing entity.
- Claims with dates of service on or after July 1, 2014 will need to be adjusted by the provider after the July 2014 NEMT rates have been approved by CMS. Notification of these July 1, 2014 published rates will be forthcoming in future Provider Bulletins.

Prior Authorization Requirements

The Department has received a number of inquiries as to when a prior authorization is required. The only NEMT procedure code required to be prior authorized is for the following:

Procedure Code	Description
A0140	Nonemergency transportation and air travel (private or commercial), intrastate or interstate travel.

Note: The PAR is specifically to approve air travel. A second PAR will still be required for medical necessity, i.e. the same PAR required for surgeries and certain medical procedures.

Please contact Doug Van Hee at Doug.Vanhee@state.co.us or 303-866-4986 with questions.

Pharmacy Providers 340B Drug Pricing Program

Per guidance from the Health Resources and Services Administration (HRSA), providers that participate in the federal 340B Drug Pricing Program, must document and ensure their compliance with all 340B Drug Pricing Program requirements.

If providers choose to purchase and dispense 340B drugs to their Medicaid members, they must inform HRSA at the time of enrollment in the 340B Program by providing their Medicaid provider and National Provider Identifier (NPI) numbers. This information will be reflected on the HRSA Medicaid Exclusion File so that states and manufacturers can verify that drugs purchased under a Medicaid provider number are not also eligible for a Medicaid rebate.

If providers decide to bill Medicaid for drugs purchased under 340B, then all drugs billed under that Medicaid provider number/NPI must be purchased under 340B.



For providers that opt to purchase Medicaid drugs outside of the 340B Program (carve-out Medicaid prescriptions), all drugs billed under that Medicaid provider number/NPI must be purchased outside the 340B Program; the Medicaid provider number/NPI should not be listed on the HRSA Medicaid Exclusion File.

In addition, per HRSA guidelines, contract pharmacies must carve out Medicaid. Providers found carving-in Medicaid at their contract pharmacies will be cited in a HRSA audit and may be sanctioned for repayment of any duplicate discounts that occur.

For all aspects of the 340B program, providers are subject to audit by the state, manufacturers, or the federal government. Failure to comply may make the provider liable to manufacturers for refunds of discounts or cause the provider to be removed from the 340B Program.

For more information on the 340B Program, providers may visit the [HRSA website](#).

Total Annual Prescription Volume Survey

The Department has contracted with Mercer Government Human Services Consulting (Mercer) to conduct the total annual prescription volume (TAPV) survey. The prescription volume information submitted by pharmacy providers will be used to determine dispensing fees for the 2015 calendar year. Mercer will begin distributing the surveys to pharmacy providers on October 1, 2014 and completion of this survey is critical. If a provider does not complete the survey by October 31, 2014, the provider will be held to the \$9.31 dispensing fee noted below.

The prescription volumes and corresponding dispensing fees are as follows:

Total Annual Prescription Volume (TAPV)	Dispensing Fee
0 – 59,999	\$13.40
60,000 – 89,999	\$11.49
90,000 – 109,999	\$10.25
110,000+	\$ 9.31
Rural Pharmacy	\$14.14
State Run Pharmacy	\$ 0.00

Please contact Mercer at CO.Rx_reimbursement@mercer.com with questions regarding the survey.

Prescription Drug List (PDL) Update

The Department reviews therapeutic drug classes on the PDL annually. Based on these reviews the Department has made several changes to the PDL effective October 1, 2014.

Januvia (sitagliptin) will become a non-preferred DPP-4 agent and Tradjenta (linagliptin) will remain preferred after a step through of metformin. Members who have tried and failed Tradjenta in the past year will be granted a prior authorization for Januvia. All other members will be required to switch to Tradjenta for continuation of DPP-4 therapy. Based on the package insert, Tradjenta requires no renal dose adjustment.

Provigil (modafanil) will continue to be approved based on the previously published criteria, however, only the branded product will be covered. Details regarding all of the PDL changes may be found in the Pharmacy [Forms](#) section of the Department's website (colorado.gov/hcpf/provider-forms).

As of September 27, 2014, the billing units for Copaxone 20mg injections were changed from a box of thirty (30) units being billed as one (1) unit to 30 units being billed as 30 units. This is limited to a maximum daily dose of one (1) unit.

Any prior authorization associated with a status change from a preferred to a non-preferred drug expired on September 30, 2014. Consistent with the Department's policy, a prior authorization request for any non-preferred product may be requested through the Help Desk at 1-800-365-4944 or can be faxed to 1-888-772-9696.



Hydrocodone Combination Product Rescheduling

Effective October 6, 2014, hydrocodone combination products will be controlled as schedule II substances under the Controlled Substances Act (CSA).

- The Drug Enforcement Agency (DEA) is also permitting legitimate hydrocodone combination product prescriptions issued prior to October 6, 2014 to be refilled until April 8, 2015, if the prescription authorizes refills.
- Colorado Medicaid will stand by the DEA in allowing these refills to be good until April 8, 2015. All prescriptions written on or after October 6, 2014 will be held to the rules set forth for schedule II controlled substances.

Please contact Chris Ukoha at 303-866-3588 with questions.

Pharmacy and Therapeutics (P&T) Meeting

Tuesday, October 7, 2014

1:00 p.m. – 5:00 p.m.

Anschutz Medical Campus

12850 East Montview Boulevard

Aurora, CO 80045

The meeting will be held in the Education Building #2 South, Room 1102.

October and November 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 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.

October 2014

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
5	6	7 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	8 *WebEx- Beginning Billing - UB-04 9:00 AM-11:30 PM *WebEx- Web Portal 837I 11:45 AM-12:30 PM Nursing Facility 1:00 PM-3:00 PM	9 Beginning Billing – Waiver 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM Practitioner 1:00 PM-3:00 PM	10	11
12	13	14 *WebEx- Beginning Billing – Waiver 9:00 AM-11:30 AM *WebEx- Beginning Billing – CO -1500 1:00 PM-3:00 PM	15 Beginning Billing – CMS 1500 - Waiver 9:00 AM-11:30 AM	16 Beginning Billing – CMS 1500 9:00 AM-11:30 AM	17	18

November 2014

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
9	10	11 Beginning Billing CO-1500 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM	12 Beginning Billing UB-04 9:00 AM-11:30 AM Web Portal 837I 11:45 AM-12:30 PM FQHC/RHC 1:00 PM-3:00 PM	13 DME Billing 9:00 AM-11:00 AM *WebEx- Home Health 1:00PM-3:00 PM	14 *WebEx- Beginning Billing UB-04 9:00 AM-11:30AM *WebEx- Web Portal 837I 11:45 AM-12:30 PM *WebEx- Provider Enrollment 1:00 PM-3:00 PM	15
16	17	18 *WebEx- Beginning Billing – Waiver 9:00 AM-11:30 AM *WebEx- Beginning Billing – CO -1500 1:00 PM-3:00 PM	19 Beginning Billing – CMS 1500 - Waiver 9:00 AM-11:30 AM	20 Beginning Billing – CMS 1500 9:00 AM-11:30 AM	21	22

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.

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