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Did You Know?

If Explanation of Benefit (EOB) code 3110 - "the rendering provider is not a group member" appears on a claim, this does **not** cause the claim to deny and is **informational only**. Currently, the Department is giving providers an extended grace period to make all necessary updates to their affiliations to avoid future claims denials. Providers should check their affiliations to make sure they are up to date and check other EOB codes to see why the claim denied.

All Providers

New Provider Rates, Legislative Increases and General Information

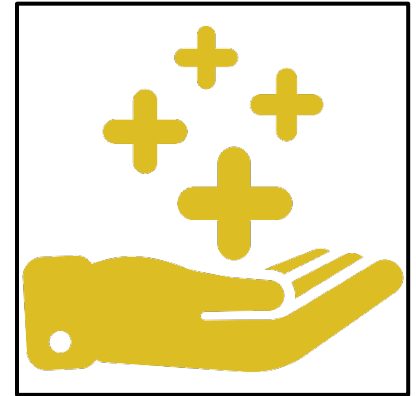
New Provider Rates:

Medicaid provider rate increases were approved during the 2016-2017 legislative session and are effective for dates of service on or after July 1, 2017. All rates require approval from Centers for Medicare and Medicaid Services (CMS). The Department is working to obtain approval from CMS to implement the rates on July 1, 2017. Some providers will be paid retroactively if there is a delay in implementation and other rate increases will be implemented when approved.

The fee schedule located on the [Provider Rates & Fee Schedule](#) web page will be updated to reflect the approved 1.4% across the board rate increase and targeted rate increases.

Approved for the Legislative Across-the-Board Increases:

- Eligible physician and clinic services
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services
- Inpatient hospital services
- Outpatient hospital services
- Laboratory & x-ray services
- Durable Medical Equipment (DME), supplies, and prosthetics
- Mental health fee-for-service
- Non-physician practitioner services
- Tobacco cessation counseling for pregnant women
- Ambulatory Surgery Center Services (ASC)
- Dialysis center services
- Physical, occupational, and speech therapy services
- Audiology services
- Screening, brief intervention, and referral to treatment (SBIRT) services
- Dental services
- Freestanding Birth Centers
- Family planning services
- Outpatient Substance Use Disorder services
- Targeted case management for behavioral health
- Targeted case management for substance use disorders
- Vision services
- Mental health and substance abuse disorder rehabilitation services for children in psychiatric residential treatment facilities
- Prosthesis services
- Mental health and substance use disorder rehabilitation services for children in residential child care Facilities
- Extended services for pregnant women
- Private Duty Nursing services
- Home Health
 - Hospice Fee for Service
 - Home and Community Based Services (HCBS) waivers:
 - HCBS - Developmental Disabilities (DD)
 - HCBS - Supported Living Services (SLS)
 - HCBS - Children Extensive Support (CES)
 - HCBS - Children Residential Habilitation Program (CRHP)

**Approved for Targeted Rate Increases:**

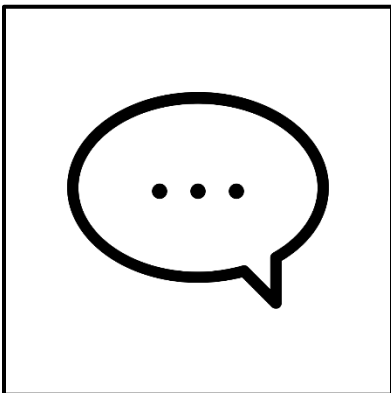
- Home Health RN will receive 6.02%
- Home Health PT, OT and ST will receive 6.01%, 6.02% and 6.01% increase
- Private Duty Nursing LPN will receive 7.24%
- Emergent and Non-Emergent Medical Transportation (NEMT) will receive 7.0%
- Physician Administered Drugs at ASP+2.5%
- Vaccinations and Immunizations will be priced at the Center for Disease Control and Prevention (CDC) fee schedule

Exclusions for the Legislative Across-the-Board Increases:

Although these rate increases will affect most Medicaid providers, a number of providers are exempted from the across-the-board increases. Additional detail regarding these exclusions can be found in the Department's R-12: "Community and Targeted Provider Rate Increase" submitted to the Legislature on November 1, 2014, found here: [Department's R-12 "Community Provider Rate Increase"](#).

Exclusions Include:

- Services listed above receiving a targeted rate increase
- Skilled Nursing Facility Services
- Public Health Agencies
- Federally Qualified Health Centers
- Home and Community Based Services (HCBS) Children with Autism (CWA) waiver
- Private Duty Nursing Registered Nurse Hourly Rate
- Physician services previously impacted by House Bill 16-1408
- Contract based administrative payments including Dental Administrative Services Organization (ASO), NEMT ASO, Consumer-Directed Attendant Support Services (CDASS) Financial Management Services (FMS) and Training vendors
- Pharmacy reimbursement
- Rural Health Centers
- The Program of All-Inclusive Care for the Elderly (PACE)
- Risk-based physical health managed care programs (Denver Health and Rocky Mountain Health Plans)
- Risk-based mental health managed care programs (Behavioral Health Organizations)



General Information

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

Updated fee schedules are forthcoming. Please refer to the [Provider Rates & Fee Schedule](#) page, located on the Department website, for the appropriate rate and fee schedule.

SB 16-120 Member Explanation of Benefits (EOB) Implementation Delay

The Department is required to make available an EOB to all Health First Colorado (Colorado's Medicaid program) members. The EOBs will allow Health First Colorado members to see claims made on their behalf so they can discover and report administrative and provider errors or fraudulent claims. The member EOBs must comply with federal requirements (42 CFR 433.116 and Section 11210 of the State Medicaid Manual) and those outlined in Senate Bill (SB) 16-120.

The Department has developed a [summary of recent activities](#) related to stakeholder and member engagement that was mandated by SB 16-120.

Due to the extension of the interChange system go-live, the member EOBs that comply with SB 16-120 will not be available beginning July 1, 2017. Once launched, the EOBs will be available in the interChange Member Portal. The Department is working to identify a launch date for the Member Portal and the SB 16-120 mandated member EOBs.

The Department is currently working to resolve policy, system and operational issues identified through internal workgroups and stakeholder engagement as they relate to the implementation of SB 16-120. This Department is also working with CMS on federal approvals.

As required by SB 16-120, the Department has developed a draft member EOB letter and educational material messaging that include member and stakeholder feedback. Following the resolution of the identified policy, system and operational issues, additional updates may be made to the draft EOB letter and educational material messaging and resources.



As information becomes known, updates on the member EOBs and information on the launch timing of the new Member Portal will be posted on Colorado.gov/hcpf.

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Providers

DMEPOS Billing Updates

Face-to-Face (F2F) Requirement

As of July 1, 2017, the DME section of the Code of Colorado Regulations (CCR), located at [10 CCR 2505-10, § 8.590](#), has been updated to incorporate the [Federal F2F requirements](#).

Compliance with the (F2F) requirements is a condition of payment for DME requiring a Face to Face (F2F).

The [DME Billing Manual](#) has been updated to include information on the F2F regulation and a notation has been made in the Comments column of the Code Table next to codes that require a F2F.

New Modifiers RA and RB

The effective date of the following modifiers is July 1, 2017. These modifiers are informational only and do not affect reimbursement but must be used when applicable. They are required on both Prior Authorization Requests (PARs) and claims.

Modifier	Description
RA	Replacement of a DME, orthotic or prosthetic item
RB	Replacement of part of a DME, orthotic or prosthetic item furnished as part of a repair

Billing with Modifiers KH and KI

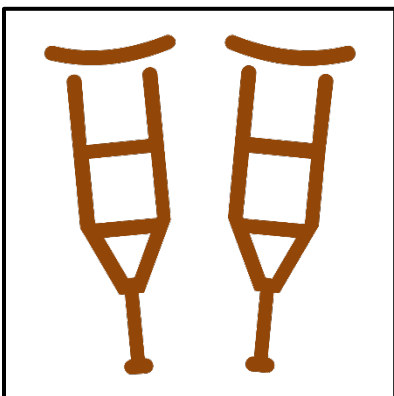
As a reminder, as of **March 1, 2017** the KH and KI modifiers cannot be used in place of the RR (Rental) modifier. They must be used in the secondary position, in addition to the RR modifier, on claims. KH and KI are informational only and do not affect pricing.

Modifier	Description
KH	DMEPOS item, initial claim, purchase or first month rental
KI	DMEPOS item, second or third month rental

The KH and KI modifier are not required on prior authorization requests but must be used on claims, when applicable, as noted in the [DME Billing Manual](#).

Example

<u>PAR</u> E0720 RR x2	<u>Claims</u> First month rental E0720 RR KH x1 Second month rental E0720 RR KI x1
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Updates to the DME Billing Manual

- As mentioned above, the manual now includes information regarding the F2F requirement.
- The Augmentative and Alternative Communication Devices (AACD) Benefit Coverage Standard (BCS) is no longer incorporated by reference in the CCR. Information found within the BCS has either been moved into Rule at [10 CCR 2505-10, § 8.590](#) or into the [DME Billing Manual](#).

Note: Additional updates have been made; please reference the Revisions Log on the manuals last page.

Medicare Billing Enforced

As of the transition on March 1, 2017, the Department is enforcing requirements to bill Medicare primary for applicable DMEPOS claims. With the exception of the codes that Medicare has deemed “Statutorily Excluded” or “non-covered,” when a member has Medicare as their primary insurance, Medicare must be billed prior to billing Medicaid. This requirement is not a new policy, only the enforcement of an existing policy. The applicable Rule may be found at [10 CCR 2505-10 Section 8.061](#).

Hospital Providers

Re-Issued FY2017-18 Inpatient Base Rates, New System Mass-Adjustment Coordination and Hospital Engagement Meetings

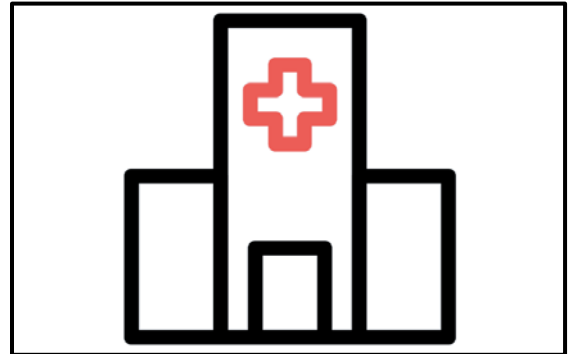
Re-Issued Inpatient Hospital Base Rates FY2017-18

[The new posting](#) was uploaded on June 9, 2017, and is the new date from which the 30-day timeframe for Informal Reconsiderations and/or Appeals will be calculated.

Please contact Diana Lambe at diana.lambe@state.co.us for more on information on hospitals who would like to receive the calculations used to arrive at their Inpatient Hospital Base Rate.

New System Mass-Adjustment Coordination

The Department has begun work on mass adjustments and will be contacting some of the larger hospital systems to begin testing. If your hospital is independent, you can expect mass adjustments to occur within the next few months. We will be reaching out to Hospital CFO/Reimbursement Professionals through our Hospital Engagement Newsletters to provide you with updates as we test the process and roll it out.



We will continue to communicate updates until the mass-adjustments have been completed.

Please contact Diana Lambe at diana.lambe@state.co.us if you have any concerns about the impending mass adjustments or would like more information. For those want to add your name to our email list for further communication please [sign up to receive the Hospital Engagement Meeting newsletters](#).

Hospital Engagement Meetings:

The Department has held several Hospital Engagement Meetings in 2017 to discuss current issues regarding payment reform and operational issues moving forward. The next meeting is scheduled for Friday, July 7, 2017.

- For those want to add your name to our email list for further communication, please [sign up to receive the Hospital Engagement Meeting newsletters](#).
- The agenda for upcoming meetings will be available on our [website](#) in advance of each meeting.
- Registration links for each session during the day will also be available prior to the meeting. Just click on the links to register for each session and you will receive the link to connect to the webinar.
- For more information, please visit the [Inpatient Hospital Payment page](#) of the Department website.
- The meetings are all held on a Friday:
 - July 7, 2017
 - September 1, 2017
 - November 3, 2017

Please contact Elizabeth Quaife at elizabeth.quaife@state.co.us or 303-866-2083 or Diana Lambe at diana.lambe@state.co.us or 303-866-5526 if you have any questions or need more information.

Pharmacy Providers

Important Information for 340B Providers

The Department is working with to allow covered entities to indicate at the claim detail level if a physician-administered drug or an outpatient drug was purchased through the 340B Drug Pricing Program. This functionality will help the Department and covered entities ensure that drug manufacturers do not provide a discounted 340B price and a Medicaid drug rebate for the same drug (also known as a duplicate discount). Effective June 1, 2017, covered entities must include the applicable indicators listed below on claims for 340B-purchased drugs.

Outpatient Drugs

All claims and encounters for outpatient drugs purchased through the 340B program should include the following on the NCPDP D.0 claim layout:



- The value of "20" in the Submission Clarification field (NCPDP Field #420-DK)
- The value of "08" or "05" in the Basis of Cost Determination field (NCPDP Field #423-DN)

For any outpatient drugs **not** purchased through the 340B program, covered entities do not need to submit any values to indicate that on the claim.

More detailed information on the NCPDP D.0 payer sheet specifications is available at Colorado.gov/HCPF/pharmacy-benefits-management-system-pbms-transition-magellan.

Physician-Administered Drugs

All claims and encounters for physician-administered drugs purchased through the 340B program should include the "UD" code modifier on the 837P, 837I and CMS 1500 claim formats.

For any physician-administered drugs **not** purchased through the 340B program, no code modifier is required to indicate that on the claim.

The Department would also like to remind all covered entities that a valid NDC number must be included on all claims and encounters for physician-administered drugs. To assist providers with billing, a HCPCS/NDC crosswalk can be found under Appendices on the [Billing Manuals page](#) of the Department website.

Providers may send questions related to this notice to the Department at Colorado.SMAC@state.co.us.

Opioid Policy Updates

- Effective August 1, 2017, policy for opioid prescriptions in members naïve to opioids:
 - Opioid prescriptions for the opioid naïve will be limited to a 7 day supply for the first fill.
 - Two refills will be allowed that are also limited to 7 day supply each.
 - Any further fills will require a prior authorization and could require a teleconsult with a pain management physician consult.

- Effective October 1, 2017, the total daily limit of Morphine Milligram Equivalents (MME) will be decreasing to 250 MME/day from current maximum of 300 MME/day.
 - Beginning October 1, 2017, the prescription that puts the member above 250 MME will reject and require a prior authorization and possibly a consult with our pain management physician.
 - It is recommended that providers and their teams work to taper Medicaid members to at or below 250 MME prior to October 1, 2017.

Drug Utilization Review (DUR) Updates

The Colorado DUR Board is seeking one MD/DO as a voting member on the DUR board, which meets quarterly to discuss Medicaid medication use criteria and other policy. If interested, please request more information by emailing SSPPS.co-dur@ucdenver.edu.

The next DUR meeting is scheduled for August 18, 2017. The following drug classes will be covered, among other individual agents (TBD):

- Oral anticoagulants, oral bisphosphonates, diabetes management classes (excluding insulins), erythropoiesis stimulating agents, HCV treatments, overactive bladder agents, stimulants and other ADHD agents
- For more information about the DUR Board's activities, please visit our [web page](#), or email SSPPS.co-dur@ucdenver.edu

Note: This article was corrected after the original publication erroneously referenced the Hepatitis C Vaccine. "HCV treatments" do not refer to the Hepatitis C Vaccine.

Drug Classes and Preferred Agents

The following drug classes and preferred agents will become effective July 1, 2017, for Colorado Medicaid:

Newer generation antihistamines and combinations

Preferred products will be cetirizine (generic over-the-counter (OTC) Zyrtec) (tab, syrup), loratadine (generic OTC Claritin) (tab, syrup)

Angiotensin Receptor Blockers and combinations

Preferred products will be Benicar, irbesartan, losartan, valsartan, Benicar-HCT, losartan/HCTZ, valsartan/HCTZ

Renin Inhibitors and Combinations

No preferred products

Fibromyalgia Agents

Preferred products will be: Lyrica, duloxetine (20mg, 30mg and 60mg)

Inhaled Anticholinergics and Combinations

Preferred products will be albuterol/ipratropium, ipratropium, Atrovent HFA, Combivent Respimat, Spiriva Handihaler



Short-Acting Inhaled Beta 2 Agonists

Preferred products will be albuterol solution, Proair HFA inhaler

Long-Acting Inhaled Beta 2 Agonists

Preferred product will be Serevent but will still require a PA

Inhaled Corticosteroids and Combinations

Preferred products will be Pulmicort nebulas (0.25mg and 0.5mg and 1mg), Asmanex Twisthaler, Flovent HFA and Diskus, QVAR, Advair Diskus, Dulera

Long Acting Opioids

Preferred products will be methadone, fentanyl patches (12mcg, 25mcg, 50mcg, 75mcg and 100mcg), morphine sulfate ER tabs, tramadol ER (generic ultram).

- Butrans patch and Nucynta ER with single step edit

Skeletal Muscle Relaxants

Preferred products will be baclofen, cyclobenzaprine 5mg and 10mg tabs, tizanidine 2mg and 4mg tabs

Testosterone

Preferred products will be Androgel 1.62%, Androderm, testosterone cypionate IM injection (generic Depo-testosterone)

Topical Immunomodulators

Preferred product will be Elidel

For updated information, please refer to the [Provider Forms](#) page on the Department website, under Pharmacy.

Physician-Administered Drugs, Partial Fills for Long Term Care (LTC) Members, DAW 9 and DAW 8, Magellan Contacts, Brand - Generic Changes

Physician-Administered Drugs

If a physician-administered medication will be administered in the patient's home or LTC facility, pharmacies should submit a place of service code 12 on the pharmacy claim at point of sale. If the medication will not be administered in the patient's home or LTC facility, then the medication should be billed to medical. Otherwise, a prior authorization will be required.

Partial Fills for LTC Members

For patients that reside in an LTC facility, pharmacies may use a dispensing status code of "P - Partial fill" on a claim to partially fill a CII prescription. Standard National Council for Prescription Drug Programs (NCPDP) fields

required for partial fills will be enforced. Dispensing fees will be applied in full on the initial fill only. Regular drug reimbursement methodology will apply to the quantity dispensed with each fill.

DAW 9 can be Utilized When Multisource Brand-Name Product is Preferred

When a brand name product is preferred over a generic product, a DAW 9 (plan prefers brand) can be entered on the pharmacy claim at point of sale. This DAW code should be used instead of a DAW 0 if brand name is not required by the prescriber (DAW 1). Based on recent NCPDP guidance, this will allow the pharmacy to better indicate why they are billing for a brand product when dispense as written is not indicated on the prescription. The claim will bypass the DAW edit denial of 8K - DAW Code Value Not Supported and the generic mandate edit. The claim will be subject to other system edits. Current examples include: Adderall XR, Benicar, Benicar-HCT, Nexium capsules and packets, Pulmicort nebulas

Drugs Used for Erectile or Sexual Dysfunction

Drugs used for erectile or sexual dysfunction are not covered by Medicaid. If a drug has an FDA-approved indication other than erectile or sexual dysfunction, then the medication will be subject to prior authorization to assess intended use. If the drug is used for an indication other than sexual or erectile dysfunction, then it may be approved. Drugs subject to this edit include: Premarin cream, Addyi, Osphepa and Xiaflex. If an ICD-10 diagnosis for an FDA approved indication other than sexual or erectile dysfunction is on the patient file, pharmacy prior authorization requirements will not apply. Please see the Appendix P document, located under the [Provider Forms](#) page of the Department website, under "Pharmacy," for more information.

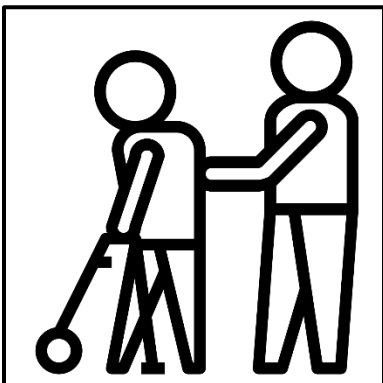
Use DAW 8 for Non-Preferred Brand Product When Marketplace Shortage of Generic Exists

When a marketplace shortage exists on a preferred generic drug, DAW 8 will be allowed to be entered by the pharmacy on the claim at point of sale. This is in addition to DAW 0 (currently) and DAW 1. Based on recent NCPDP guidance, this will allow the pharmacy to better indicate why they are billing for a brand product when the generic is preferred and generic substitution is permitted by the prescriber. The claim will bypass the DAW edit denial of 8K - DAW Code Value Not Supported and the claim will be subject to other system edits. Current example: Transderm Scop

For more information, please contact Magellan at 1-800-424-5725.

Physical & Occupational Therapy Providers

Evaluation Codes



Reimbursement has been delayed for the 2017 HCPCS physical and occupational therapy evaluation and re-evaluation codes 97161-97168. DXC will reprocess all previously submitted claims for these codes dating back to January 2017, once the Colorado interChange has been set up appropriately.

Until the system correction is implemented, providers should continue to submit claims for evaluation and re-evaluation services using the designed codes in 97161-97168.

Evaluation services cannot be billed using treatment codes. Claims paid for evaluation services which were submitted with treatment codes are improper claims and are overpayments. Improper claims must be voided or the

overpayment refunded. Evaluation services may be re-submitted using correct procedure codes within timely filing limits.

Physician Services Providers

Use of Evaluation and Management Procedure Codes for Integrated Services

Health First Colorado includes coverage of behavioral health services through a managed care system of Behavioral Health Organizations (BHOs). BHOs are responsible for reimbursement for covered mental health services. Colorado Medicaid does not allow the use of Evaluation and Management procedure codes for behavioral health services at an integrated practice when the behavioral health services are covered by specific procedure codes. Behavioral health services must be billed using the specific procedure code(s) covering the services.

When the behavioral health service is an add-on to an Evaluation and Management procedure code it should be billed in conjunction with the Evaluation and Management procedure code. Primary care visits with both the Evaluation and Management service, and the services covered by the behavioral health add-on codes can be billed by primary care providers to fee-for-service Medicaid.

For further information about physician services, contact Richard Delaney at richard.delaney@state.co.us. For further information about behavioral health services, contact Melissa Eddleman at melissa.eddleman@state.co.us.

Physician-Administered Drugs Require both National Drug Code (NDC) Number and HCPCS Code

Claims for physician-administered drugs for in office or outpatient hospital treatments must be submitted with both the NDC number and the HCPCS code. This applies to physician, outpatient hospital, EPSDT, and Medicare Part B crossover claims for physician-administered drugs. Appendix X, the Physician-Administered Drugs crosswalk, is located on the [Billing Manuals](#) page of the Department website.



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

Changes in End of Life Counseling Benefit, Including Medical Orders for Scope of Treatment (MOST)

Colorado Medicaid has changed the procedure code used for End-of-Life/Advance Care Planning Counseling services (ACP). These services can include the explanation and discussion of advance directives and may include the completion of standard forms such as a Medical Durable Power of Attorney (MDPOA) executed pursuant to C.R.S. Section 15-14-506, a declaration as to medical treatment (Living Will) pursuant to the Colorado Medical Treatment Decision Act C.R.S. Section 15-18-104, a CPR Directive under 6CCR 1015-2 and the Medical Orders for Scope of Treatment (MOST) form pursuant to C.R.S. Section 15-18.7-103. Beginning

January 1, 2017, the procedure code for this service will be 99497. The reimbursement rate will remain the same. The services can be billed in addition to the appropriate non-critical care Evaluation & Management service. Colorado Medicaid **does not** cover the extended services, procedure code 99498.

These ACP services may be billed by physicians and non-physicians, including advanced practice nurses, physician assistants, or licensed mental health providers (including social workers) and registered nurses. In order to provide this service, the provider must have received training in advance directive counseling either through medical school, their professional training or post-graduate education. The reimbursement for this service is available once per year.

Colorado Advance Directive forms may be found at [Colorado Advance Care Consortium](#). The [Five Wishes Document](#) may be used during a reimbursable visit.

The MOST form is a medical order defining patient choices for certain life-sustaining treatments. The MOST program was established by legislation in Colorado in 2010 (C.R.S. Title 15, Article 18.7). The MOST orders are typically provided for the frail elderly, or persons with serious, chronic, or terminal illness. MOST orders are portable across all healthcare settings and are intended as a key device in maintaining continuity of care and communication. For more information on MOST, including updated form templates, see [Colorado Advance Directives](#).

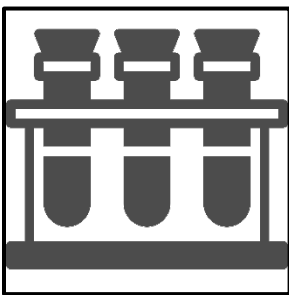
Colorado Medicaid has covered end of life counseling by primary care providers and other specialty providers since January 2014. The current procedure code of S0257 was closed on January 31, 2017.

This article updates information that was published in the [January 2014 Provider Bulletin \(B1400346\)](#).

If you have questions, please contact Richard Delaney at richard.delaney@state.co.us or 303-866-3436.

Physician Services & Independent Labs

Clinical Laboratory Improvement Amendments (CLIA) Billing



All system issues CLIA processing have been resolved. Please reference the [Known Issues](#) page for more details.

If you are encountering denials for tests appropriate for your CLIA certification type, please check your CLIA end date in the Provider Portal. The end date for the CLIA license must read 12/31/2299 to be considered active. If your license has an end date other than 12/31/2299 but is currently active, please update your CLIA information in the Provider Maintenance section of the Provider Portal and ensure that a copy of the CLIA license is attached on the last page. The update request must be approved before denied claims can be resubmitted.

Providers have noted that some CLIA waived tests are being denied when the provider has an active CLIA Certificate of Waiver on file. **Please note, many tests need a QW modifier to indicate they are waived tests.** If the modifier is not present, it indicates that the type of test being performed is of a higher complexity than the Certificate of Waiver allows, and the test will be denied. Please reference the [CMS website](#) to determine if the test you are performing requires a QW modifier.

Women's Health Providers

New Code for Kyleena: A New Long-Acting Reversible Intrauterine Contraceptive (LARC)

Kyleena is a five year, 19.5mg levonorgestrel-releasing intrauterine contraceptive system, released in October 2016 and included as a Medicaid benefit.

To bill for Kyleena effective July 1, 2017, providers should use HCPCS code Q9984. Additionally, claims should include the applicable National Drug Code (NDC) number, the appropriate family planning diagnosis code, and the family planning modifier (FP).

HCPCS Code	Description	NDC #'s	Modifier
Q9984	Kyleena - 19.5mg levonorgestrel IUS	50419-424-01 50419-424-08 50419-424-71	FP

If you are purchasing this product through the federal 340B Drug Pricing Program, you must bill Medicaid the actual acquisition cost plus shipping and handling. All other providers must bill their usual and customary charge for this item.

Note: When submitting claims for insertion and/or removal of LARC devices, use the FP modifier in addition to the appropriate ICD-10 and CPT code.

For more information, please contact Melanie Reece at melanie.reece@state.co.us.

Immediate Post-Partum Long-Acting Reversible Contraception (IPP-LARC) "Carve-out" from All Patient Refined-Diagnosis Related Group (APR-DRG) Payment Methodology

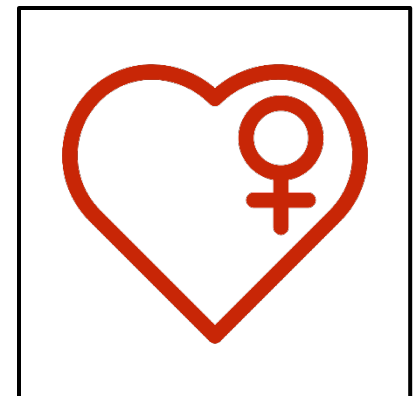
Long-Acting Reversible Contraceptives (LARCs) are the most effective, easily reversible contraceptive method available to women, providing long lasting protection from unplanned pregnancies. Colorado Medicaid currently pays for all Food and Drug Administration (FDA) approved contraceptive methods including LARCs.

The costs associated with IPP-LARCs (including intrauterine devices [IUDs] and subdermal contraceptive implants) are currently incorporated into the weights for the APR-DRGs for deliveries.

Effective July 1, 2017, following CMS approval, hospitals will be paid a separate fee schedule rate for these LARC devices in addition to the APR-DRG payment for a delivery. To receive this fee schedule payment, the LARC must be inserted prior to hospital discharge, following a delivery and billed as follows:

The claim must be:

1. Assigned to the appropriate obstetrics delivery APR-DRG (540, 542 or 560) code,



The device must be:

1. Listed as a separate line item on the Inpatient Hospital Claim form (UB-04)
2. Assigned the appropriate ICD-10 diagnosis code
 - a. Z30.430: Encounter for insertion of intrauterine contraceptive device or
 - b. Z30.018: Encounter for initial prescription of other contraceptives (use for contraceptive implant insertion)
3. Accurately identified using the device's HCPCS code
4. Assigned the LARC device's affiliated NDC number, and;
5. Assigned the family planning modifier "FP" on this same service line

Below are the current HCPCS LARC codes, description of LARC devices, affiliated NDCs (also found on the LARC device packaging) and modifier required for billing. To access current fee schedule rates please visit our [Provider Rates and Fee Schedule](#) page.

LARC Fee-for-Service Billing Information:

HCPCS Code	Code Description	Current NDC numbers	Required modifier for billing
J7297	Liletta, levonorgestrel-releasing intrauterine device 52 mg - 3 year	Two-handed inserter: 5254403554 / 52544003554 One-handed inserter: 00023585801 / 0023585801	FP
J7298	Mirena, levonorgestrel-releasing intrauterine system 52 mg - 5 year (prior code J7302 - deleted)	50419042101	FP
J7300	Paragard, (Cu-T-380TA) copper intrauterine device - 10 year	51285020401	FP
J7301	Skylla, levonorgestrel-releasing intrauterine system 13.5mg - 3 year	50419042201	FP
J7307	Nexplanon / Implanon, 68mg etonogestrel implantable device-3 year (Implanon is being phased out- Services for removal ONLY)	00052027401 00052433001 00052027201 - for Implanon ONLY	FP
Q9984	Kyleena, levonorgestrel-releasing intrauterine system 19.5 mg - 5 year	50419-424-01 50419-424-08 50419-424-71	FP

The Department is seeking approval from CMS for this carve-out. Once CMS has approved and system changes are complete, any impacted inpatient hospital claims with dates of service on or after July 1, 2017, will be retroactively adjusted to reflect the billing update and revised payment methodology. Adjustments for inpatient claims will be reflected on future Remittance Advices (RAs).

Practitioners may bill for the professional services associated with insertion of the LARC devices utilizing the appropriate ICD-10 and CPT codes, with place of service designated as inpatient hospital (POS=21). Costs associated with professional services by salaried physicians are included in the hospitals' rate structure and cannot be billed separately to Medicaid.

For more information, please contact Melanie Reece at melanie.reece@state.co.us.

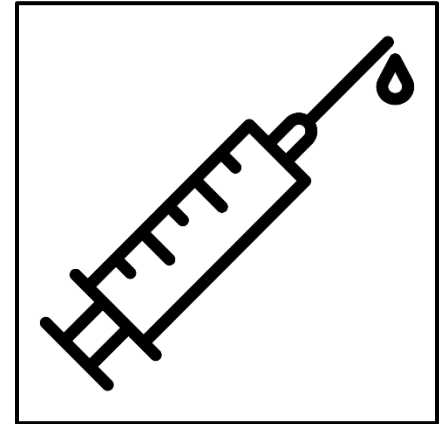
New HCPCS Codes for 17-Alpha-Hydroxyprogesterone Caproate (17P) Injections

Effective July 1, 2017, two new temporary HCPCS codes have been approved for use with 17P. The previous 17P code (J1725) will be discontinued on July 1, 2017.

17P is a covered Medicaid benefit when used to prevent a preterm birth in women with a previous preterm delivery. 17P is a weekly injection for single gestation pregnancies shown to be highly effective at reducing an additional preterm birth. 17P is available and billable both as: 1) a Medicaid benefit when provided in the setting of a physician's office, and 2) a Pharmacy Benefit when administered in the home or in a long-term care setting.

Pharmacy benefit rules regarding physician administered drugs (8.800.5.A) state that: Any drugs administered in a physician's office or clinic are considered part of the physician's services and not a pharmacy benefit. Such drugs shall be billed on the physician claim form. Pharmacies may not bill for any products that shall be administered in a physician's office or clinic.

Criteria for Medicaid coverage of 17P and billing requirements for Medical providers are listed below:



Pharmacy Benefit

Injections for 17P will be covered for the prevention of preterm birth if a prior authorization is obtained. The criteria for approval is as follows:

- The drug is being administered in the home or in a long-term care setting, and;
- Client has a singleton pregnancy and a history of singleton spontaneous preterm birth, and;
- Therapy is being initiated between 16 weeks' gestation and 20 weeks + 6 days' gestation, and;
- Dose is administered by a healthcare professional.

Medical Benefit

If the injection is given in an office setting (most scenarios) then the injection must be billed by the medical provider. Providers must use the following procedure codes when billing. A PAR is not required, but the clinical records must document that the client meets all eligibility criteria for coverage.

The two new 17P codes are listed below:

- Q9985 should be used for the generic conjugated product for 17P.
- Q9986 should be used for Makena (AMAG Pharmaceuticals, Inc.'s 17P FDA approved product).

Please note the change in reporting Units from: ONE (1) mg to TEN (10) mgs

NEW HCPCS CODE	Description	Diagnostic Code (ICD-10)	Required Code modifier	Units per HCPCS Code	Maximum Units per Injection / per weekly treatment
Q9985	17-alpha hydroxyprogesterone caproate, conjugated product - compounding pharmacy	O09.211 - O09.219	HD	10 mg	250 mg/injection Maximum units/treatment: 25 units
Q9986	17-alpha hydroxyprogesterone caproate, Makena injection	O09.211 - O09.219	HD	10 mg	250 mg/injection Maximum units/treatment: 25 units

Eligibility/Exclusion Criteria for 17P Injections for Prevention of Preterm Birth:

Eligibility criteria are as follows:

- History of a spontaneous preterm birth (< 37 weeks)
- Singleton pregnancy
- Initiation of 17P treatments between 16 weeks, 0 days and 20 weeks, 6 days and continuation until 36 weeks, 6 days or delivery, whichever occurs first

Exclusion Criteria:

- Known fetal anomaly
- Current or planned cervical cerclage
- Hypertension
- Seizure disorder

17P is not for women with:

- Multi-fetal pregnancy
- Short cervix and no prior preterm birth
- Previous medically indicated preterm birth



For Medicaid benefit questions, please contact Melanie Reece at melanie.reece@state.co.us.

For home-health or long-term care settings questions, please contact Alex Koloskus at alexandra.koloskus@state.co.us.

For Pharmacy benefit questions, please contact Robert Lodge at robert.lodge@state.co.us.

This article provides an update to HCPCS code information published in the [March 2014 Provider Bulletin \(B1400349\)](#).

Upcoming Holidays

Holiday	Closed Offices/Offices Open for Business
<p>Independence Day Tuesday, July 4th</p>	<p>State Offices, DentaQuest, DXC, and the ColoradoPAR Program will be closed. The receipt of warrants and EFTs may potentially be delayed due to the processing at the United State Postal Service or providers' individual banks.</p>
<p>Labor Day Monday, September 4th</p>	<p>State Offices, DentaQuest, DXC, and the ColoradoPAR Program will be closed. The receipt of warrants and EFTs may potentially be delayed due to the processing at the United State Postal Service or providers' individual banks.</p>

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