COLORADO
Department of Health Care Policy & Financing

Provider Bulletin

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colorado.gov/hcpf

In this issue:

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ColoradoPAR Program PARs
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Did you know...?

A special bulletin (B1700393) containing the updated Health Care Common Procedure Coding System (HCPCS) codes for 2017 has been published. The bulletin has all codes that have been added, deleted, and have had descriptions changed. You can find the special bulletin on the Department of Health Care Policy and Financing's website: https://www.colorado.gov/pacific/sites/default/files/Provider%20Bulletin_HCPCS_0117.pdf

All Providers

Deadline for Electronic Medical Claims Submissions

The deadline for **electronic** medical claims submissions and adjustments is **Friday, February 17, 2017 at 2:00 p.m. MT**. This is to allow for the Department of Health Care Policy and Financing (the Department) to make the switch to the new Colorado interChange (iC) system.

At 2:00 p.m. on February 17, 2017, all medical claims that are not resolved will be denied using edit 9999 (EOB description - Please resubmit the claim under the new Colorado interChange system). This includes all claims that are "in process" or "suspended".

Medical claims that are denied will need to be resubmitted in the new Provider Web Portal on or after March 1, 2017.

Electronic medical claims should not be submitted between 2:00 p.m. MT on February 17, 2017 and 8:00 a.m. MT on March 1, 2017.

Any questions regarding the deadline for filing electronic medical claims should be directed to Conduent at 1-800-237-0757.

Timely Filing Reminder and Changes to Late Bill Override Dates (LBOD) in the New System

As of March 1, 2017, Hewlett Packard Enterprise (HPE) will no longer use the late bill override date. It is imperative that providers submit claims within the 120-day timely filing period and every 60 days thereafter, if necessary. The Colorado iC system will then verify the previous claim was submitted within the timely filing guidelines.

The timely filing period for Colorado Medical Assistance Program claim submission is **120 days from the date of date of service**. A claim is considered filed when the fiscal agent documents **receipt** of the claim.

The provider is responsible for contacting the fiscal agent to determine the status of the claim and **resubmitting the claim, if necessary, within the 120-day period**. Holidays, weekends, and dates of business closure do not extend the timely filing period.

Waiting for prior authorization or correspondence from the Department or the fiscal agent is not an acceptable reason for late filing. Phone calls and other correspondence are not proof of timely filing. The claim must be submitted, even if the result is a denial or rejection.

Issues, including agent or software failure to transmit accurate and acceptable claims or failure to identify transmission errors in a timely manner, need to be resolved between the provider and the agent or software vendor.

If the original timely filing period expires, the next submission must be received within 60 days of the last adverse action.

The following are examples of adverse action:

- A claim denial or payment on an RA or 835
    - Payment is not an adverse action, but will suffice as proof of timely filing.
- Fiscal agent correspondence (including form letters) that identifies specific claims
- Claims that have been date-stamped by the fiscal agent or the Department and returned to the provider
- Provider enrollment letter for initial enrollment approval or a backdate approval (affiliations or updates are not acceptable reasons for late filing)
- Load letter for eligibility backdate
- Affidavit of delayed notification of member eligibility

Claims that are not able to be submitted within the 120-day guideline, but have one (1) of the above documents attached to the submission, will be reviewed by the fiscal agent.

Further information on timely filing can be found in the General Provider Information Billing Manual on the department's website.

Providers, Are You Ready for March 1, 2017?

On March 1, 2017, HPE will assume fiscal agent operations on behalf of Health First Colorado (Colorado's Medicaid program) and Child Health Plan Plus (CHP+). These operations include the transition to the Colorado interChange (a new claims payment system) and a new Provider Web Portal.

Download this Go Live Guide to make sure you're prepared.

Co-Payment Policy Changes Effective March 1, 2017

Upon implementation of Colorado iC, members will not be liable for cost-sharing greater than five percent (5%) of their household's monthly income per month. This means that all members will have a monthly co-payment maximum that providers cannot exceed in co-payment charges.

Providers will soon be able to view a member's remaining co-payment liability through the new provider portal. When a member reaches their co-payment maximum for the month, the portal will display the member as co-payment exempt. When a member reaches the monthly limit, the co-payment reimbursement reduction on claims will be automatically disabled for the remainder of that month. The co-payment maximum will be reset on the first day of each month.

Members will soon be able to view their monthly co-payment maximum in the member-facing portal, as well as on all claims filed. Therefore, members will know if they have been wrongly charged a co-payment and have the legal right to appeal the charges. The Department will communicate the specific date for the launch of the member-facing portal in future publications.

The following polices are still in place and have not changed. Refer to Rule 8.754 for complete details:

- Certain **member groups** are exempt from co-payments, such as children under the age of 19 and those receiving hospice care. Always refer to the member's eligibility status in the provider portal prior to rendering services to check if they are liable for co-payments.
- Certain **services** are exempt from co-payments, such as emergency services, pregnancy related services, family planning services, preventive care, and behavioral health services.
- A provider may not deny services to a member when the member is unable to immediately pay the co-payment amount. However, the member remains liable for the co-payment at a later date.

Updates to 2016-17 ICD-10 New Diagnosis Codes and Upcoming Hospital Engagement Meetings

- **ICD-10 New Diagnosis Codes:** Certain inpatient claims are either denying or paying incorrectly because of inaccurate APR-DRG assignments. The APR-DRG software in the current MMIS has not been updated to recognize the new ICD-10 code set that took effect October 1, 2016. Therefore, any claims with a "From" date on or after October 1, 2016 that contain diagnosis codes impacted by the ICD-10 code update, and are assigned the wrong DRG or Severity of Illness (SOI) as a result, will be mass-adjusted soon after the launch of Colorado iC, scheduled for March 1, 2017. Please note, upon implementation, the new Colorado iC system will have the APR-DRG software to correctly process claims using the updated ICD-10 code set.

- **Hospital Engagement Meetings:** The Department will hold multiple Hospital Engagement Meetings in 2017 to discuss current issues regarding payment reform and operational issues moving forward. The first meeting is scheduled for February 3, 2017.
    - The Department will continually update this link with information on upcoming meeting dates and planned topics. Please use the link below to register for the three different sessions planned on February 3, 2017 and review the planned topics for the day. More

information is available on the Department's website. You can also email Marguerite Richardson, or call 303-866-3839.

If you have any further questions or need more information, please contact Diana Lambe.

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

Modifiers

The effective date for the following modifiers is **July 1, 2017**. These modifiers are informational only and do not affect reimbursement, but must be used when applicable.

Modifier	Description
RA	Replacement of a DME, orthotic, or prosthetic item
RB	Replacement of part of a DME, orthotic, or prosthetic item furnished as part of a repair

As of **July 1, 2017**, these modifiers will be required on both Prior Authorization Requests (PARs) and claims along with the modifiers currently listed in the DMEPOS Billing Manual.

Notice: The Department apologizes, but the U1, U2 and UC modifiers will not be available or required for DME prior authorizations or claims until further notice.

Federal Rule: Face-to-Face (F2F) Requirements for Home Health Services

On February 2, 2016, the Centers for Medicare and Medicaid Services (CMS) published the Medicaid Program; Face-to-Face Requirements for Home Health Services; Policy Changes and Clarifications Related to Home Health; Final Rule. The federal rule became effective on July 1, 2016, and the requirements it outlines are set forth in the Code of Federal Regulations at 42 CFR § 440.70.

As a broad overview, there are two requirements within the F2F Rule that affect Health First Colorado's DME Benefit:

1. The definitions for Medical Equipment and Supplies were modified to more closely align with Medicare's definition of DME.
2. As a condition of payment, certain DME requires, upon initiation, that the member has met (face-to-face) with their physician.

The Department must be compliant with these new Federal Regulations **no later than July 1, 2017**. To that effect, the DME section of the Code of Colorado Regulations, located at 10 CCR 2505-10, § 8.590, is in the process of being updated.

What you need to know:

1. There will not be a significant change to either the DME or Supply definitions as the existing language is relatively similar to Medicare's (42 CFR § 414.202).
2. The F2F requirement does not apply to all DME. The federal rule requires that, at a minimum, states require an F2F for the same list of codes that Medicare published as requiring an F2F.

   Note: To date, Medicare has chosen to not enforce the F2F requirements. As a result, the list has not been updated since 2015.
3. The F2F encounter must be related to the primary reason the member requires DME and must occur no more than six (6) months prior to the date of services.

4. An F2F may be conducted by the following practitioners:
   a. Physician
   b. Nurse Practitioner (NP)
   c. Clinical Nurse Specialist (CNS)

   Note: Both the NP and CNS must report the findings of an F2F encounter to the physician.
5. The F2F encounter **must** be documented in the members file or the Department may deny claims.

What you can do now

At this time, communication to physicians and clinics is a top priority. Please communicate the new requirements to any/all clinical professionals you may work with or encounter that provide any of the DME listed below.

Many questions regarding the requirements can be answered by reading through the information on the Federal Registrar. Additional information regarding how the Department will operationalize the requirements will be forthcoming in future Provider Bulletins.

Codes that will require an F2F

Based on the Medicare list of codes that require an F2F, the list below represents the 222 codes that will require an F2F once the update to 10 CCR 2505-10, Section 8.590 has been finalized.

Note: The presence of a code on the below list does not represent the Department's coverage of the code, only that the code was listed by Medicare as requiring an F2F.

Code	Description
E0185	Gel or gel-like pressure pad for mattress, standard mattress length and width
E0188	Synthetic sheepskin pad
E0189	Lamb's wool sheepskin pad, any size
E0194	Air fluidized bed
E0197	Air pressure pad for mattress, standard mattress length and width
E0198	Water pressure pad for mattress, standard mattress length and width
E0199	Dry pressure pad for mattress standard mattress length and width
E0250	Hospital bed, fixed height, with any type of side rails, with mattress
E0251	Hospital bed, fixed height, with any type side rails, without mattress
E0255	Hospital bed, variable height, hi-lo, with any type side rails, with mattress
E0256	Hospital bed, variable height, hi-lo, with any type side rails, without mattress
E0260	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress
E0261	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, without mattress
E0265	Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, with mattress
E0266	Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, without mattress
E0290	Hospital bed, fixed height, without side rails, with mattress
E0291	Hospital bed, fixed height, without side rails, without mattress
E0292	Hospital bed, variable height, hi-lo, without side rails, with mattress
E0293	Hospital bed, variable height, hi-lo, without side rails, without mattress

Code	Description
E0294	Hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress
E0295	Hospital bed, semi-electric (head and foot adjustment), without side rails without mattress
E0296	Hospital bed, total electric (head, foot, and height adjustments), without side rails, with mattress
E0297	Hospital bed, total electric (head, foot, and height adjustments), without side rails, without mattress
E0300	Pediatric crib, hospital grade, fully enclosed, with or without top enclosure
E0301	Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress
E0302	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress
E0303	Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress
E0304	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress
E0424	Stationary compressed gas Oxygen System rental; includes contents, regulator, nebulizer, cannula or mask and tubing
E0431	Portable gaseous oxygen system rental includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing
E0433	Portable liquid oxygen system
E0434	Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, content gauge, cannula or mask, and tubing
E0439	Stationary liquid oxygen system rental, includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0441	Oxygen contents, gaseous (1-month supply)
E0442	Oxygen contents, liquid (1-month supply)
E0443	Portable Oxygen contents, gas (1-month supply)
E0444	Portable oxygen contents, liquid (1-month supply)
E0462	Rocking bed with or without side rail
E0465	Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)
E0466	Home ventilator, any type, used with non-invasive interface, (e.g., mask, chest shell)
E0470	Respiratory Assist Device, bi-level pressure capability, without backup rate used non-invasive interface
E0471	Respiratory Assist Device, bi-level pressure capability, with backup rate for a non-invasive interface
E0472	Respiratory Assist Device, bi-level pressure capability, with backup rate for invasive interface
E0480	Percussor electric/pneumatic home model

Code	Description
E0482	Cough stimulating device, alternating positive and negative airway pressure
E0483	High Frequency chest wall oscillation air pulse generator system
E0484	Oscillatory positive expiratory device, non-electric
E0570	Nebulizer with compressor
E0575	Nebulizer, ultrasonic, large volume
E0580	Nebulizer, durable, glass or autoclavable plastic, bottle type for use with regulator or flowmeter
E0585	Nebulizer with compressor & heater
E0601	Continuous airway pressure device
E0607	Home blood glucose monitor
E0627	Seat lift mechanism, electric, any type
E0629	Seat lift mechanism, non-electric, any type
E0636	Multi positional patient support system, with integrated lift, patient accessible controls
E0650	Pneumatic compressor non-segmental home model
E0651	Pneumatic compressor segmental home model without calibrated gradient pressure
E0652	Pneumatic compressor segmental home model with calibrated gradient pressure
E0655	Non- segmental pneumatic appliance for use with pneumatic compressor on half arm
E0656	Non- segmental pneumatic appliance for use with pneumatic compressor on trunk
E0657	Non- segmental pneumatic appliance for use with pneumatic compressor chest
E0660	Non- segmental pneumatic appliance for use with pneumatic compressor on full leg
E0665	Non- segmental pneumatic appliance for use with pneumatic compressor on full arm
E0666	Non- segmental pneumatic appliance for use with pneumatic compressor on half leg
E0667	Segmental pneumatic appliance for use with pneumatic compressor on full-leg
E0668	Segmental pneumatic appliance for use with pneumatic compressor on full arm
E0669	Segmental pneumatic appliance for use with pneumatic compressor on half leg
E0671	Segmental gradient pressure pneumatic appliance full leg
E0672	Segmental gradient pressure pneumatic appliance full arm
E0673	Segmental gradient pressure pneumatic appliance half leg
E0675	Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency
E0692	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 4-foot panel
E0693	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 6-foot panel
E0694	Ultraviolet multidirectional light therapy system in 6-foot cabinet, includes bulbs/lamps, timer and eye protection

Code	Description
E0720	Transcutaneous Electrical Nerve Stimulation (TENS) device, two (2) lead, localized stimulation
E0730	Transcutaneous Electrical Nerve Stimulation (TENS) device, four (4) or more leads, for multiple nerve stimulation
E0731	Form fitting conductive garment for delivery of TENS or NMES with conducting fibers separated from the patient's skin by layers of fabric, each
E0740	Incontinence treatment system, Pelvic floor stimulator, monitor, sensor, and/or trainer
E0744	Neuromuscular stimulator for scoliosis
E0745	Neuromuscular stimulator electric shock unit
E0747	Osteogenesis stimulator, electrical, non-invasive, other than spine application.
E0748	Osteogenic stimulator, noninvasive, spinal applications
E0749	Osteogenesis stimulator, electrical, surgically implanted
E0760	Osteogenesis stimulator, low intensity ultrasound, non-invasive
E0762	Transcutaneous electrical joint stimulation system, includes all accessories
E0764	Functional neuromuscular stimulator, transcutaneous stimulations of muscles of ambulation with computer controls
E0765	FDA approved nerve stimulator for treatment of nausea & vomiting
E0782	Infusion pumps, implantable, Non-programmable (Includes all components, e.g., pump, catheter, connectors, etc.)
E0783	Infusion pump, implantable, Programmable
E0784	External ambulatory infusion pump, insulin
E0786	Implantable programmable infusion pump, replacement (excludes implantable intraspinal catheter)
E0840	Tract frame, attach to headboard, cervical traction
E0849	Traction equipment cervical, free-standing stand/frame, pneumatic, applying traction force to other than mandible
E0850	Traction stand, free standing, cervical traction
E0855	Cervical traction equipment not requiring additional stand or frame
E0856	Cervical traction device, cervical collar with inflatable air bladder
E0958	Manual wheelchair accessory, one-arm drive attachment, each
E0959	Manual wheelchair accessory, adapter for amputee, each
E0960	Wheelchair accessory, shoulder harness/straps or chest strap, including any type mounting hardware
E0961	Manual wheelchair accessory wheel lock brake extension handle
E0966	Manual wheelchair accessory, headrest extension
E0967	Manual wheelchair accessory, hand rim with projections, any type, replacement only, each
E0968	Commode seat, wheelchair
E0969	Narrowing device wheelchair
E0971	Manual wheelchair accessory anti-tipping device
E0973	Manual wheelchair accessory, adjustable height, detachable armrest
E0974	Manual wheelchair accessory anti-rollback device
E0978	Manual wheelchair accessory positioning belt/safety belt/ pelvic strap
E0980	Manual wheelchair accessory safety vest

Code	Description
E0981	Manual wheelchair accessory Seat upholstery, replacement only
E0982	Manual wheelchair accessory, back upholstery, replacement only
E0983	Manual wheelchair accessory power add-on to convert manual wheelchair to motorized wheelchair, joystick control
E0984	Manual wheelchair accessory power add-on to convert manual wheelchair to motorized wheelchair, Tiller control
E0985	Wheelchair accessory, seat lift mechanism
E0986	Manual wheelchair accessory, push activated power assist
E0990	Manual wheelchair accessory, elevating leg rest
E0992	Manual wheelchair accessory, elevating leg rest solid seat insert
E0994	Arm rest, each
E1014	Reclining back, addition to pediatric size wheelchair
E1015	Shock absorber for manual wheelchair
E1020	Residual limb support system for wheelchair
E1028	Wheelchair accessory, manual swing away, retractable or removable mounting hardware for joystick, other control interface or positioning accessory
E1029	Wheelchair accessory, ventilator tray
E1030	Wheelchair accessory, ventilator tray, gimbaled
E1031	Rollabout chair, any and all types with castors 5" or greater
E1035	Multi-positional patient transfer system with integrated seat operated by care giver
E1036	Patient transfer system
E1037	Transport chair, pediatric size
E1038	Transport chair, adult size up to 300lb
E1039	Transport chair, adult size heavy duty >300lb
E1161	Manual Adult size wheelchair includes tilt in space
E1227	Special height arm for wheelchair
E1228	Special back height for wheelchair
E1232	Wheelchair, pediatric size, tilt-in-space, folding, adjustable with seating system
E1233	Wheelchair, pediatric size, tilt-in-space, folding, adjustable without seating system
E1234	Wheelchair, pediatric size, tilt-in-space, folding, adjustable without seating system
E1235	Wheelchair, pediatric size, rigid, adjustable, with seating system
E1236	Wheelchair, pediatric size, folding, adjustable, with seating system
E1237	Wheelchair, pediatric size, rigid, adjustable, without seating system
E1238	Wheelchair, pediatric size, folding, adjustable, without seating system
E1296	Special sized wheelchair seat height
E1297	Special sized wheelchair seat depth by upholstery
E1298	Special sized wheelchair seat depth and/or width by construction
E1310	Whirlpool non-portable
E2502	Speech Generating Devices prerecord messages between 8 and 20 Minutes
E2506	Speech Generating Devices prerecord messages over 40 minutes
E2508	Speech Generating Devices message through spelling, manual type
E2510	Speech Generating Devices synthesized with multiple message methods

Code	Description
E2227	Rigid pediatric wheelchair adjustable
K0001	Standard wheelchair
K0002	Standard hemi (low seat) wheelchair
K0003	Lightweight wheelchair
K0004	High strength lightweight wheelchair
K0005	Ultra-Lightweight wheelchair
K0006	Heavy duty wheelchair
K0007	Extra heavy duty wheelchair
K0009	Other manual wheelchair/base
K0606	AED garment with electronic analysis
K0730	Controlled dose inhalation drug delivery system

ColoradoPAR Documentation

Documentation for Long-Term Home Health (LTHH) Speech Therapy PARs

Pediatric LTHH PAR requirements ensure all necessary information is included in order to make an appropriate approval, partial approval, or denial.

Long-term home helth providers should attach all relevant supporting documentation to PARs. Please review the list of documents online at ColoradoPAR.com.

Long-Term Home Health Nursing Hour Reallocations

Providers must use the approved template when requesting to reallocate approved basic and extended units on a LTHH PAR via the eQSuite® Online Helpline. Please reference this template and guide to ensure your request is processed in a timely manner. Please note that while units may be changed, the total number of approved hours must remain the same.

Person- and Family-Centered Approach: Creating a Culture of Collaboration with Clients

The Department hosted a webinar in December to share our recent successes and challenges and to get input for the next phase of this work.

Over the last three years, the Department has leveraged grant funding from The Colorado Health Foundation (TCHF) to integrate person-centered principles into Department business processes, policies, and partnerships.

In 2012, the Department received grant funding from TCHF and engaged the Institute for Patient- and Family-Centered Care (IPFCC). The purpose of the IPFCC's engagement was to evaluate and provide recommendations on how to more closely align with principles of patient-and family-centeredness. Following the recommendations of the IPFCC, and with subsequent funding from TCHF in 2014, the Department began to implement the recommendations. As the effort expanded, we developed a client-only Advisory Council, an internal Person-Centeredness Champions group, and a Strategic Plan for Person-Centeredness to help guide our work and the way we provide services.

In March 2016, the Department received a second grant from TCHF to continue our work improving member and family engagement. This funding will allow us to collaborate with external partners on person- and family-centered practices and projects. This funding also

supports the continued work of our Strategic Plan for Person- and Family-Centeredness developed in the first phase of this effort.

The Department defines a "person-centered approach" as thinking and behaving in ways that respect and value other people's individual preferences, strengths, and contributions.

Note: This presentation focused on the Department's broader person- and family-centeredness accomplishments as supported by a grant from TCHF.

The recorded webinar and more information can be found on our website.

Telemedicine Stakeholder Meeting

When: February 22, 2017

Time: 10:00 a.m. – 11:30 a.m. MT.

Location: 303 East 17th Avenue, 7th Floor, Conference Room 7ABC

Access Meeting by Phone: 1-877-820-7831 Passcode: 977000#

On Wednesday, February 22, 2017, the Department will host a Telemedicine Stakeholder Meeting. We are seeking stakeholder input to further evaluate and possibly expand telemedicine. Issues we expect to discuss include, but are not limited to:

- Codes that could be added to the list of allowed services through telemedicine
- Possible new limits on usage of telemedicine services
- Asynchronous telemedicine (eConsult)

The Department welcomes all input.

Reasonable accommodations will be provided upon request for persons with disabilities. Please contact Raine Henry to make arrangements.

Community Clinic with Emergency Center Enrollment

Due to several questions raised during revalidation, the Department would like to clarify its policy on Community Clinic with Emergency Center (CCEC) enrollment.

Providers licensed as a CCEC can only enroll as a Clinic, provider type 16 (billed on the CMS1500 claim form and reimbursed for practitioner services). Health First Colorado cannot recognize these locations as part of a hospital, regardless of whether they are owned by a hospital entity, because they are not licensed as a hospital or off-campus location of a hospital. Therefore, facility charges will not be accepted. This is not a change in the Department's enrollment policy and is solely communicated due to the volume of questions we received. For further questions regarding Clinic policy, please contact Physician Services Benefit Manager, Richard Delaney.

Tax Season and 1099s

Reminder: Please ensure all addresses (billing, location, mail-to) on file with the Department's fiscal agent, Conduent, are current. 1099s returned for an incorrect address cause the account to be placed on hold and **all** payments to be suspended, pending a current W-9. Held payments can be released once a current W-9 is processed. Claims for payments not released are voided out of the Medicaid Management Information System (MMIS) twice during the year, once on June 30 and again on December 31. Please contact the State Controller's office at 303-866-4090 if you have not received a 1099.

Attention Providers: Please Keep Your Info Up to Date

Updating provider information is **critically important**. Keeping the information updated assures that payments and communication are sent timely and appropriately, and that the information in the provider directory is current.

interChange

In order to make billing information updates in the Colorado iC you will need to create a new Web Portal account and update your information online; this cannot be done until the new Web Portal goes live on February 6, 2017.

February 2016 Holiday

Presidents' Day Holiday

Due to the Presidents' Day holiday on **Monday, February 20, 2017**, State offices, DentaQuest, Hewlett Packard Enterprises (HPE), and the ColoradoPAR Program offices will be closed. Conduent is conducting business during regular business hours. The receipt of warrants and Electronic Funds Transfers (EFTs) may potentially be delayed due to the processing at the United States Postal Service or providers' individual banks.

Hospital Providers

2016-17 Inpatient Hospital Rates Update

The Department recently received approval from the CMS to update rates for fee-for-service inpatient hospital services. As outlined in the September 2016 Provider Bulletin, the hospital facility inpatient base rates are in the process of being loaded in the MMIS. Any impacted inpatient hospital claims with dates of service on or after July 1, 2016, will be retroactively adjusted to reflect the rate update and revised APR-DRG weights table. Adjustments for inpatient claims will be reflected on future Provider Claim Reports (PCRs).

Please contact Diana Lambe with questions.

Nursing Facility Providers

Important Actions for Nursing Facility Providers

All providers should download their PARs and Remittance Advice forms (RAs) from the current portal as soon as possible. The information will only be available until March 11, 2017. The normal 60-day availability will not apply to claims processed before March 1, 2017.

All providers should download the new General Information Billing Manual and the new Nursing Facility Billing Manual, the new billing manuals will be available in early February. Providers will be able to download the new billing manuals from the Provider's Section of the Department's website. These manuals have been updated to reflect changes in the new system. Of note, the nursing facility billing manual has several references to the general information billing manual. Use both manuals concurrently. If you find errors in the Nursing Facility Billing Manual – contact Cathy Fielder with the page number(s) and error identified.

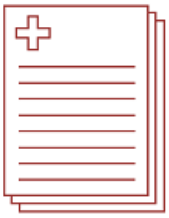
Key changes in the manuals include: Late Bill Override Date (LBOD)/Timely Filing; UB-04 claim codes; Nursing Facility PAR; and Nursing Facility PETI Process.

The new Colorado iC system will streamline some processes. Below are a few examples of what to expect.

- Late Bill Override Date (LBOD) process enforces the 60-day rule, and providers must keep documented records for this process. Full details on this process can be found in the new General Information Billing Manual. Any questions should be directed to the fiscal agent.
- Nursing Facility PAR creation has been automated in Colorado iC. The system will connect eligibility with the 5615 patient liability amount. If either is missing, claims will deny.
- For hospital back up (HBU) residents, the system will match the resident with a provider and the daily per diem rate. This allows claims to process quicker.
- If a period of ineligibility (POI) has been noted in the system for a resident by the county, any daily per diem rate claim will automatically deny until the POI has been exhausted. Contact the county with any POI questions.
- The Colorado Benefits Management System (CBMS) where the patient liability (share of cost) amount is recorded and presented to the nursing facility on the 5616 form will automatically be transmitted to Colorado iC. If the patient liability amount deducted from the claim does not match the 5615 form amount, the provider should contact the county to have the county update their system with the correct amount. The 5615 form will continue to be used to communicate income changes or resident status changes between the provider and the county.
  Colorado iC will automatically apply the patient liability amount to the first billing each month and any following billings until it's exhausted. Therefore, providers should collect payment from the resident at the beginning of each month. If a provider has problems collecting payment from the resident, contact the county for assistance.

Note: All claim billing issues should be directed to Conduent at 1-800-237-0757 until March 1, 2017. All enrollment/revalidation questions or issues should be directed to HPE at 1-844-235-2387 or CoProviderEnrollment@HPE.com. Download the Call Center Cheat Sheet to help determine the call center that can best assist you.

Nursing Facility Type of Bill Codes Change



Effective for Nursing Facility (NF) services billed with dates of service on or after March 1, 2017, Colorado iC will accept Type of Bill codes 21X, 22X and 23X. The National Uniform Billing Committee (NUBC) has identified these codes and Health First Colorado must now enforce the use of these three codes for NF claims submitted through Colorado iC. (21X > SNF inpatient includes Medicare A; 22X > SNF inpatient includes Medicare B only; 23X > SNF outpatient)

Effective for Intermediate Care Facility (ICF) services billed with dates of service on or after March 1, 2017, Colorado iC will not accept institutional claims submitted with Type of Bill 62X. The NUBC has changed this code to 65X for Level I ICFs and 66X for Level II ICFs. Health First Colorado must now enforce the use of these two codes for ICF claims submitted through the Colorado iC. (65X > ICF Pre Admission Screening and Resident Reviews (PASRR) Level 1 residents; 66X > ICF PASRR Level 2 residents)

Refer to the new Nursing Facility Billing Manual for further details or contact the fiscal agent.

Nursing Facility PETI Process Change

Effective March 1, 2017, all Nursing Facility Post Eligibility Treatment of Income (PETI) requests must be submitted via the new Provider Web Portal for approval. **Effective February 3, 2017, NF PETI requests will no longer be accepted via fax, mail, or encrypted email.** All PETI requests must be held from February 3, 2017, through February 28, 2017, for entry into the new Provider Web Portal on or after March 1, 2017. The new Nursing Facility Billing Manual provides details on how to submit a request via the web portal. Please email questions to Susan Love.

Nursing Facility Rate Letter Process Change

Effective March 1, 2017, Nursing Facility rate letters will be sent via email to the current facility administrator on file with the Department. **The rate letters will no longer be mailed.** (Note: these are the rate letters that allow the nursing facilities an opportunity to review the audited rate for accuracy and to request an informal reconsideration if desired.) To avoid delays in receipt of this important rate information, please continue to update the Department with any facility administrator changes by emailing the current administrator contact information to Susan Love.

Pharmacy Providers

Epinephrine Dosing and Drug Utilization Review Board (DUR) Meeting

Epinephrine Products

This serves as communication to facilitate the transition of Health First Colorado members to the preferred generic (generic Adrenaclick) epinephrine auto injectors 0.3 mg and 0.15 mg. This change was effective January 1, 2017. Other branded and generic epinephrine auto-injector products will require a PAR. Training videos are available in the link below:

Dosing:

Member Weight	Which epinephrine auto-injector to prescribe
Members who weigh 66 pounds or more (30 kilograms or more).	0.3 mg auto-injector (yellow colored label)
Members who weigh about 33 to 66 pounds (15 to 30 kilograms).	0.15 mg auto-injector (orange colored label)
Members who weigh less than 33 pounds (15 kilograms).	It is not known if epinephrine injection, USP auto-injector is safe and effective

http://www.epinephrineautoinject.com/how_to_use_epinephrine_injection_USP_auto_injector.php

Please review the differences between products with members and caregivers prior to use in an emergency situation. To order additional training products online for your practice or office for free, please follow the instructions below:

Visit www.epinephrineautoinject.com and click on the green button that says HOW TO ORDER PRODUCT TRAINERS or call 1-855-374-6374

Drug Utilization Review Board (DUR) Meeting:

Tuesday, February 21, 2017

6:00 p.m. – 9:00 p.m.

Skaggs School of Pharmacy and Pharmaceutical Sciences Building

12850 East Montview Blvd, Aurora CO 80045

Seminar Room- Room 1000; First floor

Parking available in the Henderson/Visitor Parking Garage

Pharmacy Dispensing Fees for Calendar Year 2017

The pharmacy dispensing fees were updated effective January 1, 2017 based on the total annual prescription volume information submitted by pharmacy providers in October 2016. Pharmacies that did not submit their prescription volume are assigned the $9.31 dispensing fee. The Department recommends that pharmacies review their reimbursement to ensure they have been assigned the appropriate dispensing fee. Providers may contact the Pharmacy Unit with any questions.

Total Annual Prescription Volume	Dispensing Fee
0 – 59,999	$13.40
60,000 – 89,999	$11.49
90,000 – 109,999	$10.25
110,000+	$ 9.31
Rural Pharmacy	$14.14
Government Pharmacy	$ 0.00
No volume submitted	$ 9.31

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Appointment by ProSymbols

Change Management by Jenny Chisnell

New Order by Ayushi Bhandari

Friend Request by Gregor Cresnar

Send Money by Corpus Delicti

President by Alez WaZa

Click by Shashank Singh

Medical Records by Grant Fisher