COLORADO
Department of Health Care Policy & Financing

Provider Bulletin

Reference: B1900429

Apr. 2019

Did You Know?

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.

All Providers

Fingerprint Criminal Background Check (FCBC)

As a reminder, high-risk providers (and any person who has ownership, or a controlling interest of 5% or more of a high-risk provider type) need to undergo an FCBC. Providers must submit fingerprints within 30 days of a request from the Centers for Medicare & Medicaid Services (CMS), the Department of Health Care Policy & Financing (the Department), Department agents or designated contractors.

On September 24, 2018, the Department of Public Safety implemented the Colorado Applicant Background Services (CABS) program. Instead of obtaining and submitting fingerprint cards from local law enforcement agencies, individuals must go to an IdentoGo location or to a Colorado Fingerprinting location to meet the requirements of the FCBC for high-risk provider types. More information is available on the Employment & Background Checks web page of the Colorado Bureau of Investigation (CBI) website.

To ensure that the fingerprint background reports are being sent to the Department for review, the individual must choose the correct code when making the appointment with IdentoGo. The code that must be used is: Medicaid - Department of Health Care Policy and Financing-service code 25YQG9*.

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

*__Note:__ If the wrong code is chosen for the background check and the results go to a different department, the report is unable to be shared between departments due to privacy requirements. The individual will be required to pay the fees to obtain another report.

For more information, refer to the Fingerprint Criminal Background Check Frequently Asked Questions (FAQs), available on the Provider FAQ Central web page under the Fingerprinting drop-down section.

Dental Providers

Verifying Member Eligibility and Appealing Claim Denials for Eligibility

Providers are reminded to verify member eligibility prior to rendering services. Records of eligibility should be retained for billing purposes. It is critical for providers to always check the eligibility response at each visit as eligibility may change. Obtaining prior authorization is not a guarantee of eligibility.

Health First Colorado (Colorado's Medicaid Program) Provider Web Portal

The Provider Web Portal is managed by DXC Technology (DXC) and is the system of record for member eligibility, **not** the DentaQuest Portal.

Providers are required to verify eligibility for each date of service through DXC either via the Provider Web Portal or via batch X12N 270.

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.

Appealing Claim Denials for Eligibility

If a claim is denied for eligibility by DentaQuest, the provider may appeal by submitting proof of eligibility from DXC. The appeal process is documented under section 7.00 of the Health First Colorado Dental Plan Program Office Reference Manual (ORM), available on the Colorado State Dental Plans web page of the DentaQuest website.

Refer to the DentaQuest Office Reference Manual for more information.

Contact DentaQuest at 1-855-225-1731 with any questions regarding this process.

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

Claims Must Match Documentation

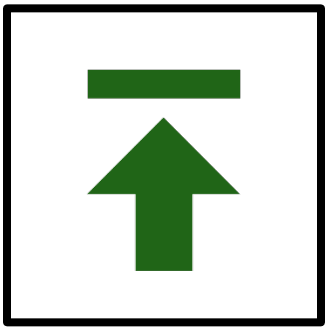
DMEPOS providers are reminded that delivery documentation such as delivery tickets and shipping invoices must match the date of service billed and entered on claims pursuant to state and federal audit requests.

Geographical Reimbursement Rates

Codes subject to the Medicare Upper Payment Limit (UPL) require reimbursement to be paid at the geographical rate. The Department has set rates according to the regions that Medicare has designated for Colorado, to include the following four regions:

- Non-Rural
- Rural
  - Zip codes associated with the Rural regions
- Competitive Bid (Denver-Aurora-Lakewood)
- Competitive Bid (Colorado Springs)
  - Zip codes associated with the Competitive Bid areas

Effective January 1, 2018, the competitive bid area (Denver-Aurora-Lakewood) interim rate has been used during Department work on the Colorado interchange system to implement rates according to region. As a result, claims will be reprocessed to reflect the appropriate rate.



Effective March 12, 2019, claims billed for codes subject to the UPL are suspending for Explanation of Benefits (EOB) 0000 – "This claim/service is pending for program review." All affected claims with dates of service on or after January 1, 2018, will be reprocessed at the correct regional rate.

Modifiers

NU (New Purchase) - The Department has not enforced the usage of the NU modifier though it should be used in all applicable situations. With the implementation of the DME UPL fee schedule, the NU modifier will be required on the UPL codes for the claim to price at its New Purchase rate.

UE (Used Purchase) - All claims for used equipment must include the UE modifier. The DME UPL fee schedule details the maximum allowable for used equipment.

Updated Prior Authorization Request (PAR) Requirements for Prosthetics & Orthotics, Effective April 1, 2019

Prosthetic and orthotic PAR requirements originally scheduled to become effective November 1, 2018, were delayed. **As a result, prosthetic and orthotic PAR requirements will become effective April 1, 2019.**

Prosthetic and orthotic PARs will be reviewed for medical necessity by the Department's PAR vendor, eQHealth Solutions. Contact the ColoradoPAR Provider Helpline at 1-888-801-9355 or visit the ColoradoPAR website with any questions on prior authorization or for more information.

Refer to the prosthetic and orthotic utilization code list below for a complete list of prosthetic and orthotic codes that will require a PAR, effective April 1, 2019.

Contact HCPF_DME@state.co.us for more information.

Additional Codes Subject to PAR Effective April 1st							
Additional Prosthetic Codes					Additional Orthotic Codes		
L5010	L5639	L5845	L6400	L7009	E1801	L1499	L2108
L5020	L5640	L5848	L6450	L7040	E1802	L1680	L2116
L5050	L5643	L5856	L6500	L7045	E1806	L1685	L2126
L5060	L5645	L5857	L6550	L7170	E1811	L1686	L2128
L5100	L5647	L5858	L6570	L7180	E1816	L1690	L2132
L5105	L5648	L5930	L6580	L7181	E1818	L1700	L2134
L5150	L5649	L5950	L6582	L7185	E1825	L1710	L2136
L5160	L5651	L5960	L6584	L7186	L0452	L1720	L2350
L5200	L5671	L5961	L6586	L7190	L0456	L1730	L2510
L5210	L5673	L5964	L6588	L7191	L0457	L1755	L2525
L5220	L5679	L5966	L6590	L7259	L0458	L1832	L2526
L5230	L5681	L5968	L6621	L7360	L0460	L1834	L2627
L5250	L5682	L5973	L6693	L7362	L0462	L1840	L2628
L5270	L5683	L5979	L6696	L7364	L0464	L1843	L2999
L5280	L5700	L5980	L6697	L7366	L0480	L1844	L3671
L5301	L5701	L5981	L6704	L7367	L0482	L1845	L3720
L5321	L5702	L5987	L6707	L7368	L0484	L1846	L3730
L5331	L5703	L5988	L6708	L7499	L0486	L1847	L3740
L5341	L5704	L5990	L6709	L8035	L0488	L1860	L3763
L5400	L5705	L6000	L6712	L8500	L0491	L1904	L3764
L5410	L5706	L6010	L6713	L8619	L0622	L1907	L3765
L5420	L5707	L6020	*L6715	L8627	L0624	L1932	L3766
L5500	L5716	L6026	L6721	L8628	L0629	L1940	L3900
L5505	L5718	L6050	L6722	L8629	L0631	L1945	L3901
L5510	L5722	L6055	L6883	L8696	L0636	L1950	L3960
L5520	L5724	L6100	L6884	*L6714	L0637	L1951	L3961
L5530	L5726	L6110	L6885		L0638	L1960	L3967
L5535	L5728	L6120	L6920		L0640	L1970	L3971
L5560	L5780	L6130	L6925		L0648	L1990	L3973
L5570	L5781	L6200	L6930		L0651	L2000	L3975
L5580	L5782	L6205	L6935		L0700	L2005	L3976
L5585	L5795	L6250	L6940		L0710	L2010	L3977
L5590	L5814	L6300	L6945		L0810	L2020	L3978
L5595	L5816	L6310	L6950		L0820	L2030	L3999
L5600	L5818	L6320	L6955		L0830	L2034	L4000
L5610	L5822	L6350	L6960		L0999	L2036	L4002
L5611	L5824	L6360	L6965		L1000	L2037	L4010
L5613	L5826	L6370	L6970		L1005	L2038	L4020
L5614	L5828	L6380	L6975		L1200	L2060	L4030
L5616	L5830	L6382	L7007		L1300	L2080	L4040
L5629	L5840	L6384	L7008		L1310	L2106	L4050
					L4631		

The following codes will not have changes to their PAR requirements:

Prosthetic Codes			Orthotic Codes			
L5312	L8031	L8047	E1840	L3070	L3300	L3510
L6880	L8032	L8048	E1841	L3080	L3310	L3520
L6881	L8039	L8049	L0112	L3090	L3320	L3530
L6882	L8040	L8499	L0113	L3100	L3330	L3540
L6890	L8041	L8505	L0130	L3140	L3332	L3550
L6895	L8042	L8507	L0140	L3150	L3334	L3560
L6900	L8043	L8509	L0150	L3160	L3340	L3570
L6905	L8044	L8510	L0160	L3170	L3350	L3580
L6910	L8045	L8610	L0170	L3215	L3360	L3590
L6915	L8046		L0172	L3216	L3370	L3595
L8030			L0174	L3217	L3380	L3600
			L0180	L3219	L3390	L3610
			L0190	L3221	L3400	L3620
			L0200	L3224	L3410	L3630
			L0220	L3225	L3420	L3640
			L3000	L3230	L3430	L3649
			L3001	L3250	L3440	S1040
			L3002	L3251	L3450	
			L3003	L3252	L3455	
			L3020	L3253	L3460	
			L3030	L3254	L3465	
			L3031	L3255	L3470	
			L3040	L3257	L3480	
			L3050	L3260	L3485	
			L3060	L3265	L3500	

Home and Community-Based Services (HCBS) Developmental Disabilities (DD), Supported Living Services (SLS) and Children's Extensive Support (CES) Providers

House Bill (HB) 18-1407 Implementation

The Department is currently working to implement HB 18-1407 rate increases effective March 1, 2019. HB 18-1407 requires the Department to implement a 6.5% increase to reimbursement rates for designated HCBS services provided to individuals receiving services through the DD, SLS and CES waivers. The increase applies to:

- Group Residential Services and Supports
- Individual Residential Services and Supports
- Specialized Habilitation
- Respite
- Homemaker Basic

- Homemaker Enhanced
- Personal Care
- Prevocational Services
- Behavioral Line Staff
- Community Connector
- Supported Community Connections
- Mentorship
- Supported Employment (Job Development and Job Coaching)

The identified HCBS fee schedules have been updated to reflect the 6.5% increase to non-negotiated rates and were posted to the Provider Rates & Fee Schedule web page under the HCBS Rate Schedule drop-down section on March 1, 2019. The Spending Plan Authorization Limits (SPALs) have been updated to include the 6.5% increase and are posted on the fee schedules. The 6.5% increase to services listed above resulted in an increase to the SPAL amounts.

General Information

Rate increases, effective for dates of service on or after March 1, 2019, were implemented in the Colorado interChange on March 7, 2019, for the DD, SLS and CES waivers in accordance with HB 18-1407, Stabilization of Direct Support Professional Workforce Stakeholder Engagement. It is recommended that providers submit charges based on usual and customary rates, when applicable. Claims with dates of service on or after March 1, 2019, will be reprocessed by DXC at the new rates in the coming weeks. Providers may also resubmit claims directly if they prefer. For more information, refer to the visit the HCBS Rates Information & Resources drop-down section of the Provider Rates & Fee Schedule web page.

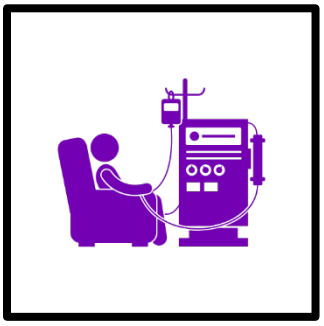
Contact Victoria Martinez at Victoria.Martinez@state.co.us for more information.

Hospital and Dialysis Providers

Billing Guidance for End-Stage Renal Disease as an Emergency Medical Condition

As a reminder, effective February 1, 2019, the Department considers End-Stage Renal Disease to be an emergency medical condition. Coverage under this policy is limited to care and services necessary in the treatment of End-Stage Renal Disease for recipients of Emergency Medicaid, including dialysis treatment at enrolled dialysis treatment centers.

The Department has received a number of claims recently without the emergency indicator. As a reminder, claims submitted for recipients of Emergency Medicaid without the appropriate emergency indicator will deny.



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 with any policy questions.

Hospital Providers

Inpatient Hospital Review Program (IHRP) Implementation Notification

The Department must implement an evidence-based hospital review program to ensure that the utilization of hospital services is based on a recipient's need for care, according to the Senate Bill 18-266 titled Controlling Medicaid Costs. Visit the Controlling Medicaid Costs Initiatives web page for additional information.

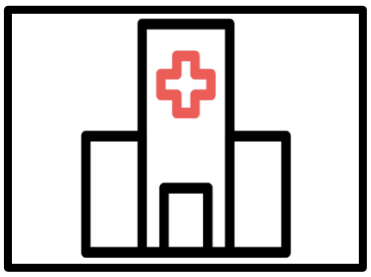
Prior Authorization Requests (PARs) will be required for inpatient hospital services for dates of service beginning May 15, 2019. Providers were able to submit PARs starting March 18, 2019.

The IHRP will include industry standard review processes for fee-for-service non-behavioral health or non-maternity related admissions, including:

- **Preadmission Certification** including preauthorization for planned, elective, holiday or weekend admissions with guidance on length of stay and care settings. For unplanned admissions under urgent/emergent circumstances, the provider will be required to enter/request a review within one business day after member is stabilized per the Emergency Medical Treatment and Active Labor Act (EMTALA) definition.
    - EMTALA reg at 42 USCS § 1395dd, "(B) The term "stabilized" means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility."
- **Continued Stay and Complex Case Reviews** including review of authorized admissions with greater than a four-day length of stay to ensure there are no early discharges that might potentially result in readmissions or inappropriate medical services.

The goals of the IHRP include:

- Improving the quality of care for Health First Colorado members
- Facilitating better care planning and care transitions
- Ensuring services occur in appropriate care settings with the optimal length of stay based on members' needs
- Monitoring hospitals to ensure appropriate billing practices
- Providing timely, accurate information and tools to partners who can then reach out to members who require extensive care



The IHRP will provide daily data feeds to Regional Accountable Entities with member diagnosis and treatment plans, highlighting opportunities for care coordination and case management for patients who are at risk for re-admission and in need of care transition support.

The Department has expanded its partnership with the prior authorization vendor, eQHealth Solutions, which already supports PARs for select outpatient and surgical procedures. Training on the use of eQSuite® and the new IHRP is now available on the Inpatient web page of the ColoradoPAR website, and the Inpatient Hospital Review Program (IHRP) Questions and Answers has been posted to the website to provide additional information.

Guidelines for providers on time frames for each type of request are listed below:

Type of Request	Guidelines for Providers
Scheduled, non-emergent admissions	Submitted review prior to admission
Unscheduled, non-emergent admission	Submitted review within one business day of admission
Unscheduled, emergent admission	Submitted review within one business day of stabilization of patient per EMTALA definition
Concurrent Review	No later than day four of inpatient admission
Pended Question Response time	1.5 business days (for example, if a review was pended to provider on Thursday afternoon, the provider would have until Monday morning, prior to 12 noon, to respond before review is denied for lack of information.)
Peer-to-Peer Review	Providers may request within five business days of the Medical Necessity Denial
Reconsideration for a PAR denial	Providers may request within five business days of the denial

The Inpatient Hospital Review Program (IHRP) Implementation Notification, available on the Provider News web page under the Hospital – General drop-down section, was previously sent to all inpatient providers via email February 27, 2019. To receive any future communications regarding IHRP, sign up by going to the Provider News web page and clicking "sign up here" in the opening paragraph. Follow the instructions to select which communications to receive.

Contact HCPF_HospitalReview@ state.co.us with any questions regarding this policy.

Contact eQHealth at 1-888-801-9355 with any questions regarding PAR submissions.

General Updates

Inpatient Hospital Per Diem Rate Group

Web Page

A new web page has been created to house the Inpatient Per Diem Rates. Providers are encouraged to visit the Inpatient Hospital Per Diem Reimbursement Group web page.

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

Psychiatric Hospital Providers – Billing Clarification

As a reminder, the Department has two sets of rates for Psychiatric Hospital providers, Step 1 and Step 2. The Step 1 rate is paid during days 1 through 7 of the member's inpatient stay when billed with revenue

code 0114. The Step 2 rate is paid from day 8 through the remainder of care at an acute level when billed with revenue code 0124. Providers must bill the first 7 days of a member's inpatient stay at psychiatric hospitals using revenue code 0114 and the remainder of the stay using revenue code 0124. This methodology is outlined in 10 CCR 2505-10 8.300.5.D.1.a. Using the correct revenue code allows the Colorado interChange to calculate payments with the appropriate step-down rate.

Contact Raine Henry at Raine.Henry@state.co.us or 303-866-4493 with any questions.

Outpatient Hospitals

Payment Reform Survey

The Department is planning to conduct a survey regarding its payment reform efforts for Outpatient Hospital Payment. The intent of the survey is to obtain input from the hospital provider community regarding how the Department directs its resources. This survey is also intended to capture information from a broader set of hospitals than the survey distributed in late 2018.

To stay updated on the distribution of the survey, please sign up for the Hospital Stakeholder Engagement Meeting newsletter mailing list below.

Contact Andrew Abalos at Andrew.Abalos@state.co.us or 303-866-2130 with any questions.

Observation Payment Clarification

The Department has received questions regarding the payment for observation services on institutional outpatient hospital claims paid through the Enhanced Ambulatory Payment Grouping (EAPG) methodology. The Department has not identified any issues in its claims processing engine relating to such payments and concludes that payment calculation is functioning as designed. Updating payment for observation services on the institutional outpatient hospital claim is being considered as a payment reform effort and will be a topic on the upcoming Payment Reform survey.

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, May 3, 2019, 9:00 a.m.- 12:00 p.m. MT at 303 E 17th Ave, Denver, Conference Room 7B & 7C. To see dates for all 2019 Hospital Engagement meetings, refer to the calendar available on the Hospital Stakeholder Engagement Meetings web page.

Sign up to receive the Hospital Stakeholder Engagement Meeting newsletters.

Visit the Hospital Engagement Meetings web page for more details, meeting schedule 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.

Pharmacy Providers

340B Drug Pricing Program

Pharmacies which participate in the 340B Drug Pricing Program must choose either to provide only 340B-purchased drugs (carve-in) or to provide no 340B-purchased drugs (carve-out) to Health First Colorado members. Providers that choose to carve-in **must**:

1. Have the National Provider Identifier (NPI) number listed on the HRSA 340B Medicaid Exclusion File.
2. Submit the **340B acquisition cost** as the ingredient cost (NCPDP Field #409-D9) on each claim.
3. Submit claims with **"20"** in the Submission Clarification field and **"05" or "08"** in the Basis of Cost Determination field.

November 1, 2018, the Department notified providers when:

- The pharmacy NPI number is listed on the HRSA 340B Medicaid Exclusion File and the submitted ingredient cost on the claim exceeds the 340B ceiling price.

Effective May 1, 2019, the Department will deny claims when:

- The pharmacy NPI number is listed on the HRSA 340B Medicaid Exclusion File and the submitted ingredient cost on the claim exceeds the 340B ceiling price.

How to resolve denied claims:

- Pharmacies must resubmit the claim with the appropriate 340B acquisition cost in the submitted ingredient cost field.
- If the pharmacy still receives a denial after submitting the correct 340B acquisition cost, then contact the Magellan Help Desk at 800-424-5725.

Contact Kristina Gould at Kristina.Gould@state.co.us with any questions.

Pharmacy Acquisition Cost Survey

The Department has contracted with Myers and Stauffer to conduct quarterly surveys of pharmacy acquisition costs for prescription drugs. The Department strongly encourages the participation of pharmacy providers to help ensure that pharmacy rates incorporate market conditions specific to Colorado. Surveys will be sent via postal mail on April 1, 2019, to a sampled group of pharmacy providers.

Invoices can be submitted via email, mail or fax. All submitted invoice data will remain strictly confidential.

General questions about the survey process can be directed to the Myers and Stauffer Pharmacy Help Desk at 800-591-1183 or pharmacy@mslc.com.

Pharmacies and All Medication-Prescribing Providers

April Preferred Drug List (PDL) Announcement

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

Atypical Antipsychotics (oral)			
Aripiprazole	Clozapine	Latuda (2nd Line)	Olanzapine
Quetiapine	Risperidone	Ziprasidone	
CGRP Inhibitors			
Emgality			
Growth Hormones			
Genotropin		Norditropin	
Insulins (Mixtures)			
Humalog 50/50 vial	Humalog 75/25 vial	Humulin 70/30 vial	Novolog 70/30 vial/pen
Insulins (Long-acting)			
first line- Lantus		Levemir	
Insulins (Intermediate-acting)			
Humulin N vial			
Insulins (Rapid-acting)			
Novolog vial/pen			
Insulins (Short-acting)			
Humulin R vial		Humulin R U-500 vial	
Intranasal Rhinitis Agents			
Azelastine	Budesonide	Fluticasone (generic Rx Flonase)	Ipratropium
Triamcinolone (generic Nasacort)	**Note: brand Nasonex and its generic mometasone will be non-preferred.**		
Leukotriene Modifiers			
Montelukast tab/chewable			
Statins/Statin Combinations			
atorvastatin	lovastatin	pravastatin	rosuvastatin
simvastatin			
Bile Salts			
Ursodiol tablet and capsule			
Other Lipotropics			
Colestipol tab	Cholestyramine	Colesevelam tab	Ezetimibe
Fenofibrate tab	Gemfibrozil	Niacin ER	Omega-3 (generic Lovaza)
Multiple Sclerosis Agents			
Aubagio (2nd Line)	Avonex	Betaseron	Copaxone 20mg

Gilenya (2nd Line)		Tecfidera (2nd Line)	
Neurocognitive Disorder Agents			
Donepezil 5mg tab	Donepezil 10mg tab		Donepezil ODT
Exelon patch		Memantine tab	
Anti-Parkinson's Agents			
Amantadine cap/syrup	Benztropine	Carbidopa/Levodopa IR	Carbidopa/Levodopa ER
Pramipexole IR	Ropinirole IR	Selegeline cap	Trihexyphenidyl tab/elixir
Ophthalmic Allergy Agents			
Cromolyn	Ketotifen	Lastacaft	
olopatadine 0.1% (generic Patanol)			Pazeo
Ophthalmic Glaucoma Agents			
Alphagan P	Azopt	Brimonidine	Combigan
Dorzolamide	Dorzolamide/Timolol	Latanoprost	Lumigan
Timolol		Travatan Z	
Sedative Hypnotics			
Eszopiclone	Zaleplon	Zolpidem IR	Temazepam 15mg
Temazepam 30mg		Triazolam	
Topical Corticosteroids (Low Potency)			
Hydrocortisone cream/oint/lotion		Derma-Smoothe oil	Desonide 0.05% cream
Topical Corticosteroids (Medium Potency)			
Betamethasone Dipropionate 0.05% cream/lotion		Betamethasone Valerate 0.1% cream/oint	Fluticasone 0.05% cream/oint
Mometasone 0.1% cream/oint/solution		Triamcinolone 0.025%, 0.1% cream/oint/lotion	
Topical Corticosteroids (High Potency)			
Betamethasone Dipropionate/Propylene Glycol 0.05% cream		Fluocinonide 0.05% gel/solution	Triamcinolone 0.5% cream/oint
Topical Corticosteroids (Very High Potency)			
Betamethasone Dipropionate/Propylene Glycol 0.05% oint		Clobetasol Propionate 0.05% cream/gel/oint/solution	

Drug Utilization Review Updates

Recent Changes to Coverage of Prescription Topical Corticosteroids

Effective April 1, 2019, topical corticosteroids are a new drug class on the Health First Colorado preferred drug list (PDL). The preferred and non-preferred topical corticosteroids listed on the PDL are grouped in four separate classes based on potency: Low Potency, Medium Potency, High Potency and Very High Potency. For all of the preferred products listed in these classes, no prior authorization is required.

Based on clinical recommendations supporting use of the lowest effective potency of topical corticosteroid for the shortest duration that achieves efficacy for treatment, all medications listed in the “High Potency” and “Very High Potency" corticosteroid classes are subject to coverage limitations based on duration of use. Claims for “High Potency” corticosteroids will deny if exceeding a limitation of four weeks for

uninterrupted, continuous therapy; and claims for "Very High Potency" corticosteroids will deny if exceeding a limitation of two weeks for uninterrupted, continuous therapy.

Coverage and prior authorization criteria for the topical corticosteroids are available for reference on the Pharmacy Resource web page.

Pharmacy and Therapeutics Committee Meeting

Tuesday, April 2, 2019

1:00 - 5:00 p.m. MT

303 E 17th Ave

11th Floor Conference Rooms 11A, 11B, 11C

The meeting agenda can be found on the Pharmacy and Therapeutics (P&T) Committee web page.

Physician Services

Changes to Sleep Study and Pulmonary Testing Procedure Codes

Effective April 1, 2019, several procedures related to sleep studies and pulmonary testing will require that a physician, advanced practice nurse or physician's assistant either perform or supervise the procedure. The supervising provider must appear on the claim as the rendering provider when the procedure is performed by a provider other than ones identified above. The supervision must be within the scope of practice of the provider in the State of Colorado.

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

Place of Service (POS) 19 and 22 for Hospital-Based Clinics

In January 2016, CMS updated the current POS code set by adding a new POS code 19 for "Off Campus-Outpatient Hospital" and revised POS code 22 from "Outpatient Hospital" to "On Campus-Outpatient Hospital".

POS 19: Off Campus-Outpatient Hospital

Descriptor: A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

POS 22: On Campus-Outpatient Hospital

Descriptor: A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

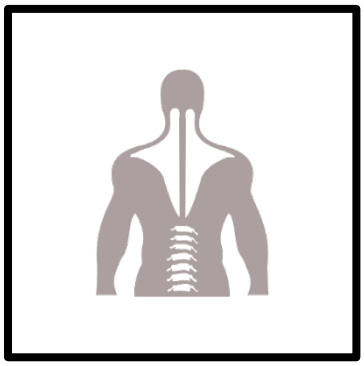
Physicians and practitioners who perform services in a hospital outpatient place of service shall use, at a minimum, POS code 19 (Off Campus-Outpatient Hospital) or POS code 22 (On Campus-Outpatient Hospital).

Physicians shall continue to use POS code 11 (Office) when services are performed in a separately maintained physician office space in the hospital or on the hospital campus.

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

Policy Update Requiring a Prior Authorization Request (PAR) for Back Surgery and Other Select Surgical Codes

Effective April 1, 2019, back surgery and other select surgical codes require a PAR through the Department's PAR vendor, eQHealth Solutions. Codes requiring a PAR will be noted on the Par'd Surgical Procedures web page of the ColoradoPAR website. The PAR can be requested utilizing the online PAR portal, eQSuite®.



Visit the ColoradoPAR website for more information, including training opportunities for utilizing eQSuite, the specific codes requiring a PAR, 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 Chris Lane at Christopher.Lane@state.co.us with any surgical policy questions.

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

Unlisted Surgical Code Pricing and Billing Bilateral Procedures

Pricing for Unlisted Surgical Procedure Codes

Providers are reminded that a solution has been implemented to correct the pricing for unlisted surgical procedure codes. Codes were priced at 50% of billed charges as an interim solution. Now that the solution is implemented for manually priced surgical services, all claims will be priced with the correct methodology. Providers are reminded to attach the Unlisted Surgical Procedure Code Form to each claim for processing via the Provider Web Portal, as detailed in the November 2018 Provider Bulletin (B1800423).

Billing Bilateral Procedures

Providers are reminded that effective May 1, 2018, the use of modifier 50 to report bilateral procedures was changed to reflect National Uniform Billing and Coding standards. Previously, the Department required bilateral procedures be reported on two (2) lines, with modifier 50 added to the second line. Beginning May 1, 2018, bilateral procedures should be reported on one (1) line by adding modifier 50 to the appropriate procedure code, using one unit of service.

Reimbursement methodology for bilateral procedures, as well as other requirements in the Medical and Surgical Services Billing Manual, available on the Billing Manuals web page under the CMS 1500 drop-down section, will remain unchanged.

Contact Christopher Lane at Christopher.Lane@state.co.us for additional information.

Speech Therapy Providers

Prior Authorization Required for Outpatient Speech Therapy

Effective April 1, 2019, the outpatient speech therapy benefit will require prior authorization for CPT codes 92507, 92508, 92526 and 92609.

Claims submitted for dates of service on or after April 1, 2019, will be denied unless there is an approved Prior Authorization Request (PAR) on file for the services being billed. Evaluation services will not require a PAR.

The Speech Therapy Billing Manual, available under the CMS 1500 drop-down section of the Billing Manuals web page, has been updated to reflect the new authorization requirements.

A "Speech Therapy PAR Frequently Asked Questions" drop-down section has been added to the Outpatient Speech Therapy Benefit web page. This section addresses common concerns about the prior authorization process.

The Department's 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, visit the ColoradoPAR website. Contact hcpf_UM@hcpf.state.co.us with any additional questions about the PAR process

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

Provider Billing Training Sessions

April and May 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, 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.

April 2019

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
31	1	2	3	4	5	6
Sunday	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
7	8	9	10	11 CMS 1500 Provider Workshop 9:00 a.m. - 11:30 a.m. MT	12	13
Sunday	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
14	15	16	17	18 UB-04 Provider Workshop 9:00 a.m. - 11:30 a.m. MT	19	20

May 2019

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

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 up to 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 Street, 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
Memorial Day – Monday, May 27, 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.

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