COLORADO
Department of Health Care Policy & Financing

Provider Bulletin

Reference: B1900425

Jan. 2019

Did You Know - Suspended Claims and Timely Filing

Providers do not need to resubmit claims that are in a suspended status to keep them within timely filing guidelines. Providers have an additional 60 days from the last pay or denial date to resubmit the claims.

If the Known Issues & Updates web page states that claims will be reprocessed, there is no need to continue resubmitting for purposes of timely filing. For information on suspended claims, please view the drop-down section on the Known Issues web page under General Updates for Suspended Claims.

All Providers

Healthcare Common Procedure Coding System (HCPCS) Updates for 2019

The Centers for Medicare & Medicaid Services (CMS) released the deletions, changes and additions to the annual 2019 Healthcare Common Procedure Coding System (HCPCS) effective for dates of service on or after January 1, 2019.

Claims billed with a HCPCS 2019 procedure code will suspend for EOB 0000 - "This claim/service is pending for program review" until the updates are completed in the Colorado interChange. Once the rates are loaded, the claims will be released.

The Department of Health Care Policy & Financing (the Department) has posted additional information regarding HCPCS procedure codes and rates on the Provider Rates & Fee Schedules web page.

Contact the Provider Services Call Center at 1-844-235-2387 with general billing questions.

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

New Fraud, Waste and Abuse Web Page

The Department has launched the new Fraud, Waste and Abuse web page. The Department's mission is to work with providers and state agency partners to improve the integrity of its programs. The new web page provides a clear message of the Department's commitment to preventing, identifying, and combating fraud, waste, and abuse for Health First Colorado (Colorado's Medicaid Program).

New content has been added, including a Provider Self-Disclosure and Provider Self-Audit web page. These pages are designed to encourage providers to conduct self-audits and to disclose any overpayments.

A Provider Termination web page has also been included, where the most current list of providers who have been terminated for cause can be found.

Provider Self-Audits

Providers are encouraged to be pragmatic and proactive. Self-audits focus on assessing, correcting, and maintaining controls to promote compliance with applicable laws, rules, and regulations. Not only can self-audits clear up coding and billing issues before the Department takes notice, but these audits can also help sort out any lost revenue issues a practice might be experiencing. No matter which method is chosen, every practice should have a self-audit schedule that includes deadlines for each audit and lists parties responsible for the audits. Enrolled providers are encouraged to use self-audits to capture any improper payments that would otherwise initiate external audits and investigations. Self-audits are tailored to the provider's needs and should be conducted regularly to ensure proper billing and remedy any issues of non-compliance in a timely manner.

Coding and billing managers should stay informed of any changes to practices or procedures. All employees involved in coding and billing should look for "red flags" that could indicate potential problems or compliance issues. Designated providers are encouraged to appoint a compliance manager to investigate reports of red flags.

Self-audits can help:

- Reduce fraud and improper payments
- Reduce incorrect coding
- Improve patient care
- Lower the chances of an external audit
- Create a robust culture of compliance

Common Audit Findings

- Non-covered Services
- Non-verified (Undocumented) Services
- Duplicate Services
- Upcoding/Under coding
- Misuse of Modifiers
- Unbundling
- Inappropriate Level of Care
- Suspended License/Certification

Provider Self-Disclosure

Self-disclosing demonstrates an organization's commitment to compliance. Section 1128J(d) of the Social Security Act requires providers to report and return overpayments to the Department within 60 days from the date the overpayment is identified. Therefore, providers have a responsibility to continuously monitor billing practices to ensure claims filed are accurate and truthful. Sometimes medical providers may not intentionally file erroneous claims, but claims filed may not accurately reflect the services provided. By forming a partnership with providers through self-disclosure, the Department's overall efforts to eliminate fraud, waste and abuse will be enhanced while simultaneously offering providers a mechanism or method to reduce legal and financial exposure.

Issues appropriate for disclosure may include but not be limited to:

- Systematic errors
- Potential violation of fraud or abuse laws
- Patterns or trends of repeated program violations or routine errors
- Nature of the noncompliant event

The Fraud, Waste and Abuse web page offers information to encourage providers to be active participants in ensuring the financial integrity of healthcare programs.

Provider Enrollment Change Regarding a Backdated Enrollment Effective Date

Effective December 5, 2018, a change to the Provider Enrollment Portal allows providers of any enrollment or provider type to request an enrollment effective date prior to the approval date, and up to 365 days prior to the current date. If the provider does not specify an enrollment date, the enrollment effective date will be the application final approval date. All requests are subject to approval.

In most cases, a provider's enrollment can be backdated 365 days from the date of enrollment approval if the provider was licensed continuously through those dates and meets all other enrollment criteria. Backdating enrollment is not a guarantee of prior authorization backdate or claim payment.

This change applies only to providers starting a new enrollment application and providers resuming an application that is still in process. For providers who are already enrolled and approved, a Backdate Enrollment Form must be completed and mailed to DXC Technology (DXC) to change the current effective date. If the effective date desired is beyond 365 days, a Backdate Enrollment Form must be completed and mailed to DXC, and will require state approval.

Providers should refer to the Backdating a New Enrollment Application Provider Enrollment Portal Quick Guide for instructions on entering a backdate on their enrollment application.

If the enrollment and backdate request are approved, the provider will receive a welcome letter which will contain the provider's effective date.

For more information, contact the Provider Services Call Center at 1-844-235-2387.

Colorado Choice Transitions

Colorado Choice Transitions (CCT) Program Ending

The last day for the CCT program to transition individuals into the community will be December 31, 2018. Ancillary services, such as Home Delivered Meals, Peer Mentorship, Independent Living Skills Training and other CCT services will continue for these members for the following year and end completely December 31, 2019.

Effective January 1, 2019, eligible individuals will have the ability to transition into the community using a combination of qualified waiver services and Targeted Case Management.

Transition services will be done through a waiver until the Targeted Case Management function is implemented. There will be training on the enrollment details starting in January, 2019.

Contact Derek (Dom) Martin at Derek.Martin@state.co.us for questions regarding the CCT program.

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

Federal Upper Payment Limit (UPL) Requirement

Effective January 1, 2018, the Department is required to comply with the Consolidated Appropriations Act of 2016 (Section 503) and the 21st Century Cures Act (Section 5002); which limits federal Medicaid reimbursement to states for DME to Medicare payment rates.

About the UPL:

1. Durable medical equipment that was not billed and paid by both Medicare and Health First Colorado during the prior calendar year is not included.
2. Orthotics, prosthetics and disposable supply codes are not included.
3. Medicare's competitive bid codes may be subject to the UPL if not excluded under points one and two. Oxygen, Continuous Positive Airway Pressure (CPAP), Bilevel Positive Airway Pressure (BIPAP) and ventilators are some of the items included.

The Department received the paid DME Medicare code list subject to the 2019 UPL in December 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 reviewed data regarding utilization for those same codes and compared the lists to determine the codes to which Colorado's 2019 UPL is subjected.

Contact January Montano at January.Montano@state.co.us with any questions.

Home and Community-Based Services (HCBS) Personal Care and Homemaker Services

Targeted Rate Increase

The targeted provider rate increase for Personal Care and Homemaker agency based and consumer directed attendant support services for the following waivers has been approved by legislature:

- Elderly, Blind and Disabled (EBD)
- Community Mental Health Supports (CMHS)
- Brain Injury (BI)
- Spinal Cord Injury (SCI)

The approved targeted rate increase is 5.25% and the new rate effective January 1, 2019, is $4.61. The fee schedules located on the Provider Rates & Fee Schedule web page have been updated to reflect the approved 5.25% increase.

Detailed information about the annual rate updates has been published in past provider bulletins as well as on the Provider Rates & Fee Schedule web page. The Department will continue to publish updates in those locations when approval is received for additional HCBS increases, rates have been loaded, and mass adjustments have occurred.

"Lower of" Pricing Logic for Rate Increases

If the Department implements rate increases, claims that were already billed with and paid at a rate lower than the new rate cannot be adjusted for the higher rate. The Department will always use the “lower of” pricing logic. Providers are advised to bill their usual and customary charges. Not all codes are listed on the Health First Colorado Fee Schedule, so providers are advised to check all fee schedules which apply to their billing practices. If a code is not listed on the Health First Colorado Fee Schedule, it may be listed on a benefit-specific fee schedule.

Contact the Provider Services Call Center at 1-844-235-2387 with questions.

Home and Community-Based Services (HCBS) Providers

Colorado Adult Protective Services (CAPS) Data System

Beginning January 1, 2019, licensed agencies that provide direct care services to at-risk adults will be required to request a check of the Colorado Adult Protective Services (APS) data system, called CAPS. The purpose is to determine whether an applicant with your agency has been substantiated of causing physical abuse, sexual abuse, caretaker neglect or exploitation of an at-risk adult in an APS investigation. The required CAPS checks will be conducted by the CAPS Check Unit.

Each agency named in the statute is required to request CAPS checks. This includes:

- Community-Centered Boards (CCBs)
- Single-Entry Points (SEPs)
- Program-Approved Service Agencies (PASAs)

These agencies **must** register with the CAPS Check Unit (CCU) prior to requesting a CAPS check on potential new employees. Registration opened on November 30, 2018, to ensure all agencies could register prior to the start of the CAPS checks. Visit the CCU website for detailed information about the CAPS check requirements and to register with the CCU.

Contact cdhs_ccu@state.co.us with questions relating to the CAPS check process.

Non-Medical Transportation Services Targeted Rate Increase Approved

The targeted provider rate increase for Non-Medical Transportation for the following waivers has been approved by CMS:

- Elderly, Blind and Disabled (EBD)
- Community Mental Health Supports (CMHS)
- Brain Injury (BI)
- Spinal Cord Injury (SCI)
- Developmental Disabilities (DD)
- Supported Living Services (SLS)

The approved targeted rate increase is 6.61% and the new rate is effective January 1, 2019. The fee schedules located on the Provider Rates & Fee Schedule web page have been updated to reflect the approved 6.61% targeted rate increase.

Detailed information about the annual rate updates has been published in past provider bulletins as well as on the Provider Rates & Fee Schedule web page. The Department will continue to publish updates in those locations when CMS approval is received for additional Home and Community-Based Services targeted rate increases, rates have been loaded, and mass adjustments have occurred.

"Lower of" Pricing Logic for Rate Increases

If the Department implements rate increases, claims that were already billed with and paid at a rate lower than the new rate cannot be adjusted for the higher rate. The Department will always use the “lower of” pricing logic. Providers are advised to bill their usual and customary charges. Not all codes are listed on the Health First Colorado Fee Schedule, so providers are advised to check all fee schedules which apply to their billing practices. If a code is not listed on the Health First Colorado Fee Schedule, it may be listed on a benefit-specific fee schedule.

Contact the Provider Services Call Center at 1-844-235-2387 with questions.

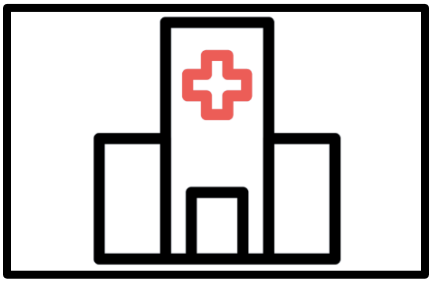
Hospital Providers

General Updates

Inpatient Hospitals

Update on Managed Care Entity (MCE) Utilization for Graduate Medical Education (GME) Payments to Teaching Hospitals

In the November 2018 Provider Bulletin (B1800423), the Department notified hospitals that it was considering amending the rules governing reimbursement for GME. The Department's proposed rule would have incorporated GME payments into managed care capitation payments. However, under C.R.S. §25.5-5-402(5), "GME funding for recipients enrolled in an MCE shall be excluded from the premiums paid to the MCE and shall be paid directly to the teaching hospital." The rule, if put into effect, would have been in direct conflict with state statute. It was therefore removed from consideration for presentation to the Medical Services Board.



Should the Department wish to incorporate GME funding into the premiums paid for recipients enrolled in an MCE, the statute must first be amended to eliminate the conflict.

Effective immediately, MCE utilization reports delivered to the Department on a quarterly basis should be resumed starting with the Q3-2018 report until C.R.S. §25.5-5-402(5) can be amended. Additionally, the Department will be reaching out to MCEs individually to notify them to resume normal reporting processes as detailed in their contracts.

Fiscal Year (FY) 2018-19 Inpatient Hospital Base Rates Update

The Department has not yet received approval from CMS on the FY2018-19 Inpatient Hospital Base Rate State Plan Amendment. The Department will mass adjust all claims with "serve to" dates of July 1, 2018, or later when CMS approval is received.

Contact Diana Lambe at Diana.Lambe@state.co.us with any questions.

Inpatient Hospital Per Diem Rate Group

Web Page
A new web page has been created to house the Inpatient Per Diem Rates. Please take a moment to visit Inpatient Hospital Per Diem Reimbursement Group web page.

There are no meetings currently scheduled. Past meeting materials are available on the Hospital Stakeholder Engagement Meeting's web page.

Outpatient Hospitals

Bi-Monthly Enhanced Ambulatory Patient Group (EAPG) Meetings
The bi-monthly EAPG meetings have merged into the Hospital Stakeholder Engagement Meetings. Please review the Hospital Stakeholder Engagement Meeting's web page for upcoming meeting dates. For 2018 EAPG Meeting materials please visit the Outpatient Hospital Payment web page.

EAPG Grouper Module Update
3M released a General Availability update of the EAPG module as of December 27, 2018. This release contains updates allowing the EAPG module to recognize January 1, 2019, updates to the CPT/HCPCS code set. The Department will update its system to utilize this new EAPG module in early January.

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

All Hospital Providers

Bi-Monthly Hospital Stakeholder Engagement Meetings
The Department will continue to host bi-monthly Hospital Engagement meetings to discuss current issues regarding payment reform and operational processing. The next meeting is scheduled for Friday, January 11, 2019, 12:30 p.m. - 4:00 p.m. at 303 E 17th Ave, Denver, Conference Room 7B & 7C. Calendar Year 2019 is currently posted.

Sign up to receive the Hospital Stakeholder Engagement Meeting newsletters.

Visit the Hospital Engagement Meeting Website for more details, meeting schedules and past meeting materials.

Contact Elizabeth Quaife at Elizabeth.Quaife@state.co.us with any questions and/or topics 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.

All Physician-Administered Drug Providers

Quarter 1 Rate Updates 2019

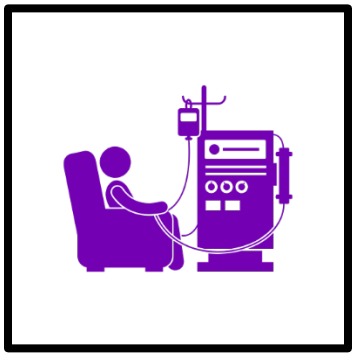
The Department has updated the Physician-Administered Drug rates for the first quarter of 2019. The new rates have a begin date of January 1, 2019. The new rates are posted to the PAD Fee Schedule web page.

Hospitals and Dialysis Providers

End-Stage Renal Disease to be Considered an Emergency Medical Condition

Effective February 1, 2019, the Department will consider End-Stage Renal Disease to be an Emergency Medical Condition. This policy change affects recipients of Emergency Medicaid. Emergency Medicaid covers emergency-only medical treatment for anyone who does not meet the citizenship requirement of Health First Colorado, but meets all other eligibility criteria.

Coverage under this policy is limited to care and services necessary in the treatment of End-Stage Renal Disease, including dialysis treatment at independent free-standing dialysis centers.



Organ transplants and home dialysis are not covered for recipients of Emergency Medicaid.

To indicate an emergency when billing:

- CMS-1500/835P: Use field 24C (EMG)
- UB-04/837I: Indicate Admission Type 1 (Emergency) or 5 (Trauma)

Contact Jess Pekala at Jessica.Pekala@state.co.us for policy questions.

Hospitals, Clinics, Non-Physician Practitioners, Speech Therapists, Rehabilitation Agencies

Update to Outpatient Speech Therapy Prior Authorization Requirement

The Department is delaying implementation of the Prior Authorization requirement for the Outpatient Speech Therapy Benefit until April 2019.

Beginning **April 1, 2019**, the Outpatient Speech Therapy Benefit will require a Prior Authorization Request (PAR). Providers may begin early submission of PARs starting **February 1, 2019,** via eQSuite®, the PAR portal.

Claims submitted for dates of service on or after April 1, 2019, will be denied unless there is an approved PAR on file for the services being billed. Evaluation services will not require a PAR. A list of billing codes which require a PAR will be published in the Outpatient Speech Therapy Billing and Policy Manual, and changes will be reflected in the Fee Schedule.

This change is being made to enforce the policy requirements of the benefit to ensure members receive medically necessary care. **There are no benefit coverage changes associated with this policy.**

The Prior Authorization vendor, eQHealth Solutions, will be reviewing the PARs via the online PAR portal, eQSuite®. For information about getting access to the PAR Portal and available training opportunities, please visit the ColoradoPAR website.

Contact hcpf_UM@hcpf.state.co.us with additional questions about the PAR process not available on the ColoradoPAR website.

Policy and program questions can be sent to Alex Weichselbaum at Alex.Weichselbaum@ state.co.us.

Further guidance is available on the Outpatient Speech Therapy Benefit web page.

Immunization Providers

New Immunization Codes Added for Shingrix and Heplisav

Two new immunization CPT codes, 90750 and 90739, have been added to the Colorado interChange.

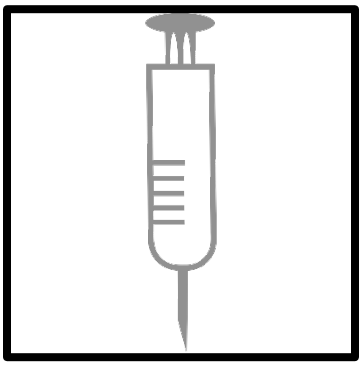
Shingrix was recommended by the Advisory Committee on Immunization Practices (ACIP) in January 2018. ACIP recommended Heplisav in February 2018. Medicaid immunization policy dictates that all ACIP-recommended vaccines are covered for all members.

Because of ACIP's recommended age ranges for these products (18 and over for Heplisav and 50 and over for Shingrix), they are not included in the Vaccines for Children (VFC) program, a federal/state partnership program that supplies providers with vaccines for administering to individuals aged 18 and under.

Both codes have effective dates of January 1, 2018, in the Colorado interChange. Providers who billed these codes after January 1, 2018, but before they were loaded into the Colorado interChange have received payment adjustments to retroactively reimburse submitted claims.

Refer to the Immunization Benefit Billing Manual for more information about how to submit claims for these and other immunization codes.

Contact the Provider Services Call Center at 1-844-235-2387 with any questions about billing these codes.



Nursing Facilities

Hospital Back-Up (HBU) Reimbursement Methodology Update

The reimbursement methodology for the HBU program is being updated to mirror Medicare Part A's skilled nursing facility reimbursement methodology utilizing the Minimum Data Set (MDS) and Resource Utilization Groups (RUG). The new payment methodology becomes effective January 1, 2019. The HBU program is a skilled nursing facility-based program for patients who qualify and have critical care needs. For more information about the HBU program and the updated reimbursement methodology, visit the Nursing Facilities web page.

Contact Heleena Hufnagel at Heleena.Hufnagel@state.co.us for policy-related questions. Contact Trevor Abeyta at Trevor.Abeyta@state.co.us with any questions regarding the updated reimbursement methodology.

Post-Eligibility Treatment of Income (PETI) Prior Authorization Request (PAR) Approver for Nursing Facilities

In July 2018, the Department awarded the Long-Term Care Utilization Management Services Program contract to Telligen, a third-party contractor that is a CMS-certified quality improvement organization for Colorado.

Telligen has begun reviewing PETI and incurred medical expense (IME) PAR submissions over the $400 limit, providing quarterly data reports to the Department, and tracing PETI program services for nursing facilities and members.

What stays the same?

- **All requests below or above 400 will continue to be submitted through the Provider Web Portal.**
- The Department will continue to review PETI-IME PAR submissions under $400.

Patricia Arellano (Patricia.Arellano@state.co.us) will continue to be the Department contact for all PETI questions.

What does this mean for nursing facilities?

- Nursing facilities will be responsible for submitting services in a timely manner.

- Nursing facilities will be responsible for maintaining copies of all PETI PAR requests for the required six years.
- Nursing facilities will keep a PETI Activity Tracking Log for each client and are required to respond to inquiries from Telligen and/or the Department regarding PETIs.
- Refer to the Nursing Facility Provider Billing Manual for information needed on the PETI Activity Tracking Log or Refer to Code of Colorado Regulations: 10 CCR 2505-10, Section 8.482.33 Post Eligibility Treatment of Income.

PETI Training and Forms

The Nursing Facilities web page has a PETI category with links to training and forms. Providers can also refer to the Submitting a Nursing Facility Post Eligibility Treatment of Income (PETI) Prior Authorization Request (PAR) Quick Guide for more information.

Providers are reminded to upload all required PETI forms to PARs. Include the PETI checklist form to verify that the resident's monthly patient payment is greater than zero; if not greater than zero then the PETI IME PA claim will be denied. All handwritten signatures must be legible for services provided or ordered. If the signature is not legible, then the name of the person may be printed below the illegible signature, so the form can be accepted.

All Medication-Prescribing Providers and Pharmacies

Preferred Drug List (PDL) Announcement

The following drug classes and preferred agents will become effective January 1, 2019:

Hepatitis C Virus Treatments

Preferred products will be: Epclusa, Harvoni, Mavyret, Ribavirin cap/tab

Antidepressants

Preferred products will be: Amitriptyline, Bupropion, Citalopram, Doxepin, Escitalopram, Fluoxetine caps/soln, Fluvoxamine IR, Imipramine HCl, Nortriptyline, Mirtazapine, Paroxetine, Sertraline, Trazodone, Venlafaxine IR, Venlafaxine ER caps

Antiemetics

Preferred products will be: Emend, Ondansetron, Transderm Scop

Epinephrine Products

Preferred products will be: Epinephrine autoinjector (generic Epipen)

Targeted Immune Modulators

Preferred products will be: Cosentyx, Enbrel, Humira, Xeljanz IR

Antipsoriatics

Preferred products will be: Acitretin, Calcipotriene cream/soln, Taclonex

Ulcerative Colitis Agents

Preferred products will be: Apriso, Canasa, Lialda, Pentasa, Sulfasalazine

Fluoroquinolones

Preferred products will be: Cipro susp, Ciprofloxacin tab, Levofloxacin tab

Antihyperuricemics

Preferred products will be: Allopurinol, Probenecid, Colchicine cap, Probenecid/Colchicine

NSAIDs

Preferred products will be: Celecoxib, Diclofenac sodium tab, Flector, Ibuprofen tab/susp, Indomethacin, Ketorolac tab, Meloxicam tab, Nabumetone, Naproxen EC tab/susp, Sulindac, Voltaren

Proton Pump Inhibitors

Preferred products will be: Esomeprazole magnesium cap, Nexium packet, Omeprazole cap, Pantoprazole tab, Prevacid solutab

H. Pylori Treatments

Preferred products will be: No changes

Pulmonary Arterial Hypertension Therapies

Preferred products will be: Adcirca, Epoprostenol, Letairis, Orenitram, Tracleer 62.5mg/125mg, Ventavis, Sildenafil (generic Revatio)

Pancreatic Enzymes

Preferred products will be: Creon, Zenpep

Antiplatelet Agents

Preferred products will be: Aggrenox, Brilinta, Cilostazol, Clopidogrel, Prasugrel

Antiherpetic Agents

Preferred products will be: Acyclovir tab/cap/susp, Denavir, Zovirax cream/ointment

Triptans

Preferred products will be: Naratriptan tab, Relpax, Rizatriptan, Sumatriptan tab/vial, Zomig intranasal

Pharmacy and Therapeutics Committee Meeting

Tuesday, January 8, 2019

1:00 – 5:00 p.m.

303 E 17th Ave Denver, CO 80203

11th floor Conference Rooms

Hepatitis C Treatment Updates Effective January 1, 2019

The prior authorization (PA) criteria for the Hepatitis C medications may be found on the Preferred Drug List (PDL).

All Hepatitis C treatments (direct acting antivirals) will continue to require a PA and the Hepatitis C specific Prior Authorization (PA) Form must be filled out and faxed to Magellan at 1-800-424-5881.

On January 1, 2018, the Department made changes to the PDL criteria for Hepatitis C treatments, including the removal of a criterion related to Metavir Fibrosis Score. These changes remain in effect and Prior Authorization Requests (PARs) will be evaluated accordingly.

The preferred agents effective January 1, 2019, are: Harvoni, Epclusa and Mavyret. There are no additional changes to the PA criteria. Additional guidance for documentation for retreatment requests has been included, and retreatment requests will continue to be evaluated on a case by case basis. The PA form has been updated for use beginning January 1, 2019.

Ribavirin products is a new PDL class added effective January 1, 2019. Generic ribavirin capsules and tablets will not require a PA. Other ribavirin products are non-preferred and will require a PA.

The Hepatitis C treatment PAR form and the PDL may be accessed from the Pharmacy Resources web page.

Contact Brittany Schock at Brittany.Schock@state.co.us with questions.

Brand Name Medications in Generic Mandate Exempt Classes on the Preferred Drug List

Health First Colorado, at C.R.S. 25.5-5-501, requires the generic of a brand name drug be prescribed if the generic is therapeutically equivalent to the brand name drug. Exceptions to this rule are: 1) If the brand name drug is more cost effective than the generic as determined by the Department, 2) If the patient has been stabilized on a brand name drug and the prescriber believes that transition to a generic would disrupt care, and 3) If the drug is being used for treatment of mental illness, cancer, epilepsy, or human immunodeficient virus and acquired immune deficiency syndrome.

Pursuant to this law, medications contained within the Anti-depressants, Anti-psychotics and Anti-convulsants class are drug classes on the PDL are not subject to the generic mandate. Therefore, the following reminder has been added to the PDL for these classes: Non-preferred brand name medications do not require a prior authorization when the equivalent generic is preferred and "dispense as written" is indicated on the prescription. Please note that this is not a change in policy or law; just a further reminder about the application of the law.

Please see the PDL or Appendix P, Brand Name Medications and Generic mandate section for more information.

Non-Preferred Brand Name Medications Favored Over Non-Preferred Generic Medications

The Department is managing certain brand name non-preferred drugs by preferring them over the generic equivalent non-preferred medications. This list changes on a quarterly basis. The following medications are brand favored over generic: Lotronex (alosetron) tablet, Emend (aprepitant) Tripak, Zyflo (zileuton) CR 600mg tablet, Treximet (sumatriptan-naproxen) 85-500 MG tablet and Kapvay (clonidine ER) tablet. If a generic is medically necessary for the member (over the equivalent Brand name), additional clinical information will need to be provided during the normal prior authorization process. This list is subject to

change. The current list is always available in Appendix P, which is accessed from the Pharmacy Resources web page.

Drug Utilization Review Updates

Changes to Prior Authorization Requirement for Proton Pump Inhibitors

As part of quarterly changes to Preferred Drug List (PDL) criteria on January 1, 2019, preferred proton pump inhibitors (PPIs) no longer require prior authorization (applies to any preferred proton pump inhibitor prescription not exceeding dose limitations). Also related to these PDL changes, all high-dose PPIs (such as omeprazole 40mg, esomeprazole 40mg, pantoprazole 40mg, etc.) will be limited to once daily dosing unless prescribed for the following diagnoses: Barrett's Esophagus, gastrointestinal bleed, H. pylori infection, hypersecretory conditions (Zollinger-Ellison), or acid reflux associated with spinal cord injury.

Twice daily dosing of the high-dose PPIs that are not prescribed for one of the aforementioned diagnoses, or those that are prescribed for gastroesophageal reflux disease (GERD), will require prior authorization approval involving prescriber verification that this dosing is appropriate to continue based on member response.

As a reminder, Health First Colorado prescribers are still expected to follow recommendations for re-evaluating PPI dose or initiating step-down H2 receptor antagonist therapy to prevent risks associated with inappropriate long-term use of PPI medications.

Availability of Prescription Polyethylene Glycol Powder Laxative

Prescription versions of polyethylene glycol powder laxative products are no longer available from manufacturers, and it is anticipated that these products will soon be unavailable for pharmacies to order as well. In response to this, over-the-counter formulations of the polyethylene glycol powder laxative will be eligible for coverage under the Health First Colorado pharmacy benefit.

Pharmacy Providers

Vivitrol Injections and Pharmacist Immunizations

Vivitrol Injections

Effective January 1, 2019, the Department plans to implement HB-1007, which stipulates that if a pharmacy has entered into a collaborative practice agreement with one or more physicians for the purposes of administering Vivitrol, that the pharmacy where the injection is administered shall receive reimbursement when an enrolled pharmacist administers it.

The relevant code for the Vivitrol injection itself is J2315.

The relevant CPT administration code for this injectable is 96372.

Pharmacist Immunizations

Effective November 1, 2018, pharmacists began enrolling with the Department and once enrolled, can administer the below vaccinations in pharmacy:

Pharmacist Immunization List	CPT Codes
HZV SubQ	90736
HZV IM	90750
PCV13	90670
PPSV23	90732
Td	90714
TDaP	90715

The relevant CPT administration codes for immunizations are:

- 90471
- 90472
- 90473
- 90474

Rates for the CPT and J Codes can be found on the Provider Rates & Fee Schedule web page.

For more information specific to pharmacist enrollment, visit the Pharmacist Enrollment: Over-the-Counter and Immunizations web page.

Immunizations and Injections are billed on a professional claim. Contact the Provider Services Call Center at 1-844-235-2387 for claim assistance.

Contact Kristina Gould at Kristina.Gould@state.co.us if there are further questions related to pharmacist enrollment or billing.

Provider Billing Training Sessions

January & February 2019 Provider Billing 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 UB-04 and 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 UB-04 Beginning Billing Workshop and CMS 1500 Beginning Billing Workshop.

Specialty training sessions provide more training for that particular provider specialty group. Providers are advised to attend a UB-04 or CMS 1500 training session prior to attending a specialty training. For a preview of the training materials used for specialty sessions, visit the Provider Training web page and click the Billing Training and Workshops drop-down list.

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

January 2019

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
6	7	8	9	10 CMS 1500 Provider Workshop 9:00 a.m. - 11:30 a.m. MT	11	12
Sunday	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
13	14	15	16	17 UB-04 Provider Workshop 9:00 a.m. - 11:30 a.m. MT	18	19

February 2019

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
3	4	5	6	7 CMS 1500 Provider Workshop 9:00 a.m. - 11:30 a.m. MT	8	9
Sunday	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
10	11	12	13	14	15	16
Sunday	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
17	18	19	20	21 UB-04 Provider Workshop 9:00 a.m. - 11:30 a.m. MT	22	23

Upcoming Holidays

Holiday	Closed Offices/Offices Open for Business
New Year's Day - Tuesday, January 1, 2019	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.
Martin Luther King Jr. Day - Monday, January 21, 2019	State Offices 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. DentaQuest and DXC will be open.
Presidents' Day – Monday, February 18, 2019	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.

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