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Did You Know?

Reconsiderations are not required for denied claims. The provider can make the necessary corrections and resubmit as a new claim. The resubmission does not need to be billed on paper. If corrections are not made to the originally denied claim, a re-bill will still deny. For more information about how to correct denied claims, please call the [Provider Services Call Center](#) at 1-844-235-2387.

All Providers

ColoradoPAR Provider Educational Resources

The [ColoradoPAR website](#), under [Provider Resources](#) or [Provider Education/Training](#), has a wealth of educational materials available to quickly assist providers in finding answers to their questions. The eQHealth Solutions® Customer Service team can be reached at 888-801-9355 to provide assistance if providers are unable to find the information they need in these resources.

Many providers that contact eQHealth Solutions® Customer Service have three specific questions that are addressed in [ColoradoPAR website](#) resources:

- What is the status of a Prior Authorization Request (PAR)?
 - [Checking the Status of a PAR:](#)
Instructions on how to check the status of a PAR submitted online via eQSuite®.
- What does a certain PAR status mean? What needs to be done if a review has a certain status?

- [Review Status Notification](#): Explains the meaning of each review status notification (e.g. *Awaiting Required Attachments, Pended for Additional Information*) that providers receive via email and offers instructions on how to take action for each status.
- How do I find my PAR Number in eQSuite®?
 - [Finding a PAR Number](#): Details three different methods to locate PAR numbers in eQSuite®.

EOHealth Solutions® provides ongoing eQSuite® education to providers. Please continue to check the [Provider Education/Training tab](#) on the [ColoradoPAR website](#) for education opportunities.

Please continue to check the Monthly Provider Bulletin, as well as the [ColoradoPAR website](#), for the *Tip of the Month* and more announcements regarding new training and educational documents.

Synagis®

The 2017-2018 Synagis® season will officially begin on November 27, 2017, and end on April 30, 2018.

Providers administering Synagis® in an outpatient and/or office setting are expected to submit Synagis® PARs online via eQSuite®. PARs can be submitted via eQSuite® starting November 27, 2017. PARs received prior to November 27, 2017, will be denied.

To request access to eQSuite®, please complete the [Request for eQSuite® Access form](#) located on the [ColoradoPAR website](#), Provider Resources tab, [PAR Forms and Instructions](#).

Co-Pay Limit for Health First Colorado Members

Health First Colorado (Colorado's Medicaid Program) now notifies members by mail when their household has met its co-pay maximum for the month. The co-pay maximum is 5% of the household monthly income.

The head of household will receive a letter showing the household has reached the monthly limit, and how the limit was calculated. Once a member has paid 5% of their monthly household income on co-pays in a month, no one in the household pays co-pays for the rest of that month.

Members who track their own co-pay amounts may claim they have reached their maximum for the month before the Provider Web Portal reflects this information. This is because providers have up to 120 days to submit claims. Please consider this possibility if Health First Colorado members in your office state they have met their monthly co-pay maximum, but the Web Portal indicates they owe a co-pay amount at the time of their visit.

For more information, visit HealthFirstColorado.com/copay.

Child Health Plan *Plus* Update



Federal funding for the Children's Health Insurance Program (known as Child Health Plan *Plus*, or CHP+, in Colorado) has ended.

At this time, there are no changes to CHP+ eligibility or the CHP+ program.

If Congress does not act to continue federal funding, CHP+ in Colorado will end January 31, 2018.

Visit the [Future of Child Health Plan Plus](#) web page for more information. This web page will be updated as new information becomes available.

Claim Submission Method for Claims with Attachments

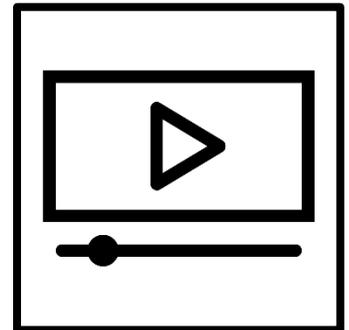
All attachments should be sent via the [Provider Web Portal](#). Claims with attachments should only be sent on paper if instructions have been given to submit paper claims as a work-around due to Web Portal issues.

Providers submitting fewer than five claims per month may submit a [request form](#); otherwise, all providers should be billing electronically, even with attachments.

Videos Now Available for Download!

[Videos in downloadable formats](#) are available for use in waiting rooms, county offices, eligibility sites-- anywhere Health First Colorado members may see them. New additions to the video library include:

- Dental Benefits
- Pregnancy Benefits
- Behavioral Health Benefits
- Teen Depression Screenings
- Substance Use Disorder Benefits
- Keeping Your Information Up to Date



Thank you for helping to communicate these important messages to Health First Colorado members!

Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) Providers

Coding Update: Miscellaneous Disposable Supplies – T5999

To date, the Department of Health Care Policy & Financing (the Department) has requested that providers bill procedure code A4649 in place of T5999. This was done as the Department limited billing of procedure code T5999 to disposable humidifier bottles, Type B oxygen cylinder tanks and large compressed air cylinders. There are now more appropriate coding options for these items so T5999 will be opened for NOS supplies.

Effective November 1, 2017, Supply and Pharmacy with DME Provider Types cannot bill claims for procedure code A4649. PARs and claims should utilize procedure code T5999 for NOS supplies. T5999 will also require a PAR.

Note: T5999 should only be utilized when the supply is not associated with a DME item and there is not a more appropriate/specific code that can be used.

Procedure code A9999 should be used when the supply is associated with DME, provided that there is not a more appropriate code.

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

Reminder: Face-to-Face (F2F) Requirement

As a reminder to providers, beginning July 1, 2017, the DME section of the Code of Colorado Regulations (CCR), located at [10 CCR 2505-10, § 8.590](#), was updated to incorporate the [Federal F2F requirements](#).

Compliance with the F2F requirements is a condition of payment for DME requiring a F2F.

Providers may reference the [February 2017 Provider Bulletin](#) for a list of the codes that require a F2F.

In the event of an audit, if appropriate documentation of the F2F is unable to be produced, the reimbursement for that product may be recouped.

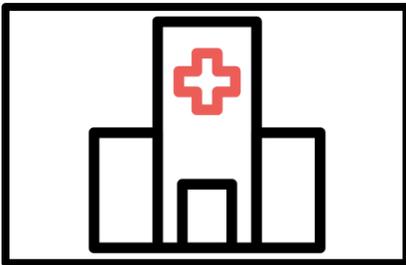
Hospital Providers

General Updates

OUTPATIENT HOSPITALS

Newly Issued Outpatient Enhanced Ambulatory Patient Groups (EAPG) Base Rates Fiscal Year (FY) 2017-18

Outpatient EAPG Base Rates to be effective FY 2017-18 have been posted on the [Outpatient Hospital Payment](#) web page. These rates were calculated by applying a 1.4% increase to the transitional hospital-specific EAPG base rates effective on October 31, 2016, following approval from the Centers for Medicare & Medicaid Services (CMS). The rule allowing the Department to implement this update to the base rates was presented to the [Medical Services Board](#) on October 13, 2017, and was approved. The base rates were loaded into the Colorado interChange system the following week, with mass adjustments on the impacted claims to occur mid-November 2017.



“Lower of Pricing” Update

The Department has been working with 3M to integrate functionality which redistributes the billed amount for outpatient hospital line items during its processing of EAPG claims. This functionality was released in the October 12 Service Pack licensed by 3M, and was installed into the Colorado interChange system shortly after. The result of EAPG payments using the redistributed billed amounts are more closely in alignment with the expected payments calculated prior to the implementation of the new payment methodology. All impacted claims will be mass adjusted by the Department starting mid-November 2017. For more information regarding the billed amount redistribution functionality, please visit the [Outpatient Hospital Payment](#) web page.

Mass Adjustment Scheduling

The Department has identified and resolved several of the issues involving variances in expected payment for certain claims in the new EAPG methodology and has tentatively scheduled mass adjustments for the impacted claims mid-November 2017. The Department will also begin performing its mass adjustments on the outpatient hospital claims processed in the Colorado interChange system with dates of service on or after October 31, 2016, so that they are reimbursed in accordance with the EAPG payment policies. For more information on the types of issues resolved and more details regarding the timelines regarding the upcoming mass adjustments, please see the [Outpatient Hospital Payment](#) web page.

Biweekly EAPG Meetings

Beginning September 22, 2017, the Department began hosting biweekly meetings dedicated to the EAPG methodology. These meetings are intended to be an informal discussion where the Department and its hospital providers can discuss issues relating to billing, payment or the EAPG methodology in general. For recordings of previous meeting and any related materials, as well as the current schedule for future meetings, please visit the Department's [Outpatient Hospital Payment](#) web page. The next meeting will be hosted by the Department on November 3, 2017.



****Please note: Starting January 12, 2018, all EAPG Biweekly Meetings will be moving to a new location 303 E. 17th Ave, Denver, Conference Room 7B.****

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

INPATIENT HOSPITALS

ICD-10 October 1, 2017 Update Installed October 4, 2017

The Department has installed the All Patients Refined Diagnosis Related Groups (APR-DRG) Version 33 Software on October 4, 2017, which recognizes the new ICD-10 codes released October 1, 2017.

FY 2017-18 Inpatient Hospital Base Rates Approved by CMS

The Department received approval from CMS for FY 2017-18 Inpatient Hospital Base Rates in late September. The new rates and mass adjustment of all inpatient claims with discharge dates on or after July 1, 2017, were reprocessed with the new rates by mid-October 2017. Approved rates for each hospital can be found on the [Inpatient Hospital Payment](#) web page.

Inpatient Claim Mass-Adjustment Coordination

The test mass adjustment was conducted on September 8, 2017, and the Department is currently reviewing the results. Our goal is to provide an update at the next Hospital Engagement Meeting on Friday, November 3, 2017 about the test results and next steps.

Please [sign up to receive the Hospital Engagement Meeting newsletters](#).

Contact Diana Lambe at Diana.Lambe@state.co.us or 303-866-5526 with any concerns about any of the above inpatient related updates.

SPECIALTY HOSPITALS

Meetings

The Department has been hosting monthly meetings with specialty hospitals (long-term acute and rehabilitation hospitals) with the next one occurring Friday, November 3, 2017. To sign up for invitations to monthly meetings, please email Elizabeth Quaife at Elizabeth.Quaife@state.co.us.

****Please note: Starting January 12, 2018, all Specialty Hospital Engagement Meetings will be moving to a new location 303 E. 17th Ave, Denver, Conference Room 7A.****

For more information please go to the Specialty Hospital section on the [Hospital Engagement Meetings](#) web page.

ALL HOSPITAL PROVIDERS

Hospital Engagement Meetings

The Department has held multiple Hospital Engagement meetings in 2017 to discuss current issues regarding payment reform and operational issues moving forward. The next meeting is scheduled for Friday, November 3, 2017.

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

The agenda for upcoming meetings will be available on our [Hospital Engagement](#) web page in advance of each meeting.

Registration links for each session during the day will also be available prior to the meeting. Just click on the links to register for each session and you will receive a link to connect to the webinar. For more information, please visit the [Hospital Engagement](#) web page.

****Please note: Starting January 12, 2018, all Hospital Engagement Meetings will be moving to a new location at 303 E. 17th Ave, Denver, Conference Room 7B & 7C.****

Contact Elizabeth Quaife at Elizabeth.Quaife@state.co.us or 303-866-2083 with any questions.

Delay in Immediate Post-Partum Long-Acting Reversible Contraception (IPP-LARC) "Carve-Out" from APR-DRG Payment Methodology

The Department continues to work with CMS to seek approval for carving-out IIP-LARC devices from the APR-DRG inpatient hospital payment methodology.

As of October 1, 2017, the Department has not received CMS approval for the State Plan Amendment (SPA) change request for an IPP-LARC carve-out. Because of federal guidelines related to public notice requirements, SPA change submission dates and CMS approval dates, retrospective IPP-LARC payments for the past fiscal quarter (July 1 - September 30, 2017) will be reimbursed through the previous CMS-approved



APR-DRG payment methodology. The Department continues to work on this IPP-LARC carve-out and SPA change request with completion targeted for the end of this calendar year.

Look for future IPP-LARC carve-out CMS-approval information in upcoming provider bulletins. For additional and previously published information related to the IPP-LARC, please check prior [provider bulletin publications](#) on the Department's website.

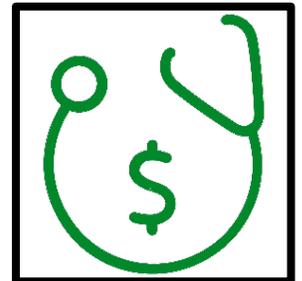
Obstetric Providers

Billing for Global Obstetrical (OB) Care

Global Billing Requirements

Colorado Medical Assistance Program OB billing guidelines (and per the American Medical Association [AMA] Current Procedural Terminology [CPT] guidelines and guidance from the American Congress of Obstetricians and Gynecologists [ACOG]) instruct that whenever possible, medical care provided during pregnancy, including antepartum care, labor and delivery and the postpartum period should be billed using the global obstetrical CPT codes.

The Global codes should be billed whenever the same group of practitioners (Same Group Physician and/or Other Health Care Professionals) all work to provide the components for the patient's obstetrical care. Group practitioners should **not** itemize and bill OB services separately when a global code is available for use. Billing by the same group of providers is identified in the Colorado interChange when specified global OB billable services (those codes used for antenatal, labor & delivery and postnatal care) are billed utilizing the same Billing Provider Medicaid ID number and the same date of service or date span.



Global OB Care fall into one of three CPT related code categories:

- Single-component codes (i.e., delivery only: 59409, 59514, 59612 or 59620)
- Two-component codes (i.e., delivery including postpartum care: 59410, 59515, 59614 or 59622)
- Three-component, or complete, global codes (including antepartum care, delivery, and postpartum care as listed below)

The complete Global OB CPT codes are identified as:

- 59400 - Routine obstetric care including antepartum care, vaginal delivery (with/without episiotomy, and/or forceps) and postpartum care
- 59510 - Routine obstetric care including antepartum care, cesarean delivery and postpartum care
- 59610 - Routine obstetric care including antepartum care, vaginal delivery (with/without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery
- 59618 - Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery

Duplicate Obstetrical Services

Duplicate OB services are identified when any two (2) of the above listed CPT codes are provided by the same or different physician on the same or different date of service during the existing pregnancy. This follows the AMA defined coding guidelines.

For example, to prevent duplicate billing errors, if one physician performs the delivery only (e.g., CPT code 59409) for a member, and a different physician in the same practice (same Billing Provider Medicaid ID number) provides all of the postpartum care (i.e., CPT code 59430), the procedure code which most accurately reflects all of the services performed by the affiliated group of providers should be billed. In this case, the CPT code 59410 (which includes both the vaginal delivery and postpartum care) should be billed.

Antepartum Care Only



Antepartum care only codes (CPT codes 59425 or 59426) should be billed when the practitioner or practitioners of the same group will **not** be performing all three (3) components of global OB care (more than three (3) antepartum visits, delivery and postpartum care). Generally, only ONE antepartum care code is allowed to be billed per pregnancy. If fewer than three (3) antepartum visits are performed, the appropriate E/M visit code should be billed, with the TH modifier appended to indicate that the visit is pregnancy related but outside of the OB global billing code.

Antepartum Care Billed with Either Delivery or Postpartum Care

There is not a comprehensive CPT code that describes antepartum care including delivery; nor is there a comprehensive CPT code that describes antepartum care with postpartum care.

- When antepartum care and delivery are performed by the same group of practitioners, the provider must itemize and bill the appropriate antepartum code in addition to the appropriate delivery code. Antepartum and delivery codes should **only** be billed if postpartum care was **not** provided by the same group of practitioners.
- If postpartum care is provided along with antepartum care by the Same Group Physician and/or Other Health Care Professional, but this group of practitioners does **not** perform the delivery, then the services should be itemized using the appropriate antepartum care code with the postpartum care code (59430). Antepartum and postpartum codes should **only** be billed if delivery was **not** provided by the Same Group Physician and/or Other Health Care Professional affiliated group (as identified by an identical Billing Provider Medicaid ID number). Hospital care related to the delivery is considered part of the delivery charge and is **not** considered part of postpartum care.

Postpartum Care Only

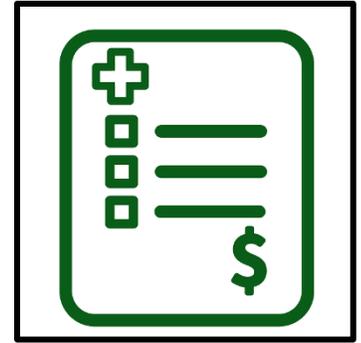
Postpartum care begins after the member is discharged from the hospital stay for delivery and extends throughout the postpartum period (ACOG guidelines considers the postpartum period to be six weeks following the date of the cesarean or vaginal delivery). The postpartum care only code (59430) should be reported by the Same Group Physician and/or Other Health Care Professional when postpartum services are provided but the same group of practitioners do **not** provide delivery.

Exceptions to Global Billing Guidelines

The following examples are additional situations where itemization of OB services may be applicable.

Physicians from different group practices (as identified by a different Billing Provider Medicaid ID number) may provide and bill for individual components (generally included with global OB billing) when:

- A member transfers into or out of a physician or group practice
- A member is referred to another non-group physician during her pregnancy
- A member has the delivery performed by another physician or other health care professional not associated with her physician or group practice
- A member terminates or miscarries her pregnancy
- A member changes insurers during her pregnancy



For more billing and service-related information, refer to the Obstetrical Billing Manual in the CMS 1500 section on the [Billing Manuals](#) web page.

Legal Abortion Claim Documentation Requirements and Use of the Department's Form(s) (Abortion Certification Statement) Required

Federal law requires abortion services to be available as a covered Medicaid benefit under very limited and specific circumstances. Abortion services are only covered when one of the following circumstances exist:

- 1) continuing the pregnancy would cause a life-endangering circumstance for the pregnant woman as a result of a medical condition, and/or;
- 2) the pregnancy is the result of a sexual assault/rape, and/or;
- 3) the pregnancy is the result of incest.

Abortion service documentation requirements are **not** applicable to procedures related to missed abortions, spontaneous abortions or incomplete miscarriages/abortions.

Complete and accurate documentation is required with claim submissions related to induced abortion-related services. Completion of the appropriate Department Certification Statement form (either for [Abortion to Save the Life of the Mother](#) or [Abortion for Sexual Assault \(Rape\) or Incest](#)), including the physician signature, is required to be attached to the claim. The Department's Abortion Certification Statement form(s) can be found under the Claim Forms and Attachments section of the [Provider Forms](#) web page.

Information requested on the Abortion Certification Statement form includes:

- The member's name, address and age
- Gestational age of the fetus

- A description of the medical condition which necessitates the abortion service/procedure (for life-endangering circumstances)
- Documentation that the pregnancy was the result of either:
 - a sexual assault/rape or
 - incest
- A description of the services and procedure codes billed
- The name of the facility where abortion services were rendered
- Date the service(s) were rendered
- A signature by the physician (certification in writing) that based on their professional judgement, the abortion (including abortions for life-endangering circumstances and those for the purpose of terminating a pregnancy caused by an act of rape or incest), are medically necessary services

Additional Documents Required to Confirm Life-Endangering Circumstances

In addition to the Abortion Certification Statement form, at least one of the following items, providing additional supporting documentation that confirms life-endangering circumstances, must be attached:

- Hospital admission summary
- Hospital discharge summary
- Consultant findings and reports
- Laboratory results and findings
- Office visit notes
- Hospital progress notes



Providers billing on the CMS 1500 claim form must use the appropriate procedure/diagnosis codes and **must** include the G7 modifier (termination of pregnancy certified as resulting from rape, incest, or a life-threatening circumstance) on the claim.

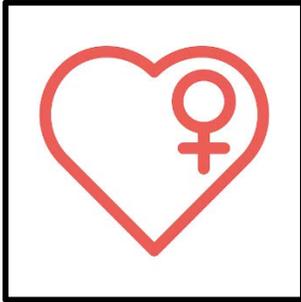
Providers billing on the UB-04 claim form must use the appropriate procedure/diagnosis codes and must include the **most appropriate condition code** on the claim from the list below:

- AA Abortion Due to Rape
- AB Abortion Done Due to Incest
- AD Abortion Due to Life Endangerment

For service provision, on or after November 1, 2017, only the Department Certification Statement Forms will be accepted with attached documentation for abortion-related claims. Claims must be submitted with required documentation attached, or they will be denied.

Sterilization Consent Forms and Partial or Unilateral Reproductive Tissue Surgical Procedure Claim Requirements

Voluntary sterilizations



Sterilization (i.e. tubal ligations, tubal occlusion and vasectomies) for the purpose of family planning is a benefit of the Colorado Medical Assistance Program when the intent of the service is to provide a permanent, irreversible procedure, preventing consenting individuals from becoming pregnant or fathering a child. Submission of family planning sterilization claims must include evidence of informed consent by providing an accurately completed MED-178 consent form with all related claims. The [MED-178 form](#) is available under the Sterilization Consent Forms section of the [Provider Forms](#) web page. Federal regulations require strict compliance with the requirements for completion of the MED-178 consent form or claim payment is denied. Claims that are denied because of errors, omissions, or inconsistencies on the MED-178 may be resubmitted if corrections to the consent form can be made in a legally acceptable manner. Any corrections to the member's portion of the sterilization consent must be approved and initialed by the member.

All sterilization-related claims (including claims for the hospital, anesthesiologist, surgeon or assistant surgeon) must be submitted and include the family planning modifier (FP) and an attached copy of the Med-178 consent form.

General requirements for sterilization procedures include the following:

- The individual must be at least 21 years of age at the time the consent is obtained.
- The individual must be mentally competent to consent for sterilization.

The individual must voluntarily give informed consent as documented on the MED-178 consent form and informed as specified in the "Informed Consent Requirements", described in the Obstetrical Care billing manual, located under the CMS 1500 section of the [Billing Manuals](#) web page.

At least 30 days but not more than 180 days must pass between the date of informed consent and the date of sterilization with the following exceptions:

- Emergency Abdominal Surgery
- Premature Delivery

For more specific information related to sterilization billing please refer to the Obstetrical Care billing manual, located under the CMS 1500 section of the [Billing Manuals](#) web page.

Billing for Unilateral or Partial Reproductive Tissue Surgeries

Many diagnoses, procedure and surgical codes do not specify whether a procedure or treatment is bilateral/unilateral or complete/partial (such as with the CPT code 58720 - Salpingo-oophorectomy, complete or partial, unilateral or bilateral). To prevent claims for partial and/or unilateral procedures from triggering sterilization associated claim edits and the requirement for an attached [Med 178 Sterilization Consent form](#), partial or unilateral procedures (if not intended for a sterilization) must include the treatment location/site by utilizing the right (RT) or left (LT) modifier with these claims. Since the intent of unilateral or partial procedures are NOT normally performed for a sterilization, the FP modifier should not be included on these claims.

Contact Melanie Reece at Melanie.Reece@state.co.us or 303-866-3693 for questions or additional information.

Outpatient Physical and Occupational Therapy Providers

Exceeding 48 Units



Effective December 1, 2017, the hard limit of 48 units per 12-month period for adult rehabilitative and habilitative outpatient physical and occupational therapy (PT/OT) can be exceeded with an approved Prior Authorization.

Contact [EQ Health Solutions](#) for details regarding the prior authorization process.

Contact Alex Weichselbaum at Alex.Weichselbaum@state.co.us for policy questions and concerns.

Pharmacy Providers

Bowel Preparation Agents: Monthly Quantity Limit

Effective November 1, 2017, certain prescription laxative products will have a quantity limit of two (2) packages per month. If a member needs more than two (2) packages in one month then a prior authorization will be required.

The associated prescription laxative drug names are:

- Colyte
- Gavilyte-C
- Gavilyte-H
- Gavilyte-N
- Gialax
- Golytely
- Moviprep
- Peg-Prep
- Trilyte



Contact Kristina Gould at Kristina.Gould@state.co.us for further information.

Total Annual Prescription Volume (TAPV) Survey

Myers and Stauffer completed the TAPV survey of pharmacy providers as of October 31, 2017. The prescription volume information submitted by most pharmacy types will be used to determine their dispensing fee for the 2018 calendar year. Pharmacies which meet the regulatory definition of a Government or Rural Pharmacy will have their dispensing fee determined by their pharmacy type (per 10 CCR 2505-10, Sections 8.800.1 and 8.800.13). If you are not a government or rural pharmacy and did not submit a TAPV form to Myers and Stauffer, please contact the Pharmacy Section at Colorado.SMAC@state.co.us.

Drug Utilization Review (DUR) Updates

Check out the most recent [DUR Newsletter!](#)

Contact a specialist about complex patients in the areas of child/adolescent psychiatry or pain management by emailing SSPPS.co-dur@ucdenver.edu. Provider-to-provider telephone consults are available with a Child/Adolescent Psychiatrist or a Pain Management Specialist free of charge for Health First Colorado members.

The next DUR meeting is scheduled for November 7, 2017, and the following drug classes will be covered, among other individual agents TBD:

anti-emetics, newer generation antidepressants, anti-herpetic agents, oral anti-platelets, epinephrine products, oral fluoroquinolones, pancreatic enzymes, proton pump inhibitors, pulmonary arterial hypertension agents, targeted immune modulators, triptans, agents for Hepatitis C infection

If interested in providing testimony for agents within these classes, see the [DUR web page](#). The formal [agenda](#) is posted.

For more information about the DUR's activities, please visit the [DUR web page](#) or email SSPPS.co-dur@ucdenver.edu.

Upcoming Holidays

Holiday	Closed Offices/Offices Open for Business
Veterans Day (Observed) Friday, November 10	State Offices, DentaQuest, 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 will be open.
Thanksgiving Day Thursday, November 23	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. Friday, November 24, State Offices, DentaQuest, DXC and the ColoradoPAR Program will be open.

Holiday	Closed Offices/Offices Open for Business
Christmas Day - Monday, December 25	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

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