COLORADO
Department of Health Care Policy & Financing

Provider Bulletin

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Did You Know?

It is not necessary to attach a copy of the Explanation of Benefits (EOB) for all claims that have a Third Party Liability (TPL) or Medicare primary. TPL and Medicare information should be reported directly on the claim. An EOB is only necessary when the claim is outside timely filing; then the EOB may serve as a timely filing waiver. All claims should be filed electronically, even if there is a primary payer. Claims with TPL or Medicare should not be filed on paper.

All Providers

Sign Up for Provider Email Communications

DXC frequently sends updates to the email address on file for providers. Providers can also sign up here to ensure they are receiving these important communications.

Providers can select "00 - All Provider Emails" as well as their specific provider type to receive:

- a weekly Last Week in Review newsletter, which includes Hot Topics, Featured Provider Resources, and status updates on Known Issues
- a monthly notification when the Provider Bulletin is published
- occasional general announcements relevant for all providers

Many providers only have one email address on file, corresponding to the person who did the initial credentialing for the organization. This may not be the appropriate person to receive these communications. Email recipients should also forward any pertinent communications to the billing staff within the organization to ensure information is received.

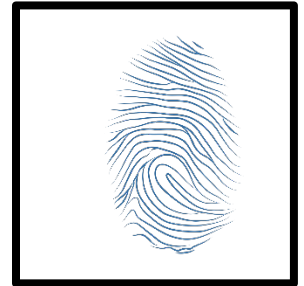
Improving health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.

For instructions on updating contact information or adding a billing email address, refer to the Provider Maintenance Provider Web Portal Quick Guide.

Looking for a recent newsletter or email? Weekly newsletters and many of the emails sent out to providers are also posted on the Provider News web page.

Fingerprint – Federal Criminal Background Check

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



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

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

This is not a request for fingerprint submission, just a notice that fingerprinting requests and federal criminal background checks will begin in April. More information will be coming soon.

Healthcare Common Procedure Coding System (HCPCS) Updates for 2018

On March 1, 2018, Health First Colorado will begin implementing the annual 2018 HCPCS deletions, changes and additions effective for dates of service (DOS) on or after January 1, 2018.

During the rate setting process, claims with added codes were suspended. Once the rates are loaded, the claims will be released and reimbursed at the Department set rate for claims on or after dates of service January 1, 2018.

Providers whose usual and customary charges are less than the Department's set rate for added codes will have to adjust their paid claims to receive the correct rate of reimbursement. For information on submitting adjustment to claims, refer to the Copy, Adjust or Void a Claim Provider Web Portal Quick Guide.

The fee schedule will be updated to reflect the added codes and rates. Additional information related to HCPCS updates can also be found at the bottom of the Provider Services web page under the HCPCS Rate Updates Information & Resources drop-down section.

Code descriptions are not contained in this bulletin. The descriptions are copyrighted by the American Medical Association (AMA). Providers should reference their 2018 HCPCS and Current Procedural Terminology (CPT) coding manuals for procedure code descriptions. These coding manuals may be purchased through the AMA and other publishers.

Discontinued Codes

The following table lists procedure codes that have been discontinued by CMS and the AMA. Codes that have been discontinued or cross referenced to other codes can be found in the 2018 HCPCS and CPT coding manuals. The discontinued procedure codes will not be reimbursed for DOS after December 31, 2017.

Discontinued Procedure Codes					
00740	55450	77422	0051T	0340T	G8698
00810	64565	78190	0052T	0438T	G8879
01180	69820	83499	0053T	A9599	G8947
01190	69840	84061	0178T	C9140	G8971
01682	71010	86185	0179T	C9483	G8972
15732	71015	86243	0180T	C9484	G9381
29582	71020	86378	0255T	C9485	G9496
29583	71021	86729	0293T	C9486	J1725
31320	71022	86822	0294T	C9489	J9300
34800	71023	87277	0299T	C9490	P9072
34802	71030	87470	0300T	C9491	Q9984
34803	71034	87477	0301T	C9494	Q9985
34804	71035	87515	0302T	D5510	Q9986
34805	74000	88154	0303T	D5610	Q9987
34806	74010	93982	0304T	D5620	Q9988
34825	74020	94620	0305T	G0202	Q9989
34826	75658	97532	0306T	G0204	
34900	75952	97762	0307T	G0206	
36120	75953	99363	0309T	G8696	
36515	75954	99364	0310T	G8697	

Code Description Changes

The following table lists procedures codes where the descriptions have changed. Providers should reference their 2018 HCPCS and CPT coding manuals for procedure code descriptions.

Codes with Description Changes							
D1354	G8941	G9786	Q4163	36474	90750	G9261	36516
D2740	G8967	G9794	0464T	37760	92015	G9262	57260
D3320	G8968	G9814	0465T	37761	94621	G9384	62290
D3330	G8969	G9815	0466T	38220	96567	G9541	62291
D3347	G9227	G9816	0467T	38221	97760	G9716	62292
D3421	G9263	G9817	0468T	4151F	97761	G9717	76000
D4230	G9313	G9840	15770	43112	99217	G9744	76098
D4231	G9348	G9841	21085	47000	99218	G9745	76881
D4355	G9504	G9843	31255	57240	99219	G9784	76882
D7111	G9607	J7321	3372F	57265	99220	J2274	81439
D7980	G9624	L3760	34812	62322	99235	11403	82043
D9223	G9637	L8618	34820	62325	E1639	14302	82044
D9243	G9638	L8624	34833	62326	G8430	17250	86003
G8442	G9656	L8691	34834	64550	G8433	31254	90651
G8535	G9758	Q4132	3494F	78351	G8938	31276	92602
G8540	G9762	Q4133	3495F	81257	G9256	31645	95250
G8808	G9763	Q4148	3496F	81432	G9257	31646	95251
G8869	G9764	Q4156	36470	82042	G9258	32998	95930
G8880	G9765	Q4158	36471	86005	G9259	36140	
G8939	G9785	Q4162	36473	90682	G9260	36468	

New Procedure Codes

The following table lists new procedure codes that are covered benefits under Health First Colorado effective for DOS on or after January 1, 2018:

New Procedure Codes							
00731	34708	71046	81334	D5622	01190	71022	88154
00732	34709	71047	81520	D7979	01682	71023	93982
00811	34710	71048	81521	D9222	15732	71030	94620
00812	34711	74018	81541	D9239	29582	71034	97532
00813	34712	74019	81551	D9996	29583	71035	97762
15730	34713	74021	86008	E0953	31320	74000	99363
15733	34714	81105	86794	E0954	34800	74010	99364
19294	34715	81106	87634	G0515	34802	74020	0178T
20939	34716	81107	87662	J0606	34803	75658	0179T
31241	36465	81108	93792	J1555	34804	75952	0180T
31253	36466	81109	93793	J1627	34805	75953	0293T
31257	36482	81110	94617	J2350	34806	75954	A9599
31259	36483	81111	94618	J3358	34825	77422	C9485
31298	38220	81112	95249	J9022	34826	78190	C9489
32994	38221	81120	96573	J9023	34900	83499	D5510
33927	38222	81121	96574	J9285	36120	84061	D5610
33928	38573	81175	97763	L3761	36515	86185	D5620
33929	43286	81176	C9738	L7700	55450	86243	G0202
34701	43287	81238	D0391	L8625	64565	86378	G0204
34702	43288	81248	D0411	L8694	69820	86729	G0206
34703	55874	81249	D5511	P9073	69840	86822	J1725
34704	58575	81258	D5512	P9100	71010	87277	J9300
34705	64912	81259	D5611	00740	71015	87470	
34706	64913	81269	D5612	00810	71020	87477	
34707	71045	81283	D5621	01180	71021	87515	

National Correct Coding Initiative (NCCI) Notification of Quarterly Updates

Providers are encouraged to monitor CMS for updates to NCCI rules and guidelines. Updates to the Procedure-to-Procedure (PTP) and Medically Unlikely Edit (MUE) files are completed quarterly with the next file update available April 2018. Find more information on the CMS NCCI website.

Pediatric Behavioral Therapies (PBT) Fiscal Year (FY) 2017-2018 Rate Updates

Legislature-approved across the board (ATB) rate increases for PBT have been loaded to the Colorado interChange and the Department will initiate mass adjustments to ensure providers are reimbursed at the increased rate effective July 1, 2017. Due to the implementation of new procedure codes for PBT services on August 7, 2017, shown in the table below, the mass adjustment will not correct claims payments for claims with DOS between July 1, 2017, and August 7, 2017.

Detailed information about action required by providers to receive the increases are outlined in the table below.

Current Procedure Code	New Procedure Code	New Procedure Modifier	Department Service Description	Unit
H2015	**H0046**		Adaptive behavior treatment, administered by technician	Per 15 Minutes
H0036	**H0046**	**TJ**	Adaptive behavior treatment, administered by BCBA or equivalent	Per 15 Minutes
H0031	**T1024**		Behavior identification assessment, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report.	Per Assessment
H0031 Modifier: TS	**T1024**	**TJ**	Behavior identification re-assessment, limited to 2 units per six months	Per 30 minutes

Claims with DOS Between July 1, 2017, and August 6, 2017

Providers must complete the following steps to ensure the rate increase is received for claims with DOS between July 1, 2017 and August 6, 2017, billed with the codes shown in the first column of the table above:

1. Void the original claim using procedure codes H0031, H0036 or H2015 for DOS between July 1, 2017, and August 6, 2017.
2. Ensure the original claim was voided after the financial cycle.
3. Rebill claims for DOS between July 1, 2017, and August 6, 2017, using the new procedure codes.

Claims with DOS on or After August 7, 2017

For providers whose usual and customary charges are greater than or equal to the increased rate for FY 2017-18, there is no need to take any action to receive the increased reimbursement. For providers whose usual and customary charges are less than or equal to the increased rate for FY 2017-18, the provider must submit an adjustment to the claims to receive the rate increase. For information on submitting adjustments to claims please refer to the Copy, Adjust or Void a Claim Provider Web Portal Quick Guide. The fee schedule will be updated to reflect the approved 1.4% across the board rate increase.

Revised Psychological/Neuropsychological Billing Policy

After review, the Department has determined it is necessary to revise the psychological and neuropsychological testing policy to require that the following codes are paid though fee-for-service when billed diagnoses are not covered under the behavioral health capitation program.

90887	96116
96101	96118
96102	96119
96103	96120

The following are the diagnoses covered under the behavioral health capitation:

Mental Health Diagnosis Codes (ICD-10)

Start Value	End Value
F20.0	F42.3
F42.8	F48.1
F48.9	F51.03
F51.09	F51.12
F51.19	F51.9
F60.0	F63.9
F68.10	F69
F90.0	F99
R45.1	R45.2
R45.5	R45.82

Substance Use Disorder (SUD) Diagnosis Codes (ICD-10)

Start Value	End Value
F10.10	F10.26
F10.28	F10.96
F10.98	F13.26
F13.28	F13.96
F13.98	F18.159
F18.18	F18.259
F18.28	F18.959
F18.980	F19.16
F19.18	F19.26
F19.28	F19.99

Providers should void any claims submitted to a Behavioral Health Organization (BHO) for the procedure codes referenced above, for diagnoses that are not covered under the capitation. Providers should submit those claims to Fee-For-Service Medicaid for payment.

Claims previously denied for payment by Fee-For Service Medicaid will be reprocessed by DXC.

Contact Melissa Eddleman at Melissa.Eddleman@state.co.us with any questions.

All Medication-Prescribing Providers and Pharmacies

Brand/Generic Changes

The following brand/generic changes will be implemented for Health First Colorado members:

Esomeprazole capsules (generic Nexium capsules) will be preferred and brand Nexium Capsules will be non-preferred. Brand Nexium Capsules will require a Prior Authorization (PA).

Please see the Preferred Drug List for more information including date of the change.

April Preferred Drug List (PDL) Announcement

The following drug classes and preferred agents will become effective April 1, 2018:

Atypical Antipsychotics
Preferred products will be: Aripiprazole Tab/ODT/Soln, Clozapine Tab/ODT, Latuda (*with step*), Olanzapine Tab, Quetiapine IR Tab, Risperidone Tab/Soln/ODT, Ziprasidone Cap

Growth Hormone
Preferred products will be: Genotropin, Norditropin

Insulins (Rapid, Short, Intermediate, Long, Mixtures)
Preferred products will be: Novolog Vial/Pen, Humulin R Vial, Humulin N Vial, Levemir Vial/Pen, Lantus (with step), Humulin 70/30 Vial, Humalog 50/50 Vial, Humalog 75/25 Vial, Novolog 70/30 Vial/Pen

Intranasal Corticosteroids
Preferred products will be: Fluticasone propionate, Nasonex (brand name only), Triamcinolone OTC

Leukotriene Modifiers
Preferred products will be: Montelukast Tab/Chewable

Multiple Sclerosis Agents
Preferred products will be: Orals: Gilenya, Tecfidera, Aubagio Injectables: Avonex, Betaseron, Rebif, Copaxone 20 mg (brand only)

Neurocognitive Disorder Agents
Preferred products will be: Donepezil 5mg/10mg Tab/ODT, Exelon Patch (brand name only), Memantine Tab

Ophthalmic Allergy
Preferred products will be: Cromolyn, Ketotifen, Pazeo, Lastacaft

Sedative Hypnotics (benzodiazepine and non-benzodiazepine)
Preferred products will be: Eszopiclone, Zaleplon, Zolpidem, Temazepam 15mg and 30mg, Triazolam

Statins and Statin Combinations
Preferred products will be: Atorvastatin, Pravastatin, Rosuvastatin, Simvastatin

The April 1, 2018, PDL will be posted on the Department's Pharmacy Resources web page. Please refer to this for all the detailed PA criteria.

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

Federal Upper Payment Limit (UPL) Requirement

As of January 1, 2018, the Department is required to comply with the Consolidated Appropriations Act of 2016 (Section 503) which limits federal Medicaid reimbursement to states for DME to Medicare payment rates. The original effective date was January 1, 2019, but the Cures Act (Section 5002) moved the effective date up by one year.

In December 2017, CMS held a webinar that provided some guidance on complying with the DME limit. The Department continues to work with CMS to resolve outstanding questions regarding this compliance.

About the UPL:

1. Orthotics, prosthetics and disposable supply codes are **not** included.
2. The DME codes included are limited to those codes that were billed/paid by both Medicare and Colorado Medicaid.
3. Medicare's competitive bid codes are included.
4. Oxygen is included.

The Department anticipates the final UPL code list by the end of February 2018.

Based on initial reimbursement analysis, the Department anticipates there will be reductions to some of the impacted codes, with the largest impact applying to oxygen supply, and some codes that may increase. The Department is discussing (both internally and with stakeholders) possible mitigation strategies. Mitigation possibilities may be limited by Federal and State regulations and budgetary restrictions.

Additional information will be published as it becomes available.

Manual Pricing

Rate Increase

The state FY 2017-18 Long Bill granted a 1.402% rate increase for DMEPOS, effective July 1, 2017, which CMS has recently approved. Codes with a fee schedule rate have been reprocessed at the new, higher rate but not the manually priced codes.

Manually priced claims with a date of service of July 1, 2017, to current will be reprocessed by DXC over the next several months.

The following are the new manually priced percentages for manufacturer suggested retail price (MSRP) and invoice methodologies.

MSRP less 18.33%

Invoice plus 19.50%

The Code of Colorado Regulations, 10 CCR 2505-10, Section 8.590.7 and the DMEPOS Billing Manual will be updated to reflect the new percentages.

Billing Process Change – By Invoice

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

Example of current process, maximum allowable:

E1399 UB $1000 (actual invoice cost)

A9901 UB $195.00 (19.50% of the invoice cost)

Process beginning July 2018, maximum allowable:

E1399 UB $1195.00 (actual invoice cost + 19.50%)

- The claims' submitted charge/billed amount should reflect the Usual and Customary charge (U&C)*
- The math for calculating the maximum allowable must be shown. It may be added to the invoice or a separate attachment. Using the above example:
  - $1000 x 1.195 = $1195.00, or
  - $1000 x .195 = $195.00 + $1000 = $1195.00

  - If the full quantity on the invoice was not provided to the member (i.e. a bulk order) a breakdown of the cost per unit multiplied by the quantity provided must be shown. In the instance where a manufacture puts the cost per unit on their invoice, the per unit price calculation does not need to be shown. However, the unit price does need to be multiplied by the quantity provided.
- After verifying the calculation, claims processors will price the claim at the lower of U&C or (actual invoice cost + the percentage).

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

Reminder to Providers: Claims Must Match Documentation

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

Contact HCPF_DME@state.co.us with any questions.

Federally Qualified Health Centers (FQHC), Rural Health Centers (RHC) and Indian Health Services (IHS) Providers

Addressing Reimbursable Claims that Pay Zero

Some claims for services from an FQHC, RHC and IHS provider are paying $0 when there is a reimbursable visit. The issue results from the way providers are including procedures on claims. Claims that include procedures that are subject to NCCI edits or include procedure codes that require National Drug Code (NDC) identifiers without the NDC can cause the claim to pay $0.

NCCI

All fee for service providers are required to submit claims for services according to NCCI guidelines. For FHQC, RHC and IHS provider types, the inclusion of procedure codes that are not allowed to be billed together may result in payment of $0 for a claim.

NCCI guidance prevents documenting two services when one service includes the other procedure. Including two procedures that cover the same service and are subject to an NCCI PTP prohibition distorts the monitoring of actual services being provided by counting the lesser procedure twice. Using Modifier 25 as allowed in the NCCI guidance is processed appropriately.

The NCCI procedure to procedure limits are available online on the Medicaid NCCI web page.

The NCCI MUEs also examine the number of units for a procedure code. Including a unit amount that is prohibited by NCCI may also result in payment of $0.

For claims with an NCCI issue, resubmitting the claim and removing the lesser procedure in the PTP edit, or revising units to match the NCCI limit will result in payment of the appropriate rate.

NDC

All claims for physician administered drugs must include the NDC for the item. For FQHC, RHC and IHS provider types, the failure to include the NDC for a physician administered drug may result in the payment of $0 for a claim.

For claims that paid $0 for an NDC issue, adjusting the claim to include the NDC will result in payment of the appropriate rate.

Clinical Laboratory Improvement Act (CLIA)

All claims for laboratory services must be provided in CLIA certified facilities or be exempt. For FQHC, RHC and IHS providers, submission of laboratory services requiring CLIA certification may result in payment of $0 for a claim. Until the CLIA issue is resolved, FQHCs can resubmit the claims and omit the laboratory procedure codes from the claim.

Contact Richard Delaney at Richard.Delaney@state.co.us with questions or requests for additional information.

Hospital Providers

General Updates

OUTPATIENT HOSPITALS

Rescheduled Enhanced Ambulatory Patient Group (EAPG) Meetings

Beginning September 22, 2017, the Department began hosting biweekly meetings dedicated to the EAPG methodology. However, due to decreasing participation and decrease in outstanding issues, these meetings will occur on a monthly basis beginning in March 2018. These meetings are intended to be an informal discussion where the Department and its hospital providers can discuss issues relating to billing, payment or the EAPG methodology in general. For recordings of previous meetings and any related materials, as well as the current schedule for future meetings, please visit the Department's Outpatient Hospital Payment web page. The next meeting will be hosted by the Department on March 2, 2018.

****Please note: Starting January 12, 2018, all EAPG Biweekly Meetings will be moving to a new location 303 E. 17th Ave., Denver, Conference Room 7B****

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

Mass Adjustment of EAPG Claims Update

The Department has been performing mass adjustments of EAPG claims processed through the Colorado interChange since mid-November. The intention behind these adjustments is to ensure that EAPG claims are adjudicating in alignment with intended payment policies. As the Department continues in this effort, more adjustments will be completed.

For continuing up-to-date information regarding the scheduling of mass adjustments on EAPG claims, please review the information found on the Outpatient Hospital Payment web page or attend the EAPG Meetings.

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

SPECIALTY HOSPITALS

Meetings

The next Specialty Hospital meetings in regard to the New Budget Neutral Rate will be March 2, 2018, starting at 1 p.m. Contact Elizabeth Quaife at Elizabeth.Quaife@state.co.us with questions, concerns or feedback.

For more information please visit the Specialty Hospital section on the Hospital Engagement Meetings web page.

ALL HOSPITAL PROVIDERS

Hospital Engagement Meetings

The Department hosted multiple Hospital Engagement meetings in 2017 to discuss current issues regarding payment reform and operational issues moving forward. The next meeting is scheduled for **Friday, March 2, 2018, at 303 E. 17th Ave., Denver, Conference Room 7B & 7C.**

Sign up to receive the Hospital Engagement Meeting newsletters.

The agenda for upcoming meetings will be available on the Hospital Engagement web page in advance of each meeting.

Registration links for each session during the day will also be available prior to the meeting. Just click on the links to register for each session and you will receive a link to connect to the webinar.

****Please note: Starting January 12, 2018, all Hospital Engagement Meetings will be moving to a new location at 303 E. 17th Ave., Denver, Conference Room 7B & 7C****

Contact Elizabeth Quaife at Elizabeth.Quaife@state.co.us if you have any questions.

Outpatient Physical Therapist (PT), Occupational Therapist (OT), Speech Therapist (ST)

March 2018 PT/OT/ST Billing Manual Update

The Outpatient Physical and Occupational Therapy and Outpatient Speech Therapy Fee-For-Service policy and billing manuals have been updated. Changes include:

- Updated coding tables for 2018 HCPCS changes
- Incorporation of policy from the Speech-Language Hearing Services Benefit Coverage Standard
- Optimized organization of content throughout

These billing and policy manuals are intended to be a comprehensive source for policies concerning outpatient therapy benefits. This does not preclude other sources of policy, such as statute, rule, NCCI and federal regulations from applying.

Contact Alex Weichselbaum at Alex.Weichselbaum@state.co.us with any questions.

Pharmacy Providers

Pharmacy Updates

Date of Service (DOS) Reminder

As a reminder, the DOS is the date that the prescription was filled by the pharmacy. Documentation housed within the pharmacy must substantiate the date of service for claims submitted in the pharmacy system, i.e. the dates should be the exact same.

Please see citation to rule for all information that should be included on pharmacy claims:

8.800.10.B. Each claim must identify the member, prescribing physician, **date of service**, NDC number of the drug actually dispensed, prescription number, quantity dispensed, days' supply, the usual and customary charge and any other information required by the Department.

Unenrolled Prescribers: NEW Prescriptions Written by Prescribers Not Enrolled with Health First Colorado Began Denying on January 1, 2018

Health First Colorado will not pay for new prescriptions written on or after January 1, 2018, if the prescriber is not enrolled with Health First Colorado. Refills written prior to January 1, 2018, by unenrolled prescribers will pay until the prescription expires or until there are no remaining refills. Prior authorizations requested by unenrolled prescribers will not be processed by the Magellan Rx Management Pharmacy Call Center beginning January 1, 2018.

If a prescriber would like more information on enrollment, please call the Provider Services Call Center at 1-844-235-2387, or visit the Ordering, Prescribing or Referring Provider (OPR) web page. After an enrollment or revalidation application is submitted, please use the Provider Next Steps web page. To verify enrollment status, please review pages 135-141 in the Provider Enrollment Manual.

If a prescriber does not wish to enroll with Health First Colorado, they should refer their patients to a prescriber that is enrolled. Patients needing new prescriptions for medications written on or after January 1, 2018, must have the prescriptions written by an enrolled prescriber for Health First Colorado to pay for and process the claims.

Pharmacy providers can identify prescriptions filled by an unenrolled prescriber with a current message that is sent back on the pharmacy claim that says, "Prescriber not enrolled. Call DXC, at 1-844-235-2387, to enroll."

In an emergency situation, the Department will place a 3-day supply override on a claim written by an unenrolled prescriber so that the member can obtain the medication(s) that they need. This will mirror the current override process (please refer to Appendix P for more information on the override process). 3-day overrides will be reviewed on a case by case basis which means that if a 3-day override is placed once it does not grant future approval. Therefore, prescribers should either enroll with Health First Colorado or refer their patient to an enrolled prescriber immediately to prevent disruption in therapy.

Additionally, Locum providers must enroll as an OPR provider with Health First Colorado if they would like to prescribe medication to Health First Colorado members.

Contact Kristina Gould at Kristina.Gould@state.co.us for additional information.

Physician Services

New Circumcision Rates Effective March 1, 2018

The Department opened circumcision codes 54150, 54160 and 54161, effective July 1, 2017. The Department received significant feedback from providers that the existing rates are not adequate to ensure Health First Colorado clients will receive services. The Department reviewed the codes and set new rates for the circumcision code set. Effective March 1, 2018, rates for circumcision services are shown in the table below:

Code	Description	Rate
54150	REMOVAL OF FORESKIN USING CLAMP OR DEVICE	$63.69
54160	REMOVAL OF FORESKIN, NEONATE (28 DAYS OF AGE OR LESS)	$80.94
54161	REMOVAL OF FORESKIN, PATIENT OLDER THAN 28 DAYS OF AGE	$154.89

Providers whose usual and customary charges are greater than or equal to the rates effective March 1, 2018, do not need to take any action to receive the increased reimbursement. Providers whose usual and customary charges are less than or equal to the increased rate for FY 2017-18 must submit an adjustment to the claims to receive the rate increase. For information on submitting adjustment to claims please refer to the Copy, Adjust or Void a Claim Provider Web Portal Quick Guide. The fee schedule will be updated.

Contact Richard Delaney at Richard.Delaney@state.co.us for more information.

Transportation Providers

Hospital Discharge Transportation Billing Update

In the October 2017 Provider Bulletin (B1700404), the Department communicated that effective January 1, 2018, all Health First Colorado hospital discharge trips in the Veyo service area must be arranged through Veyo for Health First Colorado to cover the Non-Emergent Medical Transportation (NEMT) trip.

On March 1, 2018, all NEMT providers in the Veyo service area will no longer be allowed to submit NEMT claims to the Department. Affected providers must submit NEMT claims prior to March 1, 2018.

Emergency Medical Transportation (EMT) providers will retain the ability to submit EMT claims directly to the Department. As a reminder, it is fraudulent to intentionally give false information on a claim to get an NEMT claim to pay under your EMT Provider ID.

If an organization is unable to submit NEMT claims for dates of service prior to January 1, 2018, before the March 1, 2018 deadline, please contact NEMT@state.co.us with:

- Circumstances outside of control that prevented submission of NEMT claims prior to March 1, 2018.
- Detailed claim information.

Requests to submit NEMT claims for DOS after January 1, 2018, will not be considered.

This does not apply to inter-facility transportation or NEMT services outside of the Veyo service area.

Contact Veyo with any questions about entering the Veyo network. Contact information is available on the Veyo website.

Updated Billing Manuals

The Transportation Billing Manual was revised to split Emergency Medical Transportation (EMT) and Non-Emergent Medical Transportation (NEMT) into two separate billing manuals. All providers should be using the new billing manuals. If there are questions regarding the EMT or NEMT billing manuals, contact NEMT@state.co.us with the page number(s) and question(s).

University of Colorado School of Medicine

Supplemental Payment for University of Colorado School of Medicine

This statement is notice of a supplemental payment to be made on March 31, 2018, for DOS occurring in the third quarter of FY 2016-17 (January 1, 2017, through March 31, 2017). The Department is making this supplemental payment to the University of Colorado School of Medicine in the amount of $30,773,025 for services rendered to Health First Colorado Members by physicians and other qualified professionals employed by the University of Colorado School of Medicine. The supplemental payment amount is based on an appropriation made by the Colorado General Assembly and is limited by a UPL.

Contact Josh English at Joshua.English@state.co.us for any questions or concerns regarding this payment.

DXC Contacts

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

Provider Services Call Center
1-844-235-2387

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