Provider Bulletin

Reference: B2000444

Feb. 2020

COLORADO
Department of Health Care
Policy & Financing

Did You Know?

The provider address on enrollment files must match the address on file with the National Plan and Provider Enumeration System (NPPES) for new enrollment and updates.

All Providers

Adding a New National Provider Identification (NPI) Number

In accordance with the Colorado NPI Law, all facility and group providers will be required to obtain a unique NPI for each service location and provider type. Deadlines for obtaining a new NPI for all providers will be published in future communications. If providers are currently enrolled and have already obtained a unique NPI, they do not need to re-enroll.

Functionality is now available on the Provider Web Portal under the Provider Maintenance option to allow providers to add new NPIs to the existing enrollment records. This can be done by going into the "provider maintenance" section of the provider web portal.

Refer to the Provider Maintenance – Adding an NPI Quick Guide available on the Quick Guides and Webinars web page.

If providers have not yet enrolled each service location, they must submit a new application with a unique NPI for each service location.

Per Rule 8.125.6.A, providers must separately enroll each location from which they provide services. Only claims for services provided at appropriately enrolled locations are eligible for reimbursement.

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

Frequently Asked Questions

- **I am a doctor affiliated to several groups. Do I need a unique NPI for my individual provider ID at each place I practice?** No. Only the group or facility needs a unique NPI. Individuals such as physicians are not eligible to receive more than one NPI.
- **We have many individuals linked to our group. When we add the new NPI do we have to affiliate them all again?** No. The affiliations will remain on the existing record.
- **Where do I report the new NPI on a claim?** Providers may report it as the billing provider or in the service location field.
- **We have many different locations all under one organizational Tax ID. Can we still bill with one NPI?** Yes, one NPI can be entered as the Billing NPI as long as each service location NPI and listed in the service facility location.
- **If we use each unique location NPI as the billing provider will we get separate remittance advice statements?** Yes, each billing NPI will get a separate remittance advice.
- **If we get separate remittance advice statements from the provider web portal, do we have to log in separately for each one?** No, they can be delegated to one account.
- **How do I get a new NPI?** Applying for a new NPI is easy. Visit the National Plan & Provider Enumeration System (NPPES) website for more information on how to apply for a new NPI.

Visit the NPI web page for more information or contact the Provider Services Call Center at 844-235-2387.

Out-of-State Emergency Services

Prior authorization is not needed for emergency services performed while the Health First Colorado (Colorado's Medicaid Program) member is visiting out of state.

Claims for emergency services performed outside of Colorado need to have documentation of the emergency on file (not attached to the claim), and the claim must be marked as an emergency in the correct field.

Refer to the General Provider Information Billing Manual located on the Provider Billing Manuals web page.

Provider Affiliations

EOB code 3110, "the rendering provider is not a group member", is informational only and **does not cause claims to deny at this time.**

The Department of Health Care Policy & Financing (the Department) is currently giving providers an extended grace period to make all necessary updates to their affiliations to avoid future claims denials. If EOB code 3110 appears on a claim, providers should make sure affiliations are up to date and check other EOB codes to see why the claim denied.

Refer to the Provider Maintenance Quick Guide available on the Quick Guides and Webinars web page or contact the Provider Services Call Center at 844-235-2387 with questions on updating affiliations.

Reconsiderations and Appeals

Denied claims do not need to be appealed or sent as a request for reconsideration. A denied claim should be corrected and resubmitted electronically as a new claim.

Resubmissions should not be sent on paper, even if the claim has surpassed the 365-day timely filing period or if the claim has previously denied.

Contact the Provider Services Call Center at 844-235-2387 with questions on how to correct denied claims, timely filing or other billing and policy concerns.

Reducing Prescription Drug Costs in Colorado

The Department released a comprehensive report outlining the primary drivers of prescription drug costs in Colorado. Prescription drug costs are the fastest-growing consumer health care expense. The report is intended to inform dialog about how to control the cost of prescription drugs. For more information, refer to the report and the press release.

Verifying Eligibility

As a reminder, providers must verify member eligibility prior to rendering services. It is *critical* that providers check the eligibility response at each visit, as eligibility may change. Obtaining prior authorization is not a guarantee of eligibility.

Providers are required to verify eligibility for each date of service through the Provider Web Portal, batch X12N 270 or the automated voice response system (AVRS).

For more information on how to verify member eligibility in the Provider Web Portal, refer to the Verifying Member Eligibility and Co-Pay Provider Web Portal Quick Guide, available on the Quick Guides and Webinars web page.

Member eligibility verification is available electronically, 24 hours a day, 7 days a week. Eligibility information is updated daily, except for weekends and State holidays.

Home and Community-Based Services (HCBS) Providers

Unit Change to the Independent Living Service Training (ILST) on the Brain Injury (BI) Waiver

Effective February 1, 2020, the BI waiver's ILST benefit received approval from the Centers for Medicare & Medicaid Services (CMS) to change the unit designation from an hourly unit to a 15 minute unit. This change will allow the unit rate to mirror the Life Skills Training service implemented on all adult waivers after the Colorado Choice Transition program ended in 2019. The rate for this service will change from $48.12 for an hourly unit to $12.03 for a 15 minute unit, also mirroring Life Skills Training on the other adult waivers. The ILST benefit on the BI waiver uses the T2013 procedure code.

Contact Diane Byrne at Diane.Byrne@state.co.us with questions regarding the change to ILST benefit.
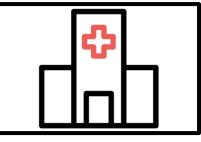
Hospital Providers

General Updates

Inpatient Hospital Rates

Rebasing Health First Colorado Inpatient Hospital Rates for Fiscal Year (FY) 2020-2021

As specified by Health First Colorado regulations, 10 CCR 2505-10, Section 8.300.5, for the purpose of rate setting effective on July 1 of each fiscal year, the Department uses the most recently audited Medicare/Medicaid Cost Report (CMS 2552) available as of March 1 of each fiscal year. In order to calculate a hospital's inpatient base rate and the Health First Colorado-specific add-ons for FY 2020-2021, it is imperative that the Department's hospital contractor, Myers and Stauffer LC, receives the agency's most recent finalized Medicare Notice of Program Reimbursement (NPR) by March 1, 2020. The Department will be using the most recent finalized report Myers and Stauffer LC has as of March 1, 2020, for rebasing inpatient hospital rates. **Please note that there is no extension to this date.**

Please submit the following:

- Electronic Cost Report (ECR) file (if available) or hard copy
- Copy of Medicare adjustments
- Notice of Program Reimbursement letter
- If a reopening was completed, send the most recent finalized report

If a facility fails to include the Notice of Program Reimbursement letter, the other documents submitted will not be used for rate setting. Electronic submissions may be sent to Kelly Swope at kswope@mslc.com or through regular mail to: Attn: Kelly Swope, Senior Manager, Myers and Stauffer LC, 6312 S Fiddlers Green Cir Suite 510N, Greenwood Village, CO 80111. Documentation needs to be received by March 1, 2020, to be accepted.

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

Inpatient Hospital Per Diem Rate Group

Claims were manually priced to the Per Diem Methodology beginning December 17, 2019. As of January 20, 2020, claims with an admit date of July 1, 2019, or later and are non-Medicare Crossover claims, began to be manually reprocessed.

When the system update has been completed, the automation of payments utilizing the Per Diem Methodology will commence and the suspended claim with manual calculation process will cease.

Contact Elizabeth Quaife at Elizabeth.Quaife@state.co.us with additional questions or concerns.

Outpatient Hospital DME Billing Guidance

Since the implementation of the Enhanced Ambulatory Patient Grouping (EAPG) payment methodology on October 31, 2016, the Department has carved out the payment for unbundled durable medical equipment from its outpatient claims and requests that such line items are billed on the CMS-1500. The Department has updated its billing manual and has added an additional resource which contains the CPT/HCPCS codes which are unbundled from the EAPG methodology. The Inpatient/Outpatient Billing Manual under the UB-04 drop-down and Appendix G under the Appendices drop-down found on the Billing Manuals web page.

Contact Andrew Abalos at Andrew.Abalos@state.co.us with any questions.

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, March 6, 2020, 9:00 a.m.-12:00 p.m. at 303 E 17th Ave, Denver, Conference Room 7B & 7C. Calendar Year 2020 meetings have been posted.**

Sign up to receive the Hospital Stakeholder Engagement Meeting newsletters.

Please see the Hospital Engagement Meeting web page for more details, meeting schedule and past meeting materials.

Contact Elizabeth Quaife at Elizabeth.Quaife@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.

Billing for Immediate Post-Partum Long-Acting Reversible Contraceptives (IPP-LARCs)

The following is an update to the billing guidance given in the January 2020 Provider Bulletin (B2000442)

Effective January 1, 2020, IPP-LARC devices inserted in a Diagnosis Related Group (DRG) Hospital may be reimbursed at the fee schedule rate or the amount billed, whichever is less.

Prior to January 1, 2020, the cost of the IPP-LARC device was included in the All Patient Refined-Diagnosis Related Group (APR-DRG) calculation for the delivery claim.

Reimbursement for IPP-LARCs requires submission of both:
- An Inpatient claim– for the DRG payment
- An Outpatient claim – for the IPP-LARC fee schedule payment

The **Inpatient Hospital Claim** must group to APR-DRG 540, 542, or 560, and include:
- ICD-10 Diagnosis Code for LARC insertion: Z30.430 or Z30.018,
- ICD-10 Surgical Procedure Code for either:
  - An IUD insertion: 0UH90HZ, 0UH97HZ or 0UH98HZ, or
  - A Contraceptive Implant insertion: 0JHD0HZ, 0JHD3HZ, 0JHF0HZ or 0JHF3HZ.

The **Outpatient Hospital Claim**:
- Must include:
  - The HCPCS for the LARC device: J7296, J7297, J7298, J7300, J7301 or J7307
  - The LARC device's affiliated National Drug Code, and
  - Both the FP and SE modifiers
- No additional revenue or procedure codes can be present on the claim
- Outpatient claim must be submitted after the affiliated Inpatient claim is paid, and
- Outpatient claim's date of service must be the date of insertion and within the affiliated Inpatient claim's From Date Of Service – Through Date Of Service.

Contact Melanie Reece at Melanie.Reece@state.co.us with questions regarding IPP-LARC devices and women's health policy questions.

Contact Raine Henry at Raine.Henry@state.co.us with hospital policy questions.

Interim Billing for Diagnosis Related Group (DRG) Hospitals

DRG Hospitals may now use adjustments to bill interim claims instead of voiding previous claims and rebilling with the new date span. Details on the billing process can be found in the Inpatient/Outpatient Billing Manual, available on the Billing Manuals web page under the UB-04 drop-down menu.

Contact Raine Henry at Raine.Henry@state.co.us with hospital policy questions.

Laboratory, Physician Services and Hospital Providers

Clinical Diagnostic Laboratory Upper Payment Limit Rates

The Department received approval on January 7, 2020, for a State Plan Amendment (SPA) submitted under transmittal number (TN) 19-0028 regarding Laboratory and Radiology Services. This amendment decreases Clinical Diagnostic Laboratory (CDL) rates on a per test basis to align with Medicare rates in accordance with the Social Security Act Section 1903(1)(7) Upper Payment Limit and is retroactively effective to November 1, 2019. Impacted claims will be reprocessed according to the amended rates.

Updated rates can be found on the Provider Rates & Fee Schedules web page.

Genetic Testing Prior Authorization Requirement

Effective February 10, 2020, the following codes will require prior authorizations:

81200	81209	81220	81241	81243	81251	81255	81256
81257	81260	81283	81290	81293	81294	81295	81296
81297	81298	81299	81300	81318	81319	81323	81327
81380	81400	81401	81402	81406	81407	81420	81432

This prior authorization requirement is in response to stakeholder concerns regarding potentially inappropriate utilization of genetic tests, as noted in the June 2019 Provider Bulletin (B1900432) and the January 2020 Provider Bulletin (B2000442). The Department intends to require prior authorization for all codes within the range 81170 through 81599 and is implementing the prior authorization requirement in phases.

Please refer to the Laboratory and X-Ray rule (10 CCR 2505-10 8.660) and the Laboratory Billing Manual, available on the Billing Manuals web page, under the CMS 1500 drop-down, for additional information about Laboratory Services, including existing requirements for the Breast Cancer Gene (BRCA) and prenatal testing.

Visit the ColoradoPAR website for more information, including training opportunities for utilizing eQSuite®, the specific codes requiring a prior authorization, and other provider resources.

Contact the ColoradoPAR Program at co.pr@eqhs.org or 888-801-9355 with any questions regarding the prior authorization process.

Contact HCPF_UM@state.co.us with any questions regarding the Utilization Management Program and PARs.

Contact Raine Henry at Raine.Henry@state.co.us with laboratory policy questions.

Urinalysis Tests Information Update

As of January 2020, substance-specific confirmatory tests, CPT codes 80320 – 80377, do not require a positive or inconclusive presumptive test or medical necessity documentation attached to the claim to be considered for reimbursement.

Contact Raine Henry at Raine.Henry@state.co.us with laboratory policy questions.

Pharmacy Providers

Pharmacy Cost of Dispensing Survey

Myers & Stauffer, LC will be conducting a survey on the cost of dispensing prescription drugs to Health First Colorado members. The Department is required to conduct this survey every two fiscal years per the Medicaid State Plan. Myers & Stauffer will distribute survey packets to all pharmacy providers in the coming weeks. The Department strongly encourages pharmacy providers to participate. The survey findings will be a significant factor in reviewing the dispensing fees paid to pharmacies.

Contact Colorado.SMAC@state.co.us with questions related to this survey.

Pharmacy and All Medication-Prescribing Providers

Drug Utilization Review Updates

Achieving Excellence in Pain Management

Health First Colorado continues to be committed to improve safety and reduce risks associated with opioid medications including the risk of overdose and opioid use disorder. Excellence in care for members with acute and chronic pain requires a coordinated, integrated, and comprehensive approach to reduce pain severity, increase function, and improve members' overall quality of life.

Health First Colorado's opioid policies for pain management, including limitations on total opioid morphine milligram equivalents (MME), do not endorse abrupt opioid discontinuation or forced tapering of opioids for any member. The Department emphasizes the importance of using an individualized, collaborative, and member-centered approach for diagnosis and treatment of acute and chronic pain, thus establishing a "therapeutic alliance" between the member and clinician team. Clinician teams are encouraged to perform

a thorough patient assessment, an evaluation of the risks and benefits of different pain treatment modalities, along with special consideration given for the individual member's needs.

Health First Colorado prescription opioid policies are available for reference on the Preferred Drug List (PDL).

The Centers for Disease Control (CDC) news release and other pain management resources are available to providers on the Pain Management Resources and Opioid Use web page.
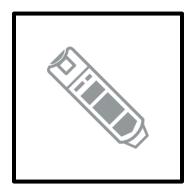

Preferred Brand Updates

Recent Changes for Brand NuvaRing®

Brand NuvaRing® will be favored by Health First Colorado. It will pay without a prior authorization.

Generic equivalents (**etonogestrel vaginal ring and Eluryng**) will be non-favored and may require a prior authorization based on clinical necessity, or if the brand name medication cannot be dispensed, an override # 55555 may be entered in the "Prior Authorization Number" field (Universal Field Number = 498-PY) by the pharmacy at point-of-sale allowing coverage of the generic equivalent drug.

Recent Changes for Preferred Generic Epinephrine Auto-Injector Products

Due to shortage resolution, generic Epipen (epinephrine auto-injector 0.15 mg and 0.3 mg) products manufactured by Teva Pharmaceuticals will be designated as non-preferred effective January 15, 2020. Authorized generic Epipen (epinephrine auto-injector 0.15 mg and 0.3 mg) products manufactured by Mylan will continue to be preferred with no prior authorization required.

Prior authorization criteria for non-preferred medications can be found on the Health First Colorado preferred drug list. For questions regarding rejected claims or prior authorization, please call the Magellan Rx Management Pharmacy Call Center at 1-800-424-5725.

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

Eligibility Criteria for Enbrel, Humira, Cosentyx or Xeljanz IR, Effective January 1, 2020

Humira or **Enbrel** may receive approval for use for Food and Drug Administration (FDA)-labeled indications.

Cosentyx may receive approval for FDA-labeled indications following trial and failure of Humira (failure is defined as lack of efficacy of a three-month trial, allergy, intolerable side effects or significant drug-drug interaction).

Xeljanz IR may receive approval for Ulcerative Colitis following trial and failure of Humira (failure is defined as lack of efficacy of a three-month trial, allergy, intolerable side effects or significant drug-drug interaction) OR Other FDA indications without trial and failure.

Diagnosis Requirements for Preferred Products in Targeted Immunomodulators Class:

FDA-labeled indication may be confirmed by ICD-10 diagnosis code in patient history via an automated prior authorization (AutoPA). FDA-labeled indication may also be confirmed by the call center (manual prior authorization). ICD-10s will not be accepted on point-of-sale (POS) claims submissions.

Non-Preferred products must meet class non-preferred criteria and additionally, may require product-specific approval criteria.

Physician Administered Drug (PAD) Providers

Quarter 1 Rate Updates 2020

The PAD rates for the first quarter of 2020 have been updated. The new rates have a start date of January 1, 2020, and are posted to the [Provider Rates & Fee Schedule web page](#) under the Physician Administered Drug Fee Schedule drop-down section.

Contact Emily Ng at Emily.Ng@state.co.us with any questions about PAD rates.

Rural Health Clinic Providers

Bi-Monthly Rural Health Clinic (RHC) Stakeholder Engagement Meetings

The Department has started to host bi-monthly RHC meetings to discuss current issues regarding payment reform and operational processing. The next meeting is scheduled for **Thursday, March 5, 2020, 12:30 p.m. – 1:30 p.m. at 303 E 17th Ave, Denver, Conference Room 7A.**

Provider Billing Training Sessions

February and March 2020 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 the CMS 1500 Beginning Billing Workshop available on the Provider Training web page under the Billing Training and Workshops drop-down section.

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 open the Billing Training and Workshops 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 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.

February 2020

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
2	3	4	5	6	7	8
9	10	11	12	13 CMS 1500 Provider Workshop 9:00 a.m. – 11:30 a.m. MT	14	15
16	17	18	19	20	21	22
23	24	25	26	27 UB-04 Provider Workshop 9:00 a.m. – 11:30 a.m. MT	28	29

March 2020

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	2	3	4	5 CMS 1500 Provider Workshop 9:00 a.m. – 11:30 a.m. MT	6	7
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
8	9	10	11	12	13	14
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
15	16	17	18	19 UB-04 Provider Workshop 9:00 a.m. – 11:30 a.m. MT	20	21

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. Do **not** register via these links if planning to attend a training session in person at the DXC office (see instructions below for RSVPing to attend in person).

For questions or issues regarding webinar registration, email co.training@dxc.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 2-3 business days to receive a response.

In-Person Training Registration

Providers who would like to attend a training session **in person** should RSVP to co.training@dxc.com by noon the day prior to the training, with the subject line "In-Person RSVP." Please include attendee name(s), organization, contact information (email address and phone number), and the name and date of the training session(s) to be attended. Allow up to 2-3 business days to receive a confirmation for in-person training reservations. Do not send an RSVP via email unless planning on attending **in person.**

In-person training sessions will be held at the following address:

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

Parking and Transportation

Free parking is not provided, and parking is limited in the downtown Denver area. Commercial parking lots are available throughout the downtown area. The daily rates range between $5 and $20. Carpooling and

early arrival are recommended to secure parking. Whenever possible, public transportation is also recommended. Some forms of public transportation include the Light Rail and Free MallRide.

Upcoming Holidays

Holiday	Closed Offices/Offices Open for Business
Presidents Day **Monday, February 17**	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 St, Suite 600
Denver, CO 80202

Provider Services Call Center
1-844-235-2387

DXC Mailing Address
P.O. Box 30
Denver, CO 80201