COLORADO
Department of Health Care Policy & Financing

Provider Bulletin

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Did You Know?

Do you know how to tell when a claim was received by the fiscal agent or what type of claim it was? The first two digits of the Internal Control Number (ICN) specify the region code, which indicates the claim type. The next five digits give the year and Julian date the claim was received. Refer to the following documents, located on the DXC and interChange Resources web page, for more information:

- Internal Control Number (ICN) Information Sheet (located under "Quick Guides")
- Region Code Information Sheet (located under "Quick Guides")
- Julian Calendar (located under "For Reference")

All Providers

Timely Filing Frequently Asked Questions (FAQs)

The following FAQs focus on common issues providers ask when trying to better understand the rules and exemptions for timely filing. Additional information on timely filing is also available in the billing manuals, available on the Billing Manuals web page.

What is the deadline for meeting timely filing requirements?

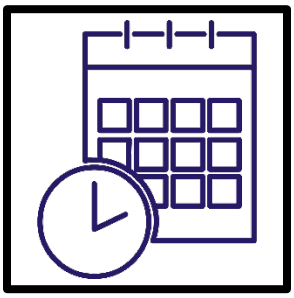
The Department of Health Care Policy & Financing (the Department) has extended timely filing to 240 days from the date of service (DOS). Therefore, the traditional 120-day window to file a claim is no longer applicable until May 1, 2018.

What date is used when considering timely filing deadlines?

A claim is considered filed when the fiscal agent documents receipt of the claim.

Improving health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.

What should providers do if the initial 240-day window for timely filing is expiring?



If the claim is nearing 240 days the provider should submit the claim, even if the result is a denial.

How can a provider qualify for a timely waiver (override)?

There are reasons that a provider may qualify for a timely waiver. If any of the following scenarios apply but are still within the 240-day window, a waiver is not needed and the provider only needs to resubmit the claim.

Please note that providers always have **at least** 240 days from the DOS to submit the claim. A timely filing waiver is only needed if the dates of service have exceeded 240 days.

Member Eligibility Delays

1. If there is a load letter attached, dated within 240 days of the received date. Load letters are only granted for backdated eligibility.
2. If there is a letter of delayed eligibility notification dated within 365 days of the DOS.

Enrollment Delays

3. If there is an enrollment letter attached for a new enrollment, dated within 240 days of the received date.
4. If there is an enrollment letter attached, for a backdate, dated within 240 days of the received date.

Previous Submissions

5. If there is a Return to Provider (RTP) letter attached dated within 60 days of the received date.
6. If the original timely filing period expires, the next submission must be received within 60 days of the last action. Providers can reference the past ICN within the 60-day window following the 240-day timely filing window.

Primary Insurance Delays

7. If there is a Medicare Explanation of Benefits (EOB) attached with an EOB date within 120 days, if there is a Third Party Liability (TPL) paid or denial date within 60 days. Currently the system is not recognizing the EOB date to automatically override timely, so the EOB will need to be attached via the provider portal for manual review, until the issue is resolved. Providers still have the initial 240-day period.

What is the 365-day rule?

The 365-day rule is the final deadline for filing a claim for TPL. The initial claim must be filed within at least 365 days of the DOS. This rule only applies to claims which have a primary commercial insurance.

How does timely filing apply to adjustments and voids?

If a claim is an adjustment and the provider is returning money, or if the provider is requesting an adjustment that does not change the reimbursement amount, timely filing does not apply. However, if the claim is an adjustment to request additional reimbursement, timely filing does apply.

If a provider submits a claim that is denied and resubmits the claim multiple times in attempt to correct the claim, could a resubmitted claim get denied because it was sent after a timely filing deadline, or is there a way to identify that the provider sent the original claim in a timely manner?

Providers must submit the initial claim within the 240-day timely filing extension from the date of service. The provider then must resubmit the claim within the 60-day window after the initial 240-day extension expires. On that resubmittal, the provider may provide the ICN, which would reference that the initial claim was filed in a timely manner.

What if my enrollment was delayed and that delay took a year?

In most cases, a provider's enrollment can be backdated 240 days from the date of enrollment approval if the provider was licensed continuously through those dates. At that point, the 240-day timely filing window would begin for filed claims. Providers can use their enrollment approval letter as an acceptable timely filing waiver by attaching it to claims submitted after the approval effective date.

Important Information for Child Health Plan *Plus* (CHP+) Providers

If Congress does not renew federal funding, CHP+ in Colorado will end on January 31, 2018.

- As of today, there are **no changes to CHP+ benefits.** Please continue to make and keep appointments for the CHP+ members your practice serves.

- Even if Congress does not act to renew CHP+ funding, enrollment and redetermination of CHP+ members will continue through January 31, 2018.
- Congress can pass a law at any time to renew federal funding for CHP+, but **there is no guarantee** that they will.

Visit the Future of CHP+ web page and click the CHP+ Provider Resources button to find resources that can be used to communicate with CHP+ members about the status of the program.

ColoradoPAR Updates

Contact eQHealth Solutions® First for Prior Authorization Request (PAR) Related Issues

PAR-related questions and issues are common among the over 40,000 providers serving Health First Colorado (Colorado's Medicaid Program) members. These issues range from simple to complex, and can be time consuming to diagnose and resolve.

Many providers contact the Department directly when they experience PAR-related issues, rather than eQHealth Solutions®, which can delay resolution.

EQHealth Solutions®, the vendor for the ColoradoPAR Program, is uniquely qualified to diagnose and resolve most PAR-related issues. Contact eQHealth Solutions® at co.pr@eqhs.org or 888-801-9355 for questions or PAR-related issues.

Nurse Advice Line

At times, members may have difficulty determining the appropriate type and level of care needed based on their unique medical situation.

The Health First Colorado Nurse Advice Line helps members determine the appropriate course of action when faced with health issues. The Nurse Advice Line provides Health First Colorado members 24/7 free access to medical information and advice in both English and Spanish by calling 1-800-283-3221.

Key Nurse Advice Line features include:

- Members can call free of charge, 24 hours a day, 7 days a week, 365 days a year
- Registered Nurses will answer members' medical questions, provide care advice, and help determine whether they should be seen right away
- Members can receive help with medical conditions, such as diabetes or asthma
- Members can receive advice on the type of doctor that may be right for a particular medical condition

The Nurse Advice Line has proven to be tremendously helpful for members. Please take a moment to ensure that offices, and the Health First Colorado members treated, are aware of the Nurse Advice Line and its benefits.

Additional information on the Nurse Advice Line can be found on the Nurse Advice Line web page.

Co-Pay Limit for Health First Colorado Members

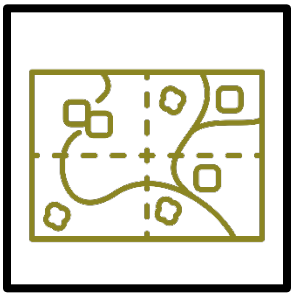
Health First Colorado now notifies members by mail when their household has met its co-pay maximum for the month. The co-pay maximum is 5 percent of the household monthly income.

The head of household will receive a letter stating that the household has reached the monthly limit and how the limit was calculated. Once a member has paid 5 percent 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.

Additional information can be found on the Health First Colorado website, on the Health First Colorado Co-Payments web page.

Colorado Health IT Roadmap Approved, OeHI Seeks Public Comment on Key Roadmap Initiative

Colorado's Health IT Roadmap— a 16 month-long collaborative effort led by the Office of eHealth Innovation (OeHI) and steered by the eHealth Commission— has concluded its planning phase. The Roadmap was developed with input from over 1,000 stakeholders from many Colorado communities, both rural and urban. Colorado's Health IT Roadmap has been reviewed and approved by both the Governor's Office and eHealth Commission, and now enters the implementation phase. To reserve a printed copy of Colorado's Health IT Roadmap, follow this link.



The Colorado Health IT Roadmap will provide strategic direction for the state of Colorado (both state and non-state entities), in ways that will most effectively support Colorado's Triple Aim – best care, best health, best value. The Roadmap identifies sixteen (16) initiatives which will help to advance the health information infrastructure of Colorado.

One of the Roadmap initiatives is to improve person identity matching (through a master patient index, or MPI), in order to better match information, coordinate and improve care, reduce costs, and improve data integrity. OeHI has released a draft Request for Proposal (RFP) for a Master Patient Index for public comment. The public comment period was twenty (20) days beginning on November 3, 2017. OeHI requested that all comments be submitted by November 23, 2017; the draft RFP is available online. A summary of comments will be presented at an upcoming eHealth Commission meeting.

OeHI continues to advance work in several other areas identified as priorities for the Roadmap, such as electronic clinical quality measures, a program management office, and a statewide master provider directory. The eHealth Commission will continue to advise and guide the implementation, (and annual updating) of Colorado's Health IT Roadmap as our state continues to advance the health of all Coloradans.

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 January 2018. Please find more information on the CMS NCCI website.

CMS 1500 and UB-04 Paper Claim Form Reminder

As part of the transition to our Fiscal Agent, DXC Technology, Health First Colorado hopes to have all claims processed as quickly and efficiently as possible. For this to occur, as of April 17, 2017, only original **red ink** claim forms submitted to the Fiscal Agent will be accepted.

All black and white CMS 1500 and UB-04 claim forms received on or after April 17, 2017, will be returned to providers unprocessed. This includes claims submitted as originals, resubmissions, reconsiderations, appeals, and adjustments.

Optical Character Recognition (OCR) scanners are better able to accept the claim form if it is in OCR red ink. For the form to be read by a scanner, the form must be in OCR red ink. This creates a "cleaner" image that is easier and faster to process with data capture automation such as ICR/OCR (Intelligent Character Recognition/Optical Character Recognition) software. By complying with this guidance, providers will see their paper claims process faster and with fewer entry errors. As a reminder, providers who submit claims through the Provider Web Portal can send attachments with the claims.

This article was originally published in the May 2017 bulletin.

General Hospitals, Radiology, Independent Laboratories, Clinics, Pharmacies

Co-Pay Policy Update

In accordance with SB17-267, the Department plans to change the following co-pay policies effective January 1, 2018:

1. The outpatient hospital visit co-pay amount will increase from $3 per visit to $4 per visit
2. Non-emergent use of the hospital emergency room in an outpatient hospital setting will increase from $3 per visit to $6 per visit

3. The pharmacy co-pay amount will change from $3 for brand name and $1 for generic drugs, to $3 for all new and refill prescriptions.

The emergency status of an Emergency Department visit must be determined by the hospital/provider. The Colorado interChange will deduct a $6 co-payment amount from the UB-04 (837I) claim based on the presence of Revenue Code 0456 or Revenue Code 0459 on the claim for all co-pay eligible members.

Additional Co-Pay Information

Effective March 2017, the Colorado interChange began correctly deducting a $1 co-pay from radiology claims in accordance with administrative rule 10 CCR 2505-10 8.754.1.L. If a member receives a radiology service from an outpatient hospital, it is possible for that member to have two co-payments if there are two claims received by the Colorado interChange: one co-pay for the outpatient hospital visit claim, and one co-pay for the radiology claim.

All providers should be aware that members are liable for no more than 5 percent of their monthly household income towards co-payments per month. The Provider Web Portal will display whether a member is co-pay eligible as of the date it is checked. Further details can be found on the Health First Colorado website, on the Health First Colorado Co-Payments web page.

Home and Community Based Service (HCBS) Providers

Specialty Code Update – Community Transition Services (CCT)

Specialty codes for Supported Living Services (SLS), Elderly, Blind and Disabled (EBD), and Community Mental Health Services (CMHS) are unavailable as enrollment choices for CCT services. They are currently only available to the Brain Injury (BI) population, but should also be applicable to the EBD, CMHS and SLS populations. DXC and the Department are working to allow the following two specialties to be available:

- 738 – Independent Living Skills Training CCT – EBD - CMHS
- 739 – Independent Living Skills Training CCT – SLS

The H2014 procedure code will still require prior authorization. The UC modifier will still be used to indicate CCT-specific populations. Providers rendering CCT services to BI, EBD and CMHS members will need to add this specialty to their existing enrollment profile, but will not need to re-enroll. This change can be done via the Provider Web Portal on the Specialty and Contact Information Changes step of Provider Maintenance.

Contact Derek Martin at Derek.Martin@state.co.us for additional information.

Hospital Providers

General Updates

Outpatient Hospitals

Distinct Procedure Modifiers (Modifiers XE, XP, XS, XU)
The Department has worked with 3M to allow distinct procedure modifiers XE, XP, XS and XU to override the

consolidation function for outpatient hospital claims describing multiple distinct procedures. Currently, modifier 59 can be used to report distinct procedures, but the additional modifiers will allow for more granular reporting and also generate extra payment. Modifier 59 can still be utilized for the reporting of distinct procedures on an outpatient hospital claim and override consolidation. The modifiers XE, XP, XS and XU will be effective for claims with DOS on or after January 1, 2018.

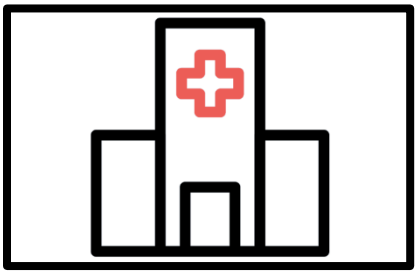
Biweekly Enhanced Ambulatory Patient Group (EAPG) Meetings
Beginning September 22, 2017, the Department began hosting biweekly meetings dedicated to the EAPG methodology. These meetings are intended to be an informal discussion where the Department and its hospital providers can discuss issues relating to billing, payment, or the EAPG methodology in general. For recordings of previous meetings and any related materials, as well as the current schedule for future meetings, please visit the Outpatient Hospital Payment web page. The next meeting will be hosted by the Department on December 1, 2017 from 2:00 – 4:00 p.m.

****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.

Inpatient Hospitals

Inpatient Claim Mass-Adjustment Coordination – System Change-Over Claims
A test mass adjustment was conducted on September 8, 2017. Based on the results of that test, the Department will be submitting a new mass adjustment during November/December to reprocess all claims that are likely to correctly adjudicate. The Department is currently exploring strategies to address claims that contain errors or changes between the old and new system that prevent the claim from correctly adjudicating. Our goal is to provide an update at the next Hospital Engagement Meeting on Friday, January 12, 2018, from 9:00 a.m. – 12:00 p.m., or through the Hospital Engagement Meeting newsletter if necessary.



Please sign up to receive the Hospital Engagement Meeting newsletters.

Contact Diana Lambe at Diana.Lambe@state.co.us if you have any concerns about any of the above Inpatient Hospital 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, December 1, from 1-2 p.m.

Contact Elizabeth Quaife at Elizabeth.Quaife@state.co.us to sign up for invitations to the monthly meetings.

****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 of the Hospital Engagement Meetings web page.

All Hospital Providers

Hospital Engagement Meetings
The Department has had multiple Hospital Engagement meetings in 2017 to discuss current issues regarding payment reform and operational issues moving forward. The next meeting is scheduled for 9:00 a.m. - 12:00 p.m., Friday, January 12, 2018, at 303 East 17th Avenue, Denver, Conference Room 7B & 7C.

Please sign up to receive the Hospital Engagement Meeting newsletters.

The agenda for upcoming meetings will be available on the Hospital Engagement Meetings 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 Meetings 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 if you have any questions.

Community Clinics with Emergency Centers

Hospital Stakeholders

The Department extends its gratitude for participation in the September 1, 2017, stakeholder meeting regarding the creation of a new Medicaid provider type for facilities licensed by the Colorado Department of Public Health and Environment (CDPHE) as "Community Clinics" or "Community Clinics with Emergency Centers" (collectively, "CCs/CCECs") that are hospital-owned and Medicare-certified.

As discussed in the meeting, the Department is pursuing a multi-stage process for seeking approval and implementing this proposal, as follows:

First, the Department is interested in learning more about facilities licensed as CCs/CCECs. At the September 1 meeting, the Department specifically asked hospital providers for data on:

- The locations of their CCs/CCECs; and
- Feedback on non-claims data sources the Department should examine in developing a future payment methodology.

Second, the Department will create and submit a State Plan Amendment seeking federal approval for the creation of a new CC/CCEC provider type, the review of which may take CMS 90 days or more.

Third, following federal approval, the Department will draft and propose rules creating a CC/CCEC provider type. These rules are subject to approval by the Medical Services Board (MSB) in accordance with the Colorado Administrative Procedure Act (APA).

Fourth, following MSB approval of the CC/CCEC provider type, qualifying CCs/CCECs will enroll under the new provider type. Once enrolled under the new provider type, the Department will begin collecting and analyzing claims data specific to these hospital-owned, Medicare-certified CCs/CCECs.

Fifth, the Department will use the claims data collected, and any other data sources determined to be relevant to this inquiry, to develop a payment methodology for hospital-owned, Medicare-certified CCs/CCECs. Any changes to the payment methodology for such CCs/CCECs will also be subject to the MSB approval through rulemaking. Thus, until a new payment methodology is approved, there will be no changes to reimbursement methodology for hospital-owned, Medicare-certified CCs/CCECs, which currently bill under the parent hospital's NPI.

Sixth, no changes are currently contemplated for Off Campus Locations (OCLs) of hospitals and those locations will be able to continue to bill for services.

As such, the existing payment methodology for hospital-owned, Medicare-certified CCs/CCECs is not temporary through December 31, 2017, as suggested in Provider Bulletin B1700395 (February 2017). The existing payment methodology for hospital-owned, Medicare-certified CCs/CCECs will remain in place until the Department completes its work on this subject and new reimbursement rules are adopted by the MSB pursuant to the APA.

As a reminder, and separate and apart from the process delineated above, please note that all CCs, CCECs, and OCLs that provide services to Medicaid beneficiaries must "enroll separately each location from which they provide services." 10 CCR 2505-10, § 8.125.6.A.

Contact Matthew Colussi at Matthew.Colussi@state.co.us for more information.

Nursing Facilities/Skilled Nursing Facilities/Intermediate Care Facilities

Important NF/SNF/ICF Provider Updates

New Nursing Facilities Operations Specialist in the Office of Community Living
Please update your contact information from Susan Love to Patricia Arellano at Patricia.Arellano@state.co.us and 303-866-4372. Patricia is responsible for Post Eligibility Treatment of Income (PETI) approvals, Change of Ownerships (CHOWs) and other duties previously handled by Susan Love.

New Dear Administrator Letter (DAL) issued July 1, 2017 Regarding Med-13 Cost Report Extensions

This DAL reminds providers about the Med-13 Cost Report submission rule located at 10 CCR 2505-10, Section 8.442. If the provider needs an extension on the submission date of their Med-13 Cost Report, it must be requested in writing 10 days prior to the submission due date and must document the reason for the extension. The DAL identifies valid and invalid reasons. The Department may grant up to a 30-day extension for valid reasons. Extension requests are sent to Patricia Arellano via email at Patricia.Arellano@state.co.us.

The following supersedes the September Provider Bulletin information.

UB-04 Nursing Facility Billing Manual Updated

Please refer to the updated Nursing Facility Billing Manual, located on the Billing Manuals web page. Changes appear in the Revenue Codes section, UB-04 Paper Claim Reference Table (Type of Bill and Revenue Code) section, the PETI section and the CHOW section. Contact Cathy Fielder at Cathy.Fielder@state.co.us with any questions.

Type of Billing (TOB) notes (see manual for TOB definitions):
For Nursing Facility – Provider Type 20
For Specialty Codes: 382 (HBU), 392 (NF/SNF), 392 (QMB Only) use TOBs 21x, 22x, 23x
For Specialty Code: 396 (Swing Bed) use TOBs 28x, 22x, 23x

For Intermediate Care Facility – Provider Type 21
For Specialty Code: 383 (ICF Level I) PRIVATELY OWNED use TOBs 65x, 22x, 23x
For Specialty Code: 394 (ICF Level II) STATE OWNED used TOBs 66x, 22x, 23x

Accommodation Revenue Codes (i.e., 129) can be billed with TOBs 21x, 28x, 65x or 66x.

PETI/IME notes:

Every PETI/IME request must be submitted through the Provider Web Portal for prior authorization. This includes any requests under $400. PETIs will only pay if a prior authorization exists in the billing system.

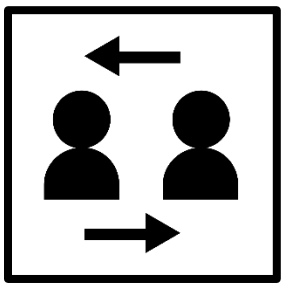
If in possession of a paper PETI/IME request approved prior to March 1, 2017, that has not yet been billed to Medicaid for reimbursement, it must be entered in the portal and all documentation attached to the request. Then bill on the next billing cycle with a patient liability amount for reimbursement.

Tips on submitting PETI/IME requests:
- Only one service request (revenue code) is permitted per request.
- In the Service Detail box, make sure the **code type** is **revenue**. There are no procedure codes associated with a NF PETI/IME. Request will deny if a procedure code is listed.
- **Only use one entry line per request**.
- In the Medical Justification box, type in an explanation for the total dollar amount. Examples:
  - Start note with: New, Replacement for, Second Request or Other
  - Acupuncture treatments for $XX per treatment, for two months – November and December
  - Health Insurance Premium $XX per month, for six months – January through June
  - Hearing services: hearing aids (left/right), warranty with date and other services listed on invoice
  - Vision frames and lens, DOS
- Upload all documents as a single document to the first line of the request. **Example:** if there are multiple treatments on multiple invoices, upload documents as one packet, not individual pages. Currently, multiple attachments cannot be retrieved for review by the Department.

Once the PETI/IME is approved, bill the PETI/IME on the next billing cycle with a patient liability amount. Do not adjust prior paid claims to add the approved PETI amount. System errors are occurring when trying to adjust prior paid claims for PETIs.

A PETI/IME activity tracking log must be kept by the nursing facility for each resident. See manual for details.

Contact Patricia Arellano at Patricia.Arellano@state.co.us, with the PA tracking number for review, for further questions.



Change of Ownership notes:
- **The new owner must apply in the Colorado interChange system before beginning to bill for rendered services.** The application requires a Colorado Department of Public Health and Environment (CDPHE) license to be attached (along with the completion of the other application requirements) before the

application will be approved by the Department.

- **Previous owners should not transfer their NPI and other billing information to the new owner. The new owner must have their own billing information in order to receive payment from Health First Colorado.**

Contact Patricia Arellano at Patricia.Arellano@state.co.us and Cathy Fielder at Cathy.Fielder@state.co.us with the application tracking number (ATN) so the Department can monitor the progress of the application and approve the application.

Outpatient Physical and Occupational Therapy Providers

Update to Billing Manual

The Physical and Occupational Therapy (PT/OT) policy and billing manual, located under the CMS 1500 drop-down section on the Billing Manuals web page, has been revised. Please note these policies apply to users of the UB-04 institutional claim form if they provide outpatient therapy (i.e. outpatient hospitals and rehabilitation facilities).

Changes include:

- General consolidation of policy from the discontinued outpatient physical and occupational therapy benefit coverage standard. Applicable policies from that document have been carried over to the policy manual for permanent location.
- Reorganization of content in accordance with removal of hard-limit 48 units for adult members.
- Updated section of 'medical necessity' to align with rule language (page 4).
- Updated section of 'documentation requirements' (page 4).
- Update to the visit/encounter notes section of 'documentation requirements.' Documentation must follow the SOAP format (page 6).
- Update to the coding table for 2018 HCPCS changes (page 12).

Contact Alex Weichselbaum at Alex.Weichselbaum@state.co.us with any questions or policy concerns.

All Medication-Prescribing Providers and Pharmacies

Drug Utilization Review (DUR) Updates

Need to speak with a specialist about complex patients in the areas of child/adolescent psychiatry or pain management? If the answer is yes, then email 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 Medicaid members.

The next DUR meeting is scheduled for February 2018 (date TBD) and the following drug classes will be covered, among other individual agents TBD:

Neurocognitive Disorder Agents, Atypical Antipsychotics, Growth Hormones, Insulin Products, Intranasal Corticosteroids, Leukotriene Modifiers, Agents for Multiple Sclerosis, Ophthalmic Allergy, Sedative Hypnotics, Statin and Combinations

If interested in providing testimony for agents within these classes, see the Drug Utilization Review Board web page. The formal agenda will be posted 30 days prior to the meeting on the DUR Home Page.

For more information about the DUR's activities, visit the Drug Utilization Review Board web page or email SSPPS.co-dur@ucdenver.edu.

Pharmacy Providers

Pharmacy Provider Updates

Opioid Overdose Treatment

Health First Colorado members will be able to receive Narcan (naloxone) nasal spray without a prior authorization beginning December 1, 2017. A prescription is still required for reimbursement from Health First Colorado (either by standing order or by a prescription written for the member by their prescribing health care professional). Prior to this change, only naloxone vials and naloxone prefilled syringes, which may be used in conjunction with a nasal atomizer, were available without a prior authorization. For more information please see the "Opioid agonist/antagonist" section on the pharmacy coverage document Appendix P, which can also be accessed from the Pharmacy Resources web page. More pertinent information and resources about opioid use and pain management, including a link to the Prescription Drug Monitoring Program (PDMP) can be accessed from the Pain Management Resources and Opioid Use web page.

Dispense as Written (DAW) Override Code Update

DAW 0 is allowed; DAW 1-Brand bypasses generic mandate – only for preferred products; DAW 8-Plan prefers Brand – use for brand name required (BNR) products; DAW 9-Generic is out of stock – call Magellan Rx Management Pharmacy Call Center (1-800-424-5725) if new issue.

The following outlines currently accepted DAW codes:

DAW Code	DAW Description	Action
DAW 0	No Product Selection Indicated	Allow
DAW 1	Substitution Not Allowed by Prescriber	Allow with exceptions Claim submitted with the generic product may pay Drugs with formulary value of BNR will bypass the DAW1 denial and will pay with a DAW1 on the claim
DAW 2	Substitution Allowed – Patient Requested Product Dispensed	Deny
DAW3	Substitution Allowed – Pharmacist Selected Product Dispensed	Deny
DAW 4	Substitution Allowed – Generic Drug Not in Stock	Deny May call helpdesk at 800-424-5725 if emergent situation exists

DAW Code	DAW Description	Action
DAW 5	Substitution Allowed – Brand Drug Dispensed as a Generic	Deny
DAW 6	Override	Deny
DAW 7	Substitution Not Allowed – Brand Drug Mandated by Law	Deny
DAW 8	Substitution Allowed – Generic Drug Not Available in Marketplace	Allow only on select drugs (currently this only applies to Transderm-SCOP patches and Canasa Suppository). The State will update select drugs as often as necessary.
DAW 9	Plan Prefers Brand Name Product	Deny Except for products that are Brand Name Required. DAW 9 will be allowed for BNR products

The Pharmacy billing manual also contains this information, which can be accessed from the Billing Manuals web page.

Unenrolled Providers: New Prescriptions Written by Providers not Enrolled with Health First Colorado will be Denied Starting January 1, 2018

Effective January 1, 2018, new prescriptions written by an unenrolled provider will not be able to be filled through Health First Colorado. Refills written by unenrolled providers will be payable until the prescription expires. PARs will not be able to be processed by Magellan Rx Management Pharmacy Call Center after January 1, 2018, for unenrolled providers. Contact the DXC Provider Services Call Center at 1-844-235-2387 or visit the Ordering, Prescribing or Referring Providers web page for more information.

If a provider does not want to enroll with Health First Colorado, they should begin referring their patients to a provider enrolled with Health First Colorado and the patient will need to receive new prescriptions for their medications needed after January 1, 2018.

After an enrollment or revalidation application is submitted, please use the Provider Next Steps web page. To verify enrollment status, please review pages 135-141 in the Provider Enrollment Manual.

January Preferred Drug List (PDL) Announcement

The following drug classes and their preferred agents will become effective January 1, 2018, for Health First Colorado:

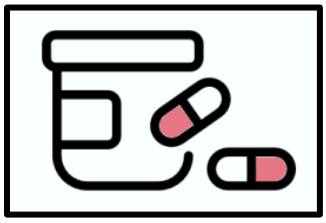
***Hepatitis C agents:** Mavyret and Epclusa

^Anti-emetics: ondansetron tablets, ODT, and oral soln

New Generation Antidepressants: Bupropion IR, SR, XL; Citalopram; Escitalopram tablets; Fluoxetine capsules and soln; Mirtazapine; Paroxetine IR tablets; Sertraline; Venlafaxine IR tabs; Venlafaxine ER capsules

Anti-herpetics (oral and topical): Acyclovir tablet, capsule, suspension; Zovirax cream, Zovirax ointment and Denavir

Oral Anti-platelets: Aggrenox, Clopidogrel, cilostazol, Brilinta



Epinephrine Products: epinephrine auto-injector (generic Epipen)

Non-steroidal anti-inflammatories (NSAIDS) (oral and non-oral): diclofenac sodium IR and SR, ibuprofen suspension and Rx tablets, indomethacin capsule and ER, ketorolac tablet, meloxicam, naproxen EC, naproxen suspension, naproxen Rx tablet, sulindac, Voltaren gel (topical)

Fluoroquinolones: ciprofloxacin tab, Cipro oral suspension, levofloxacin tab

Pancreatic Enzymes: Creon, Zenpep

Proton Pump Inhibitors: Nexium capsules and packets, Omeprazole capsules, Pantoprazole tablets, Prevacid solutab

H Pylori Agents: no preferred

Pulmonary Hypertension Agents: Sildenafil, Adcirca, Letairis, Tracleer, epoprostenol, Ventavis, Orenitram

Targeted Immunomodulators: Enbrel, Humira, Cosentyx (with step)

Triptans: Sumatriptan tablets, Sumatriptan nasal spray and injection, naratriptan tablets, rizatriptan tablets, Relpax, rizatriptan MLT tablets

*Please use new Hepatitis C Prior Authorization Request Form, available on the Pharmacy Resources web page.

Rebatable, over-the-counter (OTC) anti-emetics (pyridoxine and doxylamine) may be covered for a 3-month span with a prior authorization for diagnosis of nausea and/or vomiting associated with pregnancy.

Covered manufacturers include, but not limited to:
OTC Doxylamine 25mg: PERRIGO CO., PERRIGO/GOODSEN, AMERISOURCEBERG
OTC Pyridoxine 50mg or 100mg: MAJOR PHARMACEU, FREEDA VITAMINS

Please see the Preferred Drug List (PDL) and Appendix P, available on the Pharmacy Resources web page, for more information relating to criteria and preferred product status.

Pharmacy and Therapeutics Committee Meeting

Tuesday, January 9, 2018

1:00 – 5:00 p.m.

303 E. 17th Ave

7th floor Conference Rooms ABC

Compound Prescription Vehicles

The early refill edit no longer applies to compounded prescriptions for ingredients other than the pharmaceutical active ingredient. Prior to this change, the non-covered compounding products could hit the early refill edit. For non-covered compounding products (examples: simple syrup, sorbitol solution, Ora-Blend, Ora-Sweet, Ora-Plus, etc.), the early refill edit has been lifted. Refill too soon edits and early refill accumulation edits will apply only to the covered pharmaceutical ingredients in compounds.

Brand - Generic Changes

Effective December 1, 2017, the following brand/generic changes will be implemented for Health First Colorado members:

- Generic Epipen (Mylan epinephrine auto-injector) products will be preferred beginning December 1, 2017. These products will be preferred in addition to the current preferred generic Adrenaclick (Impax and Lineage epinephrine auto-injector) products.

Effective January 1, 2018, the following brand/generic changes will be implemented for Health First Colorado members:

- Brand Adderall IR and brand Ritalin IR will be non-preferred. Generic Adderall IR (amphetamine combo salts) and generic Ritalin IR (methylphenidate IR) will be preferred. Brand Adderall IR and Brand Ritalin IR will require a prior authorization beginning January 1, 2018, to be evaluated for brand medically necessary.
- Effective January 1, 2018, the only preferred epinephrine auto-injectors will be the generic Epipen (Mylan epinephrine auto-injector) products. Generic Adrenaclick (Impax and Lineage epinephrine auto-injector) products will be non-preferred and require a prior authorization.

Please see the current Preferred Drug List (PDL), available on the Pharmacy Resources web page. Please refer to these documents for pharmacy benefit coverage details and prior authorization criteria.

No Cost Sharing for Tobacco Cessation Medications

Beginning November 1, 2017, Health First Colorado will no longer require a co-pay for tobacco cessation medications. A PAR must be submitted in most instances for OTC and prescription medications.

Health First Colorado providers can prescribe any of the seven FDA-approved nicotine replacement therapy (NRT) and non-nicotine containing medications, all of which are on the Medicaid formulary and available to any Health First Colorado member at participating local pharmacies:

- Nicotine patch, nicotine gum, nicotine lozenge, nicotine nasal spray and nicotine inhaler
- Bupropion SR tablets (generic of Zyban) and Varenicline Tartrate tablets (generic of Chantix). This product will be co-pay exempt when a diagnosis code for smoking cessation is on the incoming claim (ICD10 Disease Group=F17; ICD10 Code Z87.891, Z72.0).

Health First Colorado covers tobacco cessation counseling services for clients who smoke or are at risk of smoking, also without co-pay.

Please see the Tobacco Cessation web page for more information.

Contact Richard Delaney at Richard.Delaney@state.co.us for more information.

Physicians, Nurse Practitioners, Certified Nurse-Midwives, Dentists, Physician Assistants

Colorado Medical Assistance Provider Incentive Repository (MAPIR) Accepting Medicaid Eligible Professionals (EPs) and Eligible Hospitals (EHs) Attestations

The Department is reminding providers that the Colorado MAPIR has been open and accepting Medicaid Electronic Health Record (EHR) Incentive Program attestations for Program Year (PY) 2016 as of October 15, 2017. Please refer to the CMS webpage for program requirements. As a reminder, for PY 2016 all providers must attest to objectives and measures using EHR technology certified to the 2014 Edition. If it is available, providers may also attest using EHR technology certified to the 2015 Edition, or a combination of the two.

Contact the Medicaid EHR Incentive Program Coordinator at MedicaidEHR@corhio.org or 720-285-3232 with any further questions.

Providers should refer to the Colorado Regional Health Information Organization (COHRIO) website, or email MedicaidEHR@cohrio.org with any questions or concerns.

University of Colorado School of Medicine

Supplemental Payment for University of Colorado School of Medicine

This statement is notice of a supplemental payment to be made on December 31, 2017, for DOS occurring the second quarter of FY 2016-17 (October 1, 2016 - December 31, 2016). The Department is making this supplemental payment to the University of Colorado School of Medicine in the amount of $30,773,025 for services rendered to Health First Colorado members by physician and other qualified professionals who are employed by the University of Colorado School of Medicine. The supplemental payment amount is based on an appropriation made by the Colorado General Assembly and is limited by an Upper Payment Limit.

Contact Josh English at Joshua.English@state.co.us with any questions or concerns regarding this payment.

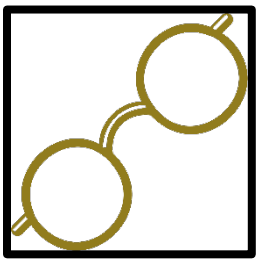
Vision Providers

Billing Guidance for Medically Necessary Eyeglass Frames for Members Under 21 Years Old

The October 2017 Provider Bulletin stated that the new rule outlining vision services coverage allows coverage for eyeglass frames as outlined in 10 CCR 2505-10 section 8.203.4.B. A member who is eligible for eyeglasses may receive frames as covered by Health First Colorado. If a member wishes to purchase frames that are a non-medically necessary upgrade from the provider's base model, the frames will not be covered by Health First Colorado.

Health First Colorado covers all medically necessary items and services for members under age 21, per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) regulations outlined at 10 CCR 2505-10 8.280. A

definition of EPSDT medical necessity is found at 10 CCR 2505-10 8.280.1, which includes the following language:



"Medical Necessity means that a covered service shall be deemed a medical necessity or medically necessary if, in a manner consistent with accepted standards of medical practice, it:

1. Is found to be an equally effective treatment among other less conservative or more costly treatment options, and
2. Meets at least one of the following criteria:
    a. The service will, or is reasonably expected to prevent or diagnose the onset of an illness, condition, primary disability, or secondary disability.
    b. The service will, or is reasonably expected to cure, correct, reduce or ameliorate the physical, mental cognitive or developmental effects of an illness, injury or disability.
    c. The service will, or is reasonably expected to reduce or ameliorate the pain or suffering caused by an illness, injury or disability.
    d. The service will, or is reasonably expected to assist the individual to achieve or maintain maximum functional capacity in performing Activities of Daily Living."

According to the rule for Durable Medical Equipment (DME) at 10 CCR 2505-10 8.590.2.Q, items used for exercise or participation in sports are excluded from coverage. Upgraded eyeglass frames provided for these purposes do not meet criteria for medical necessity.

If a provider determines that an upgraded frame is medically necessary for an individual under 21 according to this definition, Health First Colorado will cover the item. Providers are not allowed to bill members for covered services and items.

To bill for such frames, providers must use the CPT code V2025 to indicate an upgraded frame. Please see the Health First Colorado Fee Schedule for the rate associated with V2025. The current rate for V2025 will be effective as of October 1, 2017. Providers may bill claims for medically necessary upgraded frames back to October 1, 2017.

Providers must also keep on file documentation of medical necessity for upgraded frames. Client medical records are subject to audit.

Contact vision policy specialist Elizabeth Freudenthal at Elizabeth.Freudenthal@state.us.co or 303-866-6814 with any questions about this guidance.

Upcoming Holidays

Holiday	Closed Offices/Offices Open for Business
Christmas Day – Monday, December 25, 2017	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.
New Year's Day – Monday, January 1, 2018	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.

Holiday	Closed Offices/Offices Open for Business
Martin Luther King, Jr. Day – Monday, January 15, 2018	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.

DXC Contacts

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

Provider Services Call Center
1-844-235-2387

DXC Mailing Address
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Denver, CO 80201