COLORADO
Department of Health Care Policy & Financing

Provider News & Resources

March 25, 2024 Issue 89

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Did You Know?

License Update Requirement

Federal screening regulations found at 42 CFR § 455.412 require providers to maintain current licenses, without limitations, throughout the term of their agreement. A license update is required when the license on file is expiring soon.

To remain actively enrolled, update the license information in the Provider Web Portal by clicking Provider Maintenance and following the steps under Provider Identification Changes. A copy of the license showing the effective and end dates must be attached.

Refer to the Provider Maintenance - Update License and CLIA License Update Quick Guide located on the Quick Guides web page for more information.

Resolved Known Issue: Professional Claims for DME Services Denying EOB 7827

Resolved Known Issue: Institutional Claims Denying EOB 0192

Moratorium on New Enrollments for Non-Emergent Medical Transportation (NEMT)

The state has imposed a moratorium on new enrollments for Non-Emergent Medical Transportation (NEMT) due to a significant potential for fraud, waste, or abuse to the Medicaid program.

An extension of a maximum of six months was requested and approved by Centers for Medicare & Medicaid Services (CMS), effective April 1, 2024.

Ordering, Prescribing and Referring (OPR) Providers

Enrollment Requirement

Providers are reminded to include Ordering, Prescribing and Referring (OPR) providers on claims and to ensure the OPR provider is currently enrolled with Health First Colorado (Colorado's Medicaid program).

The OPR field on the CMS 1500 professional claim form is 17b.

Claims with services requiring OPR providers will post Explanation of Benefits (EOB) 1997 - “The referring, ordering, prescribing or attending provider is missing or not enrolled."

Professional claim services or items that require an OPR National Provider Identifier (NPI):

- Audiology Services

- Durable Medical Equipment (DME)/Supplies
- Laboratory Services
- Radiology Services
- Pediatric Personal Care Services
- Physical, Speech and Occupational Therapies

Refer to the program billing manuals on the Billing Manuals web page or visit the Ordering, Prescribing and Referring Claim Identifier Project web page for more information.

All Providers who Utilize the ColoradoPAR Program

Prior Authorization Request (PAR) Process When Health First Colorado is the Secondary Payer

The following is a guide for PAR submissions to Acentra when primary insurance is involved. Visit the Colorado Prior Authorization Request Program (ColoradoPAR) web page for more information about program specifics.

Health First Colorado is the payer of last resort (42 CFR Part 433 Subpart D). The other insurance is the primary insurance or payer when a Health First Colorado member has other insurance. A primary insurance can also be referred to as a Third-Party Liability (TPL) payer. Medicare or commercial or private insurance, such as UnitedHealthcare, Cigna or Blue Cross Blue Shield, are examples of what would be considered primary insurance.

When is a PAR required?	**When is a PAR *not required*? ***
The primary insurance did not pay on the claim.	TPL or Medicare paid on the claim for the services billed.
The TPL PAR is partially denied by the primary payer.	TPL covers *all* the services requested.
The member does not have Medicare or TPL.	

* **Note:** This policy does not apply to Physician-Administered Drugs (PADs) which requires a PAR if the member has TPL other than Medicare.

Contact COProviderIssue@kepro.com or the ColoradoPAR Program UM Team at HCPF_UM@state.co.us with questions about PAR submissions.

Contact the Provider Services Call Center with questions about claim submission.

Home and Community-Based Services (HCBS) Providers

Benefit Plan Extension

The member's current benefit plan (for example, Home and Community-Based Services (HCBS) - Brain Injury (BI) Waiver) will be extended for an additional year. This will allow the claims payment system to continue to pay for services even if the case management agency has not had the opportunity to provide that information through the Bridge system.

Providers are encouraged to:

- Verify eligibility for Long Term Services and Supports (LTSS) benefits if unable to locate a Prior Authorization in the HCPF Provider Web Portal
- Provide the services traditionally provided to the LTSS-eligible members
- Submit a claim for services so there is a timely record of the service being billed

The Department of Health Care Policy & Financing (the Department) may have the ability to pay for those services at a future date without requiring the provider to resubmit the claim.

Case management agencies can continue to complete and update Prior Authorization Requests (PARs) for newly enrolled members through their normal process. The case manager will be able to edit Service Plans and PARs to make an adjustment if the needs of the members change.

Featured Resource: Revalidation Frequently Asked Questions (FAQ)

Why can't some of the information on the revalidation application be changed?

Some information will be auto-populated on the application. Auto-populated information cannot be changed on the application and must be updated separately outside of the revalidation process by submitting a Provider Maintenance request. Refer to the table What information can be updated through revalidation? on the Revalidation web page to review what information can be updated when revalidating.

Note: Log into the Provider Web Portal and select **Provider Maintenance** to start a Provider Maintenance request.

Can a revalidation application be submitted while a change application is in process?

No. Providers cannot submit a revalidation application while an active change application is in process.

Providers are reminded to prioritize their revalidation application process ahead of any other change applications to reduce delays. Providers may request that an active change application be cancelled by contacting the Provider Services Call Center. After the cancellation is complete, providers may submit the revalidation application.

Pharmacy Providers

Reminder: Update Fax Numbers

Pharmacy providers are encouraged to ensure their fax numbers are accurate and current to receive important pharmacy fax blasts. Many pharmacies either do not have a fax number on file or have a corporate fax number on record.

Visit the Provider Maintenance - Provider Web Portal Quick Guide web page for more information on updating the fax number.

Recently Updated Billing Manuals

- Appendix X - HCPCS/NDC Crosswalk for Billing Physician-Administered Drugs
- Inpatient/Outpatient (IP/OP)
- Non-Emergent Medical Transportation (NEMT)
- Outpatient Imaging and Radiology
- Pharmacist Services
- Vision Care and Eyewear

Home and Community-Based Services (HCBS)

- Adult - Brain Injury (BI), Community Mental Health Supports (CMHS) and Elderly, Blind, and Disabled (EBD)
- Complementary and Integrative Health (CIH)
- Persons with Intellectual and/or Developmental Disabilities Waiver Programs & Targeted Case Management

Visit the Billing Manuals web page to locate all published manuals.

Resolved Issues

Resolved 03/19/24:

Some Professional Claims for Durable Medical Equipment (DME) Services for Procedure Code E0154 with Modifier NU Denying for Explanation of Benefits (EOB) 3530

Some professional claims for DME procedure code E0154 with modifier NU for dates of service 07/01/2022 through 06/30/2023 were denying for EOB 3530 - "There is no rate on file for the date of service. Charges cannot be processed."

Affected claims were reprocessed on 03/22/24.

Issue resolved 03/19/24.

Resolved 03/13/24:

Some Professional Claims with Durable Medical Equipment (DME) E2599, K0108 and T5999 Procedure Codes Denying for Explanation of Benefits (EOB) 7827

Some professional claims with DME procedure codes E2599, K0108 and T5999 with date of service prior to 07/01/23 were denying for EOB 7827 - "Unlisted procedure code should not be used when a more descriptive procedure code representing the service provided is available."

Affected claims were reprocessed on 03/15/24.

Issue resolved 03/13/24.

Hospital, Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC) Providers

Resolved 03/20/24:

Some Institutional Claims Billed with Physician-Administered Drugs Denying for Explanation of Benefits (EOB) 0192

Some institutional claim details with Physician-Administered Drugs (PADs) were denying incorrectly for EOB 0192 - "Prior Authorization (PA) is required for this service. An approved PA was not found."

Affected claims were reprocessed on 03/21/24.

Issue resolved 03/20/24.