COLORADO Department of Health Care Policy & Financing

Provider Bulletin

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April 2017

All Providers

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Did You Know?

The Department of Health Care Policy and Financing (the Department) has published the Go-Live Transition Special Bulletin (B1700396). This special bulletin contains information critical to providers about the new Colorado interChange (iC) system, as well as the upcoming change for submitting CMS 1500 paper claims.

All Providers

CMS 1500 Paper Claim Form Requirement Change

As part of the transition to our new Fiscal Agent, Hewlett Packard Enterprises (HPE), Health First Colorado (Colorado's Medicaid Program) hopes to have all claims processed as quickly and efficiently as possible. For this to occur, **effective on or after April 17, 2017, only original red ink claim forms submitted to the Fiscal Agent will be accepted.**

All black and white CMS 1500 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.

This is to facilitate Optical Character Recognition (OCR) scanners to accept the claim form. 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. The result is that 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.

Timely Filing Reminder and Changes to Late Bill Override Dates (LBOD) in Colorado iC

As of March 1, 2017, 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.

If there is a primary payer, Medicare or a commercial third party insurance, the system will automatically calculate timely filing from the date of the Explanation of Medical Benefits (EOMB) entered, not the date of service. Providers do not need to use an LBOD to indicate Third Party Liability (TPL) on the claim. 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 calculated 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.

Provider Web Portal Enrollment, Resources, and FAQs

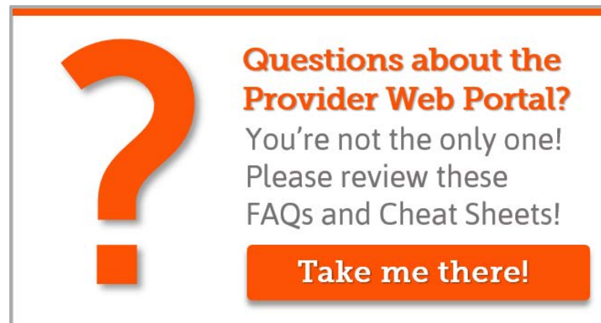
Most enrollment updates can be done through the provider web portal. Backdate requests and legal name changes currently need to be done via paper forms. All other provider changes should be done in the provider web portal. Forms for backdate requests and legal name changes can be found on the Forms page.

Remittance Advice (RAs)

RAs will be available for download every Monday morning, by 12 p.m. MST. You can get to your RA by logging into the Provider Web Portal → Resources Tab → Report Download → choose "MMIS Reports - RA" from the Report dropdown box.

835 Availability

835s will be available the Thursday following the Friday financial cycle. If you have a registered trading partner ID, 835s can be found under "file exchange", "download files".



eQHealth Prior Authorization Request (PAR) Revisions

Duplicate PARs Can Cause Delay

It is important to follow the correct PAR process for modifying an existing PAR. Please do not submit a new PAR to correct an issue or to modify an existing PAR. Duplicate PARs create confusion, delay the process, and result in the cancellation of your duplicate request.

Not all Prior Authorization Revisions are the Same

Please refer to the PAR Revision Guide when you need to request any changes to an existing PAR. The PAR Revision Guide provides detailed instructions for each service type. Some PAR Revisions require the submission of an eQHealth online helpline ticket, while other PAR Revisions are completed by selecting a "Modify Authorization" or "Continued Stay" review.

Here are a few common examples:

Please do not submit a new PAR to correct an issue or to modify an existing PAR.
Duplicate PARs create confusion, delay the process, and result in the cancellation of your duplicate request.

- eQHealth Online Helpline Request
  - Diagnostic Imaging: Request to change CPT code due to a contrast change.
  - Private Duty Nursing (PDN): Request to reallocate existing and approved units for Licensed Practical Nurse (LPN) and Registered Nurse (RN) procedures codes. - Do not submit a new request.

- Modify Authorization
  - Durable Medical Equipment (DME): Select "Modify Authorization" as the review type to increase units or add a procedure code to an existing PAR.

- Continued Stay
  - Occupational/Physical Therapy (OT/PT): Select "Continued Stay" as the review type to extend the date span for an existing PAR

For more information about PAR revision, please consult the PAR revision guides.

Definitions of Review Types

1. Admission (Initial PAR) – Select this review type for a new/initial PAR.

Please note: "Admission" is the terminology in eQSuite® for a new/initial PAR and does not indicate a hospital inpatient admission. The review type "Admission" should be used for most PARs submitted through eQSuite®.

Start

Review Type and Settings

Requesting Provider ID: Requesting Provider Name:

Are you the Billing Provider? Yes No

Billing Provider ID: Billing Provider Name:

Choose Setting: Surgical/Nonsurgical Outpt Therapy/CRT Eval Outpt Molecular Testing Outpt Diagnostic Imaging DME - Orthotics

Review Type: Admission eQHealth PAR Number: (or) APS PAR Number:

RETRIEVE DATA

2. Modify Authorization (PAR Revision) - Select this review type when there is a clinical need to increase or decrease units in a currently approved PAR, or to add a new service code within the same “from” and “thru” dates to an existing PAR.

Please note: “Modify Authorization” should not be selected if you need to change or add a procedure code due to "with or without contrast" changes for diagnostic imaging services. A helpline ticket should be submitted for this type of request.

Start
Review Type and Settings
Requesting Provider ID:
Requesting Provider Name:
Are you the Billing Provider? Yes No
Billing Provider ID:
Billing Provider Name:
Choose Setting: Surgical/Nonsurgical Outpt Therapy/CRT Eval Outpt Molecular Testing Outpt Diagnostic Imaging DME - Orthotics
Therapy Services: PT OT CRT Evaluation/Assessment
Review Type: Modify Authorization eQHealth PAR Number: (or) APS PAR Number:
RETRIEVE DATA

3. Continued Stay - Select this review type to extend the date span of a previously requested PAR. This is applicable for the private duty nursing, long term home health, and physical/occupational therapy settings. Use the “Admission” review type for other settings.

Start
Review Type and Settings
Requesting Provider ID:
Requesting Provider Name:
Are you the Billing Provider? Yes No
Billing Provider ID:
Billing Provider Name:
Choose Setting: Surgical/Nonsurgical Outpt Therapy/CRT Eval Outpt Molecular Testing Outpt Diagnostic Imaging DME - Orthotics
Therapy Services: PT OT CRT Evaluation/Assessment
Review Type: Cont Stay eQHealth PAR Number: (or) APS PAR Number:
RETRIEVE DATA

4. Retrospective PAR - Select the "Retrospective" review type if the service has already been rendered. There are several reasons for a retrospective review, including instances when a PAR could not be submitted on time due to client eligibility concerns. This type of request should be submitted as soon as possible to allow sufficient time for authorization to occur, and should be submitted prior to submission of the claim, per HCPF timely billing requirements. Please refer to the Retrospective PAR policy guidelines for additional information.

Start

Review Type and Settings

Requesting Provider ID: Requesting Provider Name:

Are you the Billing Provider? Yes No

Billing Provider ID: Billing Provider Name:

Choose Setting: Surgical/Nonsurgical Outpt Therapy/CRT Eval Outpt Molecular Testing Outpt Diagnostic Imaging DME - Orthotics

Therapy Services: PT OT CRT Evaluation/Assessment

Review Type: Retrospective eQHealth PAR Number: (or) APS PAR Number:

RETRIEVE DATA

If you are having trouble entering a revision request, please submit a Helpline Ticket through eQSuite® or call ColoradoPAR Customer Service at (888) 801-9355 and a member of the provider relations team will assist you.

Pharmacy Providers

Changes for Pharmacy Claims and Prior Authorization Processing

Pharmacy claims processing and Prior Authorization Request (PAR) processing was successfully transitioned to Magellan on February 25th, 2017.

What has **not** Changed due to the transition?

- Previously approved prior authorizations for Health First Colorado members' covered outpatient drugs
- Specialist Consultations (Pain management and child psychiatry)
- Pharmacist review of prior authorization by request if needed as an expanded review
- Pharmacy Forms can be found on the Department's website
- Prior Authorization criteria and the preferred drug list (preferred and non-preferred medications, other than specific changes as notified)
- 24 hour turnaround time for prior authorizations
- If a provider has incorrect contact information on file, this can be updated online on the provider web portal

- Drug Utilization Review board and Pharmacy and Therapeutics Committee meetings and members

What **has** changed due to the transition?

- Colorado Pharmacy Call Center for questions and PARs.
  Phone Number: 1-800-424-5725 and Fax Number: 1-800-424-5881
- Magellan staff will provide more clinical and consistent prior authorization reviews
- New provider web portal for pharmacies and prescribers

Important Information for 340B Providers

The Colorado iC will allow 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 will help 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 that covered entities comply with the following requirements **no later than June 1, 2017**.

Outpatient Drugs

All claims and encounters for outpatient drugs purchased through the 340B program should 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 program, covered entities do not need to submit any values to indicate that on the claim.

More detailed information is available on the Department's website regarding the NCPDP D.0 payer sheet specifications.

Physician-administered Drugs

All claims and encounters for physician-administered drugs purchased through the 340B 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 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 Appendix X.

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

April Preferred Drug List (PDL) Announcement

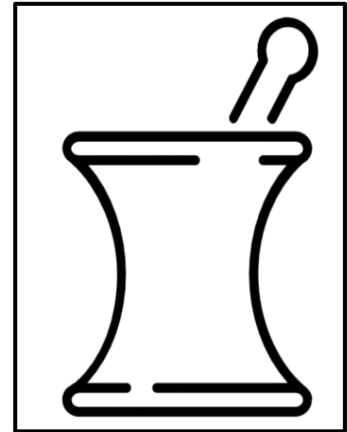
Below are the preferred products that will be effective for each drug class on April 1, 2017:

Alzheimer's Agents: donepezil 5mg and 10mg, donepezil ODT 5mg and 10mg, memantine tablets, Exelon Patch

- Galantamine products will now be non-preferred

Atypical Antipsychotics: aripiprazole tablet ODT and oral solution, clozapine, olanzapine, quetiapine IR, risperidone, risperidone ODT, ziprasidone

- Latuda will be second line
  - Current members stabilized on Latuda will be allowed to continue. New members must try and fail one preferred product before Latuda.
- Abilify tablet and Abilify ODT will require a DAW 1 to be dispensed as a Brand name product at point of sale.
- Generic aripiprazole tablet and ODT will be preferred agents.



Growth Hormones: Genotropin and Norditropin

- No change

Insulins:

- Rapid acting: Novolog vial and penShort acting: Humulin R vial
- Intermediate acting: Humulin N vial
- Long acting: Levemir vial and pen
  - Lantus will continue to be second line treatment
  - All other long-acting insulins will require a failure of Levemir and Lantus
- Mixtures: Humulin 70/30 vial, Humalog Mix 50/50 vial/pen, Humalog Mix 75/25 vial, Novolog Mix 70/30 vial/pen
- The pens for humulin 70/30, humulin N, humalog 75/25 and 50/50 will now be non-preferred

Intranasal Corticosteroids: fluticasone, Qnasl, and triamcinolone (generic Nasacort)

- Qnasl and triamcinolone are now preferred
- Nasonex and generic mometasone are now non-preferred

Leukotriene Modifiers: montelukast tablet and chewable tablet

MS Agents: Copaxone 20mg, Avonex, Betaseron and Rebif will be preferred

- All other agents will still be subject to prior authorization
- Prior authorization criteria have been updated, and can be found on the preferred drug list (PDL)

Ophthalmic Allergy Agents: cromolyn, Pataday, Pazeo, ketotifen (generic Zaditor)

- Generic patanol now non-preferred

Sedative-Hypnotics (non-benzo): eszopiclone, zaleplon, zolpidem

Statins/Statin Combinations: Crestor, atorvastatin, pravastatin, simvastatin

The April 1, 2017, PDL is posted on the Department's website. This can be found by going to the Forms page, and then selecting the Pharmacy tab. Please refer to this for all the detailed prior authorization criteria.

Other Pharmacy Updates:

- Benicar will pay at point of sale as brand name only. Generic Benicar (olmesartan) will require a Prior Authorization.
- Rosuvastatin will be preferred and brand Crestor will be non-preferred. Brand Crestor will require a Prior Authorization.

Pharmacy and Therapeutics Committee Meeting:

Tuesday, April 4th, 2017

1-5pm

303 E 17th Avenue

11th floor Conference Room

Upcoming Holidays

Holiday	Closed Offices/Offices Open for Business
Memorial Day Monday, May 29th	State Offices, DentaQuest, HPE, 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.

HPE Contacts

HPE Office
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Billing and Bulletin Questions
1-844-235-2387

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