COLORADO
Department of Health Care Policy & Financing

Provider News & Resources

September 22, 2023 Issue 77

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Upcoming Holidays:

Frances Xavier Cabrini Day - Monday, October 2, 2023

Physician Services and Behavioral Health Providers

Rate Change for Providers Conducting Psychological or Neuropsychological Testing

The prior rate reductions for assessment codes 96136 and 96137 were reversed by the Department of Health Care Policy and Financing (the Department). The 3% across-the-board rate increase for FY 2023-24 was applied. These changes are effective for dates of service beginning July 1, 2023.

Claims were reprocessed and will appear on the Monday, September 25, 2023, Remittance Advices (RAs).

Providers that have billed the lower rate instead of their usual and customary charges may need to adjust claims to the increased rate.

State Offices will be closed. The ColoradoPAR Program, DentaQuest and Gainwell Technologies will be open.

Timely Filing Resubmission Instructions

Providers can keep claims within timely filing by resubmitting every 60 days after the initial timely filing period of 365 days from the date of service (DOS). Providers may resubmit within 60 days if an adjustment or recoupment is initiated by the fiscal agent, Gainwell Technologies, or Health Management Systems Inc. (HMS).

The previous Internal Control Number (ICN) must be referenced on the claim if the claim is over 365 days.

Providers must submit all claims within 365 days. If the original timely filing period (365 days) has expired, the next submission must be received within 60 days of the last action.

Referring to the Previous ICN on a Claim

Provider Web Portal

Claims outside of timely filling must be resubmitted by entering the previous ICN in the "Previous Claim ICN" field in the Claim Information section.

Paper Claim

- **Professional CMS 1500 Claim:** Indicate a resubmission with the code 1 in box 22 and the original ICN in the adjacent 22 box. Field 22 is a split box and needs to be designated with a single-digit code and an ICN to correspond.

- **Institutional UB-04 Claim:** Enter the Type of Bill into Box 4 for a resubmission. The Type of Bill should end in a 1. Enter the ICN in Box 64a.

Electronic Data Interchange (EDI) Batch Claim

Providers need to qualify (2300/REF01) with F8 and use the previous ICN as the Payer Claim Control Number along with the 1 code in the 2300/CLM segment composite CLM05-3.

Note: Copies of all Remittance Advices (RAs) or correspondence documenting compliance with timely filing and 60-day rule requirements must be maintained in the provider's files. A copy of the RA should not be included with the claim.

Information Regarding Twelve (12) Sessions of Speech Therapy before a Prior Authorization Request (PAR) is Required

On August 23, 2023, a Speech Therapy stakeholder engagement was hosted regarding the footnote in the 2023 Long Bill mandating 12 speech therapy sessions before prior authorization is required. This change will be implemented in December 2023 and is applicable to services for both children and adults. **Providers will be notified of the specific implementation date as soon as that information is available.**

Services are limited to five units per day which equates to one session on one date of service. Separate limits of 12 sessions for habilitative and rehabilitative services are available for adult members who are enrolled in the Alternative Benefit Plan. Outpatient speech therapy services must have an order from any of the following: Physicians (MD/DO), Physician Assistants, Nurse Practitioners or an Individualized Family Service Plan for Early Intervention Speech Therapy even when a PAR is not required.

Providers should verify the remaining sessions before seeing the member to determine whether a member has utilized any sessions within the rolling calendar year. Refer to the Verifying Member Eligibility (Including Managed Care Assignment Details and Benefit Plan Information) and Co-Pay Quick Guide for more information.

The allowed number of sessions will decrement when a provider submits a claim for payment. The claims system is only capable of providing the units that have been reported and the utilization count could change at any time when a new claim is reported. There is no guarantee of payment based on the utilization information provided in the eligibility verification response. It is advised to request a PAR before the 12 sessions are exhausted if a provider believes that a member will need more sessions based on their course of

treatment.

If a claim is denied due to a claims processing issue, providers must submit a retrospective PAR to the Utilization Management (UM) vendor for those units and any additional units if applicable.

Contact the Provider Services Call Center for claim and session questions.

Contact Devinne Parsons at Devinne.Parsons@state.co.us for Speech Therapy policy-related questions.

Contact the Utilization Management team at HCPF_UM@state.co.us for PAR questions.

Training Grants Available for Direct Care Workers

Do I Qualify?
You qualify if you work in a direct care role in any of Colorado's 10 Home and Community-Based Services (HCBS) Waivers, as a Certified Nursing Assistant (CNA) or as a Home Health Aide in Long-Term Home Health!

What Can I Do With This Grant?
You can be reimbursed for the cost of training that you take to learn new skills and advance your career. Grants up to $500 can include the cost of training, required training materials, and mileage reimbursement.

A Few Training Examples

Healthy Boundaries - $115.00
Learn how to set healthy boundaries, what to do when your professional boundaries are challenged, and how to re-establish boundaries

Motivational Interviewing - $275.00
Learn ways to achieve positive outcomes when dealing with resistance and defensiveness

LGBTQ+ Older Adult Affirming Care - $79.00
Prepare to deliver affirming and welcoming care/support for LGBTQ+ older adults

Stress Management for the Caregiver - $20.00
Recognize the sources of stress and strategies/techniques for managing stress to reduce burnout

How Do I Apply?
Visit the ARPA Grant Incentives, Pilots, and Community Funding Opportunities web page to review the grant information, select the training you want to take and to complete the application.

Vaccine Providers

Updated COVID Vaccine Codes

Effective September 11, 2023, COVID-19 vaccination is only reimbursable via the following Common Procedural Terminology (CPT) product codes: 91304, 91318, 91319, 91320, 91321, 91322 and the corresponding administration code, 90480.

Effective September 12, 2023, all other COVID-19 vaccine and administration codes are closed in accordance with existing Emergency Use Authorization (EUA) or Biologics License Application (BLA) from the US Food and Drug Administration (FDA).

Effective September 12, 2023, COVID-19 vaccines for members under 19 years of age are now part of the Vaccines for Children (VFC) program. Providers who are enrolled with Health First Colorado (Colorado's Medicaid program) must also enroll with the VFC program in order to receive reimbursement for COVID-19 vaccine administration to pediatric Health First Colorado members.

Effective April 27, 2023, the age range for CPT code 90677 is 6 weeks of age and up. Affected claims will be reprocessed.

Reimbursement rates and age ranges for each CPT code are located on the Immunization Rate Schedule.

Contact Christina Winship at Christina.Winship@state.co.us with any questions.

Recently Updated Billing Manuals

- Appendix X: HCPCS / NDC Crosswalk for Billing Physician-Administered Drugs
- Appendix Z - Outpatient Hospital Specialty Drugs
- Obstetrical Care
- Pharmacists Services
- Physical and Occupational Therapy (PT/OT)

Visit the Billing Manuals web page to locate all published manuals.

Featured Quick Guide

Verifying Member Eligibility (Including Managed Care Assignment Details and Benefit Plan Information) and Co-Pay

The Quick Guide was updated to display the details for X1 and X2 benefit plans and specific coverage type details related to Behavioral Health Administration Benefits (BHAB) only members.

BHAB allows BHA Service Organization (Managed Services Organization) and Community Mental Health Centers (CMHCs) to service members who are eligible for the Behavioral Health Means tested and Behavioral Health Non-Means tested services. These services provide a limited behavioral health safety net benefit that covers the 14 critical behavioral health-related services in every region of the state.

Refer to the Verifying Member Eligibility (Including Managed Care Assignment Details and Benefit Plan Information) and Co-Pay Quick Guide to review the updated information.

Visit the Quick Guides web page to locate all published Provider Web Portal Quick Guides.
