COLORADO
Department of Health Care Policy & Financing

Provider Bulletin

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Did You Know?

The Provider Web Portal has moved! Providers are reminded to update the existing bookmarks with the new URL.

National Correct Coding Initiative (NCCI) Notification of Quarterly Updates

Providers are encouraged to monitor the Centers for Medicare & Medicaid Services (CMS) for updates to NCCI rules and guidelines. Updates to the procedure-to-procedure (PTP) and medically unlikely edit (MUE) files are completed quarterly with the next file update available April 2023. Visit the CMS NCCI web page for more information.

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 Who Utilize the ColoradoPAR Program

General Updates

Reminder to All Providers

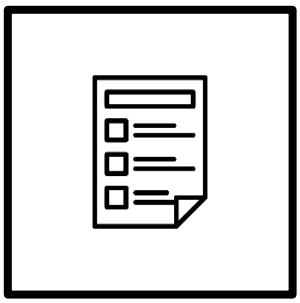
A Prior Authorization Request (PAR) cannot exceed 365 calendar days regardless of a leap year. The 365-day PAR length is a hard limit and cannot be changed.

Contact the ColoradoPAR Program Utilization Management (UM) Team at hcpf_um@state.co.us with any questions.

Synagis® Season Closed

Providers are notified that the season for Synagis has closed as of March 1, 2023. Contact the ColoradoPAR program UM Team at hcpf_um@state.co.us with any questions regarding closure of the Synagis season. Contact Kepro® Customer Service or Kepro Provider Relations at 720-689-6340 or send an email to COproviderissue@kepro.com with any questions regarding Synagis PARs.

Provider Satisfaction Survey is Now Open



The Kepro – ColoradoPAR Annual Provider Satisfaction Survey opened March 6, 2023, and will remain available until April 17, 2023. This survey is an opportunity for all providers who work with Kepro or use the Atrezzo® provider portal to provide feedback regarding Kepro services in processing PARs, customer service and timeliness.

A link will also be within the email signature of the CO PAR UM inbox and the Kepro Provider Issues inbox and on the ColoradoPAR web page.

Contact Kepro Customer Service at 720-689-6340 or send an email to COproviderissue@kepro.com with any questions regarding PARs or the Atrezzo system.

New Healthcare Common Procedure Coding System (HCPCS) Codes are Now Active

Procedure codes for healthcare services are updated annually in January to add new codes, remove obsolete codes, update existing codes and replace codes that have changed. Current Procedure Terminology (CPT) is determined and published by the American Medical Association (AMA), and HCPCS is determined and published by Centers for Medicare & Medicaid Services (CMS).

PARs:

The new codes must be added to the PAR for dates of service on or after January 1, 2023.

A process has been developed to revise approved PARs that overlap with the code changes. This process is used for all providers with HCPCS coding changes to minimize delay and burden for the provider and ensure accuracy of the PAR modification.

Existing PARs:

Providers that have approved PARs that extend beyond December 31, 2022, must enter a request for a modification via Atrezzo or by contacting Kepro Customer Service. The modification request should include the new codes requested as of January 1, 2023, and the number of units remaining on the approved PAR as of December 31, 2022, at midnight. Once approved, Kepro will transmit the modified PAR to the Colorado interChange.

New PARs:

PARs will be retroactively authorized for the period that providers were not able to request a PAR.

Durable Medical Equipment (DME) Providers

New Codes for DME

The 2023 HCPCS update includes coding changes for DME services. The new HCPCS DME codes have been implemented. The previous HCPCS codes will not be reimbursed for services provided on or after January 1, 2023.

Submit Revision Requests for K0553/K0554

Providers should send in revision requests for K0553 and K0554. Providers are reminded that the new HCPCS codes that should be requested are A4239 (replacing K0553) and E2103 (replacing K0554).

Additional Code Information

Hernia codes:

A select number of hernia codes have a consistently low enough denial rate, and providers will no longer be required to submit a PAR for the codes below:

- 49560
- 49561
- 49565
- 49566
- 49568

Speech and occupational therapy codes for autism diagnosis F84.0 and F84.5:

Authorization is being automated for occupational therapy for one (1) time per week at five (5) units max billable per day, per code, for 365 days.

Authorization is being automated for speech therapy for two (2) times per week for 365 days a year.

The affected codes are listed below:

- 92507 – Treatment of speech, language, voice or communication. OP Therapy (IQ).
- 92526 - Treatment of swallowing function. OP Therapy (IQ).

- 92609 - Therapeutic services for the use of speech-generating device, including programming and modification. OP Therapy (MCG).

Contact Kepro Customer Service or email COproviderissue@kepro.com with any questions regarding PARs or the Atrezzo system. Contact the Provider Services Call Center with any transmission or claim issues.

Behavioral Health Providers

Statewide Standardized Utilization Management (SSUM) Guidelines

Regional Accountable Entities (RAEs) and the Department of Health Care Policy & Financing (the Department) have been working to create uniform statewide utilization management (UM) standards for assessing the most appropriate level of care for children and youth referred for residential treatment.

These Level of Care (LOC) guidelines were developed as a companion to national UM standards used by the RAEs to authorize behavioral health services. RAEs will be required to use these guidelines in their UM processes starting July 1, 2023.

The Statewide Standardized Utilization Management (SSUM) Guidelines have information related to Qualified Residential Treatment Programs (QRTP) and Psychiatric Residential Treatment Facilities (PRTF). This document will continue to be edited and added to as the RAEs work to create guidelines for additional LOCs.

The SSUM Guidelines may be reviewed on the Accountable Care Collaborative Phase II – Provider and Stakeholder Resource Center web page, under the heading "Statewide Standardized Utilization Management (SSUM) Guidelines".

Contact John Laukkanen at John.Laukkanen@state.co.us with questions regarding the SSUM guidelines.

Dental Providers

Dental Rate Updates for New Healthcare Common Procedure Coding System (HCPCS) Effective January 1, 2023

The annual 2023 HCPCS were implemented on January 1, 2023, with deletions, changes and additions effective for dates of service on or after January 1, 2023. The new dental codes, effective January 1, 2023, have been retroactively implemented to coincide with these updates.

Claims billed with a dental HCPCS 2023 procedure code will suspend for Estimation of Benefits (EOB) 0000 - "This claim/service is pending for program review" until the updates are completed in the Colorado interChange. Claims will be released once the rates are loaded.

Code descriptions are not contained in this bulletin. The descriptions are copyrighted by the American Medical Association (AMA). Providers should reference the 2023 HCPCS and Current Procedural Terminology (CPT) coding manuals for procedure code descriptions. These coding manuals may be purchased through the AMA and publishers such as OptumInsight.

New Procedure Codes

D0372	D0373	D0374	D0387	D0388	D0389	D0801	D0802	D0803
D0804	D1781	D1782	D1783	D4286	D6105	D6106	D6107	D6197
D7509	D7956	D7957						

Durable Medical Equipment (DME) Providers

General Updates

Continuous Glucose Monitors (CGMs)

Covered Durable Medical Equipment (DME) procedure codes can be found in the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Billing Manual. The policies of the Department apply to these codes and the individual devices that are described by each code. The DMEPOS benefit does not include or exclude specific brands, makes and/or models when medical necessity can be determined.

There is a published list of covered continuous glucose monitor (CGM) products to provide better clarity for this benefit. This list will be updated to include the Dexcom G7, which uses procedure code E2103 for coverage. This list should always be used as a reference. It is not to be used for automatic approval or denial of a requested product.

The DMEPOS Billing Manual has also been updated to include a policy for CGM upgrades.

An upgrade to a new model or different brand of CGM may be deemed medically necessary in the following situations:

- There is documentation that the current device is no longer functional either partially or entirely, and therefore is no longer clinically effective, ***or***
- The requested upgrade is different in its capability and would be expected to provide better clinical outcomes than the current device, ***and***
- The member has been using their current device for at least three (3) years.
- If the current CGM requires repair or replacement that is no longer possible because it is obsolete, requests may be approved in cases where use is less than three (3) years. Prior Authorization Requests (PARs) may be pended to gather additional details regarding the device being obsolete.
- All requests must meet the definition of medical necessity as stated in 10 CCR 2505-10 8.076.8.

Unit Limitations Increased

There are DME codes that have had an increase in unit limits effective April 1, 2023. Some of these codes may require a PAR, and the number of units allowed increased. Others may have a conditional PAR, where the unit limit before a PAR was increased. The codes and limits can be found below.

Refer to the DME HCPCS Codes Table in the DMEPOS Billing Manual for additional information on PAR requirements.

Procedure Code	Previous Limit	New Limit
A4927	2/month	5/month
A4452	31/month	120/month
T4521-T4535, T4543, T4544	240/month combination	360/month combination
A4207	120/month	240/month
A4353	120/month	240/month
B4087 & B4088	1/month	2/month
A4216	62/month	93/month

Repairs to Complex Rehabilitation Technology (CRT) Equipment

PARs were removed for repairs to CRT equipment, effective for dates of service on or after July 1, 2022. The DMEPOS Billing Manual has been updated to include a definition for repair as it applies to this policy.

Repairing CRT is fixing any part of the equipment so that it performs in a way that is safe and functional for the member. Repair can include replacement where the replacement part was original to the equipment base. Adding equipment that was not part of the original base is a modification.

Example: If replacement armrests are needed as part of a repair, a PAR is not needed ***only*** if the replacement is the exact same type of armrests that were on the original base. If different armrests are needed, this is a modification and the applicable PAR requirements should be followed for those codes.

Prescription Dates and PAR Dates

There have been questions regarding matching PAR dates to prescription dates for DME cases. Prior authorization cases cannot be approved for dates outside of the time span on the prescription. It is understood that there may be a delay between the DME provider receiving the prescription and submitting the PAR. It is recommended that providers request prescriptions which begin later or are written for additional months to account for a potential delay.

Cases that are submitted outside of the prescription date span may be changed by the Kepro® reviewer. For example, a prescription for January 1, 2023, through December 31, 2023, that

is submitted on February 1, 2023, will have approval until the prescription expires on December 31, 2023.

Augmentative and Alternative Communication Devices (AACD Policy)

The "Augmentative and Alternative Communication Devices Benefits Collaborative Policy Statement" is discontinued effective April 1, 2023. This policy document was previously linked in the DMEPOS Billing Manual. This link will no longer be available, and the content from this policy document has been imbedded into the DMEPOS Billing Manual within the Speech Generating Devices (SGDs) section. The policy content has not changed. Providers who have a copy of this document are advised to reference the DMEPOS Billing Manual for current coverage policy of SGDs.

Hip Kits

Hip kits may be covered using procedure code E1399 and are manually priced. Pricing information should be submitted for a pre-packaged kit when requesting a hip kit. Submitting invoices for individual items and referring to them as a kit will not be approved. Each item must be listed on the PAR with a separate Healthcare Common Procedure Coding System (HCPCS) code if pricing is submitted for individual items. In these cases, medical necessity will also be determined for each item separately.

Medical necessity will be determined for the pre-packaged kit only when it contains any combination of the following items: reacher, leg lifter, sock aid, shoehorn, dressing stick and long scrub sponge. If a hip kit is requested and includes items not listed, they may be pended for additional information.

Contact Haylee Rodgers at Haylee.Rodgers@state.co.us with questions.

Federally Qualified Health Center (FQHC) Providers

Updated Rule Definition of a Supervised Encounter at FQHCs

The definition of a supervised encounter at Federally Qualified Health Centers (FQHCs) has been updated, effective September 30, 2022. The amended rule adds a candidate permit as a clinical social worker candidate (SWC) to the supervised provider types that can generate a billable encounter. Supervised visits with SWCs will be paid as encounters to FQHCs using the prospective payment system.

The updated rules can be found under 8.700.1.B.1 of the Department Program Rules and Regulations web page.

Contact Morgan Anderson at Morgan.Anderson@state.co.us with any questions.

Home and Community-Based Services (HCBS) Providers

HCBS-Intellectual/Developmental Disability (IDD) Providers Requiring Program Approval: Additional Enrollment Information Required (Update)

HCBS providers enrolling in specialties that require program approval to become a Program Approved Service Agency (PASA) must attach their approved PASA applications from the Colorado Department of Public Health and Environment (CDPHE) to their enrollment applications.

Existing PASAs enrolling additional service locations may attach a signed attestation on letterhead that states the provider is an established PASA to their enrollment application, effective April 1, 2023. Attestations will be accepted in lieu of the required copy of their PASA application from the CDPHE.

Contact the Provider Services Call Center with any questions.

HCBS Specialties Requiring Colorado Department of Public Health and Environment (CDPHE) Licensure for Revalidation

Providers must have active and current licenses to complete revalidation. CDPHE regulation at Chapter 2 - General Licensure Standards (2.5) states "a licensee seeking renewal shall provide the Department with a license application, signed under penalty of perjury by an authorized corporate officer, general partner, or sole proprietor of the applicant, as appropriate, and the appropriate fee at least sixty (60) calendar days prior to the expiration of the existing license."

Based on this regulation, CDPHE and the Department recommend that licensed providers begin the license renewal process with CDPHE at least 60 days prior to license expiration. Providers can verify the license expiration date in the CDPHE Colorado Health Facilities-Interactive (COHFI) Portal.

Contact the Provider Services Call Center with any questions regarding enrollment requirements.

HCBS Provider Enrollment Training Reminder

All new administrative staff or entities seeking to enroll as an HCBS provider are required to watch a recorded online training webinar regarding the enrollment process, effective September 1, 2021. A quiz will also be required to demonstrate understanding of the content.

Evidence of successful passage of this quiz will be required for enrollment. The prior corporate name of the fiscal agent, DXC Technology, is used throughout the training, but refers to Gainwell Technologies. Providers attest by attaching quiz results to the application.

A PDF version of the PowerPoint presented in the training video is posted to the Information by Home and Community-Based Services Provided web page. Providers are encouraged to archive the PDF for future reference.

Contact the Provider Services Call Center with any questions.

Children's Habilitation Residential Program (CHRP) Updates

CHRP services providers were required to enroll in one specialty to serve CHRP members (Specialty 619 - Children's Habilitation Residential Program).

Enrollment for CHRP services will require providers to be enrolled in newly created CHRP specialties that reflect the specific qualifications for the CHRP services they currently provide, effective November 1, 2022. Existing providers are encouraged to utilize the "Find CHRP Providers" link under the Other Useful Links section on the CHRP web page when initiating their maintenance applications through the Provider Web Portal. This ensures that all specialties for which the provider qualifies are included on one maintenance application. Existing CHRP providers must be re-enrolled in the newly created specialties by November 1, 2023. Claims for services billed by providers with only Specialty 619 will be denied if providers are not enrolled by this date.

Refer to CHRP Operational Memo 22-047 and the Information by Home and Community-Based Services Provided web page for a complete list of specialties and associated requirements.

Contact the Provider Services Call Center with questions regarding provider enrollment.

Home Delivered Meals Expanded Benefit Billing

An expansion of the Home Delivered Meals (HDM) benefit for individuals who have recently been discharged from a hospital will be available for eligible members of the Elderly, Blind and Disabled (EBD), Community Mental Health Supports (CMHS), Brain Injury (BI), Complementary and Integrative Health (CIH), Developmental Disabilities (DD) and Supported Living Services (SLS) waivers, effective April 1, 2023.

Updating the Prior Authorization Request (PAR) and Billing for the New Service

The Case Manager will use the Healthcare Common Procedural Coding System (HCPCS) code S5170 with one of the following modifiers.

- Modifier TG has been assigned for members using the first eligible 30 days of HDM services following a hospital discharge, in a service year. There is a 60-unit max for this modifier.
- Modifier TF has been assigned for members using the second eligible 30 days of HDM services following a hospital discharge, in a service year. There is a 60-unit max for this modifier.

- HDM provided as a transition service will continue to be billed utilizing HCPCS code S5170. This benefit has a maximum of 730 units and may not be combined with units utilized for the Post-Hospital Discharge benefit.
- One (1) unit equals one (1) meal.

Providers will continue to utilize the HCPCS code S5170 with either the TG or TF modifier, depending on the member's eligibility period, to properly bill HDM post-hospital discharge services.

Providers currently enrolled in HDM as part of the Transitions Services benefits (Specialty 752) will be able to bill for the benefit. Qualifying members may receive up to two (2) home delivered meals per day, for up to 30 days, following discharge from a hospital. This benefit can be accessed no more than two (2) times during a member's certification period.

Contact the Provider Services Call Center with questions regarding provider enrollment.

Hospital Providers

General Updates

All Hospital Providers

FY 23-24 Inpatient Base Rates

Fiscal year (FY) 23-24 Inpatient Hospital Base Rates using the new methodology developed over the past two years is currently being created. Part of the changes made to the new methodology include posting the calculations used to create the Graduate Medical Education (GME) Add-on and the calculation for non-prospective payment system hospital Indirect Medical Education (IME) operating and capital percent to be input into the model.

These calculations were posted to the Inpatient Hospital Payment web page as of March 15, 2023, for a 30-day review period for hospitals to review the calculations and alert the Department's contractor, Myers and Stauffer, if any changes need to be made. The posting contains contact information and other instructions. Furthermore, an email was sent to individuals listed on the Hospital Stakeholder Engagement Meeting email list as a reminder to review the hospital's calculations.

A process is available for hospitals to provide written confirmation of what data fields are incorrect and what the new numbers should be from the hospital intermediary if any of the information used in the calculation of Inpatient Hospital Base Rates which originates from the Centers for Medicare & Medicaid Services (CMS) Final Rule and correcting amendment Impact file, or other CMS-created data files, are still incorrect after the corrected file is posted. This process is available so changes can be made to the base rate model. All notification of changes regarding GME-, IME- or CMS-created data must be received by the Department or the Department's contractor by April 15, 2023, for the change to be included in the model calculating inpatient base rates for FY 23-24.

The first reading of changes to Section 8.300 Hospital Services, Long-Term Care Single Entry Point System 10 CCR 2505-10 8.300 will be presented to the Medical Services Board (MSB) on Friday, April 14, 2023, at 9:00 a.m. MT. The methodology used to create Inpatient Base Rates for Colorado Diagnostic Related Grouping (DRG) hospitals is described within this section of rule. A draft of the initial changes that were made to rule back in January 2023, is available. Providers are reminded that this is only a draft version, and the rules are likely to be modified regarding references to other sections and wording in order to pass review with the Attorney General's office and the MSB.

Visit the Medical Services Board web page for information on attending the meeting.

Contact Diana Lambe, Andrew Abalos and Kevin Martin with any input or questions on the model.

Hospital Stakeholder Engagement Meetings

Bi-monthly Hospital Engagement meetings will continue to be hosted to discuss current issues regarding payment reform and operational processing. Visit the Hospital Engagement Meeting web page for more details, meeting schedules and past meeting materials. Calendar Year 2023 meetings have been posted.

- The next All-Hospital Engagement meeting is scheduled for Friday, May 5, 2023, from 9:00 a.m. to 11:00 a.m. MT and will be hosted virtually.

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.

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 4, 2023, 12:30 p.m. to 1:00 p.m. MT and will be hosted virtually. The meetings are held on Zoom.

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

Contact Andrew Abalos at Andrew.Abalos@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.

Outpatient Hospitals

It was discussed in the March 3, 2023, Hospital Stakeholder Engagement meeting that a new hospital-specific Enhanced Ambulatory Patient Grouping (EAPG) Base Rate methodology is being developed, which will be effective July 1, 2024. Updates will continue to be provided

and feedback solicited within upcoming provider bulletins and Hospital Stakeholder Engagement meetings.

Contact Tyler Samora at Tyler.Samora@state.co.us with any questions or suggestions.

Inpatient Hospital Review Program (IHRP)

Inpatient Hospital Providers

The IHRP 2.0 is a redesigned, narrowly focused program with the primary goal of helping hospitals coordinate with the appropriate Regional Accountable Entity (RAE) for efficient and effective discharge planning and care coordination. IHRP 2.0 will focus on inpatient admission reviews for select surgical procedures, post-admission clinical reviews for a small set of diagnoses for the purpose of care coordination and post-admission clinical reviews at 30-day intervals after admission.

Training and Communication

Visit the IHRP 2.0 web page for additional information including a program overview, resources, training dates and materials provided during the Joint Operating Committee (JOC). The JOC is a recurring meeting with hospital providers, the Colorado Hospital Association (CHA), Kepro® and the Department for program updates, questions, concerns and discussion of issues. Hospitals that would like to participate in the IHRP JOC should contact the ColoradoPAR Program Utilization Management (UM) Team at hcpf_um@state.co.us.

Soft Launch

IHRP 2.0 will begin with a "soft launch" on April 3, 2023.

It is recommended for hospitals to begin entering Pre-Admission Reviews and Post-Admission Reviews to Kepro's PAR portal, Atrezzo®, starting April 3, 2023, to test internal processes and connectivity. Any input is appreciated about the usability of Atrezzo, the requirements of IHRP 2.0, communication between reviewers and hospitals, areas of opportunity and improvement, and what is working well.

Go Live

Claims will not deny for lack of an approved Pre-Admission Review from April 3, 2023, through April 30, 2023. Post-Admission Reviews ensuring compliance with the program requirements will not be reviewed during April.

Implementation will begin May 1, 2023, and inpatient hospital claims with services requiring prior authorization will deny without an approved prior authorization.

Send an email to COproviderissue@kepro.com and cc: hcpf_um@state.co.us with any concerns and feedback. Concerns and feedback will be addressed at the JOC.

Recovery Audit Contractor (RAC) Program—Upcoming Changes

A federally required post-payment review program is being added to the RAC program. Input that was gathered from the provider community regarding the current state of the program is being applied.

Changes will be implemented internally and with the recovery audit contractor, Health Management Systems, Inc. (HMS) in the coming months to:

- Offer rebilling options for certain claims identified as an overpayment
- Offer an updated informal reconsideration and appeal process
- Clarify existing standards both in the Department regulation and the RAC process

Providers will be contacted, and stakeholder engagement opportunities will be held to assist in this effort by engaging in productive discussions regarding the successes and challenges of the RAC program and to obtain additional feedback from providers.

A stakeholder engagement meeting will be scheduled in May.

Visit the HMS Colorado RAC web page or the Recovery Audit Contractor (RAC) Program web page for more information about the RAC program.

Obstetrics and Maternity Healthcare Providers

Revised Obstetrical Global Billing Requirements

Billing globally covered Obstetrics (OB)/Maternity service codes will require coding inclusions to identify prenatal (PN) and postpartum (PP) care visits and the dates PN and PP services were provided, effective June 1, 2023. The Centers for Medicare & Medicaid Services (CMS) is requiring agencies to report PN and PP care as a tool to monitor and help improve the quality of healthcare and health outcomes. A new claims system billing methodology has been developed to comply with CMS reporting which will enable providers to report provision of these critical services and to supply critical information to maximize quality maternal healthcare services for Health First Colorado (Colorado's Medicaid program) members during pregnancy.

This OB/Maternity billing change will be required and enforced for all Fee-for-Service (FFS) providers submitting professional claims.

It is recommended that Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) providers follow these new billing guidelines to identify PN care visits when billing for labor and delivery (L&D) services (outside the normal encounter rate billing methodology) to accurately capture provision of these important healthcare services and quality healthcare metrics. It is recommended to include the Common Procedural Terminology (CPT) Category II PP visit code (0503F) on the regular encounter visit claim form to capture and identify these important PP care visits.

OB/Maternity care providers should continue to bill the most accurate Global or Bundled/Partial or Individual Maternity/OB CPT codes (59400 – 59622) applicable to their provision of maternity care services. Using one of the listed CPT Category II codes to identify and document each PN and PP visit will be the new required change in the obstetrical billing methodology. The CPT Category II codes need to be added to the same global/partial maternity billed claim, ***or*** if only the PN or PP visits are provided (when billing the global/partial codes are not appropriate), the CPT Category II PN and PP codes should be included on those individual PN (using CPT codes 59425 or 59426) or PP (using CPT code 59430) claims. The identified CPT Category II "F" codes (0500F, 0501F, 0502F or 0503F) are utilized for descriptive and reporting purposes only and will not affect the claim reimbursement in any way.

Providers will need to document PN and/or PP visits on separate claim lines below the identified maternity-related (global, partial or L&D) CPT code by including:

1. The appropriately described CPT Category II code documenting the PN or PP care visit, ***and***
2. The date of service (DOS) for each of the PN and PP visits.

The claims system will identify these listed CPT Category II codes with their associated dates of service as a "no-charge" line item.

The following CPT Category II "F" codes are required to identify and document service provision for each PN and PP care visit:

Use either 0500F OR 0501F as the descriptive code for the first (initial) PN visit:

- 0500F
- 0501F
- 0502F
- 0503F

Billing Example: If the same provider who rendered the L&D also rendered antepartum (minimum of four visits) and PP care (at least one visit), the provider must report:

1. The appropriate Global OB Care code associated with the date of delivery (example: 59400 listed on claim line 1), ***and***
2. The antepartum CPT Category II descriptive codes (minimum of four visits) (example: 0500F or 0501F reported on line 2 and 0502F reported [at a minimum] on lines 3, 4 and 5), ***and***
3. The PP CPT Category II descriptive code (minimum of one visit) (example: 0503F on line 6), ***and for each identified CPT Category II code listed, also include***
4. The dates the antepartum and PP visits were rendered.

All codes should be reported on the same claim.

Refer to the recently published Special Provider Bulletin – Obstetrics and Maternity Healthcare (B2300492), which can be viewed on the Bulletins web page. This special bulletin

contains additional information related to these changed OB billing requirements. The Obstetrical Care Billing Manual will be updated with the revised OB billing information.

Contact Melanie Reece at Melanie.Reece@state.co.us with additional questions regarding these changes in Global OB/Maternity service code billing and the required billing changes to include CPT Category II codes for identifying provision of PN and PP care visits. Contact the Provider Services Call Center with billing questions.

Pharmacy Providers

General Updates

Billing for Blood Glucose Test Strips

Procedure code A4253 should be billed for the entire span of the dates of service. Up to one month of test strips may be billed at a time, which means the first date of service (FDOS) and to date of service (TDOS) should be up to one month apart. For example, the FDOS is April 1, 2023, and the TDOS is April 30, 2023.

Additionally, one unit of service is 50 strips. Claims should be billed for the number of units and not the number of strips. For example, a prescription for 4 tests per day would require 120 tests. The claim should be for 3 units, which is 150 test strips. Refer to the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Billing Manual to review this information.

Pharmacy Providers and Physician Services

Drug Utilization Review (DUR) Board Open Position

Applicants are being accepted for an open physician position for the DUR Board. The physician filling this position will be a voting member of the Board and will be expected to attend quarterly DUR Board meetings.

The actively practicing physician shall serve a two-year term and may be reappointed. Duties, membership and other term details can be found in the DUR Board Policies and Procedures, accessible under “Our Members” on the Drug Utilization Review Board web page. Refer to the Colorado Drug Utilization Review Board Policy and Procedures manual, located towards the bottom of the Drug Utilization Review Board web page, for additional information.

If interested in serving or know someone who would be qualified, submit a CV to:

Colorado Department of Health Care Policy & Financing

Attn: Jeff Taylor, PharmD

Fax to 303-866-3590 or email to Jeffrey Taylor at Jeffrey.Taylor@state.co.us.

Physician-Administered Drugs (PAD) Providers

Quarter 2 Rate Update 2023

The PAD rates for the second quarter of 2023 have been updated. The new rates are effective April 1, 2023, and are posted to the Provider Rates and 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-Administered Drugs (PAD) and Immunization Providers

2022-2023 Respiratory Syncytial Virus (RSV) Season and Synagis® Vaccine Benefit

The Colorado RSV season has continued to be monitored by Health First Colorado, and member needs have been reassessed based on Centers for Disease Control and Prevention (CDC) virology reporting and American Academy of Pediatrics (AAP) guidance. Area virology trend reporting is available on the CDC website.

An approval maximum of five (5) doses of Synagis will be maintained, with a season end date of April 28, 2023. Any exceptions based on medical necessity may be reevaluated on case-by-case basis.

Refer to the November 2022 Provider Bulletin (B2200485) located on the Bulletins web page for additional information.

Physician Services

eConsult Platform Informational Update

A statewide electronic consultation platform called the eConsult platform will be implemented for Health First Colorado. This platform will promote the Department's mission to improve healthcare equity, access and outcomes for the people served.

The eConsult platform will enable asynchronous (store and forward) clinical communications between a Primary Care Medical Provider (PCMP) and a specialty provider. The PCMP will be able to transmit an electronic clinical question to a specialty provider, and medical information will be reviewed by the specialty provider. The specialty provider will be able to review the case without the member being present. The specialty provider then supplies electronic medical consultative guidance that assists the PCMP in the diagnosis or

management of the member's healthcare needs or facilitates the appropriate referral for a face-to-face visit with a specialty provider when clinically appropriate.

Stakeholder engagement will resume late spring/early summer 2023 once the contract has been approved by Centers for Medicare & Medicaid Services (CMS) and the contract for the eConsult platform is executed. Updates will be provided closer to the implementation of the statewide eConsult platform.

Anticipated Timeline

- Fall/Winter 2022 - Contract Negotiations
- Spring 2023 – CMS Review of Contract
- Summer/Fall 2023 - Implementation Activities
- Fall/Early Winter 2024 - eConsult Platform Go Live

Note that the project timeline is subject to change without prior notice and is only provided as a reference.

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

Physician Services, Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) Providers

Well Child Check-ups Via Telemedicine Update

Temporary coverage of well child check-ups provided via telemedicine were added during the federal Public Health Emergency (PHE) for COVID-19. Telemedicine coverage of well child check-up codes will be discontinued, effective May 12, 2023. This end date aligns with the expiration of the federal PHE for COVID-19.

Procedure codes affected by this update include 99382, 99383, 99384, 99392, 99393 and 99394.

Providers will still be reimbursed for in-person well child check-ups.

Visit the Telemedicine - Provider Information web page to find an updated list of telemedicine codes.

Contact Morgan Anderson at Morgan.Anderson@state.co.us and Naomi Mendoza at Naomi.Mendoza@state.co.us with any questions.

Private Duty Nursing (PDN) Providers

Prior Authorization Requests (PAR) Update

It was announced on March 17, 2023, that the temporary administrative approval process will end April 2, 2023. This means after April 2, all PDN services will no longer be authorized based on the provider request but on the approved PAR. Any services billed that are not approved on the PAR will deny.

Refer to Informational Memo (IM) 23-010 for additional details about the ending of the temporary approval process and provider responsibilities during this time.

Contact homehealth@state.co.us with questions.

Provider Billing Training Sessions

April and May 2023 Provider Billing Training Sessions

Providers are invited to participate in training sessions for an overview of Health First Colorado billing instructions and procedures. These sessions are virtual-only webinars. 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 who 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 Beginning Billing Training: Professional Claims (CMS 1500) and the Beginning 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 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 2023

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

May 2023

Monday	Tuesday	Wednesday	Thursday	Friday
1	2	3	4	5
8	9	10	11 Beginner Billing Training: Professional Claims (CMS 1500) 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) 9:00 a.m. - 11:30 a.m. MT	26
29	30	31		

Live Webinar Registration

Click the title of the desired training session in the calendar above to register for a webinar. 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, your name and contact information (email address and phone number), and the name and date of the webinar(s) to be attended. Allow up to two (2) to three (3) business days to receive a response.

Upcoming Holidays

Holiday	Closures
Memorial Day **Monday, May 29**	State Offices, Gainwell Technologies, DentaQuest and the ColoradoPAR program will be closed. Capitation cycles may potentially be delayed. The receipt of warrants and Electronic Funds Transfers (EFTs) may potentially be delayed due to the processing at the United State Postal Service or providers' individual banks.

Gainwell Technologies Contacts

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