COLORADO
Department of Health Care Policy & Financing

Provider Bulletin

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Did You Know?

The Affordable Care Act (ACA) requires certain providers to remit an application fee. The Centers for Medicare & Medicaid Services (CMS) sets the fee annually. This fee is assessed at initial enrollment, revalidation and change of ownership, as required, and is assessed in full for each service location enrolled in Health First Colorado (Colorado's Medicaid program).

The Provider Enrollment Application Fee has been set at $709 for the 2024 calendar year, effective January 1, 2024.

Improve health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado.

All Providers

Claims for Healthcare Common Procedure Coding System (HCPCS) 2024 Procedure Codes Suspending for Explanation of Benefits (EOB) 0000

Claims billed with a Healthcare Common Procedure Coding System (HCPCS) 2024 procedure code may begin suspending for EOB 0000 - "This claim/service is pending for program review" beginning January 1, 2024. The Colorado interChange is being updated with the 2024 HCPCS billing codes based on the Centers for Medicare & Medicaid Services (CMS) annual release of deletions, changes and additions.

Claims will be released from suspense once the update is complete. A special issue of the Provider Bulletin is expected for publication in mid-to-late January with further details.

Providers are reminded to check the Provider Rates and Fee Schedule web page before billing to ensure the codes are a covered benefit. All codes must be reviewed for medical necessity, prior authorization coverage standards and rates before the codes are reimbursable.

New Explanation of Benefits (EOB) Reasons for Revalidation

Providers that need to revalidate may begin to see new Explanation of Benefits (EOB) reasons that indicate that revalidation is required. The EOB messages will notify providers within six (6) months of their revalidation due date. Providers are reminded to take action to complete the revalidation process ahead of the due date so that claims will not be denied or suspended due to revalidation delays.

Refer to the Provider Revalidation Dates Spreadsheet located on the Revalidation web page under the Revalidation Resources section for provider revalidation dates.

New Language Proficiency Field Available for Providers

A new Language Proficiency field is available in the Provider Web Portal beginning December 14, 2023. The new field is available during enrollment, provider maintenance and revalidation. Providers have the option to select a Language Proficiency other than the default value.

This field will be available to members on the Health First Colorado's Find a Doctor web page beginning summer of 2024.

New System Error for Attachments in the Provider Web Portal

An update to the Provider Web Portal now displays an error message if missing certain attachment types on the Attachments and Fees panel. This affects Provider Enrollment, Provider Maintenance and Provider Revalidation requests. The following attachments may be required based on enrollment type, provider type and specialty:

- Federal W-9 C
- Proof of Insurance
- License
- Clinical Laboratory Improvement Amendments (CLIA) Certificate
- Certification/Certificate

Providers that do not select and add attachments which are required will receive an error.

Example:

Error
The following required attachments are missing: License.

The attachment must be added before the request can be submitted. This update will help prevent the return of applications to the provider.

Refer to the Provider Enrollment Manual located under the Enrollment Resources section on the Provider Enrollment web page and the Revalidation Manual located under the Revalidation Resources section on the Revalidation web page for information on the Attachments and Fees panel.

Refer to the Provider Maintenance - Provider Web Portal Quick Guide and the Revalidation Quick Guide located on the Quick Guides web page for instructions on adding attachments.

Verifying Medicaid Coverage - New Coverage Types

New Coverage Type Not Eligible for Medicaid or Child Health Plan *Plus* (CHP+)

Providers may now see a new “Coverage” type for Behavioral Health Administration Benefits (BHAB), shown in the Provider Web Portal as “BHA Benefit Plan” and “BHAB.” BHAB is a new program utilizing the Colorado interChange system. It is overseen by the Behavioral Health Administration (BHA), a separate entity that is addressing behavioral health needs of individuals not covered by other medical assistance programs.

The BHAB program is not part of Health First Colorado or Child Health Plan *Plus* (CHP+). Individuals who only have “BHA Benefit Plan” listed are not eligible for any service under Medicaid or CHP+.

Health First Colorado and CHP+ providers must confirm that individuals have specific coverage types before rendering any Medicaid or CHP+ services or submitting claims.

Eligibility coverage types:

- **Medicaid**: "Medicaid State Plan" and "TXIX" (Title XIX)
- **CHP+**: "CHP+B"
- **Behavioral Health Coverage through the Regional Accountable Entities (RAEs)**: "Medicaid Behavioral Health Benefits" and "BHO+B"

Claims submitted to Gainwell Technologies, the fiscal agent for the Department of Health Care Policy & Financing (the Department), will be denied for individuals who do not have current Health First Colorado or CHP+ coverage listed.

Refer to the BHA Community Services High-Level Program Group FAQ or visit the BHA website for more information.

All Providers Who Utilize the ColoradoPAR Program

Information About the ColoradoPAR Program

Acentra administers the Department fee-for-service Utilization Management (UM) program under the umbrella of ColoradoPAR for the following:

- Select outpatient benefits
- Services
- Supplies
- Out-of-state inpatient hospital services
- The Inpatient Hospital Review Program (IHRP)
- Select Physician- Administered Drugs (PADs)

Prior Authorization Request (PAR) Process When Health First Colorado is Secondary Payer

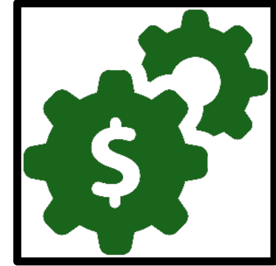
The following is a guide for PAR submissions to Acentra when primary insurance is involved. Visit the ColoradoPAR: Health First Colorado PAR Program web page for more information about program specifics.

Health First Colorado is the payer of last resort (42 CFR Part 433 Subpart D). The other insurance is the primary insurance or payer when a Health First Colorado member has other insurance. A primary insurance can also be referred to as a Third-Party Liability (TPL) payer. Medicare or commercial or private insurance, such as UnitedHealthcare, Cigna or Blue Cross Blue Shield, are examples of what would be considered primary insurance.

When is a PAR Required?	When is a PAR *Not Required*? *
The primary insurance did not pay on the claim.	TPL or Medicare paid on the claim for the services billed.
The TPL PAR is partially denied by the primary payer.	TPL covers ***all*** the services requested.
The member does not have Medicare or TPL.	

*Note: This policy does not apply to Physician-Administered Drugs (PADs) that require a PAR if the member has TPL other than Medicare.

Contact COProviderIssue@kepro.com or the ColoradoPAR Program UM Team at HCPF_UM@state.co.us with questions about PAR submissions.



Contact the Provider Services Call Center with questions about claim submission.

General PAR Submission Tips and Reminders

PARs require a provider order with submission. PARs without an order will be pended for additional information.

Pend Process

- Acentra will pend the request back to the submitting provider if additional information is required to process a PAR.
- Providers have ten (10) business days to respond to a pend. The case will be technically denied for lack of information if there is no response.
- The provider has ten (10) business days to request a PAR reconsideration or Peer to-Peer (P2P) after the date on the denial letter. A new case will need to be submitted if the provider does not request a reconsideration or P2P within that timeframe.

Reconsideration and P2P Process

What options do providers have when a PAR is denied?

- Providers can request a PAR reconsideration for any adverse action, full or partial denial or technical or medical necessity denial.
- A reconsideration request should be submitted to Acentra Health within ten (10) business days of the initial denial. Providers may upload additional supporting documentation for the case via Atrezzo®, Acentra's PAR portal.
- Ordering providers may request a P2P review within ten (10) business days of the review determination after an adverse decision.
- The purpose of a P2P call is to have a professional case discussion between an ordering or rendering physician and Acentra's medical director or a specialty physician performing a particular review on an individual case. The provider may offer clarification or additional information or can discuss to gain a clearer understanding of why a request was denied. The P2P process provides a dedicated scheduler to confirm a mutually agreed upon date and time for the P2P call to take place.
- Instructions on pursuing the appeals process are also included in the denial letter when a PAR is denied. This is a separate process from a reconsideration request and a P2P.
- Contact either the ColoradoPAR Program UM Team at HCPF_UM@state.co.us or Acentra Provider Relations at COProviderIssue@kepro.com with questions or for assistance.

Provider-Specific Training Offers PAR Submission Information Focused on the Benefit

Acentra's January provider benefit-specific training is for Diagnostic Imaging providers and will be an overview of the diagnostic imaging benefit followed by a Question and Answer (Q&A) session. All times listed are in Mountain Time (MT).

Diagnostic Imaging Training:

- Diagnostic Imaging – January 10, 2024, at 8:30 a.m. MT
- Diagnostic Imaging – January 10, 2024, at 12:00 p.m. MT
- Diagnostic Imaging – January 10, 2024, at 3:00 p.m. MT

PAR Submission Training is instruction for all new users on how to submit a PAR using the Atrezzo® Portal.

PAR Submission Training:

- PAR Submission – January 24, 2024, at 8:30 a.m. MT
- PAR Submission – January 24, 2024, at 12:00 p.m. MT

Contact COProviderIssue@kepro.com with questions or for assistance when registering for Atrezzo®, Acentra's provider PAR portal.

Continuous Glucose Monitor (CGM) Submission Tips

Acentra provides tips below to assist providers when submitting initial authorization requests, reauthorization requests and supply requests for Continuous Glucose Monitors (CGMs).

- The change of provider form must be filled out in its entirety if the provider is submitting an authorization that includes a change of provider request.
- Any and all orders should be specific to the item(s) being requested and cover the full authorization period being requested.
- All visit notes should clearly illustrate medical necessity.
- Providers should refer to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Billing Manual which outlines CGM criteria and medical necessity guidelines.

- Providers can only receive an authorization for up to six (6) months at a time per Health First Colorado guidelines.
- Submitters should ensure that the prescriber order contains the specific brand and type of CGM being requested.
- Providers need to ensure that the insulin regimen is included and complete (e.g., agent[s] and frequency).

Audiology Providers

New Coverage of Unilateral Cochlear Implants for Members Aged 20 and Under

Unilateral cochlear implants are covered for members aged 20 and under effective January 30, 2024. This service was formally covered under only the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Replacement of nonfunctioning internal or external components of existing cochlear implants is still a covered benefit regardless of age.

Contact Devinne Parsons at Devinne.Parsons@state.co.us with policy questions.

Contact the Provider Services Call Center with any claims questions or issues.

Behavioral Health Providers

American Society of Addiction Medicine (ASAM) Criteria 4th Edition

The first volume of the fourth edition of American Society of Addiction Medicine (ASAM) is now available. It has been updated and enhanced to reflect current research and clinical best practices that facilitate better patient-centered care and improve outcomes for the millions of people diagnosed with Substance Use Disorders (SUDs) each year. Refer to a summary of major changes to the ASAM Criteria 4th Edition or visit the ASAM 4th Edition web page on the ASAM website to learn more.

All changes to criteria are being reviewed by the Department, in collaboration with Behavioral Health Administration (BHA) and other state agencies. A proposed timeline for stakeholder implementation will be provided over the next two (2) months. Implementation is not anticipated before 2026.

Upcoming Changes in Substance Use Disorder (SUD) Provider Types

House Bill (HB) 22-1278 requires that by July 1, 2024, Behavioral Health Administration (BHA) establishes a comprehensive behavioral health safety net system. The Department is working to respond to and align with the new categories, criteria and infrastructure for the safety net system as detailed in BHA rules. This may require providers to meet new BHA licensing requirements and complete or update their enrollment.

The provider types Comprehensive Safety Net Providers and Essential Safety Net Providers are being developed as part of this work. Comprehensive Safety Net Providers are required to deliver outpatient Substance Use Disorder (SUD) services, and Essential Safety Net Providers may deliver SUD services.

Visit the Safety Net Provider web page to learn more about the specific requirements and services. Any SUD provider who wants to become an Essential Safety Net Provider will have the opportunity to do so.

Provider Type (PT) 64 will no longer be referred to as an SUD Clinic; it will be called an SUD Continuum. Additional outpatient specialty types under PT 64 are also being created. These changes will be discussed during the upcoming Quarterly SUD Provider Forum in January 2024.

Carfentanil Resurfaces in the United States

Carfentanil, a lethal fentanyl analogue, is increasingly being detected coast to coast and may have significant implications for overdose outbreaks. Refer to the Millennium Health Signals Alert™ Fact Sheet for more information.

Recommendations for providers include:

- Confirm clinic tests for fentanyl and for other analogues like carfentanil.
- Consider how the risk and potential positive Urine Drug Screen (UDS) results would inform both staff and patients to reduce risk of harm.
- Contact contracted labs to learn more about panel options.

Alternative Payment Methodology (APM) for Comprehensive Behavioral Health Safety Net Providers

An Alternative Payment Methodology (APM) for Comprehensive Behavioral Health Safety Net providers is being designed in partnership between the Department and stakeholders.

Refer to the Designing Alternative Payment Methodologies with Value-Based Payment for Behavioral Health Comprehensive Safety Net Providers Report developed by Health Management Associates for details.

Updated Residential Provider Billing Guidance: Qualified Residential Treatment Program (QRTP) and Psychiatric Residential Treatment Facility (PRTF)

Qualified Residential Treatment Programs (QRTPs) and Psychiatric Residential Treatment Facilities (PRTFs) each have requirements for submitting claims for services rendered to Health First Colorado members. Billing requirements and guidance are now identical regardless of whether the provider is billing such services to the Department, the Regional Accountable Entities (RAEs) or Child Health Plan *Plus* (CHP+).

The requirements listed below are the same across all payers. CHP+ billing follows the Department's billing manuals.

PRTF

Providers must submit outpatient claims on an institutional claims form (UB-04) using Revenue Code 0911 and Type of Bill (TOB) 89x to receive payment. The Admission Date is not required. Billing provider name, address and telephone number ***are*** required. The Pay-to Name and Address are required ***only*** if different from the Billing Provider. The Pay-to Name and Address ***must not*** be sent if they are the same as the reported Billing Provider.

Providers must also enter their Federal Tax ID Number (TIN), which must be the number associated with the National Provider Identifier (NPI) on the provider's enrollment.

Refer to the PRTF Billing Manual for additional guidance and claim submission instructions.

RAEs can refer to the State Behavioral Health Services Billing Manual for additional guidance.

QRTP

Providers must submit outpatient claims on a professional claims form (CMS 1500) using Current Procedural Terminology (CPT) Code H0019 with a U1 modifier to receive payment. Billing provider name, address and telephone number are required. The Service Facility Location ***must not*** be sent if it is the same address as reported with the Billing Provider Name.

Providers must also enter their Federal TIN, which must be the number associated with the NPI on the provider's enrollment.

New: Providers ***must*** include the Rendering Provider's NPI. The "Rendering Provider" NPI in the context of QRTP claims should refer to the enrolled licensed mental health professional responsible for overseeing the care of the member associated with the claim.

Refer to the QRTP Billing Manual for additional guidance and claim submission instructions.

RAEs can refer to the State Behavioral Health Services Billing Manual for additional guidance.

Contact Christina Winship at Christina.Winship@state.us.co with questions regarding billing Gainwell Technologies.

Contact HCPF_BHCoding@state.co.us with questions regarding RAE billing.

Contact Amy Ryan at Amy.Ryan@state.co.us with questions regarding CHP+ billing.

Durable Medical Equipment (DME) Providers

General Announcements

Updates to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Provider Billing Manual

New codes have recently been added to the Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI) Medically Unlikely Edits (MUE). The Durable Medical

Equipment (DME) benefit allows span billing so that providers may remain compliant with the MUE and Department monthly limits and avoid the need to submit multiple claims for different dates of service (DOS) each month. The span billing policy has been updated to account for the MUE updates.

Refer to the Transcutaneous or Neuromuscular Electrical Nerve Stimulators (TENS or NMES) section of the DMEPOS Billing Manual for policy language for osteogenic stimulators.

Update to Procedure Code E0118

The rental (RR modifier) rate has been updated and claims reprocessed due to an error with the rate and modifier combination for procedure code E0118. E0118 will no longer be reimbursable for purchases (NU modifier) for claims with a DOS on or after February 1, 2024.

Refer to the Health First Colorado Fee Schedule for updates to these rates.

Incontinence Products

As a reminder, incontinence products and briefs are limited to 360 per month of any combination of diapers, liners and undergarments. This may include different sizes of the same product.

Refer to the Incontinence Products or Briefs section of the DMEPOS Billing Manual for more information.

Calculation Error, Retroactive Adjustment Upwards

The rate for Healthcare Common Procedure Coding System (HCPCS) code A6590 has been retroactively adjusted effective April 1, 2023, to reflect the appropriate increases based on the Medicare benchmark rate. Rates have been adjusted on the fee schedule and in the Colorado interChange from $64.17 to $333.12.

Note: Providers billing the fee schedule rate instead of their usual and customary charges must manually adjust claims to the increased rate if claims with dates of services on or after April 1, 2023, were billed using the previous rate. Providers billing usual and customary charges will see claims adjustments via claims reprocessing.

Home and Community-Based Services (HCBS) Providers

Licensure or Certification Required from Colorado Department of Public Health and Environment (CDPHE)

Enrollment processes for existing and prospective Home and Community-Based Services (HCBS) providers required to be licensed and/or certified by the Colorado Department of Public Health and Environment (CDPHE) are being changed. Providers enrolling in one or more

specialty that require CDPHE licensure and/or certification must download the Certification and Transmittals (C&T) form from the CDPHE Colorado Health Facilities Interactive (COHFI) Provider Portal and attach it to provider applications as necessary in the Provider Web Portal, effective January 1, 2024.

Visit the Memo Series web page to view the Operational Memo titled “Provider Enrollment Process Change: All HCBS Providers Who Require Licensure and/or Certification from CDPHE.” This memo is expected to be published in early January 2024.

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

Hospital Providers

General Updates

Hospital Stakeholder Engagement Meetings

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

- The next Hospital Stakeholder Engagement meeting is set for Friday, January 12, 2024, from 1:00 p.m. to 3:00 p.m. Mountain Time (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 2024 meeting dates have been posted.

Contact Tyler Samora at Tyler.Samora@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.

Inpatient Hospital Specialty Drug Policy

Some Physician-Administered Drugs (PADs) will pay based on a percentage of actual acquisition cost submitted and not the applicable All Patients Refined Diagnosis Related Group (APR-DRG) when administered in the inpatient hospital setting, effective January 1, 2024.

Additional policy guidance will follow, and all information will be posted on the Physician-Administered Drugs web page. Refer to the PAD Billing Manual and the Inpatient/Outpatient (IP/OP) Billing Manual for billing requirements and policy guidance.

Refer to Appendix Z for PADs included in this policy that require approval of a member-specific prior authorization before administration.

Contact HCPF_PAD@state.co.us with questions.

Inpatient Hospital Base Rates Fiscal Year (FY) 23-24 Update

Centers for Medicare & Medicaid Services (CMS) has extended the review of the Inpatient FY 23-24 rates by issuing a Request for Additional Information (RAI). This can extend the review

for up to an additional 90 days with each response. Approval is anticipated to be granted by end of first quarter 2024.

Additional provider communications on this topic will be published when the rates are approved and when claims with the last service date of July 1, 2023, and later are re-priced.

Outpatient Hospitals

An error in Enhanced Ambulatory Patient Groups (EAPG) assignment for diagnosis code Z0384 was noticed and corrected. Diagnosis code Z0384 was incorrectly assigning to EAPG code 857 instead of EAPG code 867. Any claims affected will be reprocessed within the month of January 2024.

Contact Tyler Samora at Tyler.Samora@state.co.us with any questions related to outpatient hospital payment.

Nursing Facility Providers

Nursing Facility Swing Bed Rate Effective January 1, 2024

The Department rule 10 CCR 2505-5, §8.443.1.E requires the nursing facility swing bed rate be updated annually and "shall be determined as the state-wide average class I nursing facilities payment rate at January 1 of each year."

The updated swing bed rate effective January 1, 2024, is $276.16. The rate has been updated in the Colorado interChange and claims reimbursement should reflect the updated rate for dates of services on or after January 1, 2024.

Pharmacy and All Medication-Prescribing Providers

Over-the-Counter (OTC) Nicotine Replacement Therapy

Over-the-Counter (OTC) and prescription nicotine replacement therapies are eligible for coverage when prescribed by enrolled providers. This includes OTC nicotine gum (up to 200 units per fill), nicotine patches (up to 30 patches per 30 days), nicotine lozenges (up to 288 units per fill) and prescription Nicotrol®.

The pharmacy should find a Medicaid Drug Rebate-participating product for the member if the pharmacy bills Health First Colorado for a nicotine replacement therapy product and receives the denial message "70: product/service not covered."

Contact the Magellan Rx Management Pharmacy Call Center at 1-800-424-5725 for further technical assistance related to finding a covered nicotine replacement therapy product.

As a reminder, per 10 CCR 2505-10 8.012.2.C., providers are prohibited from collecting or attempting to collect payment from members for covered items or services (e.g., nicotine replacement therapies).

Contact Korri Conilogue at Korri.Conilogue@state.co.us with questions.

Coverage Change for Generic Fluticasone Hydrofluoroalkane (HFA) Inhaler

Additional changes are being made to the Preferred Drug List (PDL) "Respiratory Agents" drug class due to brand Flovent hydrofluoroalkane (HFA) being removed from the market. Generic fluticasone HFA will be covered as a preferred option under the pharmacy benefit for members 12 years of age and under with no prior authorization required, effective January 18, 2024. This medication will continue to require non-preferred prior authorization for all other age groups.

Refer to the table below for a listing of preferred medication options within this drug class.

PDL Drug Class	Preferred	Non-Preferred
Respiratory Agents: Inhaled Corticosteroids and Combos	• Arnuity Ellipta • Asmanex® HFA • Trelegy Ellipta	• Fluticasone HFA *(covered without prior authorization for members ≤ 12 years of age, effective 1/18/24)* • Alvesco inhaler • ArmonAir® Digihaler® • Qvar RediHaler®

Preferred Drug List (PDL) Announcement of Preferred Products

Changes will be made for the following Preferred Drug List (PDL) classes effective January 1, 2024:

PDL Drug Class	Moved to Preferred	Moved to Non-Preferred
Fluoroquinolones – Oral		• Ciprofloxacin oral suspension
Immune Globulins		• Gammaked 10% IV/SQ liquid • Gammaplex 5%, 10% IV liquids
Newer Generation Antihistamines		• Cetirizine 5 mg/5 ml solution (Unit Dose Cups)
Intranasal Rhinitis Agents	• Dymista® (azelastine/ fluticasone) nasal spray	• Azelastine (Astepro®) 205 mcg nasal spray

PDL Drug Class	Moved to Preferred	Moved to Non-Preferred
Targeted Immune Modulators - Self-administered	• Adbry® syringe • Dupixent® pen and syringe • Hadlima™ syringe and PushTouch • Tezspire pen	
Newer Hereditary Angioedema Products	• Firazyr® (icatibant acetate) syringe	
Respiratory Agents - Inhaled Corticosteroids and Combos	• Arnuity Ellipta inhaler • Asmanex® Hydrofluoroalkane (HFA) inhaler • Trelegy Ellipta inhaler	
Respiratory Agents - Phosphodiesterase Inhibitors (PDEIs)	• Roflumilast tablet	

No changes will be made for the following PDL classes:

PDL Drug Class	PDL Drug Class
Antibiotics, Inhaled	Anti-Herpetic Agents - Oral and Topical
Hepatitis C Virus Treatment (Direct Antivirals [DAAs] and Ribavirin)	HIV Treatments, Oral
Antihistamine/Decongestant Combinations	Leukotriene Modifiers
Methotrexate	Epinephrine Products
Respiratory Agents - Inhaled Anticholinergics and Combos	Respiratory Agents - Short-Acting and Long-Acting Beta2 Agonists

Pharmacist Services Billing Code and Policy Update

The following Common Procedural Terminology (CPT) codes have been added to the Procedure Code List included in the Pharmacist Services Billing Manual.

81002	87809	93788	95251
81003	87880	93790	
87804	93784	95249	
87807	93786	95250	

The Pharmacist Services Billing Manual has been updated to add universal billing guidance related to testing performed by pharmacists. Pharmacists, along with their affiliated clinics and pharmacies, must also reference the Laboratory Services Billing Manual for additional requirements related to testing.

Physician Services Providers

How to Participate in Colorado Medicaid eConsult

Health First Colorado providers will have access to a free and secure statewide electronic consultation platform through Colorado Medicaid eConsult, anticipated on February 1, 2024.

Colorado Medicaid eConsult aims to improve access to specialty care for members. The platform is designed to assist participating providers in the management of member healthcare needs with the electronic clinical guidance of specialty providers. It is an alternative to the traditional curbside consultation between providers and reduces unnecessary face-to-face visits for members.

Enroll as a Participating Provider to Receive Specialty Guidance for Clinical Questions

Participating providers will be reimbursed for each successfully completed eConsult.

Contact the eConsult Vendor Safety Net Connect (SNC) at ColoradoSupport@safetynetconnect.com if interested in becoming a participating provider. SNC will send eConsult Enrollment paperwork and instructions once contacted. SNC will work with practices to outline a timeline for navigating the onboarding process and coordinating training sessions upon submission of the enrollment paperwork.

Training will be personalized for each provider and practice and offered in a variety of formats, from live interactive web-based sessions to recorded videos organized by topic. SNC will also offer e-learning tools and comprehensive user guides.

Interested providers are invited to an upcoming webinar to learn more about Colorado Medicaid eConsult. Additional stakeholder meetings will be posted on the eConsult Platform web page.

- Enhancing Access: eConsults for Specialty Providers
  - January 10, 2024, from 8:00 a.m. to 9:30 a.m. MT
  - Register in advance for this webinar.

Timeline

- Winter 2023-24 – Colorado Medicaid eConsult Platform Implementation Activities
- February 1, 2024 - Colorado Medicaid eConsult Platform Go Live

Visit the Colorado Medicaid eConsult Platform web page or email HCPF_eConsult@state.co.us for more information.

Physician-Administered Drugs (PAD) Providers

Quarter 1 Rate Update 2024

The Physician Administered Drug (PAD) rates for the first quarter of 2024 have been updated. Visit the Provider Rates and Fee Schedule web page under the Physician-Administered Drug Fee Schedule section for the new rates effective January 1, 2024.

Transportation Providers

Claim Editing for Non-Emergent Medical Transportation (NEMT) Providers

A claim edit related to the policies found in program rules 10 C.C.R. 2505-10 8.014.4 has been implemented. Non-Emergent Medical Transportation (NEMT) must be provided to transport the member to the closest available provider qualified to provide the treatment service the member needs. The closest provider is defined as a provider within a 25-mile radius of the member’s residence or the nearest provider if one is not practicing within a 25-mile radius of the member’s residence.

Exceptions are allowed based on the following:

- The closest provider is not willing to accept the member.
- The member has complex medical conditions that restrict the closest medical provider from accepting the member.
- The member may use NEMT to their established treatment provider seen in their previous locale if the member has moved within the three (3) months preceding an NEMT transport.
- **Note:** The member and treatment provider must transfer care to the closest provider as defined at Section 8.014.4.B. or determine transportation options other than NEMT during these three (3) months.

Any NEMT claim billed for procedure codes A0425 or S0209 will be suspended for review if the billed units of service exceed 52. Suspended claims will be denied if they do not have an attachment which meets the requirements as specified below. Reviewed claims will be denied if the attachment is not sufficient pursuant to these specifications.

Claims ***must*** have a document attached which contains the following information about the trip which is being billed:

- The pick-up address
- The destination address
- Date and time of the trip
- Member’s name or identifier
- Confirmation that the driver verified the member’s identity

- Confirmation by the member, escort or medical facility that the trip occurred
- The actual pick-up and drop-off times
- The driver's name
- Identification of the vehicle in which the trip was provided
- A rationale and certification from the member's treating provider as to why the member cannot be treated by the closest provider within 25 miles of the member's residence

Refer to program rules 10 C.C.R. 2505-10 8.000, 8.130.2 and 8.014.3.C for further details on NEMT and provider record maintenance. Each provider shall maintain legible, complete and accurate records necessary to establish that conditions of payment for Medical Assistance Program-covered goods and services have been met and to fully disclose the basis for the type, frequency, extent, duration and delivery of goods and/or services provided to Medical Assistance Program members, including but not limited to the following:

- Billings
- Prior Authorization Requests (PARs)
- All medical records, service reports and orders prescribing treatment plans
- Records of goods prescribed, ordered for or furnished to members as well as unaltered copies of original invoices for such items
- Records of all payments received from the Medical Assistance Program
- Records required elsewhere in Section 8.000 et seq. The records shall be created at the time the goods or services are provided.

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

Provider Billing Training Sessions

January and February 2024 Provider Billing Training Sessions

Providers are invited to sign up for an upcoming beginner billing training webinar. Two (2) beginner billing trainings are offered each month:

1. Professional claims (CMS-1500)
2. Institutional claims (UB-04)

Click "Which Training Do I Need?" on the Provider Training web page to find trainings aligned to provider type. All sessions are held via webinar on Zoom, and registration links for the next two months are shown below.

Visit the Provider Training web page under the Billing Training – Resources drop-down section to preview training materials.

Refer to the Provider Web Portal Quick Guides located on the Quick Guides web page for more training materials on navigating the Provider Web Portal.

Who Should Attend?

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

These training sessions provide a high-level overview of member eligibility, claim submission, prior authorizations, Department website navigation, Provider Web Portal use and more.

Live Webinar Registration

Click the title of the desired training session in the calendar to register for a webinar. An automated response will confirm the reservation.

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

January 2024				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
1	2	3	4	5
8	9	10	11 Beginner Billing Training: Professional Claims (CMS-1500) – Thursday, January 11, 2024, 9:00 a.m. – 11:30 a.m. MT	12
15	16	17	18	19
22	23	24	25 Beginner Billing Training: Institutional Claims (UB-04) – Thursday, January 25, 2024, 9:00 a.m. – 11:30 a.m. MT	26
29	30	31		

February 2024				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
			1	2
5	6	7	8 Beginner Billing Training: Professional Claims (CMS-1500) – Thursday, February 8, 2024, 9:00 a.m. – 11:30 a.m. MT	9
12	13	14	15	16
19	20	21	22 Beginner Billing Training: Institutional Claims (UB-04) – Thursday, February 22, 2024, 9:00 a.m. – 11:30 a.m. MT	23
26	27	28	29	

Upcoming Holidays

Holiday	Closures
New Year's Day, Monday, January 1, 2024	State Offices, Gainwell Technologies, DentaQuest, AssureCare 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.
Martin Luther King Jr. Day Monday, January 15, 2024	State Offices, DentaQuest, AssureCare 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 will be open.
Presidents Day Monday, February 19, 2024	State Offices, Gainwell Technologies and AssureCare 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. DentaQuest and the ColoradoPAR Program will be open.

Gainwell Technologies Contacts

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1-844-235-2387

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