COLORADO
Department of Health Care Policy & Financing

Provider News & Resources

August 29, 2022 Issue 54

In This Issue:

Did You Know?

Provider Enrollment Applications

Provider enrollment applications can include a "Requested Effective Date" of up to 365 days prior. Applications that include an earlier effective date must also include insurance coverage and licensure (if needed) for that time period.

For example, an application submitted on July 1, 2022, with an effective date of November 1, 2021, must include insurance coverage from November 1, 2021, forward. Applications submitted without continuous insurance coverage will be returned for corrections.

3014 and EAPG Error Code 3102

Resolved Known Issue:
Claims Denying EOB 4000

Resolved Known Issue:
Hospital Claims with Split Eligibility

Featured Resources:

August 2022 Provider Bulletin (B2200481)

Upcoming Holidays:

Labor Day:
Monday, September 5, 2022

State Offices, the ColoradoPAR Program, DentaQuest and Gainwell Technologies will be closed.

Vaccination Rates Update

Effective July 1, 2022, claims for the following Common Procedural Terminology (CPT) vaccine product codes will be reimbursed at higher rates: 90620, 90632, 90636, 90715, 90740, 90747, and 90750.

New rates are available on the Immunization Rate Schedule. Claims with a date of service of July 1, 2022, or later will be reprocessed. Claims submitted at the previous lower rate must be adjusted in order to receive the higher rate.

Contact Christina Winship at Christina.Winship@state.co.us with any questions.

National Provider Identifier (NPI) Reminder

Providers are reminded that notices will be sent to complete revalidation six months before the revalidation date. Providers should submit a revalidation application before that date.

The revalidation date can be found on the Revalidation web page in the Revalidation Resources box by clicking on "Provider Revalidation Dates Spreadsheet". In accordance with the Colorado National Provider Identifier (NPI) Law, organizational healthcare providers must have a unique NPI for each provider type and location **before** revalidating, which requires submission of a maintenance update to add the new unique NPI.

Additional outreach will be made to notify providers with shared NPIs past their revalidation date.

Administrative Password Reset Process Change

The following are process changes for providers requesting an administrative password reset. Requests for an administrative password reset for the provider web portal must still be submitted in writing by submitting a letter on company letterhead to noreply.providerwebportal@gainwelltechnologies.com but with the following changes:

1. Providers must give both their NPI and Health First Colorado ID
2. Letter must be dated within last 30 days

When all documentation has been received, verification calls will be made to confirm that the request is valid and all information is accurate. Once the information is confirmed, the administrative password reset will be sent.

Password resets must have verbal authorization from the provider before completion, which may extend the processing time.

Contact the Provider Services Call Center with questions or refer to the Provider Web Portal Administrative Password Reset Process Quick Guide for more information.

Electronic Funds Transfer (EFT) Process Change

A change has been made for any providers who wish to change their bank account information for payments from Health First Colorado. Additional documentation will be required from the providers to reduce risk of fraud. Gainwell Technologies will also be calling the provider directly to verify that the change has been requested.

EFT changes must include the following attachments when submitting a provider maintenance update:

1. Letter from the provider on letterhead with the following information:
    - Business or individual provider name
    - Must be dated within six months of the submission date
    - Name of the bank
    - Account and routing number

- Must be hand-signed *by an authorized representative*

2. One of the following two options are also required:
    1. Voided Check
        - A photocopied or scanned image of an actual check is required. It cannot be an image from a website.
    2. Letter from the bank verifying the account and routing number

Use the current EFT Request process to make these submissions through the Provider Web Portal. Visit the Updating Electronic Funds Transfer (EFT) - Provider Web Portal Quick Guide for more information.

After receiving the EFT information, validation calls will be made using the contact information on file. Please make sure the information is current. Changes must have verbal authorization from the provider before completion, which may extend the processing time.

Contact the Provider Services Call Center with questions.

Deficit Reduction Act of 2005 due November 1, 2022

Section 6032 of the Deficit Reduction Act of 2005 (DRA) requires providers who meet the definition of entity and who make or receive annual Medicaid payments of $5 million or more to establish and disseminate certain written policies for preventing and detecting fraud, waste and abuse. The entities must also provide information to employees and contractors about the Federal False Claims Act and other applicable federal and state false claims laws, the administrative remedies for false claims and statements, and the "whistleblower" protections afforded under such laws.

For Federal Fiscal Year 2022 (FFY2022) providers who are subject to Section 6032 must submit the DRA Declaration FFY2022 form, a copy of the employee handbook or Code of Conduct containing the written polices, the rights of employees to be protected as whistleblowers and a copy of policies and procedures for detecting and preventing fraud, waste and abuse.

The completed DRA Declaration and all required documents listed above must be emailed to hcpf_draact2005@state.co.us no later than November 1, 2022.

Contact Eileen Sandoval at hcpf_draact2005@state.co.us with questions related to the DRA.

Family Planning Benefit Expansion

Providers are reminded that effective July 1, 2022, eligibility types were expanded to include additional populations for family planning services.

There are two different categories for this expansion.

• **EMS (Emergency Medical Services) Benefit Plan**

EMS benefit plan is for undocumented individuals and previously only covered emergency services. Members with EMS coverage may now receive any **family planning** service regardless of an emergency.

• **Family Planning (FAMPL) Benefit Plan**

FAMPL is a new benefit plan for individuals who are within the 133%-260% of the Federal Poverty Level (FPL) income bracket. Providers using a batch X12N 271 response to verify eligibility will receive the program aide code of "FP" (family planning) or "PF" (presumptive family planning). Providers using the provider web portal will see the benefit plan of "FAMPL". Members with FAMPL coverage may now receive any **family planning** or **family planning related service**.

Individuals must apply for services and have a valid member ID for the provider to submit claims. Providers are encouraged to check eligibility for each date of service.

Refer to the email Family Planning Benefit Expansion - 08-08-2022 for more information.

Pediatric Behavioral Therapy Providers:

Electronic Visit Verification (EVV) Program Update

Pediatric behavioral therapy services are based in the home and community, as are Electronic Visit Verification (EVV) mandated services. Pediatric behavioral therapy providers will be required to collect EVV for Telehealth to streamline EVV requirements for providers and ensure services are delivered to members across service delivery methods.

Co-treatment is allowable and EVV helps the Department of Health Care Policy & Financing (the Department) to look at the whole treatment picture for the child or youth, such as comparing co-treatment plans in the prior authorization (PAR) system. The inclusion for pediatric behavioral therapy Telehealth will allow the Department to monitor across service delivery methods.

Effective October 1, 2022, pediatric behavioral therapy services performed in the following places of service will require EVV prior to claims processing. If EVV is incomplete or not present, the claim will not pay.

- 02 - Telehealth Provided Other than in Patient's Home
- 10 - Telehealth Provided in Patient's Home

Please note that pediatric behavioral therapy providers are not eligible for the Live-In Caregiver EVV Exemption and claims billed using the CMS 1500 billing methodology, Place of Service 99 requires EVV.

Providers are responsible to ensure that the member's location is correctly captured when services are rendered by Telehealth/Telemedicine. Guidance on Telehealth/Telemedicine and Alternate Location can be found in the EVV Program Manual.

The EVV record must indicate the location of the member receiving services through Telemedicine or Telehealth, and many EVV technologies automatically record the location of the caregiver providing services. Provider Agencies may utilize the Alternate Location methodology as needed.

Newly enrolled pediatric behavioral therapy providers are not automatically enrolled in the EVV Program and are responsible to submit the EVV Attestation form for EVV enrollment. A 30-day grace period is given from the EVV requirement after enrollment to complete EVV setup.

Contact evv@state.co.us with any EVV related questions.

Additional Information

The EVV Program Manual continues to improve. EVV stakeholder meetings are held monthly; more information on these meetings can be found on the EVV Stakeholder Workgroup web page. Visit the EVV web page for information about EVV implementation.

Contact Gainwell Technologies with questions regarding billing. Contact Sandata Technologies by phone 855-871-8780 or email cocustomercare@sandata.com with questions regarding the State EVV Solution or connecting a Provider Choice EVV System. Contact the Department at evv@state.co.us with all other questions.

Recently Published Billing Manuals and Fee Schedules

- 340B Policy and Procedures
- Appendix X - HCPCS and NDC Crosswalk for Billing Physician-Administered Drugs
- Appendix Z - Outpatient Hospital Specialty Drugs
- Federally Qualified Health Center/Rural Health Center (FQHC/RHC)
- Home Health
- Laboratory Services
- Outpatient Imaging and Radiology
- Private Duty Nursing
- Qualified Residential Treatment Program (QRTP)

Visit the Billing Manuals web page to locate all published manuals.

- Health First Colorado Fee Schedule
- Immunization Rate Schedule

Visit the Provider Rates and Fee Schedule web page to locate all published fee schedules.

Resolved Issues

Resolved 07/28/22:

Institutional Claims for Diagnosis Codes Z28310, Z28311, Z2839 Denying for Explanation of Benefits (EOB) 3014 EAPGS - "Diagnosis is either invalid for date(s) of service or requires greater specificity" and Enhanced Ambulatory Patient Grouping (EAPG) Error Code 3102 - "Secondary Diagnosis"

Some institutional claims for the diagnosis codes listed below were denying for EOB 3014 -

"EAPGS Diagnosis is either invalid for date(s) of service or requires greater specificity" and Enhanced Ambulatory Patient Grouping (EAPG) Error Code 3102 - "Secondary Diagnosis".

- Z28310 - Unvaccinated for COVID-19
- Z28311 - Partially vaccinated for COVID-19
- Z2839 - Other under-immunization status

Approval from the Centers for Medicare and Medicaid Services (CMS) was received to implement EAPG version 3.16. This version has been implemented.

Issue resolved 07/28/22.

Resolved 08/24/22:

Claims Denying for Explanation of Benefits (EOB) 4000 - "The Member Has Other Insurance"

Some provider claims were incorrectly denying for EOB 4000 - "The member has other insurance. Bill the charges to the other insurance before billing Medicaid. Complete the other insurance payment information fields on the claim and retain a copy of the explanation of benefits," when the member had limited Third Party Liability coverage unrelated to the services on the claim. For example, inpatient or outpatient claims may have denied for a prescription-only policy.

Claims should adjudicate and pay appropriately.

Issue resolved 08/24/22.

Resolved 08/24/22:

Hospital Claims with Split Eligibility

Some inpatient hospital claims were denying for the following Explanation of Benefits (EOB) codes when subject to All Patient Refined Diagnosis Related Groups (APR/DRG)

payment where the member was not Medicaid-eligible for the entire inpatient hospital stay.

- EOB 2029 - The Services Must Be Billed to The Members RAE.
- EOB 2030 - The Services Must Be Billed to Denver Health Medicaid Choice Plan.
- EOB 2031 - The Services Must Be Billed to Rocky Mountain Health Plan Prime.

Claims should adjudicate and pay appropriately.

Issue resolved 08/24/22.

Please do not reply to this email; this address is not monitored.