COLORADO
Department of Health Care Policy & Financing

Provider Bulletin

Reference: B1800417

June 2018

Did You Know?

Claims with a date of service (DOS) over 365 days do not need to be submitted on paper. Claims with Third Party Liability (TPL) or Medicare information also do not need to be submitted on paper. The Medicare or TPL information should be populated directly on the electronic claim. The Explanation of Benefits (EOB) does not need to be attached to the electronic claim.

All Providers

Reminder: Reference the Special Provider Bulletin for Colorado interChange Common Questions

The Common Questions Special Provider Bulletin (B1800413) contains a summary of frequently-asked provider questions from the past year's transition to the Colorado interChange. Remember to reference this special bulletin for important information about general billing, claim submission, eligibility and enrollment.

Timely Filing Period Extended to 365 Days – Effective June 1, 2018

Effective June 1, 2018, the timely filing period will be permanently extended to 365 days.

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

- Providers always have **at least** 365 days from the DOS to submit a claim. A timely filing waiver is only needed if a claim is submitted beyond the 365-day timely filing period and there is no previous Internal Control Number (ICN). Providers are required to **resubmit claims every 60 days after the initial timely filing period** (365 days from the DOS) to keep the claim within the timely filing period **even if the claim denies**. The previous Internal Control Number (ICN) must be referenced on the claim, even if the claim is over 365 days. A copy of the Remittance Advice (RA) should not be included with the claim.

- Providers who receive a payment or denial from Medicare or other insurance/TPL no longer need to attach the Explanation of Benefits (EOB) to the electronic claim. Providers have an additional 120 days from a Medicare payment or denial and must include the Medicare EOB date on the claim. Providers must keep the EOB and supporting documentation on file. Claims with commercial insurance/TPL must be received within 365 days with no additional extension.
- **Waiting for prior authorization or correspondence from the Department of Healthcare Policy & Financing (the Department) or the fiscal agent is not an acceptable reason for late filing. Phone calls and other correspondence are not proof of timely filing. The claim must be submitted, even if the result is a denial.** Issues resulting in failure to transmit accurate and acceptable claims or failure to identify transmission errors in a timely manner must be addressed. If the issue is between the provider and the software vendor, billing agent or clearinghouse, this does not constitute an acceptable reason to be outside the timely filing period.
- Claims that are not submitted within the 365-day guideline, but have one (1) of the below documents attached to the submission, will be put into suspended status and reviewed by the fiscal agent. Attachments should be submitted with the claim via the Provider Web Portal. The fiscal agent does not accept attachments via batch submissions.

  The following are examples of acceptable proof of timely filing:

  - Claims that have been date-stamped by the fiscal agent or the Department and returned to the provider
  - A backdate approval letter (new enrollments, affiliations or updates are **not** acceptable reasons for late filing). Providers must enroll and submit claims within 365 days from the DOS.
  - A load letter for member eligibility backdate

This extension does not apply to dental claims submitted through DentaQuest or pharmacy claims submitted through Magellan. Timely filing will remain 120 days from date of service for pharmacy and dental claims.

For more information on timely filing, refer to the General Provider Information Billing Manual.

Fiscal Year (FY) 2018-2019 Provider Rate Increases and Adjustments

Health First Colorado (Colorado's Medicaid Program) provider rate increases were approved during the 2018-2019 legislative session and are effective for DOS beginning July 1, 2018. All rates require approval from Centers for Medicare & Medicaid Services (CMS), and the Department is working to obtain this approval to implement the rates. Some providers will be paid retroactively if there is a delay in implementation and other rate increases will be implemented when approved.

The fee schedules located on the Provider Rates & Fee Schedule web page will be updated to reflect the approved 1.0% across-the-board (ATB) rate increase and targeted rate increases (TRI).

Services & Supplies Approved for ATB Increases:

- Eligible physician and clinic services
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services
- Inpatient hospital services
- Outpatient hospital services
- Laboratory & x-ray services
- Durable Medical Equipment (DME) - excluding those impacted by Section 1903(i)(27) of the Social Security Act
- Disposable supplies
- Mental health fee-for-service
- Non-physician practitioner services
- Tobacco cessation counseling for pregnant women
- Ambulatory Surgery Center (ASC) Services
- Dialysis center services
- Physical, occupational and speech therapy services
- Audiology services
- Screening, Brief Intervention and Referral to Treatment (SBIRT) services
- Dental services
- Freestanding Birth Centers
- Family planning services
- Outpatient substance use disorder services
- Targeted case management for behavioral health
- Targeted case management for substance use disorders
- Vision services
- Mental health and substance use disorder rehabilitation services for children in psychiatric residential treatment facilities
- Prosthesis services
- Mental health and substance use disorder rehabilitation services for children in residential child care facilities
- Extended services for pregnant women

- Private Duty Nursing services
- Home Health
- Hospice Fee-for-Service
- Home and Community Based Services (HCBS) waivers:
    - HCBS - Elderly, Blind and Disabled (EBD)
    - HCBS - Community Mental Health Supports (CMHS)
    - HCBS - Brain Injury (BI)
    - HCBS - Spinal Cord Injury (SCI)
    - HCBS - Children's Home and Community Based Service (CHCBS)
    - HCBS - Children with Life Limiting Illness (CLLI)
    - HCBS - Children Residential Habilitation Program (CRHP)
    - HCBS - Developmental Disability (DD)
    - HCBS - Supported Living Services (SLS)
    - HCBS - Children's Extensive Supports (CES)
- Colorado Choice Transitions (CCT) - increases will mirror the ATB and TRI on the waiver for the CCT population

Approved for TRI:

- Emergent and Non-Emergent Medical Transportation will receive a 6.61% increase
- Neonatology set to 92% of 2014 Medicare Rate
- Primary Care Alternative Payment Model Codes will receive a 1.81% average increase
- HCBS Alternative Care Facilities (ACF) will receive a 25.0% increase
- HCBS Non-Medical Transportation will receive a 6.61% increase
- HCBS agency based and CDASS Personal Care and Homemaker on the EBD, CMHS, BI and SCI waivers will receive a 5.25% increase

- HCBS Personal Care, Homemaker, Day Habilitation, Prevocational Services, Res Habilitation, Mentorship, Behavioral Line Staff, Respite, Community Connector and Supported Employment on the DD, SLS and CES waivers will receive a 6.5% increase

Note: HCBS targeted rate increases will not be effective July 1, 2018, and all HCBS TRI are pending CMS approval. The HCBS ACF increase is expected to be effective no sooner than October 1, 2018. Non-Medical Transportation, Personal Care and Homemaker services on the HCBS EBD, CMHS, BI and SCI waivers are expected to be effective no sooner than January 1, 2019. All HCBS DD, SLS and CES services receiving a TRI are expected to be effective no sooner than March 1, 2019. Please note that the HCBS DD, SLS, and CES services receiving a TRI will also receive the 1.0% ATB increases. All other HCBS services receiving a TRI will not receive the ATB rate increases. Detailed information about the HCBS increases has been published in past provider bulletins as well as on the

Provider Rates & Fee Schedule web page. The Department will continue to publish updates in those locations when CMS approval is received, rates have been loaded, and mass adjustments have occurred.

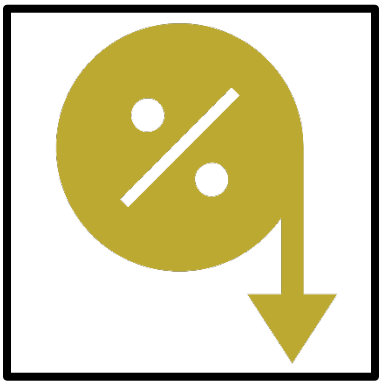
Exclusions for the Legislative ATB Increases

Although these rate increases will affect most Health First Colorado providers, a number of providers are exempted from the ATB increases.

Exclusions Include:

- Services listed above receiving a TRI (excluding HCBS DD, SLS and CES services receiving the TRI listed above)
- Durable Medical Equipment (DME) impacted by Section 1903(i)(27) of the Social Security Act
- Immunizations and Vaccinations with CDC pricing
- Skilled Nursing Facility Services
- Public Health Agencies
- Federally Qualified Health Centers
- HCBS Children with Autism (CWA) waiver
- Contract based administrative payments including Dental Administrative Services Only (ASO), Non-Emergent Medical Transportation (NEMT) ASO, Consumer Directed Attendant Support Services (CDASS), Financial Management Services (FMS) and Training vendors
- Pharmacy reimbursement
- Rural Health Centers
- The Program of All-Inclusive Care for the Elderly (PACE)
- Risk-based physical health managed care programs (Denver Health and Rocky Mountain Health Plans)
- Risk-based mental health managed care programs (Behavioral Health Organizations)

"Lower of" Pricing Logic for Rate Increases



If the Department implements rate increases, claims that were already billed with and paid at a rate lower than the new rate cannot be adjusted for the higher rate. The Department will always use the "lower of" pricing logic. Providers are advised to bill their usual and customary charges.

Not all codes are listed on the Health First Colorado Fee Schedule, so providers are advised to check all fee schedules which apply to their billing practices. If a code is not listed on the Health First Colorado Fee Schedule, it may be listed on a benefit-specific fee schedule.

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

Co-Pay Collection

Collecting Health First Colorado Co-Pays

Some Health First Colorado members must pay a co-pay for certain services. These members are liable for no more than 5% of their monthly household income towards co-pays per month. The following are three steps for collecting co-pays from Health First Colorado members.

1) **On the DOS, check the Provider Web Portal for a co-pay amount.** Co-pay status is indicated by the dollar amount listed for each benefit row found in the Member Eligibility Verification section of the Web Portal under Coverage Details > Benefit Details. For step-by-step instructions on verifying member eligibility, reference the Provider Web Portal Quick Guide - Verifying Member Eligibility.

   Co-pays are only applied to the TXIX coverage plan. Providers should only collect co-pay amounts indicated on rows where the coverage is TXIX.

   Rows for coverage BHO+B and ABP do not accurately report co-pay liability and should **not** be used to determine any co-pay that is due.

2) **Ask the member if they have met their 5% co-pay maximum**. Members may reach their co-pay maximum before it is reflected in the Web Portal. If this is the case, providers may choose to wait to collect member co-pays until after receiving the remittance advice to minimize the need to refund co-pays.

3) **Review the remittance advice (RA)**. The RA will show whether a co-pay was deducted from the claim. If a co-pay has already been collected from the member, but the RA shows no co-pay was deducted from the claim, **the co-pay must be refunded to the member**. The Department **cannot** refund money to members.

Managed Care Organization (MCO) Laboratory Policy

Beginning July 1, 2018, Rocky Mountain Health Plans Prime (RMHP Prime) and Denver Health Medicaid Choice (Denver Health) will be responsible for the coverage and payment of laboratory codes 80047 – 89398 submitted on professional claims and provided to their members by all provider types for the following mental health and substance use disorder (SUD) ICD-10 diagnoses:

Mental Health Diagnoses Ranges	
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	F98.4
F98.8	F99
R45.1	R45.2
R45.5	R45.82

SUD Diagnoses Ranges	
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

Laboratory services without these respective diagnoses codes will continue to be paid by RMHP Prime and Denver Health.

Remember to always determine if a member is assigned to RMHP Prime or Denver Health before submitting a claim. If a member is not assigned to RMHP Prime or Denver Health, submit claims to Health First Colorado for reimbursement.

Contact the Department's MCO representative at hcpf.mcos@state.co.us with any questions regarding this policy change. Contact Raine Henry at Raine.Henry@state.co.us for all other fee-for-service laboratory coverage policy questions.

Fingerprint Criminal Background Check

On May 1, 2018, the Department sent the official request for fingerprint submissions to high-risk providers. Federal regulations (42 CFR 455.434) established by CMS require a fingerprint criminal background check (FCBC) for all high-risk providers, and any person who has direct or indirect ownership interest of five percent (5%) or more in a high-risk provider. This will be an ongoing requirement for all new high-risk enrollments, as well as a potential requirement during revalidation.

Refer to the FCBC Frequently Asked Questions (FAQs) for a list of provider types designated as high categorical risk. If a provider meets the qualifications of a high-risk provider, **and** if the owners received a notice stating that fingerprints were required, **the provider must comply with this notice**. If fingerprint cards have not yet been submitted, please submit them immediately to avoid disenrollment.

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

HCBS Providers

Children with Autism Waiver Ending June 30, 2018

On July 1, 2018, the Children with Autism (CWA) waiver will end. All children enrolled in the CWA waiver will be disenrolled on July 1, 2018. Providers can be reimbursed for any of the following billing codes if enrolled as a Pediatric Behavioral Therapy provider type for any DOS on or after July 1, 2018: Lead Therapist-H0004; UL, Senior Therapist-H0004; UL, HN, Line Staff H2019; UL, Initial/Ongoing Treatment Evaluation-H2000; UL, Post Service Evaluation-H200; UL, TS.

Information on this service and how to enroll as a Pediatric Behavioral Therapy provider can be found on the Pediatric Behavioral Therapies Information for Providers web page.

Hospital Providers

Rate Updates

Inpatient Rates

Fiscal Year (FY) 2018-19 Inpatient Hospital Base Rate Notifications

Hospitals were able to apply for the Low Volume Payment Adjustment until the end of May 2018. The Department anticipates that the proposed rates will be posted by the end of June to the Inpatient Hospital Payment web page for all hospitals to review.The Department will then work to implement those rates as soon as possible. All hospitals that have signed up for notifications will receive notice when this has been completed.

Sign up here to receive an email notice when the rates are posted. Contact Diana Lambe at Diana.Lambe@state.co.us with questions.

Outpatient Rates

Enhanced Ambulatory Patient Groups (EAPG) Rate Updates for July 1, 2018

The State of Colorado authorized a 1% increase to current outpatient hospital rates effective July 1, 2018. The Department has posted its updated rates to the Outpatient Hospital Payment web page in lieu of sending individual letters. The posting will contain a date from which the 30-day timeframe for Informal Reconsiderations and/or Appeals will be calculated.

The Department requires approval from CMS prior to implementing the updated rates. Once approval is obtained, updated rates will be loaded into the Colorado interChange and any impacted claims will be retroactively adjusted.

Drug Carveout from Outpatient Hospital Claims

The Department is currently exploring different options for the reimbursement of drugs delivered in the outpatient hospital setting. Currently, drugs billed on the institutional outpatient hospital claim are reimbursed using the EAPG methodology. After receiving feedback regarding inappropriate levels of reimbursement, the Department intends to discuss its progress in exploring these alternatives and the potential impacts this may have on hospital reimbursement during its recurring EAPG meetings.

Mass Adjustment of Xerox EAPG Claims Update

The Department has completed most of the mass adjustments involving claims paid in the Xerox legacy system that were to be reprocessed using the EAPG methodology. These claims appeared on the April and May 2018 weekly Remittance Advice (RAs). Claims which could not be adjusted are being investigated. Hospitals requiring special instruction for having their claims reprocessed will be contacted individually.

For up to date information regarding EAPG claims, visit the Outpatient Hospital Payment web page or attend the Monthly EAPG Meetings.

Outpatient Cost Settlements

Contact Andrew Abalos at Andrew.Abalos@state.co.us or 303-866-2130 with questions and concerns related to outpatient cost settlements.

Hospital Meetings

Outpatient EAPG Meetings

The next EAPG Meeting is scheduled for June 1, 2018, from 1 - 3 p.m. This meeting will include a brief update by the Department followed by a 3M presentation on EAPGs.

Note: Starting July 13, 2018, EAPG Meetings will be held from 11 a.m. - 12:30 p.m.

Please visit the Outpatient Hospital Payment web page for a complete schedule of meetings as well as recordings of previous meetings and meeting materials.

Specialty Hospital Meetings

The next Specialty Hospital Meeting regarding the Budget Neutral Rate is scheduled for June 8, 2018, from 3 - 4 p.m.

All Hospital Engagement Meetings

The Department will continue to host bi-monthly Hospital Engagement Meetings for 2018 to discuss current issues regarding payment reform and operational processing. The next meeting is scheduled for July 13, 2018, from 9 - 10:30 a.m. at 303 East 17th Avenue, Denver, Conference Rooms 7B & 7C.

Registration is not required. Participation can be via conference line, webinar and/or in person. The agenda for upcoming meetings will be available on the Hospital Engagement Meeting web page on the Monday preceding the meeting. Visit the Hospital Engagement Meeting web page for more details and the meeting schedule.

Sign up to receive the Hospital Engagement Meeting newsletters.

Contact Elizabeth Quaife at Elizabeth.Quaife@state.co.us with any questions and/or topics for discussion at future meetings. Advance notice will provide the Department time to bring additional personnel to the meetings to address different concerns.

Technical and Professional Component Modifiers on Outpatient Hospital Claims

The TC (technical component) modifier will no longer be required on outpatient institutional claims (UB-04) for procedure codes that allow a technical and professional component split. The technical component, not the global service, will be assumed for these codes when billed on the UB-04 claim. Claims that would have their payment impacted due to the previously required TC modifier will be reprocessed with this system change.

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

Pharmacy Providers, All Medication-Prescribing Providers

Preferred Drug List (PDL) Announcement

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

Acne Agents (topical)

Preferred products will be: Benzoyl Peroxide Cleanser, Clindamycin Phosphate Soln/Swab, Clindamycin Benzoyl Peroxide Pump, Differin Gel (brand), Erythromycin Soln, Retin-A Cream/Gel (brand), Sulfacetamide Sulfur Cleanser

Acne Agents (oral isotretinoin and tetracyclines)

Preferred products will be: Amnesteem, Claravis, Doxycycline Hyclate Cap/Tab, Doxycycline Monohydrate 50mg 100mg Cap, Doxycycline Monohydrate Tab, Minocycline Cap

Androgenic Agents

Preferred products will be: Androderm, Androgel 1.62% Packet (2.5G)/Pump, Testosterone Cypionate Vial

Angiotensin Modulators

Preferred products will be: Benazepril, Benicar, Benicar HCT, Enalapril, Enalapril HCTZ, Fosinopril, Irbesartan, Lisinopril, Lisinopril HCTZ, Losartan, Losartan HCTZ, Olmesartan, Olmesartan HCTZ, Quinapril, Ramipril, Valsartan, Valsartan HCTZ

Antihistamines (newer generation)

Preferred products will be: Cetirizine Soln/Tab, Loratadine Soln/Tab

Fibromyalgia Agents

Preferred products will be: Duloxetine 20mg 30mg 60mg Cap, Gabapentin Cap/Soln/Tab, Lidocaine Patch, Lyrica Cap

Opioid Analgesics (short-acting)

Preferred products will be: Hydrocodone APAP Soln/Tab, Hydrocodone Ibuprofen Tab, Hydromorphone Tab, Morphine Soln/Tab, Oxycodone Soln/Tab, Oxycodone APAP Tab, Tramadol Tab, Tramadol APAP Tab

Opioid Analgesics (long-acting)

Preferred products will be: Fentanyl 12mcg 25mcg 50mcg 75mcg 100mcg Patch, Methadone, Morphine ER Tab, Tramadol ER

Topical Immunomodulators

Preferred products will be: Elidel

Respiratory Inhalants

Preferred products will be: Advair Diskus, Albuterol Soln, Albuterol Ipratropium Soln, Asmanex Twisthaler, Atrovent HFA, Combivent Respimat, Dulera, Flovent Diskus, Flovent HFA, Ipratropium Soln, Proair HFA, Pulmicort Nebules (brand), QVAR, Serevent Diskus, Spiriva Handihaler, Symbicort

Skeletal Muscle Relaxants

Preferred products will be: Baclofen, Cyclobenzaprine 5mg 10mg Tab, Tizanidine Tab

Preferred and non-preferred products are viewable on the PDL, located on the Pharmacy Resources web page.

Pharmacy and Therapeutics Committee Meeting:

July 10, 2018

1 - 5 p.m.

303 E 17th Ave, Denver

7th floor Conference Rooms A, B & C

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

Opioid Treatment Naïve Policy Reminder

The opioid treatment naïve edit was implemented August 1, 2017 (see the August 2017 Provider Bulletin [B1700401]; an update to the Opioid Treatment Naïve Policy article was posted in the May 2018 Provider Bulletin [B1800415]).

Beginning May 29, 2018, the opioid treatment naïve "lookback" period will change from 365 days (one year) to 180 days (six months). The opioid treatment naïve edits will begin to apply to members who do not have an opioid claim in the last 180 days.

Current opioid policies are published in Appendix P.

Rx/Over the Counter (OTC) Vitamin Coverage Change

Effective June 16, 2018, some vitamin products will not be covered due to a change in First Data Bank (FDB) policy. If a Health First Colorado member is affected, they should change to a prescription (Rx) required product for continued coverage. See Appendix P for full coverage details or contact the member's pharmacy for patient-specific/claim level questions. The Magellan Rx Management Pharmacy Call Center (1-800-424-5725) can also assist with questions.

Long Term Care (LTC) Providers – Floor Stock List

Various OTC drugs and supplies for LTC facility residents shall be furnished by the facility, within the per diem rate, at no charge to the resident pursuant to 10 CCR 2505-10 Skilled Nursing Facility: 8.440 NURSING FACILITY BENEFITS. These OTC drugs and supplies, also known as products on a "floor stock list", are not covered under the pharmacy benefit for LTC members and will not be payable by pharmacies. These drugs and supplies are reimbursed by Medicaid under the per diem rate for LTC facilities.

OTC drugs/supplies including but not limited to:

1. Artificial tears;
2. Aspirin, acetaminophen, ibuprofen, and other non-prescription analgesics available now or in the future;
3. Cough and cold supplies, i.e., cold tablets, decongestants, cough syrup/tablets;
4. Douches;
5. Evacuant suppositories, laxatives, stool softeners, enemas;

6. First aid supplies, i.e., alcohol, hydrogen peroxide, merthiolate and other antiseptics/germicides, Betadine, Phisohex, chlorhexidine gluconate, providone/iodine solution and wash, epsom salt;
7. Lubricants, rubbing compounds and ointments, i.e., petroleum jelly, bag balm, other body lotions for treatment of dry skin or skin breakdowns, bacitracin ointment and other ointments used in treatment of wounds;
8. Vitamins (multi and single) and mineral supplements.

Prior authorizations will not be granted for coverage for "floor stock list" products for LTC members. If a member is not residing in a LTC facility, regular OTC pharmacy benefit coverages apply, which may be referenced in Appendix P.

Contact Brittany Schock, PharmD, at Brittany.Schock@state.co.us for questions.

Physician Services, Laboratory, Imaging

Technical and Professional Component Modifiers on Professional Claims

Effective July 1, 2018, Health First Colorado will align all codes that use modifier TC (technical component) and 26 (professional component) to match the way those modifiers are used for Medicare. Rates for these procedure configurations will be reflected in the July 2018 fee schedule.

The following tables identify the payable configurations of these codes for professional services.

The codes below will only be payable as professional services when billed with modifier 26. There will be no coverage of the procedure code when billed without a modifier.

Payable Professional Service Codes when Billed with Modifier 26						
70170	74425	76930	78812	86320	93532	93620
70555	74445	76932	78813	86325	93533	93624
70557	74450	76940	78814	86327	93561	93631
70558	74470	76941	78815	86334	93562	93640
70559	74742	76945	78816	86335	93571	93641
74190	74775	76975	79300	87164	93572	95951
74235	75801	76998	79445	87207	93600	95965
74300	75803	77013	83020	88371	93602	95966
74301	75805	77022	84165	88372	93603	95967
74328	75807	78282	84166	89060	93609	G0252
74329	75810	78414	84181	92978	93610	
74330	75894	78459	84182	92979	93612	
74340	75898	78491	85390	93315	93615	
74355	75970	78492	85576	93317	93616	
74363	76001	78608	86255	93530	93618	
74420	76125	78811	86256	93531	93619	

The following procedure codes will be payable as professional services when billed with modifier 26, with modifier TC, or without a modifier.

Payable Professional Service Codes when Billed with Modifiers 26, TC or w/o a Modifier						
75774	76101	78018	88380	91133	92537	95803
75825	76102	78070	91112	91200	93025	
75833	77750	78647	91132	92065	93351	

Contact Raine Henry at Raine.Henry@state.co.us with laboratory questions.
Contact Alex Weichselbaum at Alex.Weichselbaum@hcpf.state.co.us with imaging questions.
Contact Richard Delaney at Richard.Delaney@state.co.us with medical procedure questions.

Transportation Providers

Non-Emergent Medical Transportation (NEMT) Non-Covered Services

The Department is reminding NEMT providers that the following services are not covered under Health First Colorado:

- Services provided only as a convenience to the client
- Charges incurred while client is not in the vehicle, except for lodging and meals
- Transportation to/from non-covered medical services, including services that do not qualify due to coverage limitations (e.g., transportation to a medical service after the limit on number of appointments has been reached)
- Waiting time
- Cancellations
- Transportation which is covered by another entity (e.g. transportation provided by the Veterans Administration or a school)
- Metered taxi services
- Charges for additional passengers except when acting as an escort for a child or at-risk adult
- Transportation for nursing facility or group home residents to medical or rehabilitative services required in the facility's program, unless the facility does not have an available vehicle
    - Nursing facilities and group homes should instead report transportation as part of their allowable costs on their state-approved cost report

Charges incurred while client is not in the vehicle (i.e., deadhead, empty leg, dead mileage, etc.) cannot be billed.

Resources:

- NEMT Benefit Coverage Standard
- NEMT Billing Manual

Contact the applicable State Designated Entity with any questions on the process to arrange NEMT services. For a list of State Designated Entities, visit the Non-Emergent Medical Transportation (NEMT) web page.

Contact NEMT@state.co.us with policy questions.

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 June 30, 2018, for DOS occurring within the fourth quarter of State Fiscal Year (SFY) 2016-17 (April 1, 2017 -June 30, 2017). The Department is making this supplemental payment to the University of Colorado School of Medicine in the amount of $30,773,025 for Medicaid services rendered by physician and other qualified professionals who are 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 an Upper Payment Limit (UPL).

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

Upcoming Holidays

Holiday	Closed Offices/Offices Open for Business
Independence Day – Wednesday, July 4, 2018	State Offices, DentaQuest, DXC and the ColoradoPAR Program will be closed. The receipt of warrants and EFTs may 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