COLORADO
Department of Health Care Policy & Financing

Provider Bulletin

Reference: B2200478

May 2022

Did You Know?

The Provider Revalidation Dates Spreadsheet, listing all providers and their revalidation dates, is posted on the Revalidation web page under "Revalidation Resources". This information is updated weekly. Providers are reminded to submit their revalidation applications by their listed due date. If providers are uncertain of the revalidation status, contact the Provider Services Call Center for assistance.

All Providers

Providers Help to Keep Member Contact Information Up to Date

Help spread the word to Health First Colorado (Colorado's Medicaid program) and Child Health Plan *Plus* (CHP+) members to update their contact information.

Improve health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado.

During the public health emergency (PHE), members stay enrolled in health coverage even if they have household or income changes. At the end of the PHE, many Health First Colorado and CHP+ members will receive a packet to renew their coverage.

Members who fail to fill out necessary information may lose their benefits.

Many members have moved over the past few years, and it is crucial to have correct addresses so that members get the information needed to keep or change their coverage. The Department of Health Care Policy & Financing (the Department) has collaborated with community partners to create an "Update Your Address" campaign for members. Please use the following resources to spread the word.

Update Your Address outreach materials in Microsoft Word format (English and Spanish)

Reminder: Enrollment License Requirement and License Panel Updates

Current Health First Colorado providers that are required to maintain a license as part of their enrollment will receive a letter from the Department when the primary license is approaching expiration or has reached its expiration date. Providers are reminded that Health First Colorado enrollment may be inactivated if the provider's license, certification, or accreditation has expired or is subject to conditions or restrictions. Visit the General Provider Information Manual web page for more information.

The License panel of the Provider Web Portal (Provider Maintenance function) was recently updated to require additional information when adding a new license or updating/renewing an existing license. This update only impacts provider types and specialties required to submit and maintain a license(s) as part of their Health First Colorado enrollment. Visit the Information by Provider Type web page for license requirements by provider type and specialty.

Reference the Revalidation Manual available on the Revalidation web page or the Revalidation Quick Guide web page for details on adding or updating a license for revalidation applications. Visit the Provider Maintenance - License Update Quick Guide web page for instruction on adding or updating a license through a Provider Maintenance request.

Behavioral Health Providers

Updated Provider Enrollment and Claims Submission Policy

Effective May 1, 2022, practitioners who are eligible to enroll in Health First Colorado and have applied for credentials with a Regional Accountable Entity (RAE) may continue to submit claims under a supervising provider until they are contracted with a RAE. This guidance will be added to the July 1 edition of the Uniform Services Coding Standards (USCS) Manual.

Child Health Plan *Plus* (CHP+) Providers

Contracting Alert Ahead of Friday Health Plans Transition

Effective July 1, 2022, Friday Health Plans (FHP) will no longer operate as a Managed Care Organization (MCO) in Colorado under the Child Health Plan *Plus* (CHP+) program. Providers who do not have an active contract with another CHP+ MCO will not be eligible for reimbursement for services delivered to FHP CHP+ members after June 30. Affected providers should contact the CHP+ MCOs in their area to begin the contracting process. Contact the following for more information about CHP+ contracting:

CHP+ MCO	Contact Information
Colorado Access	ProviderRelations@coaccess.com
Denver Health	(303) 602-2003
Kaiser Permanente	(866) 866-3951
Rocky Mountain Health Plans	Western Slope Providers: (970) 244-7798 Front Range Providers: (303) 689-7372

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

Update to the Enclosed/Safety Bed PAR Process

Effective May 1, 2022, Questionnaire #19 will no longer be used for Prior Authorization Requests (PARs). Requests for these items will now consist of a single attestation within Keystone Peer Review Organization (Kepro's) electronic system, Atrezzo. Providers will be asked to confirm that caregivers have been educated on safe and proper use of the bed. The corresponding policy in the DMEPOS Billing Manual should be disregarded until it can be removed.

Contact Haylee.Rodgers@state.co.us with any questions.

Family Planning Providers

Rates for Modifier FP

The rates for the Evaluation and Management (E&M) Current Procedural Terminology (CPT) code 99203, when billed with the Family Planning modifier (FP) or FP + GT (telemedicine modifier) were loaded into the Colorado interChange incorrectly.

The rates have been corrected on the FY 19-20, FY 20-21 and FY 21-22 Health First fee schedules. Claims submitted for 99203 (FP) or 99203 (FP+GT) with dates of service on or following March 28, 2020, were reprocessed April 4, 2022, for the additional payment.

The corrected rate amounts, per fiscal year, for 99203 (FP) and 99203 (FP + GT) are listed below:

Code	Modifier Combinations		Note
99203	**FP**	**FP+GT**	
FY 21-22	$122.77	$127.84	2.5% increase applied to FY 20-21 rate
FY 20-21	$119.78	$124.73	1.0% decrease applied to FY 19-20 rate
FY 19-20	$120.99	$125.94	Base rate

Contact Melanie Reece at Melanie.Reece@state.co.us with family planning program-related questions about 99203, or Marli Firillo at Marli.Firillo@state.co.us for rates-related concerns about 99203.

Hospital Providers

General Updates

All Hospital Providers

Hospital Stakeholder Engagement Meetings

Bi-monthly Hospital Engagement meetings will continue to be hosted to discuss current issues regarding payment reform and operational processing. Sign up to receive the Hospital Stakeholder Engagement Meeting newsletters.

- The All-Hospital Engagement meeting is scheduled for **Friday, May 6, 2022, from 9:00 a.m. - 12:00 p.m. MT** and will be hosted virtually.

Visit the Hospital Stakeholder Engagement Meeting web page for more details, meeting schedules and past meeting materials. **Calendar Year 2022 meetings have been posted**

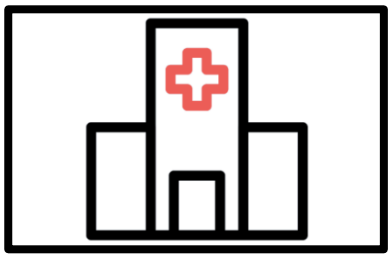
Outpatient Hospitals

Update to Version 3.16 of Enhanced Ambulatory Patient Grouping (EAPG) Methodology

The Department has been collaborating with its vendors and hospital stakeholders over the last year preparing for the implementation of a new version of the EAPG (3.16) methodology which calculates payment for outpatient hospital services. This new version of EAPG will be implemented retroactively with an effective date of January 1, 2022, and requires both

Medical Services Board and State Plan authority for implementation. The base rate methodology for maintaining revenue neutrality among hospitals and their groups, which was shared in the November Stakeholder Meeting, and the relative weights Colorado intends to use for EAPG payments have been posted to the Outpatient Hospital Payment web page for review.

Until State Plan approval for payment using this methodology, outpatient hospital claims will continue to process using version 3.10 of the EAPG methodology with base rates in effect immediately prior to January 1, 2022. All claims billed using Healthcare Common Procedural Coding System (HCPCS) codes effective January 1, 2022, will remain in suspense until Centers for Medicare & Medicaid Services (CMS) approval for this update is obtained.



For information regarding the update to version 3.16, see the meeting notes contained on the Hospital Engagement Meeting web page.

Contact Andrew Abalos at Andrew.Abalos@state.co.us and Tyler Samora at Tyler.Samora@state.co.us for any questions regarding this update.

Upcoming Rule Change for EAPG Rates for New and Out-of-State Hospitals

A rule change to the Medical Services Board (MSB) will be proposed by the Department on May 13, 2022. This rule change intends to add granularity to the peer groups used in EAPG rate calculation such that rates set for new and out-of-state hospitals are calculated based on more accurate categorizations which are in greater alignment with those category's hospital cost profiles. Effective August 1, 2022, the proposed rule change will update rates for out-of-state hospitals. New hospitals enrolled on or after September 1, 2022. will have their rates set based on these new peer group definitions following the approval of these rule change proposals.

Contact Andrew Abalos at Andrew.Abalos@state.co.us and Tyler Samora at Tyler.Samora@state.co.us for information regarding this rule change.

Rural Health Clinics

Bi-monthly Rural Health Clinic Engagement meetings will continue to be hosted to discuss current issues regarding payment reform and operational processing.

- The next Rural Health Clinic Engagement meeting is scheduled for **Thursday, May 5, 2022, from 12:30 p.m. to 1:30 p.m.- MT** and will be hosted virtually on Zoom.

Visit the Rural Health Clinic Engagement Meeting web page for more details, meeting schedules and past meeting materials.

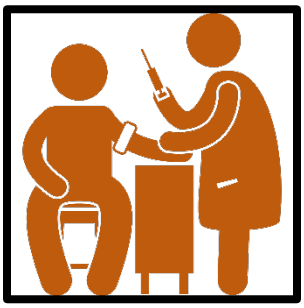
Rural Health Clinic Change-in-Scope Rate Adjustment Applications are due by **May 31, 2022**. The applications and instructions may be found on the Rural Health Clinic Forms Page.

Contact Erin Johnson at Erink.Johnson@state.co.us with any questions or topics to be discussed at future meetings. Advanced notice will provide the Rates team time to bring additional Department personnel to the meetings to address different concerns.

Hospitals, Federally Qualified Health Clinic (FQHC), Rural Health Clinic (RHC), Physician Services, Home Health, Managed Care Plans, Nursing Facilities, Pharmacies

COVID-19 Monoclonal Antibodies and Other Therapeutics

The U.S. Food and Drug Administration (FDA) issued Emergency Use Authorizations (EUA) for an additional investigational monoclonal antibody COVID-19 therapy. On February 11, 2022, the EUA for bebtelovimab was issued for treatment of COVID-19 in certain adult and pediatric individuals.



Effective February 24, 2022, Q0221 (Tixagev and cilgav, 600mg) was issued for the existing EUA for Evusheld (tixagevimab co-packaged with cilgavimab) and may be billed. Previously denied claims for dates of service beginning February 24, 2022 will be reprocessed.

When doses of any COVID-19 therapy are provided without charge from the federal government, providers should bill Health First Colorado for the administration procedure codes and may bill for the monoclonal antibody or other therapy specific procedure codes on the claim. If codes are billed for the monoclonal antibodies or other therapies, the lines may pay at zero or be denied. This information is subject to change dependent on the COVID-19 public health emergency declaration.

The following table may be used as a procedure code reference for the duration of the declaration and only includes the most recent coverage additions to COVID-19 monoclonal antibodies and other COVID-19 therapeutics covered by the Department.

Procedure Code	Long Description	Short Description	EUA Effective Date	EUA End Date
Q0220	Injection, tixagevimab and cilgavimab, for the pre-exposure prophylaxis only, for certain adults and pediatric individuals (12 years of age and older weighing at least 40kg) with no known sars-cov-2 exposure, who either have moderate to severely compromised immune systems or for whom vaccination with any available covid-19 vaccine is not recommended due to a history of severe adverse reaction to a covid-19	Tixagev and cilgav, 300mg	12/08/2021	TBD

	vaccine(s) and/or covid-19 vaccine component(s), 300 mg			
Q0221	Injection, tixagevimab and cilgavimab, for the pre-exposure prophylaxis only, for certain adults and pediatric individuals (12 years of age and older weighing at least 40kg) with no known sars-cov-2 exposure, who either have moderate to severely compromised immune systems or for whom vaccination with any available covid-19 vaccine is not recommended due to a history of severe adverse reaction to a covid-19 vaccine(s) and/or covid-19 vaccine component(s), 600 mg	Tixagev and cilgav, 600mg	02/24/2022	TBD
M0220	Injection, tixagevimab and cilgavimab, for the pre-exposure prophylaxis only, for certain adults and pediatric individuals (12 years of age and older weighing at least 40kg) with no known sars-cov-2 exposure, who either have moderate to severely compromised immune systems or for whom vaccination with any available covid-19 vaccine is not recommended due to a history of severe adverse reaction to a covid-19 vaccine(s) and/or covid-19 vaccine component(s), includes injection and post administration monitoring	Tixagev and cilgav inj	12/08/2021	TBD
M0221	Injection, tixagevimab and cilgavimab, for the pre-exposure prophylaxis only, for certain adults and pediatric individuals (12 years of age and older weighing at least 40kg) with no known sars-cov-2 exposure, who either have moderate to severely compromised immune systems or for whom vaccination with any available covid-19 vaccine is not recommended due to a history of severe adverse reaction to a covid-19 vaccine(s) and/or covid-19 vaccine component(s), includes injection and	Tixagev and cilgav inj hm	12/08/2021	TBD

	post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider-based to the hospital during the covid-19 public health emergency			
Q0222	Injection, bebtelovimab, 175 mg	Injection, bebtelovimab , 175 mg	02/11/2022	TBD
M0222	Intravenous injection, bebtelovimab, includes injection and post administration monitoring	Bebtelovimab injection	02/11/2022	TBD
M0223	Intravenous injection, bebtelovimab, includes injection and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider-based to the hospital during the covid-19 public health emergency	Bebtelovimab injection home	02/11/2022	TBD
J0248	Injection, remdesivir, 1 mg	Inj, remdesivir, 1 mg	N/A	N/A

Note: Procedure code J0248 was issued by Centers for Medicare & Medicaid Services(CMS) and effective as of December 23, 2021, for remdesivir when administered in outpatient settings.

Links to Appendix X, the PAD Fee Schedule, and Physician-Administered Drugs (PAD) Billing Manual can be found on the Physician-Administered Drugs resources web page.

Additional Emergency Use Authorization (EUA) information can be found on the CMS COVID-19 Vaccines and Monoclonal Antibodies web page.

Contact Felecia.Gephart@state.co.us and Morgan.Anderson@state.co.us with questions or concerns.

Immunizations, All Vaccine Providers

Expanded Coverage under the Emergency Medical Service (EMS) COVID-19 Only Benefit Plan

The "EMS COVID-19 Only" emergency benefit for uninsured Coloradans has been updated in compliance with the American Rescue Plan Act (ARPA) to include coverage of any service for

COVID-related testing, treatments, and vaccines. This update impacts all claim types with dates of service on or after March 11, 2021.

Dates of service prior to March 11, 2021 should be processed according to the policy at that time which was limited to specific procedure codes (See Provider News & Resources Issue 17 - February 26, 2021).

Claims with dates of service on or after March 11, 2021, under this benefit plan must have one or more of the following diagnosis codes OR a COVID-19 vaccine code present to identify the services as COVID-related or the claim will deny.

Diagnosis Codes			
B94.8	B99.9	J12.82	J18.9
M35.81	M35.89	O98.5	R05
R06.02	R50.9	U07.0	U07.1
U09.9	Z11.52	Z11.59	Z13.9
Z20.818	Z20.822	Z20.828	Z86.16

Only the enumerated diagnosis codes and COVID-19 vaccines are covered under this benefit. The COVID-19 Information for Health First Colorado and CHP+ Providers and Case Managers web page has been updated accordingly. Affected claims with dates of service on or after March 11, 2021, where the member is eligible for the EMS COVID-19 benefit, will be reprocessed. Providers may submit claims with these diagnosis codes, or COVID-19 vaccine codes that were previously not covered for this benefit on or after March 11, 2021, but are now included in the new coverage criteria.

Managed Care Organizations (MCO)

Upcoming Expansion of Rocky Mountain Health Plans Prime Service Area

Effective July 1, 2022, the service area for Accountable Care Collaborative (ACC) Managed Care Organization (MCO) Rocky Mountain Health Plans Prime (RMHP) will be expanding. Delta, Ouray and San Miguel counties will be added to the current service areas, and the maximum number of enrollees will be increased.

Some Primary Care Medical Providers (PCMPs) within the ACC MCO RMHP service areas will be contracted directly, and eligible members attributed to those PCMPs will be reattributed to ACC MCO RMHP.

Contact RAESupport@rmhp.org with any questions.

Pharmacy, Clinics

Carved-Out Procedure Codes

Providers are reminded that these certain procedure codes which are currently carved out from the two physical health managed care plans (Denver Health and Rocky Mountain Health Plans) will be ending effective July 1, 2022.

86701	87389	87806	96372	99202	99203
99204	99205	99211	99212	99213	99214
99215	99401	99402	99403	99404	99406
99407	99408	99409	99411	99412	99441
99442	99443	G0108	G0109	G0433	

Providers are encouraged to enroll with Rocky Mountain Health Plans and Denver Health Plans since these managed care organizations (MCOs) will become responsible for claim reimbursement for their members when the carveout ends.

Contact Cameron Amirfathi at Cameron.Amirfathi@state.co.us with any questions.

Physician Services

Behavioral Health for Gender-Affirming Care

Gender-affirming surgery criteria, which can be found in Department Rule (8.735.4.F.) as well as the Gender-Affirming Care Billing Manual, require that a member has been evaluated by a licensed behavioral health provider within the past sixty (60) days from the time of the surgical consult.

Effective July 1, 2022, behavioral health services with a primary diagnosis of F64.0-F64.9 will no longer be billed through the outpatient behavioral health fee-for-service (FFS) benefit for members enrolled in the Accountable Care Collaborative (ACC) and assigned to a Regional Accountable Entity (RAE). Behavioral health providers must contract directly with the RAEs in order to bill for behavioral health services provided for these diagnoses.

More information about reporting behavioral health services can be found in the Uniform Service Coding Standards Manual. The latest version is available on the ACC Provider Resource web page.

Contact Chris Lane at Christopher.Lane@state.co.us with questions regarding gender-affirming care policy.

Contact Sandy Grossman at Sandra.Grossman@state.co.us with questions regarding behavioral health policy.

Billing Guidance: Avastin Used for Ophthalmology Treatment of Age-related Macular Degeneration (AMD)

Effective April 1, 2022, when treating a Health First Colorado member for Food and Drug Administration (FDA)-approved or compendia-supported ophthalmology treatment of age-related macular degeneration (AMD) with Avastin (bevacizumab), providers should utilize the following billing guidance as most appropriate:

HCPCS	NDC	HCPCS Units	Unit of Measure	Effective Date
J7999	50242006001	1 per eye	mL	04/01/2022
J7999	50242006101	1 per eye	mL	04/01/2022
C9257	50242006001	1 per 0.25 mg	mL	02/26/2004
C9257	50242006101	1 per 0.25 mg	mL	02/26/2004

For Health First Colorado-only members, the Department does not pay for wasted drug from single or multi-use vials; a provider must bill only for the amount of drug administered to the member. For members having both Health First Colorado and Medicare (dual-eligible), a provider may bill for wasted drug on a second line with the JW modifier on Medicare Part B Crossover claims.

For dates of service prior to April 1, 2022, providers should continue to bill for J9035 and the national drug code (NDC) of the drug administered to the member.

Any claims billed after April 1, 2022, must be billed according to the provided guidance in the table. Any claim billed otherwise should be resubmitted accordingly.

Contact HCPF_PAD@state.co.us with questions regarding this guidance.

Global Surgery Policy Update

The global surgery reimbursement policy has been updated. Changes will be effective for services rendered on or after May 1, 2022.

The post-operative period for a surgical procedure code is determined by the value given in the Medicare Physician Fee Schedule Database, and is either 0, 10, or 90 days. Evaluation and management services rendered by the surgeon during this period that are related to recovery from the surgery are included in the payment for the surgery, and not separately reimbursable. This includes any services required of the surgeon during the post-operative period because of complications which do not require additional trips to the operating room.

Services that are considered related to the surgery include but are not limited to:

- For dates of service before May 1, 2022: Evaluation and Management (E/M) services when the first three digits of the diagnoses associated with the E/M match the first three digits of the diagnoses associated with the surgery.
- For dates of service May 1, 2022 and after: E/M services when the diagnoses associated with the E/M match exactly any of the diagnoses associated with the surgery.

See the Medical-Surgical Billing Manual for additional details.

Contact Chris Lane at Christopher.Lane@state.co.us with questions.

Physician-Administered Drug (PAD) Prior Authorization Request (PAR) Policy Clarification

Units Requested on the Prior Authorization (PA)

When submitting a prior authorization request (PAR), providers must request the total number of units appropriate and necessary for the course of the treatment to be covered by the PA and as indicated for the specified diagnosis.

For Health First Colorado-only members, the Department does not pay for wasted drug from single or multi-use vials; a provider must bill for only the amount of drug administered to the member. For members having both Health First Colorado and Medicare (dual-eligible), a provider may bill for wasted drug on a second line with the JW modifier on Medicare Part B Crossover claims only.

The requested units shall not include waste or discarded drugs from single-dose vials nor should a PA be requested for any PAD not purchased directly by the provider.

Additional guidance on unit calculation and billing policies can be found in the PAD billing manual.

Retroactive PARs

Retroactive authorizations are not allowed, with a few exceptions due to extenuating circumstances.

Exceptions are granted only when the provider is able to document that appropriate action was taken to meet the submission requirements and that the provider was prevented from requesting the PA as the result of extenuating, unforeseen and uncontrollable circumstances. Requests for retroactive authorization must contain a detailed description of the circumstance that was beyond the control of the provider.

Note: Office/clinic employee negligence, employer failure to provide sufficient, well-trained employees or failure to properly monitor the activities of employees and agents (e.g., billing services) are not considered extenuating circumstances beyond the provider's control.

A detailed description and applicable documentation of the extenuating circumstances must be included in the request for retroactive authorization.

Coordination of Benefits (COB)- PA requirements for Health First Colorado members who have Medicare coverage (dual-eligible) and members with other Third-Party Liability (TPL) health insurance coverage

Dual-Eligible members

When a PAD listed on Appendix Y meets criteria for a local coverage determination (LCD) and/or a national coverage determination (NCD) and is billed to Medicare as primary and Health First Colorado secondary, no prior authorization is needed and no PAR submission is required.

Other Third-Party Liability (TPL)

Providers must submit a PAR to Kepro for any PAD listed on Appendix Y when a member has additional TPL health insurance coverage other than Medicare. Kepro will process a PAR according to the criteria on Appendix Y and notify the provider of the determination per all PAD PAR policy and procedure requirements.

- The requesting provider must submit a PAR to Kepro, regardless of the TPL PA determination and must include:
    - Any and all determination letters and clinical documentation
    - A note of the approval or denial made by TPL

Any guidance regarding PAR requirements related to COB received prior to May 1, 2022, will not be considered and all members with TPL will require a PAR.

PAR Submission

When entering a PAD PAR, the servicing provider is the billing provider. If entering the rendering/administering provider as the servicing provider, there may be instances where the rendering provider type is producing a PAR submission error. Ensure the billing provider (typically the clinic/office) is entered on the PAR as the servicing provider to successfully submit the PAR and to avoid subsequent PAD claims processing issues.

For any approved PAR on file in which the billing provider was not entered as the servicing provider, complete the following steps for the pertinent scenario to ensure the information on the PAR is accurate and to avoid PAD claims processing issues:

1. There has been at least one claim billed on the PAR
    a. Submit a new prior authorization request
    b. Add a note to include:
        i. A description of the error
            (a) Example: Previous PAR was approved with incorrect provider listed as the servicing provider
        ii. The request to end-date the previous PAR and include the case ID
2. There have been no claims billed on the PAR
    a. File a revision request on the submitted PAR in Atrezzo
    b. Follow the instructions for How to Make Revisions to Submitted Request

Visit the Physician-Administered Drugs web page to find the PAD PAR Frequently Asked Questions for more information.

Physician-Administered Drugs (PAD) Providers

Appendix Y

All physician administered drug (PAD) prior authorization procedures and clinical criteria effective May 1, 2022, can be found on the most recently published Appendix Y: Physician Administered Drug Medical Benefit Prior Authorization Procedures and Criteria posted on the PAD Resources webpage.

PARs may be submitted and will be processed via the Kepro portal. Keystone Peer Review Organization (Kepro) has various recorded trainings and user guides which can be found at ColoradoPAR: Health First Colorado Prior Authorization Request Program.

Email HCPF_PAD@state.co.us with all other PAD questions.

Physician Services, Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), Indian Health Services (IHSs), Telemedicine

Telemedicine: Public Health Emergency (PHE) and Beyond

At the start of the COVID-19 PHE, Health First Colorado authorized temporary changes to facilitate the safe delivery of health care services to members. Health First Colorado authorized temporary changes to the existing telemedicine policy to allow telemedicine for Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs) and Indian Health Services (IHS) clinics. In July of 2020, Health First Colorado received approval from the Centers for Medicare & Medicaid Services (CMS) to make those changes permanent. Telemedicine is defined in Rule 8.200.3.B as the delivery of medical services and any diagnosis, consultation, treatment, transfer of medical data or education related to health care services using interactive audio, interactive video or interactive data communication instead of in-person contact.

Health Insurance Portability and Accountability Act (HIPAA) Compliance

The Office of Civil Rights (OCR) has issued enforcement discretion regarding provider use of an audio or video communication platform during the COVID-19 PHE. As a result of OCR's enforcement discretion, an enrolled health care provider that wants to use audio or video communication technology to provide telemedicine to Health First Colorado members during the PHE can use any available non-public facing audio or video communication technology in connection with the good faith provision of telehealth to patients without risk of OCR imposing a penalty on the provider for violating applicable Health Insurance Portability and Accounting Act (HIPAA) Privacy, Security, and Breach Notification Rules (the HIPAA Rules).

When the PHE ends, enrolled health care providers may continue to provide services via telemedicine in compliance with the applicable HIPAA Rules, as they could before the PHE went into effect. OCR will issue a notice to the public when it is no longer exercising its enforcement discretion based on the expiration date of the declared PHE or the Health and Human Services Secretary declares that the PHE no longer exists, whichever occurs first.

Audio-only and HIPAA Compliance Post-PHE

Audio-only is a real-time interactive voice-only discussion (including relay calls), usually between a Health First Colorado member and a provider, and generally only requires a working phone. Telephone communications meet the HIPAA conduit exception.

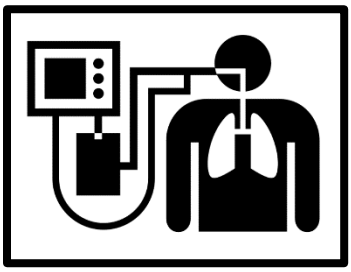
When communicating by telephone, providers must comply with state and federal laws regarding privacy including the Privacy and Security Rules, the Telephone Consumer Protection Act, the Telemarketing and Consumer Fraud and Abuse Prevention Act, and the Telephone Robocall Abuse Criminal Enforcement and Deterrence (TRACED) Act. Additionally,

providers should review 45 CFR 160.103 to ensure compliance with business associate agreements and electronic protected health information.

Prior Authorization Requests (PARs) - Keystone Peer Review Organization (Kepro)

Ventilator Tubing PARs

Information has been requested on how often Health First Colorado will pay for ventilator tubing and whether prior authorization request (PAR) processes will impact the approval.



Respiratory care equipment requires a prescription for the requested equipment or supplies and the quantity needed, signed by a MD, DO, physician assistant or advanced registered nurse practitioner with an ink signature or an electronic/digital signature with a date and time stamp. Supporting documentation such as a Face2Face (chart notes) validates the medical need. If the member needs additional tubing, it needs to be addressed specifically on the prescription.

For certain durable medical equipment (DME), there are codes for continuous rental that include all supplies and accessories. In these cases, it is expected that the DME supplier provides what each member needs as stated on the prescription. For example, if a member needs to replace their tubing three times per month, then that should be clearly stated on the prescription so the DME supplier can provide that as part of the rental.

Providers may bill separately for the following codes:

E0465	Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)
E0466	Home ventilator, any type, used with non-invasive interface, (e.g., mask, chest shell)

The following code may not be billed separately for individual components of the devices (unbundled).

E0467	Home ventilator, multi-function respiratory device, also performs any or all of the additional functions of oxygen concentration, drug nebulization, aspiration, and cough stimulation, includes all accessories, components and supplies for all functions

Contact HCPF_benefitsupport@state.co.us with questions about situations that may fall in this category.

Additional information is also included on the Durable Medical Equipment HCPCS Codes webpage under the Oxygen & Respiratory Care - General Use section regarding member or caregiver concerns about lack of needed supplies.

"No PAR Required" Codes entered into Kepro's Provider PAR portal, Atrezzo

Effective immediately, Kepro, the Department's third-party utilization management (UM) vendor, will shut off the ability to submit PARs for codes that do not require them. When a provider attempts to submit a PAR for a code that does not require it (NO PAR required), they will receive an alert in Atrezzo and will not be allowed to proceed.

Providers with specific code questions can refer to the Health First Colorado fee schedule or contact the Department directly at HCPF_benefitsupport@state.co.us for any policy or code-related questions.

Retroactive PARs

Currently, due to the public health emergency (PHE), Kepro is not denying PARs for services that were already provided (for example, untimely reviews or "retro" reviews). Exceptions to this policy include Durable Medical Equipment (DME) requests where providers have up to 90 calendar days to request PAR for services rendered and for Private Duty Nursing (PDN), providers have 10 calendar days to submit a retro request. If a PDN request is submitted after 10 calendar days, the start will be the day of submission and the end date is adjusted to reflect the original length of services requested.

Note: PARs submitted more than six months beyond the requested start of care date may result in a PAR being "pended" for more information. Kepro may inquire why the submission was late if the information is not noted in the case. Retro PARs submitted over one year after the requested start of care date will be forwarded from Kepro to the appropriate policy manager for permission and assistance in claims payment.

Providers can be proactive and email the Policy inbox at HCPF_benefitsupport@state.co.us and copy the UM Inbox (HCPF_UM@state.co.us) with questions about this process or to request retro approval before submitting the PAR in Atrezzo.

Reminder for Home Health if Providing Private Duty Nursing (PDN)

Prior authorization is a requirement for all Private Duty Nursing (PDN) services. Providers are expected to continue following the guidance in the November 2021 Provider Bulletin (B21000470) regarding prior authorization submission timelines and volume for PDN services.

Service Type	Revenue Code
PDN-RN	552
PDN-LPN	559

PDN-RN (group-per client)	580
PDN-LPN (group-per client)	581
"Blended" group rate / client*	582

* The "blended" rate is available on request for a Home Health Agency that provides Private Duty Nursing to multiple clients at group care settings. All Private Duty Nursing provided in those settings is billed at the same rate and revenue code for an RN or LPN.

As a reminder, Adult Home Health does require a PAR.

Read the frequently asked questions and the updated Operational Memo for more information. Visit the PAR Updates web page for more information and updates.

Kepro is Here for Colorado Providers!

- Contact a live agent in Kepro's customer service department at 720-689-6340 from 8:00 a.m. to 5:00 p.m. MT, Monday through Friday.
- If the Customer Service Representative (CSR) is unable to provide a response to a question (for example, if the issue needs a response from a clinical staff person) the CSR will attempt to transfer to the reviewer who worked/is working the case or, if the reviewer is not available, the CSR will then transfer the call to a supervisor for resolution.
    - If neither the reviewer nor supervisor are available at the time of the call, call - back information is sent to the clinical team for call back and resolution.
- An additional option is to contact the provider relations team by email at coproviderissue@kepro.com. Include the case ID number or PAR number in the email, as well as a summary of the issue.
    - If the email is pertaining to a request for additional information ("pend") from Kepro, please note that in the subject line of the email (Subject: Pend Issue case ID#.).
- Provider relations staff will respond within one business day.

Women's Health, Physician Services, Clinics

Changes to Family Planning Services: Undocumented and Expanded Income Group

Effective July 1, 2022, several changes will occur related to the family planning benefit.

Twelve-Month Supply of Contraceptives

Providers can prescribe a 12-month supply of contraceptives to Health First Colorado (Colorado's Medicaid program) members eligible for family planning services.

Family Planning Services for Undocumented Individuals

Health First Colorado will provide family planning services for undocumented individuals who have enrolled.

Family planning services provided through Health First Colorado include a 12-month supply of any Food and Drug Administration (FDA)-approved contraceptive drug, device, or product or an alternative if indicated by a health care provider. This includes:

- Any contraceptive drug, device or product approved by the FDA.
- Services related to the administration and monitoring of such products, including management of side effects.
- Counseling services for continued adherence to a prescribed regimen.
- Device insertion and removal.
- Any other contraceptive method and counseling services identified by the Department of Health and Human Services (HHS) or the Women's Preventive Services Guidelines.

Family Planning and Family Planning-Related Services for Expanded Income (up to 260% of the Federal Poverty Level)

The Colorado interChange is being updated in accordance with Senate Bill (SB) 21-009 and SB 21-025 to expand the Family Planning Benefit to undocumented Coloradans and individuals who do not exceed the currently defined federal poverty level.

Health First Colorado will provide family planning and family planning-related services for individuals whose income exceeds levels for general Health First Colorado benefits. Individuals with incomes up to 260% of the Federal Poverty Level can be presumptively eligible and then fully eligible for these services.

A new billing manual for expanded income and undocumented family planning services, including more details on enrollment for members and billing by providers, will be issued in June 2022.

Sign up for the Maternal, Child and Reproductive Health Newsletter and visit the Maternal, Child and Reproductive Health web page for the latest information regarding this program.

Email hcpf_MaternalChildHealth@state.co.us with questions about these changes.

Post-Partum Coverage Extended to 12 Months for Child Health Plan *Plus* (CHP+) and Health First Colorado Members

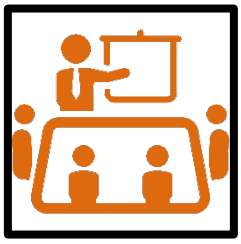
The Colorado interChange is being updated in accordance with Senate Bill (SB) 21-194 to extend postpartum medical benefits coverage from 60 days to 12 months to persons who qualified for benefits while pregnant. Per the American Rescue Plan Act (ARPA), CHP+ must implement the same 12-month extension implemented for Medicaid.

Visit the Obstetrical Care Billing Manual web page for more information on this policy.

Provider Billing Training Sessions

May and June 2022 Provider Billing Webinar-Only Training Sessions

Providers are invited to participate in training sessions for an overview of Health First Colorado billing instructions and procedures. The current and following months' workshop calendars are shown below.



Who Should Attend?

Staff who submit claims, are new to billing Health First Colorado services, or need a billing refresher course should consider attending one or more of the following provider training sessions.

The institutional claims (UB-04) and professional claims (CMS 1500) training sessions provide high-level overviews of claim submission, prior authorizations, navigating the Department's website, using the Provider Web Portal, and more. For a preview of the training materials used in these sessions, refer to the Beginner Billing Training: Professional Claims (CMS 1500) and Beginner Billing Training: Institutional Claims (UB-04) available on the Provider Training web page under the Billing Training – Resources drop-down section.

For more training materials on navigating the Provider Web Portal, refer to the Provider Web Portal Quick Guides available on the Quick Guides web page.

Note: Trainings may end prior to 11:30 a.m. MT. Time has been allotted for questions at the end of each session.

May 2022

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	2	3	4	5	6	7
8	9	10	11	12 Beginner Billing Training: Professional Claims (CMS 1500) 9:00 a.m. – 11:30 a.m. MT	13	14
15	16	17	18	19	20	21
22	23	24	25	26 Beginner Billing Training: Institutional Claims (UB-04) 9:00 a.m. – 11:30 a.m. MT	27	28
29	30 **Memorial Day**	31				

June 2022

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			1	2	3	4
5	6	7	8	9 Beginner Billing Training: Professional Claims (CMS 1500) 9:00 a.m. - 11:30 a.m. MT	10	11
12	13	14	15	16	17	18
19	20	21	22	23 Beginner Billing Training: Institutional Claims (UB-04) 9:00 a.m. - 11:30 a.m. MT	24	25
26	27	28	29	30		

Live Webinar Registration

Register for a live webinar by clicking the title of the desired training session in the calendar above and completing the webinar registration form. An automated response will confirm the reservation. For questions or issues regarding webinar registration, email co.training@gainwelltechnologies.com with the subject line "Webinar Help." Include a description of the issue being experienced, name and contact information (email address and phone number), and the name and date of the webinar(s) to be attended. Allow up to 2-3 business days to receive a response.

Upcoming Holidays

Holiday	Closed Offices/Offices Open for Business
Memorial Day Monday, May 30	State Offices, Gainwell Technologies, DentaQuest and the ColoradoPAR Program will be closed. Capitation cycles may potentially be delayed. The receipt of warrants and EFTs may potentially be delayed due to the processing at the United State Postal Service or providers' individual banks.
Independence Day Monday, July 4	State Offices, Gainwell Technologies, DentaQuest and the ColoradoPAR Program will be closed. Capitation cycles may potentially be delayed. The receipt of warrants and EFTs may potentially be delayed due to the processing at the United State Postal Service or providers' individual banks.

Gainwell Technologies Contacts

Provider Services Call Center
1-844-235-2387

Gainwell Technologies Mailing Address
P.O. Box 30
Denver, CO 80201