COLORADO
Department of Health Care Policy & Financing

Provider Bulletin

Reference: B2200477

Apr. 2022

Did You Know?

If a member has a Medicare Advantage plan, the primary billing information should be reported on a claim in the Medicare fields, not as Third-Party Liability (TPL) fields. A Medicare Advantage plan (such as a Health Maintenance Organization [HMO] or Preferred Provider Organization [PPO]) is another Medicare health plan choice a member may have as part of Medicare.

Reference the Submitting a Claim with Other Insurance or Medicare Crossover Information quick guide for more information.

All Providers

Delayed Member Notification of Health First Colorado (Colorado's Medicaid program) Eligibility

It is not effective to rely solely on the member notifying the provider of their eligibility. Billing statements, or collection agencies should also not be the only means of obtaining eligibility information.

Providers are expected to take appropriate and reasonable action to identify Health First Colorado (Colorado's Medicaid program) eligibility within 365 days (timely filing guidelines). Some examples of appropriate action include:

- Reviewing past medical and accounting records for eligibility and billing information for services provided
- Requesting eligibility information from the referring provider or facility where the member was seen
- Contacting the member by phone, by email and by mail
- Verify eligibility via the Provider Web Portal or via batch

If the timely filing period expires because the provider is not aware that the member is Health First Colorado eligible, the fiscal agent is not authorized to override timely filing.

License Panel Update for the Provider Enrollment Portal and the Provider Web Portal

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

Providers are reminded that Health First Colorado enrollment may be inactivated if the provider's license, certification, or accreditation has expired or is subject to conditions or restrictions. Visit the General Provider Information Manual web page for more information.

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

Ordering, Prescribing, Referring (OPR) Guidance Update

Effective July 1, 2022, the federal requirement 42 CFR § 455.440 that claims for certain types of services contain the National Provider Identifier (NPI) of the provider who ordered the service, and that the NPI is actively enrolled with Health First Colorado, will be enforced.

Providers are instructed to place the NPI of the ordering provider into the following locations for claim submission. This field may be labelled as "Referring Provider" in the Provider Web Portal.

Professional claims

- Paper claims use field 17.b
- Electronic submissions use loop 2420e with qualifier DK.

Institutional claims

- The Attending Provider field (#76) or the Other ID fields (#78 or #79) for both paper and electronic claims.
- Providers should refer to their applicable UB-04 billing manuals for guidance on how each field is used.

Visit the Ordering, Prescribing, and Referring Claim Identifier Project web page for further information on this project.

Providers may contact the Provider Services Call Center for specific assistance with claim submission.

Payment Error Rate Measurement (PERM) Audit

The Centers for Medicare & Medicaid Services (CMS) will start its Review Year 2023 Payment Error Rate Measurement (PERM) audit on Health First Colorado and Child Health Plan *Plus* (CHP+) claims in the spring of 2022. CMS will randomly select a set number of paid or denied claims from July 1, 2021, to June 30, 2022, for its review.

CMS has contracted with NCI Information System, Inc (NCI), who will contact providers by phone and letter to request medical records that support claims providers submitted for payment. A blank copy of the letter is available on the Payment Error Rate Measurement (PERM) web page. NCI will review the medical records to determine if the payment for the corresponding claim was justified. Providers have 75 calendar days to provide medical record documentation to NCI.

If the initially submitted medical record documentation is not sufficient, NCI will contact providers to request additional documentation. Providers have 14 calendar days to provide the additional documentation. If documentation is not provided or is insufficient, the provider's claim will be considered to be paid in error, and the Department of Health Care Policy & Financing (the Department) will initiate recovery for the monies associated with the claim from the provider. The Department will also investigate the reasons why the provider did not submit proper documentation.

Provider Education Webinars

CMS is hosting Provider Education webinars. These are trainings for providers to learn about the PERM process, provider responsibilities and best practices. The webinars are:

1) Tuesday, April 12, 2022, from 11:00 a.m. to 12:00 p.m. MT
2) Wednesday, April 13, 2022, from 1:00 p.m. to 2:00 p.m. MT
3) Thursday, April 14, 2022, from 2:00 p.m. to 3:00 p.m. MT

Visit the CMS Webinar Registration web page to register. Registration is due by April 10, 2022, at 3:00 p.m. MT. All three webinars will cover the same material. All webinar sessions will be recorded. Email PERMRC_ProviderInquries@nciinc.com with any questions.

What is PERM?

PERM is a federally mandated audit that occurs once every three years. This is a review of claim payments and eligibility determination decisions made for states' Medicaid and Children's Health Insurance Program to ensure payment accuracy and verify that states only pay for appropriate claims. The collection and review of protected health information

contained in medical records for payment review purposes is authorized by U.S. Department of Health and Human Services regulations at 45 C.F.R. 164.512(d), as a disclosure authorized to carry out health oversight activities, pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA); CMS PERM Review Contractor activities are performed under this regulation.

Visit the CMS Payment Error Rate Measurement (PERM) web site and the Department's Payment Error Rate Measurement (PERM) web page for more information. Contact Matt Ivy at Matt.Ivy@state.co.us or at 303-866-2706.

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

Colorado interChange Update for Geographic Rates for Durable Medical Equipment (DME) Codes Subject to Medicare Upper Payment Limit (UPL)

The Colorado interChange has been updated to price claims based on the member's zip code in compliance with the Consolidated Appropriations Act of 2016 (Section 503). Claims for Durable Medical Equipment (DME) codes subject to the Medicare Upper Payment Limit (UPL) will now process through the system without suspending Explanation of Benefits (EOB) 0000 - "This claim/service is pending for program review."

Visit the Provider Rates & Fee Schedule web page under the Durable Medical Equipment, Upper Payment Limit section for the rates on codes that fall within the scope of the DME UPL. Reference this letter to providers and the September 2019 Provider Bulletin (B1900435) for additional UPL information.

Home and Community-Based Services (HCBS) Providers

Remote Supports Providers

Effective January 1, 2022, a Remote Supports benefit was added to the following Home and Community-Based Services (HCBS) waivers: Brain Injury (BI) waiver; Community Mental Health Supports (CMHS) waiver; Elderly, Blind and Disabled (EBD) waiver; Spinal Cord Injury (SCI) waiver and Supported Living Services (SLS) waiver.

Remote Supports is the provision of support by staff at a remote location who are engaged with the member to assist, monitor, and respond to their health, safety, and other needs through technology/devices with the capability of live two-way communication. Member interaction with support staff may be scheduled, on-demand, or in response to an alert from

a device in the remote support equipment system. Remote Supports use is by the choice of the member and policy requires assessment for use through the support planning process by the authorizing Case Management Agency (CMA).

Provider Enrollment

Providers interested in enrolling to provide Remote Supports are encouraged to review all provider requirements outlined in regulation at 10 CCR 2505-10 8.488.50. Provider agencies are required to complete the Remote Supports Provider Training provided by the Department and must submit the certificate of completion as part of the provider enrollment process. A full list of provider agency enrollment requirements can be found on the Provider Enrollment web page.

Beginning **March 11, 2022,** Remote Supports provider enrollment applications will be reviewed by Gainwell Technologies and the Department.

All Remote Supports Providers will need to participate in Electronic Visit Verification (EVV). Federal guidance requires Electronic Visit Verification (EVV) for Home and Community-Based Services (HCBS) that include an element of Personal Care Services. Colorado requires the use of EVV for several other services that are similar in nature and delivery to the federally mandated services, including Homemaker Services. More information about EVV can be found on the Electronic Visit Verification Program web page.

Provider Type: 36

Provider Specialty: 756

Billing Information

Prior Authorization is required for Remote Supports.

Service Description	Procedure Code	Modifier
Personal Care - Remote Supports	T1019	SE
Homemaker - Remote Supports	S5130	SE
PERS - Remote Support Technology	S5160	SE

Review the HCBS Rate Schedule for rates effective January 1, 2022.

Refer to the HCBS Provider Billing Manual(s) for additional billing information.

Contact Courtney Montes at Courtney.Montes@state.co.us with policy questions about Remote Supports.

Rate Increase for Some Waiver Services Paid to Targeted Case Management (TCM), Community Centered Boards (CCBs)

Between April 1, 2022, and March 31, 2023, rates paid to Community Centered Boards (CCBs) for Targeted Case Management (TCM) for members receiving services on the following Home and Community-Based (HCBS) waivers will increase temporarily by 2.11%.

- HCBS Waiver for Persons with Developmental Disabilities (HCBS-DD)
- HCBS Children's Extensive Support Waiver (HCBS-CES)
- HCBS Children's Habilitation Residential Program (HCBS-CHRP)
- HCBS Supported Living Services Waiver (HCBS-SLS)

This funding is part of an overarching effort to leverage the HCBS American Recovery Program Act (ARPA) funds to stabilize and increase the direct care workforce. The purpose of this funding is to support hiring and retention efforts.

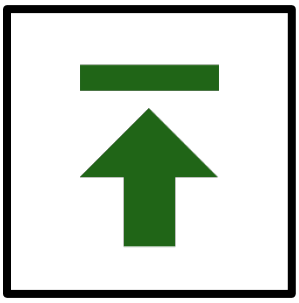
Review the "Targeted Case Management 4/1/22" Targeted Case Management Fee Schedule, located on the Provider Rates & Fee Schedules web page to determine the appropriate rate to bill.

The increase applies to the Per Member/Per Month service, the Monitoring Visit(s), and the Rural Add On service.

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

Temporary Rate Increase Extension

Effective April 1, 2022, the 2.11% temporary rate increases retroactive to April 1, 2021, and originally set to expire March 31, 2022, are being extended through July 31, 2022.



This funding is part of an overarching effort to leverage the Home and Community-Based Services (HCBS) American Recovery Program Act (ARPA) funds to stabilize and increase the direct care workforce. The purpose of this funding is to support hiring and retention efforts.

Operational Memo 22-010 contains a list of the impacted services.

Review the HCBS American Rescue Plan (ARPA) Rate Schedule, "Rates Effective 1/1/2022", located on the Provider Rates and Fee Schedule web page to determine the appropriate rate to bill.

Over Cost Containment (OCC)

If the average daily cost for a PAR exceeds the $285 OCC amount due to the increased rates, the case manager does not need approval from Telligen.

Alternative Care Facility (ACF) and Supported Living Program (SLP) Providers Only

- The ARPA Base Wage increase as well as the 2.11% increase can continue to be billed through July 31, 2022.
- Providers do not need to adjust claims for ACF and SLP services in order to get the rate increase.
- In order to get the increase, providers must bill a supplemental, temporary code to get the differential between the amount paid for the original DOS and the rate increase. The Department will load these codes onto each impacted PAR.
    - Steps necessary before providers bill temporary codes:

    - Provider checks Prior Authorizations for presence of supplemental, temporary code, or verifies its existence by contacting the Provider Services Call Center.
    - The rates for the base rate listed below may vary by member. Continue to verify each member's daily per diem rate with the case manager or in the Provider Web Portal.
- Refer to Operational Memo 22-010 for more detailed instructions on how to bill for these services.

Additional information can be found in Operational Memorandum 22-010, "HCBS ARPA Rate Increase Continuation," on the Memo Series Communication web page.

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

Home Health Providers

Extension on Pause for Prior Authorization Requests (PARs)

In January 2022, the Department temporarily paused prior authorizations requests (PARs) for a series of pediatric long-term home health services and home health therapies until June 1, 2022. Those included PARs for pediatric long-term home health Certified Nursing Assistant (CNA) services, and home health physical therapy, occupational therapy, and speech language pathology therapy services.

Effective February 28, 2022, the pause will extend until March 2024 and will now include:

- Pediatric long-term home health CNA services
- Pediatric long-term home health therapies: occupational therapy, physical therapy, and speech-language pathology therapy
- Pediatric long-term home health intermittent skilled nursing

This change impacts the following:

Pediatric Long-term Home Health Benefit	Billing Code	Secondary Billing Code	PAR Requirement
LTHH CNA Services	Rev Code 571 (Basic)	Rev Code 579 (Extended)	PAR Paused
Physical Therapy (Pediatric Only)	Rev Code 0421 (pediatric LTHH only)		PAR Paused
Occupation Therapy (Pediatric Only)	Rev Code 0431 (pediatric LTHH only)		PAR Paused

Pediatric Long-term Home Health Benefit	Billing Code	Secondary Billing Code	PAR Requirement
Speech Language Pathology (Pediatric Only)	Rev Code 0441 (pediatric LTHH only)		PAR Paused
RN/LPN Standard Visit	Rev Code 0551		PAR Paused
RN Brief 1st of Day	Rev Code 0590		PAR Paused
RN Brief 2nd or >	Rev Code 0599		PAR Paused

Though the PARs are suspended temporarily, providers should continue to provide and bill for only medically necessary and ordered services in accordance with state law. Failure to comply with medical necessity and benefit limitations in the regulations noted below may result in compliance monitoring. This could include prospective and post-payment reviews of claims and recovery of any identified overpayment in accordance with state law.

Additional guidance will be issued through the provider bulletin before the PAR requirements temporary suspension ends. Information will also be posted on the ColoradoPAR: Health First Colorado Prior Authorization Request Program web page.

Rule Requirements to Provide Services:

10 Code of Colorado Regulations (CCR) 2505-10, Section 8.520 (Home Health Services) and 10 CCR 2505-10, Section 8.520.5.B. (Certified Nurse Aide Services) (Rev Codes: 571 & 579)

10 CCR 2505-10, Section 8.520.5.C. (Therapy Services) (Rev Codes: 421, 430 & 441)

10 CCR 2505-10, Section 8.520.5.A (Nursing Services)

10 CCR 2505-10, Section 8.076 (Program Integrity)

Email the Department at hcpf_UM@state.co.us for questions regarding prior authorization.

Email the Department at homehealth@state.co.us for policy-related questions.

NOTE: The information above only refers to **pediatric** authorizations. Adult home health still requires authorization.

Hospital Providers

General Updates

All Hospital Providers

Hospital Stakeholder Engagement Meetings

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

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

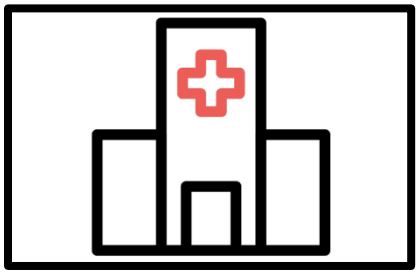
Visit the Hospital Stakeholder Engagement Meeting web page for more details, meeting schedules and past meeting materials. **Calendar Year 2022 meetings have been posted.**

Outpatient Hospitals

Inpatient-Only Procedures in Outpatient Hospitals Updates

The Department will be utilizing version 3.16 of the Enhanced Ambulatory Patient Grouping (EAPG) methodology for payment calculation for outpatient hospital claims effective for claims with all dates of service on or after January 1, 2022. Upon approval from Centers for Medicare a& Medicaid Services (CMS), outpatient hospital claims impacted by this update will begin reprocessing.

Part of the transition to the new version will entail an update to the EAPG Inpatient-Only procedure list. As the Department processed claims using version 3.10 for outpatient hospital claims until CMS approval and version 3.16 uses a different EAPG Inpatient-Only procedure list, line items that had previously been assigned EAPG 993 (Inpatient-Only Procedures) in version 3.10 may be eligible for payment under version 3.16. Once CMS approval is received for this update, for any denied claims with all dates of service on or after January 1, 2022, that had an EAPG 993 assignment, providers are encouraged to resubmit those claims to receive payment.



Reference Appendix O – EAPG Inpatient Only List on the Billing Manuals web page for details regarding which procedures are contained in the version 3.10 and 3.16 inpatient-only lists through EAPGs. For questions on whether a claim should be resubmitted in accordance with the guidance above or generally regarding the transition to version 3.16, contact Andrew Abalos at Andrew.Abalos@state.co.us and Tyler Samora at Tyler.Samora@state.co.us.

Rural Health Clinics

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

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

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

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

Rates for House Bill 21-1198 Health Care Billing Requirements for Indigent Patients Now Available

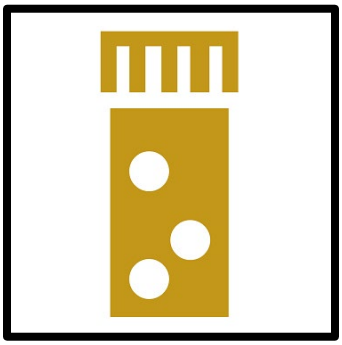
Inpatient, outpatient, and professional rates for House Bill (HB) 21-1198 Health Care Billing Requirements for Indigent Patients are now available on the Provider Rates and Fee Schedules web page under the Hospital Discounted Care heading. These rates apply to patients and members at or below 250% of the Federal Poverty Guidelines. These rates are effective June 1, 2022, and will be updated every July 1 to coincide with the state fiscal year.

Email the Hospital Discounted Care team at hcpf_HospDiscountCare@state.co.us with any questions regarding these rates.

Pharmacies and All Medication-Prescribing Providers

Brand Name Medication Favored over Equivalent Generic

Certain brand name products are managed by favoring them over the generic equivalent non-preferred medications. **Brand favored over Generic products are listed on a document titled "Brand Favored Product List"** which may be accessed from the Pharmacy Resources web page.



If a generic is medically necessary for the member when an equivalent brand is favored over generic, additional clinical information will need to be provided during the normal prior authorization process.

As a reminder, Brand Suboxone Film is favored over generic buprenorphine-naloxone film and does not require a prior authorization. Please see the Appendix P, BUPRENORPHINE CONTAINING PRODUCTS section, for details.

Pharmacies may reach out to Magellan Rx Management Pharmacy Call Center at 1-800-424-5725 for assistance, if needed, available 24 hours a day, 7 days a week.

Health First Colorado Preferred Drug List Announcement of Preferred Products

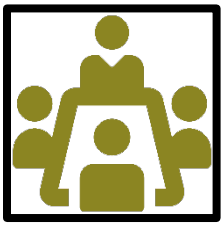
The Preferred Drug List (PDL) Announcement of Preferred Products, effective April 1, 2022, is available on the Pharmacy and Therapeutics (P&T) Committee web page, under the January 11, 2022, meeting tab. The PDL effective April 1, 2022, is available from the Pharmacy Resources web page.

Addition to the Pharmacy Resources web page:

FAQs for the quarterly change process is now available on the Pharmacy Resources web page titled "FAQs - P&T Committee and DUR Board Decision Making Process"

Any questions related to the Pharmacy and Therapeutics (P&T) Committee can be directed to Brittany Schock at Brittany.Schock@state.co.us. Questions related to the Drug Utilization Review (DUR) board can be directed to Jeffrey Taylor at Jeffrey.Taylor@state.co.us. Questions related to medications covered under the medical benefit can be directed to Rachele Poissant at Rachele.Poissant@state.co.us.

Pharmacy and Therapeutics (P&T) Committee Meeting



Tuesday, April 12, 2022

1:00-5:00 p.m. MT (to be held virtually, not in person)

Agenda and meeting information can be found at the Pharmacy and Therapeutics (P&T) Committee web page.

Pharmacist Services Providers

Billing Manual Update

Comprehensive Medication Management and place of service codes sections have been added to the Pharmacist Services Billing Manual.

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

Pharmacy Providers

Pharmaceutical Rate Methodology

Effective April 1, 2022, the pharmaceutical rate methodology will be updated to include Average Acquisition Cost (AAC) and Clotting Factor Maximum Allowable Cost (CFMAC) rates for clotting factor drugs. The new methodology will be as follows:

- The allowed ingredient cost for clotting factor drugs shall be the lesser of AAC or submitted ingredient cost. If AAC is not available, the allowed ingredient cost shall be the lesser of the CFMAC or submitted ingredient cost.
- Clotting factor claims that are reimbursed at AAC or Submitted Ingredient Cost will receive an enhanced $0.03 per unit dispensing fee, in addition to the usual professional dispensing fee that the pharmacy receives.

Pharmacies are encouraged to participate in the AAC rate setting process for clotting factor drugs. Myers and Stauffer is the contractor responsible for setting and maintaining AAC rates and will be in contact with pharmacies at least bi-yearly to request submission of clotting factor invoice data.

Drugs Subject to this Methodology				
Advate	Adynovate	Afstyla	Alphanate	Alphanine SD
Alprolix	Benefex	Coagedex	Corifact Kit	Eloctate
Esperoct	Feiba NF	Hemlibra	Hemofil M	Humate-P
Idelvion	Ixinity	Jivi	Kcentra	Koate
Koate-DVI	Kogenate FS	Kovaltry	Novoeight	Novoseven
Nuwiq	Obizur	Profiline	Rebinyn	Recombinate
Rixibus	Sevenfact	Tretten	Vovendi	Wilate
Xyntha	Xyntha Solofuse			

Visit the Provider Rates & Fee Schedules web page under Pharmacy Rate List for more information regarding AAC and CFMAC rates.

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

Physician-Administered Drugs (PADs) Providers

Prior Authorization Request (PAR) Policy

Effective **January 18, 2022**, a select number of Physician Administered Drugs (PADs) are subject to prior authorization request (PAR) requirements.

Providers must ensure that an approved PA is on file **prior** to PAD administration. Retroactive authorizations will not be approved. There must be an approved PA on file for each of the PADs requiring a PAR that a member receives.

All PAD PAR procedures and clinical criteria can be found on Appendix Y: Physician Administered Drug Medical Benefit Prior Authorization Procedures and Criteria.

All other PAD questions can be directed to HCPF_PAD@state.co.us.

Quarter 2 Rate Update 2022

The Physician-Administered Drugs (PADs) rates for the second quarter of 2022 have been updated. The new rates are effective April 1, 2022, and are posted to the Provider Rates & Fee Schedule web page under the Physician Administered Drug Fee Schedule section.

Contact Tyler Collinson at Tyler.Collinson@state.co.us with any questions about PAD rates.

Physician, Hospital and Laboratory Services

Newborn Metabolic Screen (NMS) Test

The Newborn Metabolic Screen (NMS) is a set of essential lab tests crucial for all newborn infants. The NMS test utilizes two small newborn blood samples/blood spots and screens for a variety of serious medical conditions. NMS samples are processed through the Colorado Department of Public Health and Environment's (CDPHE) Public Health Laboratory.

The NMS blood test screens for metabolic and genetic conditions which can be life-threatening and normally cannot be seen at birth. Many of these identified NMS medical conditions can be effectively treated when found early. Some identified NMS conditions include: Amino acid disorders, Endocrine disorders, Fatty Acid Oxidation disorders, Hemoglobin disorders, Organic Acid conditions and other disorders like Biotinidase Deficiency, Cystic Fibrosis, classic Galactosemia, Critical Congenital Heart disease, Severe Combined Immunodeficiency and Spinal Muscular Atrophy.

The NMS test is a reimbursable Health First Colorado benefit, but the NMS payment methodology will differ depending on the delivery site and sample collection scenario.

A. Two neonatal blood samples are collected and utilized for this NMS test. The first sample is collected at 24-48 hours after delivery and the second at 8-14 days following delivery.

    1) For the majority of newborn deliveries, the initial NMS test sample collection will occur in a facility [such as a hospital or a Free-Standing Birthing Center (FSBC)].

        a) NMS reimbursement, when associated with billable Labor and Delivery services provided in hospitals and FSBCs, is incorporated as part of the facility fee payments.

            i) Costs associated with NMS are included in the inpatient hospital diagnosis related grouper (DRG) calculation and the birthing center facility fee payment.

        b) NMS costs (in these scenarios) may not be billed separately by the hospital, birthing center or by the maternity service provider(s).

    2) For a home delivery (when no facility fee payment is included or reimbursed) the provider may bill for the NMS test.

a) Healthcare Common Procedure Coding System (HCPCS) code S3620 may be submitted for this NMS test.

b) When S3620 is used for the NMS test, it includes both blood sample collections. Sample collection for the NMS test does not require a Clinical Laboratory Improvement Amendments (CLIA) certification.

3) Home Delivery services may be provided and billed by the following Medicaid enrolled practitioners:

a) Physicians (MDs/DOs) and

b) Certified Nurse Midwives (CNMs)

c) Practitioners who provide home delivery/maternity care services are required to have additional insurance, which covers provision of these home delivery services.

B. Additional NMS processing information (as noted below) can be found through CDPHE on the Public Health Laboratory website.

4) CDPHE classifies NMS specimens, which are able to be linked to a previously submitted specimen from the same child, as second-screen specimens.

a) In cases where the specimen cannot be linked, it is treated as an initial newborn screening specimen, regardless of the age of the child at the time the specimen is collected. The named submitter on the demographic slip is billed for NMS.

b) If the named submitter was not reimbursed for delivery of the child, the submitter may submit CPT S3620 for reimbursement.

5) Because NMSs are performed by CDPHE's laboratory and not the provider collecting and submitting the specimen, unbundling the NMS and billing for the individual tests performed by CDPHE's laboratory is not allowed (10 CCR 2505-10 8.660.4.C.).

Refer to the Obstetrical Care, Inpatient and Outpatient Hospital and Laboratory Services Billing Manuals for additional information. Contact the Provider Services Call Center with questions.

Prior Authorization Requests (PARs)

Longer Pend Times for Keystone Peer Review Organization (Kepro) Prior Authorization Requests (PARs)

Effective **April 4, 2022,** all providers will have ten (10) business days to respond to Keystone Peer Review Organization (Kepro) pends asking for additional information to complete medical reviews for PARs. Providers will notice the timeline change in Atrezzo, Kepro's portal, and in response notes from utilization management reviewers.

PARs pending for additional information dated prior to April 4, 2022, will still have seven (7) business days to respond.

Visit the ColoradoPAR: Health First Colorado Prior Authorization Request Program web page for additional details or reach out to the utilization management inbox at hcpf_um@state.co.us with questions or concerns.

Provider Billing Training Sessions

April and May 2022 Provider Billing Webinar-Only Training Sessions

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

Who Should Attend?

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

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

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

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

April 2022

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

May 2022

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

Live Webinar Registration

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

Upcoming Holidays

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

Gainwell Technologies Contacts

Provider Services Call Center

1-844-235-2387

Gainwell Technologies Mailing Address

P.O. Box 30
Denver, CO 80201