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Did You Know?

Providers are required to submit all claims electronically through the Provider Web Portal or batch.

Exceptions may be made for providers who submit less than five (5) claims per month. Complete the [Request to Submit Paper Claims Form](#), available under the Provider Enrollment & Update Forms drop-down section of the [Provider Forms web page](#), to request paper claim submission.

Claims with attachments must be sent via the Web Portal unless providers have been approved to submit paper claims.

All Providers

Clinical Trial Coverage

The Department of Health Care Policy & Financing (the Department) does not cover clinical trials because they are experimental and/or investigational (10 CCR 2505-10 8.076). However, medically necessary services are covered when needed during the trial, provided they are within the standard of care, and the clinical trial is not obligated to cover the services (10 CCR 2505-10 8.011). This coverage includes the treatment of complications arising from the clinical trial that are not otherwise covered by the clinical trial.

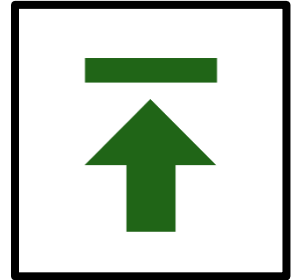
A previously released memorandum written by the Colorado Legislative Council Staff incorrectly characterized the Department's coverage of services related to clinical trials.

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

"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 by DXC Technology (DXC). 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.



Payment Error Rate Measurement (PERM) Audit

Starting this summer, the Centers for Medicare & Medicaid Services (CMS) will begin its Review Year 2020 Payment Error Rate Measurement (PERM) audit on Health First Colorado (Colorado's Medicaid Program) and Child Health Plan *Plus* (CHP+) claims. CMS will randomly select a set number of paid or denied claims from July 1, 2018, to June 30, 2019, for its review.

CMS has contracted with AdvanceMed, an NCI Company, who will contact providers by phone and letter to request medical records that support claims providers submitted for payment. AdvanceMed will review the medical records to determine if the payment for the corresponding claim was justified. Providers have 75 calendar days to provide medical record documentation to AdvanceMed.

If the initially submitted medical record documentation is not sufficient, AdvanceMed will contact providers to request additional documentation. Providers have 15 calendar days to provide the additional documentation. If documentation is not provided or is insufficient, the provider's claim(s) will be considered in error, and the Department will initiate recovery for the monies associated with the claim from the provider. The reasons why the provider did not submit proper documentation will be investigated.

What is PERM?

PERM is a federally-mandated audit that occurs once every three years. This is a review of claim payments and eligibility determination decisions made for states' Medicaid and Children's Health Insurance Program to ensure payment accuracy and verify that states only pay for appropriate claims. The collection and review of protected health information contained in medical records for payment review purposes is authorized by U.S. Department of Health and Human Services regulations at [45 C.F.R. 164.512\(d\)](#), as a disclosure authorized to carry out health oversight activities, pursuant to the [Health Insurance Portability and Accountability Act of 1996 \(HIPAA\)](#); CMS PERM Review Contractor activities are performed under this regulation.

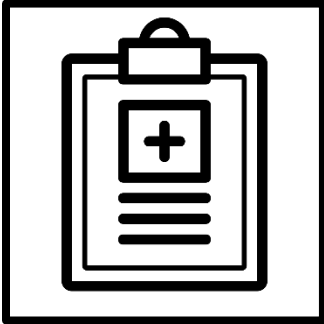
Visit the [PERM web page of the CMS website](#) and the [PERM web page of the Department's website](#) for more information. Email CMS at PERMProviders@cms.hhs.gov or contact Matt Ivy at Matt.Ivy@state.co.us or 303-866-2706 with any questions.

Updates to Eligibility Verification

Effective June 26, 2019, eligibility verification has been updated within the Provider Web Portal, the Interactive Voice Response (IVR) System and the Electronic Data Interchange (EDI) HIPAA 271 X12 batch

transactions to ensure the eligibility data is consistent and sufficient for providers to make a determination as to whether they will be reimbursed for services rendered to a member. Changes include replacement of existing terminology with new language, appearance of eligibility response data within the Web Portal, and additional response data for both IVR & EDI HIPAA X12 271 batch transactions that ensure eligibility responses match across all three verification platforms.

The term Client Overutilization Program (COUP) is no longer referenced within the information provided during eligibility response. The term “Lock-in” replaces COUP within these eligibility searches.



Members who are assigned to a Lock-in Plan are restricted to a specific provider. To authorize services for a member by a provider other than the designated Lock-in Plan Provider, claims must include the referring provider’s National Provider Identifier (NPI). The Lock-in Details panel provides the Lock-in Provider’s DBA Name and Provider Phone information. Prior to billing services for members, providers must verify the member’s Lock-in Plan information. If services are provided without a referral by a provider that is not the Lock-in Plan provider, claims may be denied. For more information, visit the [Client Overutilization Program web page](#).

Refer to the updated [v5010 X12 270 271 Companion Guide](#), available under the Companion Guides and Instructions drop-down section of the [EDI Support web page](#), for more information. Contact the [Provider Services Call Center](#) at 1-844-235-2387 and select option 2 and then option 3 for EDI assistance.

Refer to the updated [Provider Web Portal Quick Guide - Verifying Member Eligibility and Co-Pay](#), available on the [Quick Guides and Webinars web page](#), to view Provider Web Portal changes associated with these updates.

All Providers Who Submit Prior Authorization Requests (PAR) to eQHealth Solutions

PAR Determination Letter Change

Effective June 17, 2019, all letters regarding PAR determinations that are reviewed by eQHealth Solutions, will be posted to eQHealth’s PAR portal, eQSuite®. PAR letters will no longer be posted in DXC Technology’s (DXC’s) Provider Web Portal. A full list of services requiring authorization can be found on the [ColoradoPAR website](#).

PAR determination letters can be found in eQSuite® by clicking on “view letter” on the individual review under the Letters tab. A How-To Guide will be published on the ColoradoPAR website.

Contact eQHealth at co.pr@eqhs.org or 888-801-9355 with any issues or questions regarding PAR determination letters.

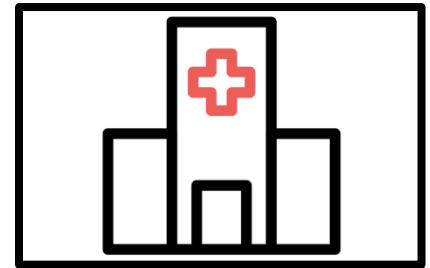
Hospital Providers

General Updates

Inpatient Hospitals

Fiscal Year 2019-20 Inpatient Hospital Base Rate 30-Day Review Period

Inpatient Hospital Base Rates were reposted June 17, 2019, to the [Inpatient Hospital Payment web page](#). Individuals on the [Hospital Engagement Newsletter email list](#) received a notification when rates were reposted for the 30-day review period.



One hospital provided evidence of incorrect data reported by Centers for Medicare & Medicaid Services (CMS)/Novitas. Since inpatient base rates must remain budget neutral, this changed the “Percentage of Medicare Base Rate” for all hospitals and rural/urban peer group averages.

Hospitals can update the calculation they received earlier by updating: 1) the peer group average if they are a new, low-discharge or critical access hospital, or 2) the “Percentage of Medicare Base Rate” to 87.10% if they are a Prospective Payment System (PPS) hospital. This should result in same hospital base rate as listed in the new posting.

Hospitals can also request the updated calculation used to arrive at their hospital’s Medicaid base rate by sending an email to Diana Lambe at Diana.Lambe@state.co.us. Remember to include the hospital name and Medicare ID along with the request.

The 30-day review period ends July 16, 2019; the posted rates will be implemented as soon as possible.

Contact Diana Lambe at Diana.Lambe@state.co.us with any questions about the above topics.

Inpatient Hospital Per Diem Rate Group

Web Page

A new web page has been created to house the Inpatient Per Diem Rates. Providers are encouraged to visit [Inpatient Hospital Per Diem Reimbursement Group page](#).

There are no meetings currently scheduled. Past meeting materials are available on the [Hospital Stakeholder Engagement Meetings page](#).

Outpatient Hospitals

Bi-Monthly Enhanced Ambulatory Patient Group (EAPG) Meetings

The bi-monthly EAPG Meetings have merged into the Hospital Stakeholder Engagement Meetings. Review the [Hospital Stakeholder Engagement Meetings page](#) for upcoming meeting dates. For 2018 EAPG Meeting materials, visit the [Outpatient Hospital Payment web page](#).

Contact Andrew Abalos at Andrew.Abalos@state.co.us or 303-866-2130 with any questions regarding EAPG rates or the EAPG methodology.

All Hospital Providers

Bi-Monthly Hospital Stakeholder Engagement Meetings

The Department will continue to host bi-monthly Hospital Engagement meetings to discuss current issues regarding payment reform and operational processing. The next meeting is scheduled for Friday, July 12,

2019, 12:30 p.m. - 4:00 p.m. at 303 E 17th Ave, Denver, Conference Room 7B & 7C. To see dates for all 2019 Hospital Engagement meetings, refer to the calendar available on the [Hospital Stakeholder Engagement Meetings web page](#).

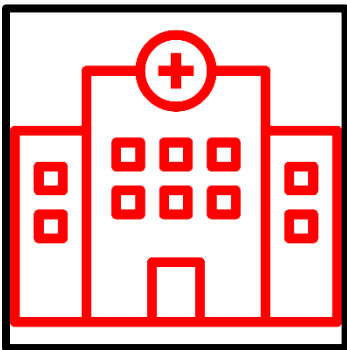
[Sign up to receive the Hospital Stakeholder Engagement Meeting newsletters.](#)

[Visit the Hospital Stakeholder Engagement Meetings web page for more details, meeting schedule and past meeting materials.](#)

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

Hospital Transformation Program (HTP) Update

Additional Quality Scoring Measures Available



An updated draft of the [Hospital Transformation Program Measures List](#) has been added to the Hospital Transformation Program Overview & Framework drop-down section of the [Colorado Hospital Transformation Program web page](#). The May 13 draft includes the definitions and data sources for each statewide and local measure. This document is a working draft and will be updated as the hospital and quality workgroups continue to meet and refine the measures and specifications. The process for finalizing quality scoring measures will include collaboration and input from key stakeholders including the Department, the Centers for Medicare & Medicaid Services (CMS), the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Board, the Colorado Hospital

Association, participating hospitals and broader stakeholders participating in the program. Additional information about quality scoring measures can be found in the [Scoring Framework Proposal](#), available under the Hospital Transformation Program Overview & Framework drop-down section on the [Colorado Hospital Transformation Program web page](#).

Midpoint Reports

On April 19, 2019, hospitals participating in the HTP submitted Community and Health Neighborhood Engagement (CHNE) [Midpoint Reports](#), available under the Community and Health Neighborhood Engagement (CHNE) Process drop-down section on the [Colorado Hospital Transformation Program web page](#). A comprehensive overview of the CHNE process can be found beginning on page 9 of the [Hospital Transformation Program Concept Paper](#), available under the Hospital Transformation Program Overview & Framework drop-down section on the [Colorado Hospital Transformation Program web page](#). Currently, the Department is reviewing Midpoint Reports and sharing findings with hospitals. The review process ensures the Department has the most complete picture of how the CHNE process is progressing before plans are available to external stakeholders and the public. The Department is using this as an opportunity to look for missing information or areas of clarification, as well as provide feedback and allow for any revisions. Reports are being evaluated by an independent reviewer against the requirements found in the [Guidebook](#), [Midpoint Report template](#) and Midpoint Report review criteria, all available under the Community and Health Neighborhood Engagement (CHNE) Process drop-down section on the Colorado Hospital Transformation Program web page.

Final Reports from HTP participants are due September 20, 2019. Hospitals must submit a [Final Report](#), available under the Community and Health Neighborhood Engagement (CHNE) Process drop-down section on the Colorado Hospital Transformation Program web page, at the end of the pre-waiver CHNE process, which

will include information about the entirety of the process but with a primary focus on efforts to prioritize community needs, select target populations, identify initiatives and develop any partnerships.

HTP Newsletter

Providers may [sign up](#) to receive updates about the HTP via the [HTP Newsletter](#). To complete the sign-up process, enter contact information and click the “Hospital Transformation Program” box.

To learn more about the HTP, visit the [Colorado Hospital Transformation Program web page](#) and read past editions of the HTP Newsletter on the [HTP Newsletter Archive web page](#).

Contact Courtney A. Ronner, Hospital Relations and Communication Manager, at 303-866-2699 or Courtney.Ronner@state.co.us with any additional questions about the HTP.

Inpatient Medicare Part B-Only and Medicare Part A Exhaust Interim Solution Update

A process for inpatient crossover claims with Medicare Part B only and inpatient crossover claims with exhausted Medicare Part A is being implemented to ensure proper payment for services until a permanent fix is in place.

For this procedure, Medicare Part B only claims will be prioritized since this represents the majority of the claims identified. Once this has been applied to Medicare Part B only claims, Medicare Part A exhausted claims will be identified. This method requires provider participation to be effective.

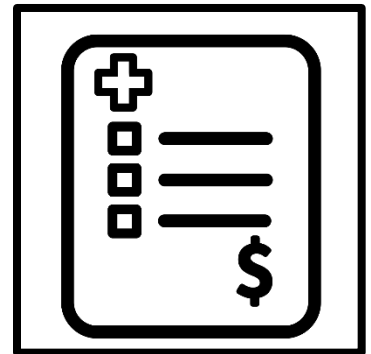
When voiding claims, as instructed below, **begin with the oldest claims first**. If the claims are not voided before reprocessing is initiated, the claims will deny as duplicates. Coordinated timing is critical for this procedure.

The approach is as follows:

Medicare Part B Only Claims

Providers are advised to:

- Void any paid inpatient claims for the Medicare Part B only inpatient stay. These are claims that did not have Medicare reported in the Medicare fields.
- Void any paid outpatient crossover claims with Type of Bill (TOB) 12X for the inpatient stay
- If the provider (or Coordination of Benefits Agreement [COBA]) has not submitted an inpatient crossover claim for the Part B only inpatient stay, the claim will need to be submitted as an inpatient crossover claim by including the Part B information in the Medicare fields.
 - Include all Medicare paid amounts, and coinsurance and deductible at the header level
 - Provide a list of the resubmitted Internal Control Numbers (ICNs) to Juan Espejo at Juan.Espejo@state.co.us with "Medicare Part B Interim Solution" as the subject line. Include the provider name and National Provider Identifier (NPI) in the email.
- Claims that meet the following criteria will be reprocessed:
 - Inpatient crossover claim type
 - TOB 11X
 - Member has TXIX and Medicare Part B and does not have Medicare Part A on through date of service



Claims will be put into a suspended status and will be manually priced at Medicaid Allowed Amount less Medicare Paid Amount.

Medicare Part A Exhausted Claims

Providers are advised to:

- Identify any Medicare Part A exhausted inpatient claims
- Send the Medicare Part A exhausted inpatient crossover claim ICNs to Juan Espejo at Juan.Espejo@state.co.us with "Medicare Part A Exhaust Interim Solution" as the subject line.
 - This list should not include Medicare Part B only claims (claims addressed with the above interim solution)
 - This list should not include members that are Qualified Medicare Beneficiary (QMB) only and do not have TXIX on the through date of service.

Claims will be reprocessed and manually priced.

Contact Raine Henry at Raine.Henry@state.co.us or Juan Espejo at Juan.Espejo@state.co.us with any questions.

Hospitals and Dialysis Providers

End-Stage Renal Disease (ESRD) Vascular Access Procedures for Recipients of Emergency Medicaid Services

Recipients of Emergency Medicaid Services can receive care and services related to the treatment of ESRD. Providers have the discretion to determine what is necessary in the treatment of ESRD. Covered Health First Colorado benefits for vascular access procedures and pre-surgery imaging are considered to be necessary in the treatment of ESRD.

The Colorado Benefit Management System (CBMS) will only authorize a medical assistance eligibility span (med-span) for the month in which the emergency occurs and then discontinue coverage; therefore, individuals will need to re-apply for Health First Colorado coverage and provide verification of emergency services each month. This one-month med-span means that individuals who qualify for Emergency Medicaid Services may not appear eligible when trying to schedule appointments for vascular access procedures or imaging; however, please note that coverage is based on the month in which the application is submitted and will be retroactive to the first day of that month.

Contact Jess Pekala at Jessica.Pekala@state.co.us with any policy questions.

Indian Health Services

New Grant Opportunity

A "Care Coordination Agreement for Tribal Providers" grant opportunity is being offered by the Department in partnership with The Colorado Trust. This funding opportunity is primarily designed for providers in the Southwest region of Colorado that service the American Indian/Alaskan Native population.

The Department is working to facilitate Care Coordination Agreements between tribal and non-tribal providers to improve care coordination, communications and patient outcomes for the tribal populations. Providers interested in reading more about these



agreements and entering into a contract with their respective Tribal Health Facility should contact Brooke Greenky at Brooke.Greenky@state.co.us for more information on requirements and eligibility.

Pharmacies and All Medication-Prescribing Providers

Medication Administration

Medications Administered in a Member's Home by a Health Care Professional

The Department currently allows for drugs administered by a health care professional to be payable by the pharmacy benefit when they are administered in the member's home. Drugs administered by a health care professional in a provider's office or clinic is payable under the medical benefit. This policy is not changing, but additional information will be required for pharmacy benefit Prior Authorization Requests (PARs) for these drugs beginning August 1, 2019. This information is required to validate the authorization placement under the pharmacy benefit.

A new Pharmacy Prior Request Authorization Form will be posted on the [Pharmacy Resources web page](#) under the Other Forms section.

For medications administered in a member's home by a home health agency, the following additional information will be required:

- Name of agency
- Phone number
- If Home Health Authorizations is required, then include:
 - Home Health Authorization number
 - Approval dates



Magellan Rx Management Pharmacy Call Center staff will begin to ask for this information starting July 1, 2019, but it is not required for the Prior Authorization until August 1, 2019. For drugs that are not administered by a health care professional in the home, there is no additional information needed and this section of the Pharmacy Prior Authorization Request form does not need to be filled in.

Also, as a reminder to pharmacies, only for claims for medications that are administered by a health care professional in the member's home, a '12' may be entered in the "Place of Service" field (307-C7). This field will most likely be found under the member's profile in the pharmacy's Point of Sale system.

Medications Administered by a Health Care Professional to Members Who Reside in a Long-Term Care Facility

The Department currently allows for drugs administered by a health care professional to be payable by the pharmacy benefit when they are administered to the member in a long-term care facility. Drugs administered by a health care professional or physician in a provider's office or clinic is payable under the medical benefit. This policy is not changing, but additional information will be required for Pharmacy PARs for these drugs beginning August 1, 2019. This information is required to validate the authorization placement under the pharmacy benefit.

A new Pharmacy Prior Authorization Request form will be posted on the [Pharmacy Resources web page](#) under the Other Forms section.

For members receiving medication in a long-term care facility, the additional required information will be the name of the facility and its phone number.

Magellan Rx Management Pharmacy Call Center staff will begin to ask for this information starting July 1, 2019, but it is not required for the Prior Authorization until August 1, 2019. For drugs that are not administered by a health care professional in a long-term care facility, there is no additional information needed and this section of the Prior Authorization Request form does not need to be filled in.



Contact the Magellan Rx Management Pharmacy Call Center at 1-800-424-5725 for pharmacy claim processing or prior authorization questions. Contact Brittany Schock at Brittany.Schock@state.co.us with any other questions.

Pharmacy and Therapeutics Committee Meeting

Tuesday, July 9, 2019

1:00 p.m. - 5:00 p.m.

303 E 17th Ave

7th Floor Conference Rooms A, B & C

The agenda can be found at the [Pharmacy and Therapeutics \(P&T\) Committee web page](#).

Physician-Administered Drug (PAD) Providers

Quarter 3 Rate Updates 2019

PAD rates for the third quarter of 2019 have been updated. The new rates have a start date of July 1, 2019, and are posted to the [Provider Rates & Fee Schedule web page](#) under the Physician Administered Drug Fee Schedule drop-down section.

Provider Billing Training Sessions

July and August 2019 Provider Billing Training Sessions

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

Who Should Attend?

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

The UB-04 and 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 [UB-04 Beginning Billing Workshop](#) and

[CMS 1500 Beginning Billing Workshop](#), available on the [Provider Training web page](#) under the Billing Training and Workshops drop-down section.

Specialty training sessions provide more training for that particular provider specialty group. Providers are advised to attend a UB-04 or CMS 1500 training session prior to attending a specialty training. For a preview of the training materials used for specialty sessions, visit the [Provider Training web page](#) and open the Billing Training and Workshops drop-down section.

For more training materials on navigating the Provider Web Portal, refer to the Provider Web Portal Quick Guides available on the [Quick Guides and Webinars 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.

July 2019

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
7	8	9	10	11 CMS 1500 Provider Workshop 9:00 a.m. - 11:30 a.m. MT	12	13
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
14	15	16	17	18	19	20
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
21	22	23	24	25 UB-04 Provider Workshop 9:00 a.m. - 11:30 a.m. MT	26	27

August 2019

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
28	29	30	31	1 CMS 1500 Provider Workshop 9:00 a.m. - 11:30 a.m. MT	2	3
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
4	5	6	7	8 UB-04 Provider Workshop 9:00 a.m. - 11:30 a.m. MT	9	10

Live Webinar Registration

Register for a live webinar by clicking the title of the desired training session in the calendar above and completing the webinar registration form. An automated response will confirm the reservation. Do **not** register via these links if planning to attend a training session in person at the DXC office (see instructions below for RSVPing to attend in person).

For questions or issues regarding webinar registration, email co.training@dxc.com with the subject line "Webinar Help." Include a description of the issue being experienced, name and contact information (email address and phone number), and the name and date of the webinar(s) to be attended. Allow up to 2-3 business days to receive a response.

In-Person Training Registration

Providers who would like to attend a training session **in person** should RSVP to co.training@dxc.com by noon the day prior to the training, with the subject line "In-Person RSVP." Please include attendee name(s), organization, contact information (email address and phone number), and the name and date of the training session(s) to be attended. Allow up to 2-3 business days to receive a confirmation for in-person training reservations. Do not send an RSVP via email unless planning on attending **in person**.

In-person training sessions will be held at the following address:

DXC Technology Office
Civic Center Plaza
1560 Broadway St, Suite 600
Denver, CO 80202

Parking and Transportation

Free parking is not provided, and parking is limited in the downtown Denver area. Commercial parking lots are available throughout the downtown area. The daily rates range between \$5 and \$20. Carpooling and early arrival are recommended to secure parking. Whenever possible, public transportation is also recommended. Some forms of public transportation include the [Light Rail](#) and [Free MallRide](#).

Upcoming Holidays

Holiday	Closed Offices/Offices Open for Business
Independence Day Thursday, July 4, 2019	State Offices, DentaQuest, DXC and the ColoradoPAR Program will be closed. The receipt of warrants and EFTs may potentially be delayed due to the processing at the United State Postal Service or providers' individual banks.
Labor Day Monday, September 2, 2019	State Offices, DentaQuest, DXC and the ColoradoPAR Program will be closed. The receipt of warrants and EFTs may potentially 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 St, Suite 600
Denver, CO 80202

Provider Services Call Center

1-844-235-2387

DXC Mailing Address

P.O. Box 30
Denver, CO 80201