Provider Bulletin

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colorado.gov/hcpf

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Denver Club Building
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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

Did you know...?

Electronic claims format submission is the required method to submit claims unless a provider is pre-approved to submit by paper or a paper claim is specifically authorized by the Department of Health Care Policy and Financing (the Department). Claims that include third party information or need a delayed reason code for timely filing are not required to be processed on a paper claim submission. Providers still need to maintain any records of explanation of benefits from a primary payer and supporting documentation for timely filing for at least six (6) years.

All Providers

ColoradoPAR Program

Retraction – Physical Therapy (PT)/Occupational Therapy (OT) Prior Authorization Requests (PARs)

Incorrect information was communicated in the Department's March 2015 Provider Bulletin (B1500364). All PT/OT PAR requests for chronic conditions will be approved for a twelve (12) month duration, not a six (6) month duration as was stated.

PAR Revisions:

A PAR revision request should be made in CareWebQI (CWQI) when a change to an approved PAR is necessary. PAR revisions should be completed to request additional days, visits, units, and/or a change in provider. Complete a PAR revision by:

- Selecting 'YES' in the CWQI dropdown menu on the Episode Edit screen for an **existing** PAR. **Note: Revisions cannot be made to an expired PAR.**
- Adding a comment stating exactly what is to be included in the PAR revision. Note: The episode will be denied for lack of information if no PAR revision information is provided.

Canceling Episodes:

Providers should **not** cancel episodes that have been auto-authorized. Auto-authorized episodes are automatically transmitted into the Medicaid Management Information System (MMIS). Canceling and then resubmitting these episodes will result in a denial of a PAR due to duplication. Please contact the ColoradoPAR Program at 1-888-454-7686 with questions.

Retraction/Clarification- Durable Medical Equipment (DME) PARs:

In the Department's March 2015 Provider Bulletin (B1500364), it should have stated that a **quote or invoice** must be submitted for all DME PARs in order to be processed.

CareWebQI Messages:

Please remember to check messages in CWQI. The ColoradoPAR Program regularly communicates with providers regarding PAR submissions via the CWQI secure messaging feature.

New Process for Complex Rehabilitation Technology (CRT) PARs

On January 1, 2015, the revision to the Medical Assistance Client and Clinical Care Durable Medical Equipment Rule Concerning Complex Rehabilitation Technology (CRT), Section 8.590, was passed. The rule restricts the provision of CRT to qualified CRT suppliers who meet certain standards. The new process for CRT PARs is:

- Complex Rehabilitation Technology providers must contact the Department to become an approved CRT provider;
- The Department will provide a Letter of Intent that the provider must fill out and return;
- Providers will be notified of approval to enter PARs for CRT services within one (1) to two (2) weeks of letter receipt.

Please contact Carrie Smith at Carrie.Smith@state.co.us or 303-866-3406 with questions regarding the CRT guidelines.

Colorado Medicaid Nurse Advice Line:

The Colorado Medicaid Nurse Advice Line offers Colorado Medicaid members free, 24-hour access to medical information and advice by calling 1-800-283-3221 any day of the week. The Nurse Advice Line provides:

- Registered Nurses who will answer medical questions, provide care advice, and help members determine whether they should be seen by a medical provider immediately.
- Advice and treatment referrals for chronic conditions, such as diabetes or asthma.
- Advice on the appropriate provider type and setting to treat a member's medical condition.
- Accessible health information for Colorado Medicaid members free of charge, 24 hours a day, seven (7) days a week, and 365 days a year.

Please share Nurse Advice Line information with your members. Further information can be accessed and printed from the Colorado Medicaid Nurse Advice Line website.

New Medicaid Members are Looking for Providers: Please Update Provider Contact Information Maintained in the Medicaid Management Information System (MMIS)

The Department is asking all providers to verify and/or update their information in the Medicaid Management Information System (MMIS) as soon as possible. With the expansion of Medicaid benefits, Colorado has many new members looking for a health care provider. Please remember, it is the responsibility of each provider to update the contact information contained in the MMIS. Keeping the information updated also assures that payments and communications are sent timely and appropriately. Updating provider information on file with the Department's fiscal agent, Xerox State Healthcare, is critically important, as the information provided (address and phone number in particular) is used in the Department's Find a Provider web search, which uses information maintained in the MMIS. The information on file is only as good as what is provided. Updating the information in the Colorado Medical Assistance Web Portal (Web Portal) via the MMIS Provider Data Maintenance option is the easiest and most efficient method to keep information current. However, submission of a Provider Enrollment Update form is available for providers who do not have the capability to make updates through the Web Portal.

Please contact the Department's fiscal agent at 1-800-237-0757 with questions.

National Correct Coding Initiative (NCCI) Notification of Quarterly Updates

Providers are encouraged to monitor the Centers for Medicare and Medicaid Services (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 April 2015. Please find more information on the CMS NCCI website.

Modifier '59' and New Modifiers

The Medicaid NCCI includes PTP edits that define when two (2) Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) codes should not be reported together, either in all situations or in most situations. For PTP edits that have a Correct Coding Modifier Indicator (CCMI) of '0,' the codes should never be reported together by the same provider for the same beneficiary on the same date of service. If these codes are reported on the same date of service, the column one (1) code will be eligible for payment, and the column two (2) code will deny for payment. For PTP edits that have a CCMI of '1,' the codes may be reported together only in defined circumstances, which are identified on the claim by the use of specific NCCI-associated modifiers. One function of NCCI PTP edits is to prevent payment for codes that report overlapping services, except in those instances where the services are "separate and distinct." Modifier '59' is an important NCCI-associated modifier that is often used incorrectly.

The CPT Manual defines modifier '59' as follows:

Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-evaluation & management (E/M) services performed on the same day. Modifier '59' is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used instead of modifier '59.' Modifier '59' should only be used if there is no more descriptive modifier available, and the use of modifier '59' best explains the circumstances. Note: Modifier '59' should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier '25.'

Modifier '59' and other NCCI-associated modifiers should NOT be used to bypass a PTP edit unless the proper criteria for use of the modifier is met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier that is used.

Below are some appropriate and inappropriate uses for Modifier '59.'

1. **Modifier '59'** is used appropriately for different anatomic sites during the same encounter only when procedures that are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.
2. **Modifier '59'** is used appropriately when the procedures are performed in different encounters on the same day.
3. **Modifier '59'** is used inappropriately if the basis for its use is that the narrative description of the two codes is different.
4. Other specific appropriate uses of **modifier '59'** include:
    a. **Modifier '59'** is used appropriately for two services described by timed codes provided during the same encounter only when they are performed sequentially.

b. **Modifier '59'** is used appropriately for a diagnostic procedure that precedes a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure.

c. **Modifier '59'** is used appropriately for a diagnostic procedure that occurs subsequent to a completed therapeutic procedure only when the diagnostic procedure is not a common, expected, or necessary follow-up to the therapeutic procedure.

Use of modifier '59' does not require a different diagnosis for each HCPCS / CPT coded procedure. Conversely, different diagnoses are not adequate criteria for use of modifier '59.' The HCPCS / CPT codes remain bundled unless the procedures are performed at different anatomic sites or separate member encounters or meet one (1) of the other three (3) scenarios described above.

Modifiers 'XE', 'XS', 'XP', and 'XU' were effective January 1, 2015. These modifiers were developed to provide greater reporting specificity in situations where modifier '59' was previously reported and may be utilized in lieu of modifier '59' whenever possible. (Modifier '59' should only be utilized if no other more specific modifier is appropriate.) Although NCCI will eventually require use of these modifiers rather than modifier '59' with certain edits, providers may begin using them for claims with dates of service on or after January 1, 2015. The modifiers are defined as follows:

'XE' – Separate Encounter: A service that is distinct because it occurred during a separate encounter. This modifier should only be used to describe separate encounters on the same date of service.

'XS' – Separate Structure: A service that is distinct because it was performed on a separate organ/structure.

'XP' – Separate Practitioner: A service that is distinct because it was performed by a different practitioner.

'XU' – Unusual Non-Overlapping Service: The use of a service that is distinct because it does not overlap usual components of the main service.

Billing the Member for Colorado Medical Assistance Program Services

The Colorado Medical Assistance Program and fiscal agent representatives frequently address questions as to what can be billed to Colorado Medical Assistance Program members. Please share this information with your billing offices and use the following questions (Q) and answers (A) as a guide for determining whether members can be billed for services rendered.

Q: Can Colorado Medical Assistance Program members be charged for services covered by the Colorado Medical Assistance Program?

A: No. Participating providers agree to accept the Colorado Medical Assistance Program payment as payment in full for benefit services rendered.

Required deductibles, co-insurance or co-payments, and those specific to specialty areas of practice are described in the billing manuals located in the Provider Services Billing Manuals section of the Department of Health Care Policy and Financing's (the Department) website.

Q: What if the Colorado Medical Assistance Program payment does not cover all of my costs? Can I charge the difference to the member?

A: No. All providers submitting medical services claims to the Colorado Medical Assistance Program certify that, "I accept as payment in full, payment made under the Colorado Medical Assistance Program, and certify that no supplemental charges have been, or will be billed to the member, except for those non-covered items or services, if any, which are not reimbursable under the Medical Assistance Act."

Q: What if I no longer want to be a Colorado Medical Assistance Program provider? Can I bill the Colorado Medical Assistance Program members for my services?

A: No. Members may not be billed if the failure to obtain Colorado Medical Assistance Program payment is caused by the provider's failure to comply with Colorado Medical Assistance Program billing procedures. Constraints against billing Colorado Medical Assistance Program members for benefit

services apply whether or not Colorado Medical Assistance Program makes or has made payment and whether or not the provider participates in the Colorado Medical Assistance Program.

Q: Can I bill Colorado Medical Assistance Program members for missed appointments?

A: No. Providers may not bill the Colorado Medical Assistance Program members for missed appointments, telephone calls, completion of claim submission forms, or medication refill approvals.

Q: Can I discharge a member from my practice?

A: Yes. Providers may dismiss an enrolled member from their practice for cause at any time. The provider shall give no less than a 45-day notice to both the Department and the member.

Cause shall be defined as any of the following:

- The member misses multiple scheduled appointments.
- The member fails to follow the recommended treatment plan or medical instructions.
- The primary care physician cannot provide the level of care necessary to meet the member's needs.
- The member and/or member's family is abusive to the provider and/or staff in compliance with 42 CFR 438.56(a)(2).
- The physician moves out of the service area.
- Other reasons satisfactory to the Department.

Q: Can I bill Colorado Medical Assistance Program members for services not covered by the Colorado Medical Assistance Program?

A: Yes. Before providing services that will not be covered by the Colorado Medical Assistance Program, providers shall have the member sign an acknowledgment of financial responsibility. Only if a written agreement is developed do members have the following responsibilities:

- If the service is not a covered benefit of the Colorado Medical Assistance Program, members may be billed for the service.
- Members are responsible for Colorado Medical Assistance Program co-payment. By federal law, providers may not refuse services if the member cannot pay the co-payment when services are rendered. Members may be billed for unpaid co-payment. Providers may apply standard collection policies if the member fails to satisfy co-payment obligations.
- Members in nursing facilities are responsible for member payment when under Medicare A (skilled nursing) coverage. If the member payment amount exceeds the Medicare A co-insurance due, the difference is refunded to the member.
- Colorado Medical Assistance Program members enrolled in a Colorado Medical Assistance Managed Care Program must follow the rules of the Prepaid Health Plan (PHP). Members who insist upon obtaining care outside of the PHP network may be charged for non-covered services.
- Colorado Medical Assistance Program members enrolled in the Primary Care Physician (PCP) Program are required to follow PCP Program rules. Non-emergency care in a setting that is not authorized by the primary care physician is not a benefit of the Colorado Medical Assistance Program. Members who insist upon obtaining non-emergency care in an emergency or urgent care setting without PCP authorization may be charged for the cost of those services.
- Colorado Medical Assistance Program members who have commercial insurance coverage that requires them to obtain services through a provider network must obtain all available services through the network.
- Members who insist upon obtaining non-managed-care covered services outside the network may be charged for such services.

Refer to the following sites for questions concerning charging Medical Assistance Program members for services rendered:

- Code of Federal Regulations: Title 42 Section 447.15 - Acceptance of State payment as payment in full.
- Colorado Revised Statutes: 25.5-4-301 - Recoveries–overpayments–penalties–interest–adjustments–liens.
- Code of Colorado Regulation for Medicaid (10 CCR 2505-10, Volume 8) (State Rules Concerning the Medical Assistance Program): 10 CCR 2505-10, 8.000 et seq. 10 CCR 2505-10, section 8.012 10 CCR 2505-10, section 8.205.4.I in the Medicaid Rules and State Plan section of the Department's website.
- Colorado Medical Assistance Program Provider Participation Agreement, Page 2 Item G in the Provider Enrollment Application located under each provider type in the Provider Services Enrollment for New Providers section of the Department's website.
- Colorado Medical Assistance Program General Provider Information manual in the Provider Services Billing Manuals section of the Department's website.

Medicaid and Child Health Plan *Plus* 2015 Income Guidelines

The Federal Poverty Level (FPL) are low-income guidelines established annually by the Department of Health and Human Services (HHS), used as an eligibility criterion for Medical Assistance Programs. Federal poverty levels are used to determine eligibility for certain programs and benefits. In accordance with federal law, the Department has updated the FPLs for all Medical Assistance Programs. The new income levels will be effective April 1, 2015. For additional information, please see the Agency Letters. Updated income charts are now available for Medicaid, Medicaid Buy-in for Working Adults with Disabilities, Medicaid Buy-in for Children with Disabilities, Medicare Savings Program and Low Income Subsidy, and CHP+.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Attention all Providers

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a covered benefit for all Colorado Medicaid members ages 12+. SBIRT is the process of screening members for use of drugs and excessive alcohol followed by a session of brief intervention and/or referral to treatment. A pre-screening must precede the SBIRT process to determine whether it should be initiated. SBIRT is usually conducted in primary care, hospital emergency department, or school settings. More information about the benefit, including provider qualifications, can be found in the SBIRT billing manual available under the CMS 1500 section.

Treatment referrals should be made to the member's regional Behavioral Health Organization (BHO). Please visit the BHO web page for referral contact information.

Billing Policy Reminders

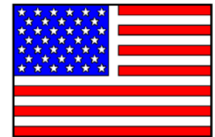
- Pre-screening means asking several short questions related to the member's drug or alcohol use. These questions should be asked of every member as part of normal medical management and are not separately reimbursable. A positive pre-screen result determines if a full screening is necessary.
- Members must receive a pre-screen prior to a full screen: Alcohol Use Disorders Inventory Test (AUDIT); Drug Abuse Screening Test (DAST); Car, Relax, Alone, Forget, Friends, Trouble Screening Test (CRAFT); etc.
- Full screening following a negative pre-screen result is not reimbursable.
- Member SBIRT benefits are limited to two (2) full screenings and two (2) sessions of brief intervention per state fiscal year (July-June).

Billing Policy Changes

- The Department recognizes a full screen may be negative and therefore not require brief intervention. Negative full screens are still reimbursable using HCPCS code **H0049**. **H0049** may only be billed for a negative full screen result.
- The complete SBIRT process of full screening followed by brief intervention and/or referral may only be billed using **99408** (15-30 minutes) or **99409** (30+ minutes). These two (2) codes are no longer restricted to just Federally Qualified Health Center (FQHC) use. They may not be billed on the same date of service as **H0049** as they are inclusive of the full screening.
- **H0050** is no longer open for billing.
- National Correct Coding Initiative (NCCI) Procedure-to-procedure (PTP) billing edits affect SBIRT codes. When applicable, attach bypass modifiers (typically '25' or '59') to **H0049**, **99408**, and **99409** line items to indicate that a separate amount of time was spent conducting the SBIRT process from other office procedures. Not all code pairings may be unbundled using a bypass modifier. Please refer to the Medicaid NCCI website for further instruction on bypass modifier use.

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

Memorial Day 2015



Due to the Memorial Day holiday on Monday, May 25, 2015, State, DentaQuest, the Department's fiscal agent, and the ColoradoPAR Program offices will be closed. The receipt of warrants and Electronic Funds Transfers (EFTs) may potentially be delayed due to the processing at the United States Postal Service (USPS) or providers' individual banks.

Dental Providers

General Dental Program Billing Instruction Updates

Fee Schedule Update

An up-to-date Colorado Medicaid Dental Fee Schedule is posted online within the "DentaQuest Resources" section.

2015 HCPCS and Updates to Billing Procedures for Visiting Dental Anesthesia Providers

For mobile anesthesia consultation appointments, dental providers should no longer use code **D9310** (Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician) when billing for reimbursement for these services through DentaQuest. The American Dental Association's (ADA) 2015 Current Dental Terminology (CDT) Manual added code **D9219** (Evaluation for deep sedation or general anesthesia) for this purpose, and code **D9219** is now the appropriate CDT code to use when billing for dental anesthesia and/or deep sedation evaluation services. All mobile/visiting dental anesthesia service providers who previously used **D9310** to bill for reimbursement of dental anesthesia and/or deep sedation evaluation services provided to Medicaid members should now bill for reimbursement using code **D9219** for services rendered on or after January 1, 2015. The pricing for code **D9219** has been set to reflect the same reimbursement fee schedule amount as code **D9310**.

Additionally, the Colorado Medicaid dental program opened the following 2015 ADA CDT Manual dental procedure codes for reimbursement:

- **D0351** – 3d photographic image (limited to members age 0 through 20 years)
- **D1353** – Sealant repair - per tooth (limited to members age 0 through 20 years)

Please refer to Exhibits A & B in the DentaQuest Office Reference Manual (ORM) for further information regarding benefit limitations and allowed frequencies for these new codes. The associated rates can be found on the updated dental fee schedule.

Dental Services for Medicaid-Eligible Refugees and Qualified Disabled Widows

The Department has been given approval by CMS to include Medicaid-eligible Refugees and Qualified Disabled Widow members as eligible for Colorado Medicaid dental program benefits. The Department expects these members to show correct dental eligibility with DentaQuest no later than April 1, 2015. The eligibility will be retroactive to July 1, 2014. If any Colorado Medicaid dental provider previously billed a claim for services rendered to these members and it was denied for a date of service on or after July 1, 2014, the Department has coordinated the necessary claims reprocessing with DentaQuest. There are several major claims processing projects currently underway at DentaQuest, and they will reprocess affected denied claims as soon as possible after April 1st.

Dental Program – Adult Dental Rule Update

The revisions to the Adult Dental Services rule passed its final reading for permanent adoption at the Medical Services Board (MSB) meeting on March 13, 2015 and will be effective on April 30, 2015. The final version will be made available on the Code of Colorado Regulations web page and can be found in section 8.201 of the rule. The final rule was updated to add clarification based on stakeholder feedback provided during the drafting of the children's dental rule and feedback the Department received from the dental provider community since implementing the adult dental benefit on July 1, 2014. In response to the feedback, the Department changed a few of the policies in order to increase access for adults and to reduce the burden on providers by removing unnecessary PAR requests. The Department also corrected a few typos and technical errors.

Dental Administration Services Organization (ASO) Updates from DentaQuest

The most recent version of the Colorado Summit, the DentaQuest quarterly e-newsletter for Colorado's Medicaid dental providers, is available on the DentaQuest Colorado Providers website. Providers may contact their DentaQuest Provider Relations (PR) representative or contact DentaQuest Provider Services at 1-855-225-1731 with questions.

Durable Medical Equipment (DME) and Supply Providers

Durable Medical Equipment (DME) and Supply Billing Manual Update

The DME and Supply billing manual, Complex Rehabilitation Technology (CRT) code section, has been updated to include when a code requires a specialty evaluation.

Note: Ventilators are a continuous rental item that do not convert to purchase, and tablet computers used as Augmentative and Alternative Communication Devices (AACDs) under procedure code **E1399-AV** have a reimbursement cap of $600.

Complex Rehabilitation Technology (CRT) Provider List

A list of the enrolled CRT providers has been added to the DME web page.

Note: Provider information updates will only be completed on the CRT list if the provider has updated their information in the Medicaid Management Information System (MMIS).

Manually Priced Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

The Department would like to remind providers that all claims with manually priced DMEPOS codes must be submitted on paper with pricing information attached. Electronic claims with manually priced codes will be denied. Per 10 CCR 2505-10, Section 8.590.7.I, claims will pay at the lessor of:

- Submitted charges;
- Current manufacturer suggested retail price (MSRP) less 19.86%; OR,
- By invoice of actual acquisition cost, minus any discount to the provider as set forth in policy, plus 17.26%.
- An invoice should only be submitted when the MSRP is not available.

Please contact Carrie Smith at Carrie.Smith@state.co.us to update CRT supplier information or with questions.

Home and Community Based Service (HCBS) Providers

Prior Authorization Request (PAR) Process for Home and Community-Based Services Waiver for Spinal Cord Injury (HCBS-SCI)

Effective May 1, 2015, case managers should send all HCBS-SCI Waiver PARs directly to the Department's fiscal agent, as a Department signature will no longer be required. Send all new, Continued Stay Review (CSR), and revised PARs to:

Xerox State Healthcare
PARs
P.O. Box 30
Denver, CO 80201-0030

Additional instructions for submitting PARs can be found on the instruction page of the PAR as well as the HCBS-SCI billing manual. Case managers will be responsible for checking on the status of the PAR through the PAR Status Inquiry in the Web Portal as well as downloading PAR letters and distributing them to providers.

Please contact the Department's fiscal agent at 1-800-237-0757 with questions.

Hospice Providers

Hospice Legislative Rate Increases Effective October 1, 2014

The Department has received approval for the Hospice State Plan Amendment (SPA) for the Fiscal Year 2014-15 legislative rate increases. The Hospice rate increase of 10.43% has been applied to the following revenue codes:

Revenue Code	Service Description
0651	Routine Home Care
0652	Continuous Home Care
0655	Inpatient Respite Care
0656	General Inpatient Care

The rates have been updated by the Department and are effective for dates of service on or after October 1, 2014. To receive the rate increase, providers will have to make adjustments to all Hospice claims for dates of service on or after October 1, 2014. The Department will provide additional instructions to Hospice providers explaining the necessary steps for adjusting claims.

Please contact Randie Wilson at Randie.Wilson@state.co.us with questions regarding rates.

Please contact Alex Koloskus at Alex.Koloskus@state.co.us with questions regarding Hospice policy.

Medical/Surgical Providers

Abortion Services Update

Medicaid providers need to be aware that abortion services are not a covered benefit for Medicaid-eligible members except under the following three (3) limited circumstances:

1) the pregnancy is the result of rape;

2) the pregnancy is the result of incest; or

3) continuing the pregnancy would cause a life-endangering circumstance for the pregnant member.

All induced abortion service claims must be submitted on paper with a Department Certification statement and supporting documentation, allowing the Department's fiscal agent to review and verify the circumstances regarding the service. The Certification statement must be signed by a physician. Claims for the service submitted electronically will be denied.

The Certification statement is located on the Forms web page.

Please contact the Department's fiscal agent at 1-800-237-0757 with questions.

Residential Child Care Facility (RCCF) Providers

Residential Child Care Facilities Update

The NCCI has approved the Department's request to remove all edits on claims submitted by RCCFs. With this change, RCCFs will no longer experience either caps on the number of units of service billed or issues surrounding mutually exclusive codes billed on the same day of service.

Effective January 1, 2015, changes will be applied retroactively.

Please contact Elizabeth Freudenthal at Elizabeth.Freudenthal@state.co.us with questions.

Pharmacy Providers

Preferred Drug List (PDL) Update of Preferred Products

Effective April 1, 2015, these are the following drug classes and preferred agents:

Alzheimer Agents

Preferred products will be donepezil tablet, donepezil ODT, Namenda immediate release, galantamine, and galantamine ER.

Atypical Antipsychotics

Preferred products will be Abilify, Abilify ODT, risperidone, risperidone ODT, Risperdal, Latuda, clozapine, Clozaril, Geodon, ziprasidone, quetiapine, Seroquel immediate release, Zyprexa, and olanzapine.

Growth Hormones

Preferred product will be Genotropin.

Insulin

Preferred products will be:

Rapid acting duration – 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

Insulin mixtures – All mixtures will be preferred including pens and vials

Intranasal Corticosteroids

Preferred products will be fluticasone and Nasonex.

Leukotriene Modifiers

Preferred product will be montelukast.

Multiple Sclerosis Agents

Preferred products will be Copaxone 20mg injection, Avonex, Betaseron, and Rebif, Gilenya will be preferred with a trial and failure with Copaxone 20mg or a preferred interferon.

Ophthalmic Allergy agents

Preferred products will be cromolyn, Patanol, and Pataday.

Sedative/Hypnotics (non-benzodiazepine)

Preferred products will be zolpidem, zaleplon, and eszopiclone.

Statins/Statin Combinations

Preferred products will be Crestor, atorvastatin, pravastatin, and simvastatin.

Please refer to the PDL on the Forms web page for more information.

Genotropin Update

Effective April 1, 2015, Genotropin will be the preferred growth hormone. Prescribers please plan accordingly for the transition of members to the preferred product.

The Department understands that, although the devices for the products are similar, they are not identical and thus training on the new device is necessary. For providers who need assistance training members in the use of the Genotropin device, providers may take advantage of the Pfizer Bridge Program. This Program provides training on the devices used to administer Genotropin as well as coordination of the entire prescription process. Nurse trainers are available to perform training sessions in a provider's office as well as in a member's home any time, including evenings and weekends.

Any specialty pharmacy can fill a Genotropin prescription. The device used to administer Genotropin also requires a prescription. The device will be sent directly from Pfizer to the member or may be sent to the member's provider if requested. The completed Bridge Program Statement of Medical Necessity form is required to be faxed to the Bridge Program to initiate the process.

A member may continue to receive a non-preferred drug in the following situations:

- If a member is taking Serostim and is an HIV patient with wasting or cachexia.
- If a member is taking Zorbtive and has a diagnosis of Short Bowel Syndrome.
- Note: per Department policy, if the member is receiving a product through their primary insurance, Medicaid will continue to be the secondary payer and will pay for the product approved by the primary insurance.

April and May 2015 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.

April 2015

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
12	13	14 CMS 1500 9:00AM-11:30AM Web Portal 837P 11:45AM-12:30PM Transportation 1:00PM-3:00PM	15 ***WebEx*** UB-04 9:00AM-11:30AM ***WebEx*** Web Portal 837I 11:45AM-12:30PM Hospice 1:00PM-3:00PM	16 ***All Classes WebEx*** Waiver 9:00AM-11:30AM Web Portal 837P 11:45AM-12:30PM Home Health 1:00PM-3:00PM	17 Practitioner 9:00AM-11:00AM FQHC/RHC 1:00PM-3:00PM	18

May 2015

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10	11	12 CMS 1500 9:00AM-11:30AM Web Portal 837P 11:45AM-12:30PM DME/Supply 1:00PM-3:00PM	13 UB-04 9:00AM-11:30AM Web Portal 837I 11:45AM-12:30PM	14 Waiver 9:00AM-11:30AM Web Portal 837P 11:45AM-12:30PM Personal Care 1:00PM-3:30PM Web Portal 837P 3:45PM-4:30PM	15 ***All Classes WebEx*** CMS 1500 9:00AM-11:30AM Web Portal 837P 11:45AM-12:30PM Provider Enrollment 1:00PM-3:00PM	16

Reservations are required for all workshops

Email reservations to: workshop.reservations@xerox.com

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

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 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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