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## Did You Know?

The Department of Health Care Policy & Financing's (the Department's) Fiscal Agent, DXC Technology (DXC), has produced a guide for providers to explain the new Remittance Advices (RAs). This guide has important information providers should know about the RA. The "Provider Web Portal Quick Guide: Reading Your Remittance Advice (RA)" can be found on the [Department's website](#).

## All Providers

### Visit the Known Issues Web Page

Please visit the [Known Issues & Updates](#) web page for general updates, provider web portal updates, and regularly updated information pertaining to known issues and work-arounds, resolved issues, and non-issues. The Department updates this page frequently, but please note this is not a complete list.

### Monitoring Prior Authorization Request (PAR) Submissions through eQSuite

*eQSuite and the Health First Colorado (Colorado's Medicaid Program) Provider Web Portal*

eQSuite is eQHealth Solutions' web-based software designed to facilitate the submission, modification and review of PARs for Health First Colorado clients. It can also provide PAR-related reports and information to requesting providers, and allow providers to communicate with eQHealth Solutions staff including nurse reviewers, provider relations, and customer service.

*Improving health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.*

The Health First Colorado Provider Web Portal is a resource operated by the Department's Fiscal Agent, DXC. The web portal allows providers to submit claims to Health First Colorado, as well as view and print PAR approval/denial letters.

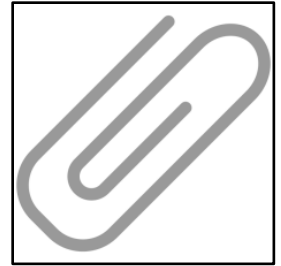
### ***Supporting Documentation Overview***

All PARs require documentation supporting the medical necessity of the requested services. Failure to submit supporting documentation for a PAR in a timely manner will result in a technical denial for lack of information (LOI).

Once a PAR is submitted, its status becomes "Awaiting Required Attachments." The requesting provider then has 24 hours to submit the required documentation.

If, after 24 hours supporting documentation still has not been submitted, the PAR's status becomes "Pended for Additional Information." The requesting provider then has 10 business days to submit the required documentation.

If, after 10 business days supporting documentation still has not been submitted, the PAR is issued a technical denial for LOI. Once a PAR is denied for LOI, it must be resubmitted for consideration. This can cause a delay in care to the member.

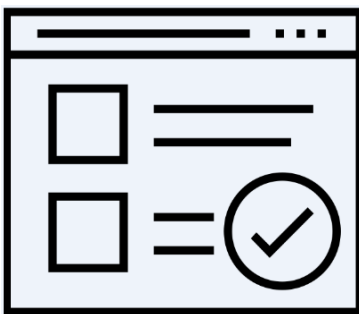


Some PARs are approved automatically without nurse review and therefore bypass the initial opportunity to submit supporting documentation. However, supporting documentation is still required to support the medical necessity of the request. Please see section 1.3 of the [Provider Guide](#) for instructions.

### ***Avoiding LOI Denial***

The easiest way to avoid a denial due to LOI is to monitor the status of submitted PARs and to take action as quickly as possible, when necessary.

Providers who submit PARs online via eQSuite can change their settings to receive email notifications each time a PAR status changes. Email settings are found in the "Update My Profile" section of eQSuite. Alternatively, providers can run the O1 (Outpatient Review Status for a Given Bene) report in eQSuite. This report gives the current status of a particular client's PARs, as well as pertinent information about those PARs.



### ***Responding to a Request for Additional Information***

If a PAR's status is "Pended for Additional Information," the requesting provider must submit the required supporting documentation either online in eQSuite or via fax. First, however, providers must understand what specific additional information is required.

To do this, click "Respond to Add'l Info" in the menu bar of eQSuite. Next, click "View Letter" followed by "View" in the row of the PAR being viewed. You may need to disable your web browser's pop-up blocker. Once you identify what information needs to be submitted and are ready to submit, click "Open" in the same row.

Responses to simple questions can be typed directly into the "ADDITIONAL INFO" text box. If documents are required, they can either be uploaded electronically or faxed in after typing a brief message (e.g. "Additional information submitted via fax") in the "ADDITIONAL INFO" box, clicking "Submit Info," and following the appropriate prompts.

For step-by-step instructions, please reference the [Submitting Supporting Documentation in eQSuite provider guide](#) available on the [ColoradoPAR website](#) in the Provider Education/Training section, under eQSuite Guides, then Submitting Supporting Documentation.

### ***Location of Important Forms***

The [ColoradoPAR website](#) contains many of the [forms](#) commonly required for PARs that have been “Pended for Additional Information,” such as the “Change of Provider” form and “DME Questionnaire #8”.

These [PAR Resources and Forms](#) are available in the Provider Resources section, under Forms and Instructions.

## **Accountable Care Collaborative (ACC) Request for Proposals (RFP) Now Available**

The Department has released the formal RFP for seven Regional Accountable Entities for the next iteration of the ACC. We have made the scope of work of the RFP available for viewing on our [Accountable Care Collaborative Phase II website here](#).

In accordance with [State procurement rules](#), the Department may only respond to questions from potential bidders regarding the RFP through the official inquiry process. The Department is also restricted from discussing the RFP until contract awards are formally announced and all protests and appeals are settled.

Potential bidders must access the RFP using the [State’s procurement website](#) then click “Public Access.” The deadline for proposal submission is July 28, 2017.



## **Paper Claim Form Requirement Change**

As part of the transition to our new Fiscal Agent, DXC, Health First Colorado hopes to have all claims processed as quickly and efficiently as possible. For this to occur, as of April 17, 2017, only original **red** ink claim forms submitted to DXC will be accepted.



All black and white CMS 1500 and UB-04 claim forms received on or after April 17, 2017 will be returned to providers unprocessed. This includes claims submitted as originals, resubmissions, reconsiderations, appeals, and adjustments.

While the information about CMS 1500 paper claims was originally communicated in the April provider bulletin ([B1700397](#)), UB-04 paper claims were not mentioned in the article. Any returned CMS 1500 or UB-04 paper claim needs to be resubmitted to DXC on a red ink claim form. As a reminder, providers who submit claims through the web portal can send attachments with the claims.

# Fingerprint – Federal Criminal Background Check

Federal regulations (42 CFR 455.434) established by Centers for Medicare and Medicaid Services (CMS), require enhanced screening and revalidation of all Medicare, Medicaid and Child Health Plan *Plus* (CHP+) providers.

Most Health First Colorado and CHP+ providers have already met the requirements for this revalidation cycle. However, we want to remind “high-risk” providers (and any person who has ownership or a controlling interest of five percent [5%] or more of a high-risk provider) that they will still need to undergo fingerprinting and a federal criminal background check.

Providers must submit fingerprints within 30 days of a request from CMS, the Department, Department agents or designated contractors.



This is not a request for fingerprint submission, just a reminder that fingerprinting requests and federal criminal background checks will likely begin later this month. More information coming soon.

## National Correct Coding Initiative (NCCI) Notification of Quarterly Updates

Providers are encouraged to monitor 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 July 2017. Please find more information on the [CMS NCCI](#) website.

## Face-to-Face Encounter Requirements for Home Health Services Initiated on or after July 1, 2017

### ***Background***

This bulletin provides guidance to Health First Colorado providers and prescribers of home health services regarding the face-to-face encounter requirements for home health services. For home health services, physicians or certain authorized non-physician practitioners (NPP) (collectively “authorized practitioners”) must document the occurrence of a face-to-face encounter with the Medicaid-eligible beneficiary. The

Centers for Medicare & Medicaid Services published a final rule on February 2, 2016, revising the Medicaid Home Health service definition consistent with section 6407 of the Patient Protection and Affordable Care Act of 2010 (the Affordable Care Act) and section 504 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) adding this requirement.



### ***Requirements***

1. Federally authorized practitioners include:
  - a. The ordering physician. In order to be an ordering physician, the physician must be enrolled in Health First Colorado.

- b. The physician who cared for the patient in an acute or post-acute care facility (from which the patient was directly admitted to home health).
  - c. An NPP, which includes one of the following in a home health context:
    - (1) A nurse practitioner (NP) or clinical nurse specialist (CNS) who is working in collaboration with the ordering physician or the acute/post-acute care physician;
    - (2) A certified nurse midwife;
    - (3) A physician assistant under the supervision of the ordering physician.
2. A face-to-face encounter with a Federally authorized practitioner is required for initial orders for home health services and for all episodes initiated with the completion of a start-of-care OASIS assessment. A face-to-face encounter is not required at recertification of home health services.
3. The plan of care must document that a Federally authorized practitioner conducted a face-to-face encounter with the member related to the primary reason the member requires home health services. The face-to-face encounter required for initial orders must take place no more than 90 days before or 30 days after the start of home health services.

### ***Guidelines on Specific Populations***

1. Well Mom and Baby Visits: Face-to-face encounters need to be conducted for home health services that arise from well mom and baby visits. If, in the course of such a visit, an authorized practitioner determines that home health services are required to address the condition of the mother or child, such a visit could be the basis for a documented face-to-face encounter to the extent that the visit involves examining the condition of the mother or child.
2. Dual-Eligible Members: If the source of payment for the member's care has changed from Medicare to Medicaid, and a face-to-face encounter was performed at the start of home health services, a new face-to-face encounter is not required.

Note: In this circumstance, the **Medicare** face-to-face documentation will meet the **Medicaid** face-to-face documentation requirement.



### ***Guidelines for Documentation***

1. The face-to-face encounter must be documented on the ordering physician's plan-of-care and must include:
  - a. The primary reason the patient requires home health services,
  - b. the date of the face-to-face encounter, and;
  - c. the identity of the practitioner (physician or NPP) who conducted the face-to-face encounter.
2. The documentation needs to be sufficient to make the link between the individual's health conditions, the services ordered, an appropriate face-to-face encounter, and actual service provision.
3. The attending acute or post-acute physician or NPP can perform the face-to-face encounter. The physician (but not NPP) may also serve as the ordering physician writing the plan of care. Members discharged from a hospital to home health services are not required to receive a separate face-to-face encounter, as long as a physician or allowed NPP performs the face-to-face encounter in the hospital and

communicates the clinical findings of the face-to-face encounter to the ordering physician in the community. This requirement is necessary to ensure that the ordering physician has sufficient information to determine the need for home health services in the absence of conducting the face-to-face encounter himself or herself.

Note: Clinical findings can be communicated in the form of clinical and progress notes and discharge summaries.

4. The clinical findings must be reflected in a written or electronic document in the member's medical record by the authorized practitioner.

5. The home health agency must maintain a copy of the face-to-face documentation.

### ***Questions***

If you have any questions about the information in this bulletin, please email [Alexandra Koloskus](#) or call 303-866-5578.

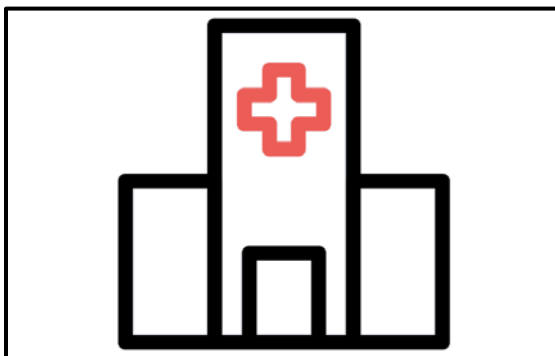
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## **Hospital Providers**

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

#### ***Inpatient Hospital Base Rates FY2017-18***

During the Hospital Engagement Meetings this year, the Department has discussed the issues surrounding the production and mailing of hospital rate letters. This process consumes substantial time and money. Based on feedback from hospitals, the Department will be posting this year's Inpatient Hospital Base Rates on our Inpatient Hospital Payment webpage. The posting will contain a date from which the 30-day timeframe for Informal Reconsiderations and/or Appeals will be calculated.



- Rates will be posted on June 1, 2017 to [the Department's website](#).
- Hospitals who would like to receive the calculations used to arrive at their Inpatient Hospital Base Rate should contact [Diana Lambe](#) or call 303-866-5526.

#### ***New System Mass-Adjustment Coordination***

The Department is beginning to 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 sometime during the month of June, 2017. We will be reaching out to Hospital chief financial officer/Reimbursement Professionals through our Hospital Engagement Newsletters to provide you with updates as we test the process and roll it out.

- Please email [Diana Lambe](#) if you have any concerns about the impending mass adjustments or would like more information.

- For any concerns regarding outpatient hospital claim adjustments following the EAPG implementation, please contact [Andrew Abalos](#).
- If you 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 been holding multiple [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.

- The [agenda](#) for upcoming meetings will be available on our external 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 see [the Department's website](#), email [Diana Lambe](#), or call 303-866-5526.
- The meetings are all held on Fridays:
  - July 7, 2017
  - September 1, 2017
  - November 3, 2017

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## **Pharmacy Providers**

### **Important Information for 340B Providers**

The Colorado interChange allows covered entities to indicate, at the claim 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 on the Department's website.



## ***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.

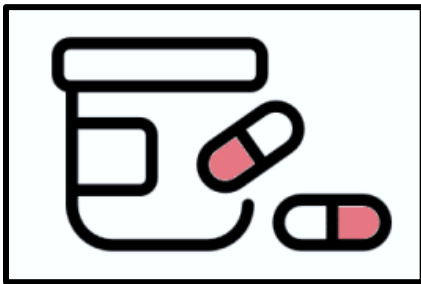
For any physician-administered drugs not purchased through the 340B program, no code modifier is required to indicate that on the claim.

The Department would also like to remind all covered entities that a valid National Drug Code (NDC) must be included on all claims and encounters for physician-administered drugs. To assist providers with billing, a Health Care Common Procedure Coding System (HCPCS)/NDC crosswalk can be found under [Appendices](#).

Providers may send questions related to this notice to the [Department](#).

## **Brand and Generic Changes**

Effective June 1, 2017, the following brand/generic changes will be implemented for Health First Colorado members:



- Valsartan/HCTZ (generic Diovan HCT) will be preferred and brand Diovan HCT will be non-preferred. Brand Diovan HCT will require a Prior Authorization.
- Brand Benicar HCT (olmesartan/HCTZ) will be preferred although it will **not** require a DAW 1 to be dispensed as a Brand name product at point of sale. Generic olmesartan/HCTZ will be non-preferred and require a prior authorization if brand cannot be used.
- Brand Pulmicort nebulas (used via nebulizer) will pay at point of sale as brand name only for all strengths. Brand Pulmicort nebulas will **not** require a DAW 1 to be dispensed as a Brand name product at point of sale. Generic budesonide nebulas will be non-preferred and require a Prior Authorization.

## **Drug Classes and Preferred Agents**

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

### **Newer generation antihistamines and combinations**

Preferred products will be: cetirizine (generic 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

**Pharmacy and Therapeutics Committee Meeting:**

Tuesday, July 11<sup>th</sup>, 2017

1-5pm

303 E 17<sup>th</sup> Avenue

11<sup>th</sup> floor Conference Rooms

### ***Drug Utilization Review (DUR) Announcements:***

- DUR recently published its first newsletter which has some general DUR information and highlights positive impact of the opioid policy pertaining to opioid prescriptions greater than 300 morphine equivalent doses (MED) implemented in February 2016. The [DUR's first newsletter](#) is available on the Department's website. Click on "Check out our first newsletter!"
- The DUR Board has an opening for one MD/DO!
  - Do you or somebody you know have a passion for serving the Medicaid population and availability for a quarterly three-hour meeting (with some preparation) to provide your/their expertise to the process of drafting medication use criteria for the state of Colorado?
  - If so, please send an email to [Brandon Utter](#) for more information!
- DUR provides a teleconsultation service for Medicaid members. Currently, pain management and child psychiatry consults are available by request and for members who meet specific criteria.
  - If you have a complex pain management or child psychiatry case and would like another opinion from an MD/DO in those fields, please send an email to [Brandon Utter](#) for more information.
- The next DUR quarterly meeting will be in August 2017 (date TBA) and will be reviewing the following drug classes:
  - Oral Anticoagulants, Oral Bisphosphonates, Diabetes Management Classes, Erythropoiesis Stimulating Agents, Hepatitis C Virus Treatments, Overactive Bladder Agents, Stimulants and other ADHD Agents

## **Upcoming Holidays**

Holiday	Closed Offices/Offices Open for Business
Independence Day Tuesday, July 4 <sup>th</sup>	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.

## **DXC Contacts**

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

Provider Service Call Center  
1-844-235-2387

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Denver, CO 80202