Provider Bulletin

COLORADO
Department of Health Care
Policy & Financing

colorado.gov/hcpf

Contacts

Billing and Bulletin Questions
1-844-235-2387

**Claims, PAR Submissions,
Correspondence, Inquiries,
and Adjustments**
P.O. Box 30
Denver, CO 80201

ColoradoPAR Program PARs
www.coloradopar.com

Did you know...?

If you retrieve reports from the file and report service on the Provider Web Portal, please ensure you have a copy of **all** your reports prior to Saturday March 11, 2017 by 3:00 pm MT. Reports will not be transferred to HPE's Provider Web Portal after this date.

All Providers

Health First Colorado is Now Live with the New interChange (iC) and Provider Web Portal

The Department of Health Care Policy and Financing (the Department) will fully transition to our new Fiscal Agent, Hewlett Packard Enterprises (HPE), as of March 1, 2017. The new claims payment system, Colorado interChange (iC), will be used for processing payments for services rendered to Health First Colorado (Colorado's Medicaid Program) and Child Health Plan Plus (CHP+) members.

The new Provider Web Portal (Web Portal) has been available for providers to enroll since February 6, 2017 and will start accepting claim submissions, reports, and prior authorization status on March 1, 2017. HPE will be the only fiscal agent for the Department as of March 1, 2017. Providers should call 1-844-235-2387 for all provider inquiries. **Please be patient, longer hold times are expected as call volumes will likely increase during the launch of Colorado iC.**

Each Provider ID requires separate Web Portal registration, and if applicable, the accounts can be tied together using delegate access. Providers are not required to obtain a trading partner ID to enroll for the Web Portal. Only submitters who send batch files need to obtain a trading partner ID.

Claims Submission

As of March 1, 2017, interactive claims must be submitted through the new Web Portal. If you submit batch, or have a vendor who submits batch on your behalf, make sure you have a new approved trading partner ID with HPE.

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March 2017

(Exceptions include claims submitted by DentaQuest, Delta Dental, Veyo, etc. Providers who submitted claims to one (1) of these entities should continue to do so in Colorado iC.)

On or after March 1, 2017, providers will be able to adjust old claims, submitted through Legacy Medicaid Management Information System (MMIS), in the new Colorado iC. All claims data from the old system has been migrated to the new system. In order to adjust a TCN submitted prior to February 17, 2017, providers must obtain the converted Internal Control Number (ICN) that has been assigned to that claim. Providers can obtain the ICN by using the web portal and doing a claim status inquiry by member ID and date of service. The newly assigned ICN for the old claim must be referenced on the claim submitted for adjustment. For more details on how to submit an adjustment, please use the appropriate billing manual, found on the Department's website.

Important change for paper claim billing: Claims submitted through the new Colorado iC now require providers to use the **National Provider Identifier (NPI)** and **not** the Legacy Provider ID, unless they are "Atypical".

Claims requiring attachments should now be sent through the new Web Portal.

Claims with a date of service over one (1) year-old must still be sent via the appropriate paper claim form. Paper claims should still be sent to P.O. Box 30, Denver CO, 80201, as that address has been transferred to HPE.

Enrollment

Health First Colorado providers can no longer submit most enrollment updates via paper forms. Most updates can be made through the new Web Portal. A new ATN will be created for every provider enrollment update request.

The address of P.O. Box 1100, Denver CO, 80201 is no longer valid for submitting paper enrollment update forms.

Eligibility

Faxback eligibility is no longer an option in the new system. Please use the Web Portal or enroll as a trading partner to submit a batch 270.

Reports

The Remittance Advice (RA) (previously called the provider claim report (PCR)) is available on the new Web Portal under "resources", "report download". If you have a registered trading partner ID, 835s can be found under "file exchange", "download files".

Prior Authorization Requests (PARs)

There are no changes to PARs currently submitted to eQHealth (the Colorado PAR Program).

There are changes to where you submit the following PARs on or after March 1, 2017:

- Nursing Facility PETI PARs – now submitted through the Care Management portion of the new Web Portal.
- Nursing Facility PARs – no longer required.
- Targeted Case Management for Home and Community Based Services Waivers for Children and Adults with Intellectual and/or Developmental Disabilities – no longer required.
- All HCBS Waiver PARs (including HCBS PETI PARs) – now submitted to the Bridge.

- Long Term Home Health PARs – now submitted to LTHHPARS@state.co.us (more information to come).

Attention Health First Colorado and Child Health Plan Plus (CHP+) Providers

The Department has provided documents to make sure each provider is prepared and familiar with the available resources. Below, you can find links to our Guide to Go Live, our new Billing Manuals, a list of important dates, and training information for the new Web Portal.

Download this Guide to Go Live

It's very important that you read this document. Please share it across your organization.

New Billing Manuals

Make sure you download the General Provider Information Billing Manual and the Billing Manual specific to your provider type.
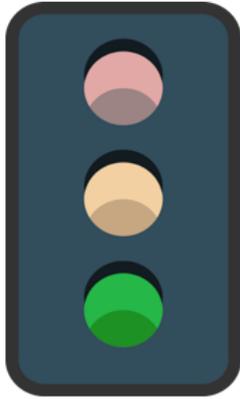

Important Dates & Deadlines for Claims, PARs, and More

It's very important that you read this document. Please share it across your organization.

Featured Download

Important Transition Dates for all providers! **Deadlines for claims, PARs, and More!**

Download Now!

Training Sessions for the New Web Portal – Watch the Webinar Recordings Now!

Click here to view the list of webinar recordings and Web Portal FAQs.

Provider Web Portal Training

Webinar recordings and FAQs are available now!

Click to Access

Fingerprint – Federal Criminal Background Check

Federal regulations (42 CFR 455.434) established by the Centers for Medicare and Medicaid Services (CMS) require enhanced screening and revalidation of all Medicare, Medicaid, and Child Health Plan Plus (CHP+) providers.

Most Health First Colorado and CHP+ providers have already met the requirements for this revalidation cycle. However, we want to remind "high risk" providers (and any person who has ownership or a controlling interest of five percent (5%) or more of a high risk provider) that they will still need to undergo fingerprinting and a Federal Criminal background check.

Providers must submit fingerprints within 30 days of a request from CMS, the Department, Department agents, or designated contractors.

This is not a request for fingerprint submission, just a reminder that fingerprinting requests and Federal Criminal background checks will likely begin later this year (2017). More information coming soon.

Accountable Care Collaborative Phase II Update – Draft Request Comments

The next phase of the Accountable Care Collaborative (ACC) seeks to leverage the proven successes of the Health First Colorado programs to enhance the member and provider experience. The goals of the ACC Phase II are to improve health and life outcomes of members, while using state resources wisely. Learn more about ACC Phase II.

The Department sought targeted comments from stakeholders between November 4, 2016 and January 13, 2017 on the draft request for proposals (RFP). More than 255 comments were provided on the draft ACC Phase II RFP. These comments, coupled with feedback the Department received from 16 in-person meetings across the state and three (3) live-webinars, is helping refine the content for the formal release of the RFP in the spring 2017.

Respondents expressed appreciation for the process and the opportunity to provide comments. Some of the themes from the feedback included:

- Strong support for the focus on the integration of physical and behavioral health
- Mixed response to the proposed attribution methodology
- Requests for greater clarification regarding the six (6) behavioral health visits that can be offered in primary care practices
- Suggestions for stronger incorporation of substance use disorder services into the program
- Recommendations that cannot be incorporated into the RFP, such as suggestions for expanding Health First Colorado benefits or alterations to federal managed care regulations

All comments submitted to the Department have been made publicly available and can be found on the Department website.

The Department is working to review all comments received and making updates to the RFP that align with our agency authority, state and federal rules, and the goals of ACC Phase II.

The Department plans to release the final RFP in Spring 2017. Below is a high level timeline for the ACC Phase II.

Accountable Care Collaborative Phase II Procurement Timeline

Influenza Immunization Code Changes for 2017

As part of the 2017 Health Care Procedural Coding System (HCPCS) annual update, nine influenza immunization Current Procedure Terminology (CPT) codes were changed. Age range limitations were removed for 90655, 90656, 90657, and 90658. In addition, long descriptions changed for 90661, 90685, 90686, 90687, and 90688.

The Colorado Medicaid Management Information System has been updated to reflect these changes. The Immunization Rate Schedule has also been updated.

These are the affected codes and their 2017 long descriptions and age ranges:

90655: Vaccine for influenza for administration into muscle, 0.25 ml dosage, 0-999

90656: Influenza virus vaccine, split virus, preservative free, 0.5 mL, for intramuscular use, 0-999

90657: Vaccine for influenza for administration into muscle, 0.25 ml dosage,0-999

90658: Vaccine for influenza for administration into muscle, 0.5 ml dosage, 0-999

90661: Vaccine for influenza for administration, CCiv3 derived from cell cultures, subunit, preservative and antibiotic free Intramuscular use, 0-999

90685: liv4 Vaccine for influenza for administration into muscle, 0.25 ml dosage, 0-999

90686: liv4 Vaccine for influenza for administration into muscle, 0.5 ml dosage, preservative free, 0-999

90687: liv4 Vaccine for influenza for administration into muscle, 0.25 ml dosage, 0-999

90688: liv4 Vaccine for influenza for administration into muscle, 0.5 ml dosage, 0-999

National Correct Coding Initiative (NCCI) Notification of Quarterly Updates

Providers are encouraged to monitor 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 April 2017. Please find more information on the CMS NCCI website.

Children with Autism (CWA) Modifier Code Change

Effective March 1, 2017, the modifier codes for the Children with Autism (CWA) waiver has changed. The first modifier code for all CWA Waiver services will change from "UL" to "U2". Please refer to the chart below for the new codes. Please contact Laura Russell with questions.

Service Description	Proc Code	Mod #1	Mod #2	Rate Effective 07/01/15	Rate Effective 07/01/16	Unit Value	Comments
Behavior Therapies - Lead Therapist	H0004	U2		$ 21.64	$ 21.64	15 minutes	Combined maximum of $25,000 per Service Plan year.
Behavior Therapies - Senior Therapist	H0004	U2	HN	$ 11.21	$ 11.21	15 minutes	
Behavior Therapies - Line Staff	H2019	U2		$ 3.53	$ 3.53	15 minutes	
Initial / Ongoing Treatment Evaluation	H2000	U2		$ 20.08	$ 120.48	1 evaluation	Up to 90 minutes, included in $25,000 maximum per Service Plan Year.

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March 2017

Post Service Evaluation	H2000	U2	TS	$ 20.08	$ 20.08	15 minutes	Maximum of 6 units per Date of Service (In addition to the $25,000 per Service Plan year limit)

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

Modifier Update

The effective date of the following modifiers is **July 1, 2017**. These modifiers are informational only and do not affect reimbursement, but must be used when applicable. They will be required on both prior authorization requests and claims.

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 claims, along with the modifiers listed in the DMEPOS Billing Manual.

Notice: The U1, U2, and UC modifiers will not be available or required for **Durable Medical Equipment (DME)** prior authorizations or claims until further notice.

New Billing Requirement for Modifiers KH and KI

Effective March 1, 2017, the KH and KI modifiers cannot be used in place of the RR (Rental) modifier. They must be used in the secondary position, in addition to the RR modifier, on claims. KH and KI are informational only and do not affect pricing.

Modifier	Description
KH	DMEPOS item, initial claim, purchase or first month rental
KI	DMEPOS item, second or third month rental

The KH and KI modifier are not required on prior authorization requests and will no longer be entered into eQSuite™. The modifiers must be used on claims, when applicable, as noted in the DMEPOS Billing Manual.

Example:

PAR   Claims

E0720   RR   x2   First month rental
                                E0720   RR   KH   x1
                              Second month rental
                                E0720   RR   KI   x1

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colorado.gov/hcpf
March 2017

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

On February 2, 2016, CMS published the [Medicaid Program; Face-to-Face Requirements (F2F) for Home Health Services; Policy Changes and Clarifications Related to Home Health; Final Rule](). The federal rule became effective on July 1, 2016 and is codified at [42 CFR § 440.70]().

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.

Overview of the F2F Regulations

1. 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.

2. 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.

3. An F2F may be conducted by the following practitioners:

   a. Physician
   b. Physician Assistant
   c. Nurse Practitioner
   d. Clinical Nurse Specialist

4. The physician or allowed non–physician practitioner must document the occurrence of an F2F encounter.

5. If a non-physician practitioner performs an F2F encounter, they must communicate the clinical findings of the F2F encounter to the physician responsible for prescribing the related DME. Those clinical findings must be incorporated into a written or electronic document included in the member's medical record.

6. A physician who prescribes DME requiring an F2F encounter must document the following:

   a. F2F encounter was related to the primary reason the member requires the prescribed DME
   b. Practitioner who performed the F2F encounter
   c. Date of the F2F encounter
   d. F2F encounter occurred within the required timeframe

Prior Authorization of the F2F Codes

Beginning July 1, 2017, with the exception of oxygen, all F2F codes noted in the February 2017 Provider Bulletin will require prior authorization. The **physician's documentation** of the F2F encounter must be included with all prior authorization requests for F2F codes.

The <u>end date</u> of all prior authorizations for F2F codes cannot extend beyond six (6) months after the date of the F2F encounter. The prior authorization vendor, eQHealth, is aware of this requirement and will be able to assist with the allowable prior authorization date spans.

Example:
Date of F2F encounter: July 1, 2017
Date of PAR submission: August 10, 2017
Date range on PAR: August 10, 2017 – December 31, 2017

Codes That Will Require an F2F

Please refer to the February 2017 Provider Bulletin for the list of codes requiring an F2F encounter as of July 1, 2017.

Important Information for 340B Providers

The Colorado iC allows covered entities to indicate, at the claim level, if a physician-administered drug or an outpatient drug was purchased through the 340B Drug Pricing Program. This functionality helps the Department and covered entities ensure that drug manufacturers do not provide a discounted 340B price and a Medicaid drug rebate for the same drug (also known as a duplicate discount). The Department requests covered entities comply with the following requirements as soon as practicable, but **no later than June 1, 2017**.

Outpatient Drugs

As of February 25, 2017, all claims and encounters for outpatient drugs purchased through the 340B Drug Pricing Program must include the following on the NCPDP D.0 claim layout:

- The value of "20" in the Submission Clarification field (NCPDP Field #420-DK)
- The value of "08" **or** "05" in the Basis of Cost Determination field (NCPDP Field #423-DN)

For any outpatient drugs **NOT** purchased through the 340B Drug Pricing Program, covered entities do not need to submit any values to indicate that on the claim.

More detailed information on the NCPDP D.0 payer sheet specifications, has been posted to the Department's website.

Physician-administered Drugs

Beginning March 1, 2017, all claims and encounters for physician-administered drugs purchased through the 340B Drug Pricing Program should include the "UD" code modifier on the 837P, 837I, and CMS 1500 claim formats.

For any physician-administered drugs **NOT** purchased through the 340B Drug Pricing Program, no code modifier is required to indicate that on the claim.

The Department would also like to remind all covered entities that a valid NDC number must be included on all claims and encounters for physician-administered drugs. To assist providers with billing, an HCPCS/NDC crosswalk can be found under Appendices in the Billing Manuals section of the Department website.

Providers may send questions related to this notice to the Department.

Vision Billing Manual and Fee Schedule Changes

The Vision and Eyewear Billing Manual published on March 1, 2017, includes changes that align published billing policy with the current Medicaid Management Information System (MMIS). In addition, changes will be made to the fee schedule to align with the MMIS.

Previously, billing manual policy, prior authorization request (PAR) policy, the fee schedule, and the MMIS had conflicting information about Vision and Eyewear Benefit coverage. The Department has decided to align billing manual, fee schedule, and prior authorization documentation to the MMIS.

The MMIS was changed in 2012 to remove PAR requirements from many vision codes, as published in this [November 2012 provider bulletin](#).

The billing manual is now updated to reflect these changes. The revised billing manual states that only contact lenses require prior authorization. The revised billing manual also no longer describes a policy that may allow providers to charge Health First Colorado members for non-covered eyewear. The Department removed this language because it does not comply with federal regulations prohibiting charging clients for care.

The fee schedule will be updated to remove PAR requirements from V2744, V2745, V2750, V2755, V2770, V2780, and V2784. The MMIS currently has no PAR required for payment on those codes.

These changes to documentation are temporary, pending promulgation of a Vision and Eyewear Benefit rule later this year. Once the rule is approved, the fee schedule, MMIS, and PAR requirements may change again to align with the new rule.

Please email [Elizabeth Freudenthal](#), or call 303-866-6814 with any questions about these changes.

Hospital Providers

Additional Billing Changes

These are previously published billing changes that will go into effect on March 1, 2017.

Mental Health Hospital – TOB Change

- **In the legacy MMIS**

  The Department processed Mental Health Hospital claims with various TOBs.

- **Starting March 1, 2017**

  Fee-for-service claims and BHO encounters for Mental Health Hospital services, must be submitted with TOB 86x. Claims submitted with any other TOB will be denied.

Note: This applies only to inpatient services only, as there are no outpatient services for Mental Health Hospitals.

Institutional Claims – Line item DOS

- **In the legacy MMIS**

  The Department processed institutional claims, even if the Date of Service (DOS) was ONLY listed in the header.

- **Starting March 1, 2017**

  Institutional claims without a line item DOS, will be denied.

Hospital Engagement Meetings 2017

The Department will be holding multiple Hospital Engagement Meetings in 2017 to discuss current payment reform and operational topics moving forward. The next meeting is scheduled for March 3, 2017.

The agenda for upcoming meetings will be available on the Department's Inpatient Hospital Payment page in advance of each meeting.

Registration links for each session will also be available prior to the meeting. Just click on the link to register for a session. Attendees will then receive the link to connect to the webinar.

For more information, visit the Department's Inpatient Hospital Payment page, email Marguerite Richardson, or call 303-866-3839.

Upcoming meeting dates for 2017:

- March 3, 2017
- May 5, 2017
- July 7, 2017
- September 9, 2017
- November 3, 2017

Resubmitting Denied Claims Containing ICD-10 New Diagnosis Codes

Please remember to resubmit denied inpatient hospital claims affected by the ICD-10 diagnosis code updates effective October 1, 2016 to the iC system.

Please contact Diana Lambe if you have further questions.

Outpatient Hospital Crossover Medicare and Medicaid Claims

Due to an oversight in design, the Colorado iC MMIS is configured to process crossover outpatient hospital claims using the Enhanced Ambulatory Patient Grouping (EAPG) methodology for claims with all dates of service on or after October 31, 2016. Payment using this configuration will price crossover claims at the lower of one the following amounts:

- The sum of the Medicare coinsurance and deductible
- The difference between the Medicare payment and Medicaid payment as calculated through EAPG

However, due to complicated differences in payment methodologies and billing practices between Health First Colorado and Medicare, the Department intends to update its MMIS, so that payment will only be the sum of the Medicare coinsurance and deductible for all outpatient hospital claims with all service dates on or after October 31, 2016. No comparison between Medicaid and Medicare payment will take place. The Department is working with HPE to update the iC MMIS to reflect this change. Once this change is implemented, the affected claims will be mass adjusted and made identifiable on the Remittance Advice.

The Department will provide more information regarding timelines. For any questions in the meantime, please email Andrew Abalos or call 303-866-2130.

Pharmacy Providers

Prior Authorization Request Notification

Effective February 25, 2017, all PARs will be handled by Magellan Rx Management.

All PARs need to be called or faxed to the Colorado Pharmacy Call Center:

Phone Number: 800-424-5725

Fax Number: 800-424-5881

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