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Did You Know?

The information providers keep on file directly correlates to the information displayed for members in the [Provider Directory](#). In order to ensure Health First Colorado (Colorado's Medicaid Program) members have the most up-to-date information, providers are encouraged to update their profile via the [Provider Web Portal](#). Specifically, providers must update the panel to accept new Health First Colorado members under "Provider Maintenance" and "Network Participation." Refer to the [Provider Maintenance Provider Web Portal Quick Guide](#) for more information.

All Providers

Fingerprint Criminal Background Check (FCBC)

On May 1, 2018, the Department of Health Care Policy & Financing (the Department) will send the official Request for Fingerprint submissions to providers considered high risk. Federal regulations (42 CFR 455.434) established by the Centers for Medicare & Medicaid Services (CMS) require a fingerprint criminal background check for all high-risk providers, and any person who has direct or indirect ownership interest of five percent (5%) or more in a high-risk provider.

Providers have 30 days from the date of the request letter to comply with this requirement. Individuals may not fingerprint themselves; fingerprints must be obtained from a law enforcement agency. Providers should contact local law enforcement agencies to verify the agency has fingerprinting services available and to identify the associated cost. Most [law enforcement agencies](#) will provide the Applicant Fingerprint Card as part of their service.

Once the fingerprint card has been completed, mail the completed card(s) to:

DXC Technology
Attn: Provider Enrollment - Fingerprinting
P.O. Box 30
Denver, CO 80201



Fingerprint cards must be sent directly to DXC Technology (DXC) for processing. Original cards must be sent; copies, faxes, emails or electronic versions will not be accepted. The Department strongly recommends providers obtain a tracking number when the fingerprint cards are mailed. The Department is not responsible for lost fingerprint cards.

Fingerprint cards are currently being accepted. High-risk providers may submit cards before they receive the request letter, but all fingerprints must be received by June 1, 2018.

For more information, refer to the [Fingerprint Criminal Background Check Frequently Asked Questions \(FAQs\)](#).

Accountable Care Collaborative (ACC) Phase II: Important Information about Provider Contracting

Beginning July 1, 2018, the next iteration of the ACC is scheduled to begin. The Department awarded contracts to seven Regional Accountable Entities (RAEs). These entities will be responsible for developing and managing a network of primary care physical health providers and behavioral health providers. This function is currently provided by the Regional Collaborative Care Organizations (RCCOs) and Behavioral Health Organizations (BHOs).

All primary care providers who want to serve as a primary care medical provider (PCMP) and receive an Administrative Medical Home payment for Health First Colorado patients must contract directly with the RAE(s). The Department will no longer make Per Member Per Month payments directly to PCMPs. Physical Health services will continue to be reimbursed by the Department fee-for-service through the Colorado interChange.

Behavioral Health providers will need to contract with and be credentialed by the RAE to receive reimbursement for providing capitated behavioral health services as of July 1, 2018. Behavioral Health providers must be enrolled as a Health First Colorado provider before they can be credentialed by a RAE.

Note: Contracting with the RAE is handled separately from revalidation through the Colorado interChange. Health First Colorado providers with a current enrollment (meaning those providers who have successfully completed revalidation through the Colorado interChange) with the fiscal agent, DXC, do **not** need to make changes to their enrollment to contract with the RAE(s).

Refer to the [Primary Care Medical Provider](#) and [Behavioral Health Provider](#) Contracting Fact Sheets on the [ACC Phase II web page](#) for more information.

All ColoradoPAR Providers

Prior Authorization Requests (PARs) Through eQHealth Solutions Guidance

Long Term Home Health Providers that Submit PARs Through eQHealth



When submitting a PAR for Long Term Home Health with the Health First Colorado Pediatric Home Assessment Tool (PAT), please ensure that all appropriate documentation to support the score of the PAT is submitted. For example, if submitting the PAT with a score for Section 12: Range of Motion (ROM)/Exercise, provide all documentation related to a skilled exercise program and/or skilled range of motion needs as stated in the plan of care.

Personal Care services would fall under section 12.a and be scored at 0. The documentation to support the score may be included in the Plan of Care or submitted independently; however, it must contain the specific exercise tasks, prescribed frequency of each task and documentation to support the skill required, all specific to the member. If this information is missing from a PAR submission, it will be pended back in eQSuite to the provider to request this information.

Long Term Home Health/Private Duty Nursing Reallocation Requests and Changes to Active PARs

A PAR must be current and active for changes to be successfully transmitted to the fiscal intermediary. All reallocation or correction requests must be submitted via HelpLine Ticket to eQHealth Solutions, with a minimum of five business days prior to the end date of the PAR in order to allow for review and transmittal time. It is recommended that these changes be submitted as far in advance as possible to allow for communication if there are discrepancies or issues that will prevent completion as submitted.

Please include all pertinent information to avoid the request being returned. For reallocation requests, the remaining unit balance per revenue code must be provided at the time of request, along with the exact quantity of units to be allocated to each revenue code for the entire duration of the authorization period.

Contact the eQHealth Provider Relations Specialist at 888-801-9355 (toll free phone) or co.pr@eqhs.org for additional information or assistance with the ColoradoPAR program.

Durable Medical Equipment, Prosthetic, Orthotic and Supply (DMEPOS) Providers

Federal Upper Payment Limit (UPL) Requirement

As of January 1, 2018, Health First Colorado is required to comply with the [Consolidated Appropriations Act of 2016](#) (Section 503) which means Health First Colorado cannot pay more than what Medicare would have paid in the aggregate for certain DME services. The original effective date was January 1, 2019, but the [21st Century Cures Act](#) (Section 5002) changed the effective date to January 1, 2018.

In December 2017, CMS held a webinar that provided some guidance on complying with the UPL. Since that webinar, the Department has continued to work with CMS to resolve outstanding questions regarding this compliance.

About the UPL:

1. Compliance is measured by Health First Colorado's aggregate expenditure on a per calendar year basis.
2. If the code was **not** billed/paid by both Medicare **and** Health First Colorado during the prior calendar year, it is **not** included.
3. Only DME codes beginning with A, E and K are included.
4. Orthotics, prosthetics and disposable supply codes are **not** included.
5. Medicare's competitive bid codes that are in line with points two and three are included.
6. Oxygen and oxygen systems are included.

The Department received the paid DME Medicare code list subject to the 2018 UPL near the end of February 2018. The list was generated, per CMS request, by Medicare's Pricing, Data Analysis and Coding (PDAC) contractor, Noridian Healthcare Solutions and included Medicare utilization information for the codes that fell under the scope of the UPL. The Department pulled its utilization for those same codes and cross-referenced the lists to determine the codes to which Colorado's 2018 UPL is subjected.

The Department is discussing (both internally and with stakeholders) possible mitigation strategies. Mitigation possibilities are limited by Federal and State regulation and budgetary restrictions.

Reimbursement Rates

The Department intends to set rates according to the regions that Medicare has designated for Colorado.

There are four regions:

- Non-Rural
- Rural
 - [Zip codes associated with the Rural regions](#)
- Competitive Bid (Denver-Aurora-Lakewood)
- Competitive Bid (Colorado Springs)
 - [Zip codes associated with the Competitive Bid areas](#)

At this time, the Colorado interChange is not able to price based on the member's zip code. Once the Colorado interChange has been updated, all claims from January 1, 2018, through current will be reprocessed at the correct regional rate.

Interim Rate

While the Colorado interChange is being updated, an interim rate based on the competitive bid (Denver-Aurora-Lakewood) will be used. In the absence of that rate, codes will price at the non-rural rate.

The interim rates were effective January 1, 2018; however, DXC and the Department are working to load these rates in the Colorado interChange.

Claims with a date of service from April 1, 2018, to current will be reprocessed by the Department at the interim rates. This will likely result in a recoupment of funds, displaying on your Remittance Advice (RA) as a system-generated adjustment.

As there is legislation in process to potentially offset the rate decrease with supplemental payments for the first several months of this calendar year, the Department will not reprocess claims with dates of service between January 1, 2018, and March 31, 2018, until after the legislation is finalized.



Guide to New DME UPL Fee Schedule

The new DME UPL fee schedule has been posted to the Department's website on the [Provider Rates & Fee Schedule web page](#), under Durable Medical Equipment, Upper Payment Limit. It includes the rates that were effective from July 1, 2017, through December 31, 2017, the interim rates, and the future regional rates. Below is information on how to read the new fee schedule.

Change Indicator (CI)

The numeric values in the first column denote the changes to each code. All code- modifier combinations had a change to their fee schedule rate, but many also had a policy and/or billing method change.

- 0 - Change in rate only
- 1 - Modifier change (KR to RR)
- 2 - Used purchase (UE) rate added
- 3 - Rental rate (RR) added
- 4 - Modifiers TT, QE, QF, and QG no longer alter the reimbursement. There is only one rate for each code.
- 5 - Daily rental (KR) rate removed; KR is no longer billable.
- 6 - Rate transitioned from daily to monthly
- 7 - Rate transitioned from hourly to monthly
- 8 - KF modifier now required



Modifiers

- **NU (New Purchase)** - The Department has not enforced the usage of the NU modifier though it should be used in all applicable situations. With the implementation of the DME UPL fee schedule, the NU modifier will be required on the UPL codes for the claim to price at its New Purchase rate.
- **UE (Used Purchase)** - All claims for used equipment must include the UE modifier. The DME UPL fee schedule details the maximum allowable for used equipment.

Rate Effective July 1, 2017

- The rates in **bold** were effective between July 1, 2017, and December 31, 2017.
- Rates that are **grayed out** were not on the fee schedule; they represent a converted rate for comparison to the new rates. For some code/modifier combinations, the converted rate represents an average of the applicable rates.
- **MP** - Manually Priced

Interim Rate Effective January 1, 2018

- These are the rates that will be loaded with an effective date of January 1, 2018, and will be used to price claims until the Colorado interChange is able to pay claims based on the member's zip code.

Non-Rural, Rural, Colorado Springs, Denver-Aurora-Lakewood

- These are the final rates to be effective January 1, 2018, once the Colorado interChange can reimburse claims based on the member's zip code. Claims with dates of service from January 1, 2018, and after will eventually be reprocessed to price at these rates.

Manual Pricing Billing Process Change – By Invoice

As of July 2018, A9901 will no longer be used for Invoice Manual Pricing. The percentage above the Invoice cost will be calculated in line with the base code, similar to how Manufacturer's Suggested Retail Price (MSRP) works.

Example of current process, maximum allowable:

E1399 UB	\$1000 (actual invoice cost)
A9901 UB	\$195.00 (19.50% of the invoice cost)

Process beginning July 2018, maximum allowable:

E1399 UB	\$1195.00 (actual invoice cost + 19.50%)
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- The claims' submitted charge/billed amount should reflect the Usual and Customary charge (U&C)*
- The math for calculating the maximum allowable must be shown. It may be added to the invoice or a separate attachment. Using the above example:
 - $\$1000 \times 1.195 = \1195.00 , or
 - $\$1000 \times .195 = \$195.00 + \$1000 = \1195.00
 - If the full quantity on the invoice was not provided to the member (i.e. a bulk order) a breakdown of the cost per unit multiplied by the quantity provided must be shown. In the instance where a manufacturer puts the cost per unit on an invoice, the per unit price calculation does not need to be shown. However, the unit price does need to be multiplied by the quantity provided.
- After verifying the calculation, claims processors will price the claim at the lower of U&C or (actual invoice cost + the percentage).

*U&C: What a provider would charge the general public for the product.

Reminder to Providers: Claims Must Match Documentation

The Department would like to remind DMEPOS providers that delivery documentation such as delivery tickets and shipping invoices must match the date of service billed and entered on claims pursuant to state and federal audit requests.

Contact HCPF_DME@state.co.us for more information.

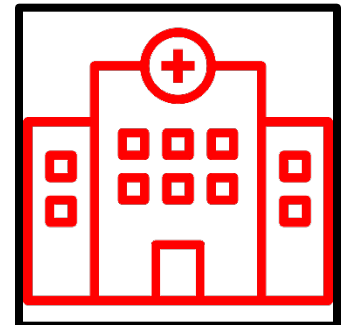
Hospital Providers

General Updates

OUTPATIENT HOSPITALS

New Enhanced Ambulatory Patient Group (EAPG) Grouper Module Release

As of April 6, 2018, the new EAPG software has been installed in the Colorado interChange which will accommodate the April 2018 Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) codes updates. No claims have been found to have priced incorrectly in the Colorado interChange resulting from this change. However, 3M created a new set of "Agency Values" effective March 11, 2018, which has an erroneous implementation of the upcoming change in 340B drug discount percentage. Please install the April 12, 2018, Service Pack release, where 3M has corrected the error to ensure payments for 340B drugs can be modeled correctly. As no claims were priced incorrectly in the Colorado interChange as a result, no adjustments will be necessary.



DXC has also been made aware of this error and will continue paying 340B drugs at their 50 percent discounted rate, until the Department receives State Plan approval from CMS to calculate payments for 340B drugs using 80 percent of their total EAPG Relative Adjusted Weight effective March 11, 2018. Once approval is obtained and 3M's software is verified as functioning as intended, the Department will begin calculating payment accordingly and retroactively adjust any claims impacted by the updated 340B drug discount percentage.

Monthly EAPG Meetings

Starting February 9, 2018, the Department moved the biweekly EAPG meetings to monthly meetings. These meetings are intended to be an informal discussion where the Department and its hospital providers can discuss issues relating to billing, payment and/or the EAPG methodology in general. For recordings of previous meetings, related meeting materials and the current schedule for future meetings, please visit the [Outpatient Hospital Payment web page](#). The next meeting hosted by the Department will be on May 4, 2018.

Note: Starting March 30, 2018, EAPG Meetings were rescheduled to a new time. EAPG Meetings will now be held from 1 - 3 p.m.

Contact Andrew Abalos at Andrew.Abalos@state.co.us or 303-866-2130 for any questions regarding the EAPG methodology in general.



Mass Adjustment of Xerox EAPG Claims Update

The Department finalized its tests with DXC for reprocessing claims processed through the Xerox legacy system that should have been paid using the EAPG methodology. The Department began reprocessing these claims in March, with the earliest reprocessed claims appearing on the April 6, 2018, RA. Due to the claim volume, this process will take several weeks to complete. The Department will be closely monitoring the results to ensure that unexpected takebacks do not occur - if claims do not process as expected, the Department may delay the reprocessing.

For continuing up-to-date information regarding the scheduling of mass adjustments on EAPG claims, visit the [Outpatient Hospital Payment web page](#) or attend the Monthly EAPG Meetings.

Contact Andrew Abalos at Andrew.Abalos@state.co.us or 303-866-2130 for assistance in identifying claims which have been adjusted.

Outpatient Cost Settlements

As of March 19, 2018, issues and inquiries related to Outpatient Cost Settlements are handled by Andrew Abalos. Contact Andrew.Abalos@state.co.us or 303-866-2130.

SPECIALTY HOSPITALS

Meetings

The next Specialty Hospital meetings regarding the Budget Neutral Rate will be May 4, 2018, from 3 - 4 p.m. Contact Elizabeth Quaife at Elizabeth.Quaife@state.co.us with questions, concerns or feedback.

For more information, go to the Specialty Hospital section on the [Hospital Engagement Meetings web page](#).

Note: Starting May 4, 2018, Specialty Hospital Meetings will move to a new time. Specialty Hospital Meetings will be held from 3 - 4 p.m.

ALL HOSPITAL PROVIDERS**Hospital Engagement Meetings**

The Department has had multiple Hospital Engagement Meetings in 2017 and 2018 to discuss current issues regarding payment reform and operational processing moving forward. The next meeting is scheduled for Friday, May 4, 2018, 9 a.m.-12 p.m. at 303 E 17th Ave, Denver, Conference Room 7B & 7C.

[Sign up to receive the Hospital Engagement Meeting newsletters.](#)

Registration for the Hospital Engagement Meetings are no longer required. Participation can be by conference line, webinar and/or in person. The agenda for upcoming meetings will be available on the [Hospital Engagement Meeting web page](#) the week of each meeting. Visit the [Hospital Engagement Meeting web page](#) for more details and the meeting schedule.

Contact Elizabeth Quaife at Elizabeth.Quaife@state.co.us if you have any questions and/or topics that you would like to be discussed at future meetings. Advance notice will provide the Rates Team time to bring additional Department personnel to the meetings to address different concerns.

Physician Services and Hospitals**PAR Not Needed for Emergencies**

Emergencies should be marked as such on the claim form and do not require a PAR.

The provider rendering service must determine whether the service is an emergency and mark the claim appropriately. To indicate an emergency service on a professional 1500 claim, "Y" may be marked. Box 24C of the paper form may be used. To indicate an emergency service on an institutional UB claim, admit type of 01 (Emergency) or 05 (Trauma) may be used.

Emergencies are defined as sudden, urgent, usually unexpected occurrences or occasions requiring immediate action, such as:

- Active labor & delivery
- Acute symptoms of sufficient severity and severe pain in which, the absence of immediate medical attention might result in:
 - Placing health in serious jeopardy
 - Serious impairment to bodily functions
 - Dysfunction of any bodily organ or part



Contact the [Provider Services Call Center](#) at 1-844-235-2387 for further information.

Physician and Family Planning Service Providers**Kyleena: New HCPCS Code and Other Long-Acting Reversible Contraceptive (LARC) Information**

Kyleena, a LARC method, has a new permanent HCPCS code. Kyleena is a five-year 19.5mg levonorgestrel-releasing, intrauterine system and is a Health First Colorado benefit.

Effective January 1, 2018, to bill for provision of Kyleena, providers should use HCPCS code J7296. Additionally, when billing please include the applicable National Drug Code (NDC), the appropriate family planning diagnosis codes, and, if the intent of this service is pregnancy prevention, include the family planning modifier (FP) on the claim.

HCPCS Code	Description	NDC #	Modifier
J7296	Kyleena - 19.5mg levonorgestrel IUS-5yrs	50419042401	FP

If purchasing this product through the federal 340B Drug Pricing Program, Health First Colorado must be billed the actual acquisition cost plus shipping and handling. All other providers must bill the usual and customary charge for this item. Current reimbursement rates for physician administered drugs (PADs) and devices such as contraceptive intrauterine devices (IUDs) and implants can be found on the [Physician Administered Drug Fee Schedule](#).

Below is additional information for other LARC devices:

HCPCS Code	Description	NDC #	Modifier
J7297	Liletta - 52mg levonorgestrel IUS-3yrs	Two-handed inserter: 52544003554 / One-handed inserter: 00023585801	FP
J7298	Mirena - 52mg levonorgestrel IUS-5yrs	50419042101, 50419042301	FP
J7300	Paragard - (CuT38A) - 10 years	51285020401	FP
J7301	Skyla IUD - 13.5mg levonorgestrel IUS-3yrs	50419042201	FP
J7307	Nexplanon - 68mg etonogestrel implant- 3yrs	00052027401, 00052433001	FP

Contact Melanie Reece at Melanie.Reece@state.co.us or 303-866-3693 with any questions.

Physician Services

Preventive Services Billing



Billing for Preventive Service exams (99385-99387 or 99395-99397) is limited to one annual visit each year for adults 21 years or older. To prevent claim denials for exceeding this annual limit, primary and specialty care providers should communicate and coordinate provision of annual exam services when billing with these specific preventive service codes. If similar annual exams are provided (although exams may differ in anatomical focus), other service codes, such as the E/M codes (99201-99205 or 99211-99215), are available for billing for these annual exams.

When date of service timeframes potentially overlap an annual coverage time limit, providers should coordinate their provision of these services. For example, if a primary care practitioner provided a whole-body focused annual exam and an OB/GYN specialist also provides a reproductive tissue specific gynecological exam, these two providers should communicate and coordinate on needed service provision and details as to when the annual preventive service code for that Health First Colorado member was or could be billed.

Providers should notify Health First Colorado members when a preventive service annual exam is being provided. Clear communication with Health First Colorado members assists providers in identifying whether a prevention service code could be billed.

Medical service coding on claims is determined by each practitioner or practitioner group. However, by communicating intent of care with other providers who may provide overlapping services to an individual Health First Colorado member, providers may be able to prevent claim denials for exceeding the annual limit.

Contact the [Provider Services Call Center](#) at 1-844-235-2387 with questions.

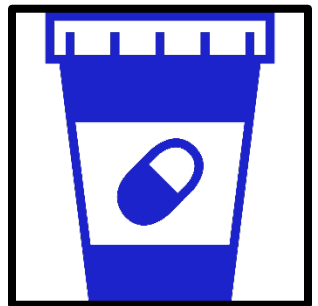
PAD - Drugs and Biologicals Discarded/Not Administered to Any Member (JW Modifier)

Health First Colorado does not reimburse for any drug which is discarded or not administered to a Health First Colorado member. The amount of PAD administered to a Health First Colorado member must be documented in the member's medical record and the provider must only bill for this amount.

An exception to this rule is in accordance with Pub. 100-04, Medicare Claims Processing Manual, chapter 17, section 40. This policy states that claims for Part B drugs and biologicals are required to use the JW modifier to identify unused drugs or biologicals from single-use vials or single-use packages that are appropriately discarded. This modifier, billed on a separate line, will provide payment for the amount of discarded drug or biological. Both the amount administered and discarded must be noted in the member's medical record.

Therefore, Health First Colorado will reimburse for PADs discarded/not administered to any member with the JW modifier for Medicare Crossover claims only. Also, multi-use vials are not subject to payment for discarded amounts of drug or biological.

Contact Felecia Gephart at Felecia.Gephart@state.co.us with questions.



Pharmacy Providers

Opioid Treatment Naïve Policy

The opioid treatment naïve edit was implemented August 1, 2017, [refer to the [August 2017 Provider Bulletin \(B1700401\)](#)]. Currently, members that have not received an opioid claim in the past 365 days are considered opioid treatment naïve. Specifically, at the time a claim for an opioid prescription is processed at point of sale at the pharmacy, the pharmacy system looks back at the past 365 days of claim history for that member for an opioid claim.

Beginning in May 2018, this look-back period will change from 365 days (one year) to 180 days (six months). The opioid treatment naïve edits will begin to apply to members who do not have an opioid claim in the last 180 days.

Current opioid policies can be found in [Appendix P \(Prior Authorization Procedures and Criteria for Physicians and Pharmacists\)](#).

Pharmacy and Prescribing Providers

Drug Utilization Review (DUR) Announcements

Update to Clobazam Coverage for Use in Dravet Syndrome

Effective May 1, 2018, prior authorization criteria for the epilepsy medication Onfi (clobazam) will be updated to include coverage for members age \geq 1 year with a diagnosis of Dravet syndrome. Prior authorization criteria for this medication can be found in [Appendix P \(Prior Authorization Procedures and Criteria for Physicians and Pharmacists\)](#).

Upcoming Holidays

Holiday	Closed Offices/Offices Open for Business
Memorial Day - Monday, May 28, 2018	State Offices, DentaQuest, DXC and the ColoradoPAR Program will be closed. The receipt of warrants and EFTs may be delayed due to the processing at the United State Postal Service or providers' individual banks.
Independence Day - Wednesday, July 4, 2018	State Offices, DentaQuest, DXC and the ColoradoPAR Program will be closed. The receipt of warrants and EFTs may be delayed due to the processing at the United State Postal Service or providers' individual banks.

DXC Contacts

DXC Office

Civic Center Plaza
1560 Broadway Street, Suite 600
Denver, CO 80202

Provider Services Call Center

1-844-235-2387

DXC Mailing Address

P.O. Box 30
Denver, CO 80201