COLORADO
Department of Health Care Policy & Financing

Provider Bulletin

Reference: B1800412

April 2018

Did You Know?

If the Colorado Department of Health Care Policy & Financing (the Department) implements rate increases, claims that were already billed with, and paid at, a rate lower than the new rate cannot be adjusted for the higher rate. **The Department will always use the "lower of" pricing logic**. Providers are advised to bill their usual and customary charges. Additionally, timely filing rules will not be waived to allow providers to adjust and rebill at the new rates. Refer to the October 2017 Provider Bulletin (B1700404) for more details on timely filing.

All Providers

Fingerprint – Federal Criminal Background Check (FCBC)

Beginning May 1, 2018, DXC Technology (DXC) will be mailing official requests for Fingerprint submissions to providers considered high risk on behalf of the Department. Providers will have 30 days from the date of the request letter to comply with this requirement. Individuals may **not** fingerprint themselves; fingerprints **must** be obtained from a law enforcement agency. Providers should contact their local law enforcement agencies to verify the agency has fingerprinting services available and to identify the associated cost. Most law enforcement agencies will provide the Applicant Fingerprint Card as part of their service.

Once the fingerprint card has been completed, mail the completed card(s) to:

DXC Technology
Attn: Provider Enrollment - Fingerprinting
P.O. Box 30
Denver, CO 80201

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

Fingerprint cards must be sent by the individual directly to DXC Technology for processing (see address above). Original cards must be sent; copies, faxes, emails or electronic versions will not be accepted.

Fingerprint cards are currently being accepted. Once the official fingerprint background check notification letter in May has been received, providers are limited to the 30 days from the date of the letter to respond.

Reminder: Health First Colorado (Colorado's Medicaid Program) Members Cannot Be Billed for Services

It is important that all health care providers know that **Health First Colorado members cannot be billed for services covered by Health First Colorado.**

Federal statutes and regulations provide that state Medicaid agencies must limit provider participation to those who will accept Medicaid reimbursement as "payment in full" (42 C.F.R. §447.15). Providers must participate in the state Medicaid agency to be reimbursed for covered services. Further, state Medicaid member payments are limited to **state-defined cost sharing arrangements** (42 U.S.C. §1396a (a)(14)). State Medicaid cost sharing arrangements are limited to established co-pays for services received.

Colorado law (C.R.S. 25.5-4-301(II)), provides that no Health First Colorado member shall be liable for the cost, or the cost remaining after payment by Health First Colorado, Medicare or a private insurer, of medical benefits authorized under Title XIX of the Social Security Act. This law applies whether or not Health First Colorado has reimbursed the provider, whether claims are rejected or denied by Health First Colorado due to provider error and **whether or not the provider is enrolled with Health First Colorado**. This law applies even if a Health First Colorado member agrees to pay for part or all of a covered service.

Payment may be collected from or billed to a Health First Colorado member only if the service rendered is not covered by Health First Colorado. In this situation, the Department strongly recommends that providers obtain a statement signed by the Health First Colorado member acknowledging that the specific service is not a Health First Colorado-covered benefit and agreeing to pay. Questions regarding whether or not a service is covered by Health First Colorado may be referred to the Provider Services Call Center at 1-844-235-2387.

For more information about this policy, visit the Policy Statement: Billing Health First Colorado Members for Services web page.

Accountable Care Collaborative (ACC): New Resources for Providers

The next iteration of the Accountable Care Collaborative is scheduled to begin July 1, 2018. The goals of the next phase are to improve member health and reduce costs.

The Department continues to prepare for the implementation of the next phase of the ACC and is working hard to ensure a smooth transition of the program. For a timeline of the major activities, visit the ACC Phase 2 web page. New webinars and fact sheets for providers, including contracting guidance, are also available on this page.

Additionally, interested parties can submit questions using the ACC Phase II Question Form on the ACC Phase 2 web page. The Department will not be able to respond directly to all inquiries, but will use the questions submitted to tailor upcoming communications and resources.

Health First Colorado Recovery Audit Contractor (RAC) Begins Work

In compliance with Section 6411(a) of the Affordable Care Act, the Department has contracted with Health Management Systems, Inc. (HMS) to serve as its RAC to conduct post-payment reviews of claims submitted for fee-for-service and managed care services. This is a federally-mandated contract program. In February, HMS began reviews to identify overpayments and assist the Department in recovering any overpayments made to providers for Health First Colorado and CHP+ medical claims.

The RAC audits claims from as far back as seven years (84 months) from the date the claim was originally paid, and this lookback period applies to **all claim and provider types**.

All providers are encouraged to update their contact information using the HMS RAC Provider Portal, even if they have not received a letter that they are in an active audit. This insures the letters get to the preferred address and personnel. Providers that have access to the HMS Provider Portal already for other contracts will need to register for HMS RAC Provider Portal to have access to the RAC audit information.

The HMS RAC Provider Portal is a tool that providers can use to track the progress of their audits and add contact information that is specific to RAC correspondence. **This is separate from the DXC Provider Web Portal.** If a provider does not update address and contact information in the HMS portal, all correspondence will go to the provider's service address listed in the Colorado interChange.

Visit the Recovery Audit Contractor (RAC) Program web page for resources and information available for providers. HMS has also published a number of resources for providers including a webinar and FAQs. For more information, visit the HMS Colorado RAC web page.

Contact RAC HMS Provider Services (available Monday – Friday, 8 a.m. - 5 p.m. MT) at 877-640-3419.

Updates to CMS 1500 Specialty Manual and Appendix T Billing Guidance

The Department has recently updated the CMS 1500 Specialty Manual and Appendix T billing guidance, which are now available to providers on the Billing Manuals web page. The changes made to the billing guidance reflect changes made to the Uniform Services Coding Standards, as well as general clean up.

Contact Stacey Davis at Stacey.Davis@state.co.us with any questions.

Durable Medical Equipment, Prosthetic, Orthotic and Supply (DMEPOS) Providers

Federal Upper Payment Limit (UPL) Requirement

As of January 1, 2018, Health First Colorado is required to comply with the Consolidated Appropriations Act of 2016 (Section 503) which limits Federal Medicaid reimbursement to states for DME to Medicare payment

rates. The original effective date was January 1, 2019, but the Cures Act (Section 5002) moved the effective date up by one year.

In December 2017, the Centers for Medicare & Medicaid Services (CMS) held a webinar that provided some guidance on complying with the DME limit. The Department continues to work with CMS to resolve outstanding questions regarding this compliance.

About the UPL:

1. Orthotics, prosthetics, and disposable supply codes are **not** included.
2. Only DME codes beginning with A, E and K are included.
3. If the DME code was not billed/paid by both Medicare and Health First Colorado during the prior calendar year, it is not included.
4. Medicare's DME competitive bid codes are not excluded.
5. Oxygen and some oxygen supplies are included. Per CMS, as oxygen cannot be utilized by a member without the accompanying supplies, they are an integral component of oxygen.

The Department received the final UPL code list near the end of February 2018.

Based on our reimbursement analysis, the Department anticipates there will be reductions to some of the impacted codes, with the largest impact applying to oxygen. There may be some codes that will increase. The Department is discussing (both internally and with stakeholders) possible mitigation strategies. Mitigation possibilities may be limited by Federal and State regulation and budgetary restrictions.

Additional information will be published as it becomes available.

Manual Pricing

Rate Increase

The state fiscal year (FY) 2017-18 Long Bill granted a 1.402% rate increase for DMEPOS, effective July 1, 2017. Codes with a fee schedule rate have been reprocessed at the new, higher rate, but the manually priced codes will continue to be reprocessed by DXC over the next month or so.

The following are the new manually priced percentages for manufacturer suggested retail price (MSRP) and invoice methodologies.

MSRP less 18.33%

Invoice plus 19.50%

The DMEPOS Billing Manual and the Code of Colorado Regulations, 10 CCR 2505-10, Section 8.590.7, will be updated to reflect the new percentages.

Billing Process Change – By Invoice

As of July 2018, A9901 will no longer be used for Invoice Manual Pricing. The percentage above the Invoice cost will be calculated in line with the base code, similar to how MSRP works.

Example of current process, maximum allowable:

E1399 UB	$1000 (actual invoice cost)
A9901 UB	$195.00 (19.50% of the invoice cost)

Process beginning July 2018, maximum allowable:

E1399 UB $1195.00 (actual invoice cost + 19.50%)

- The claims' submitted charge/billed amount should reflect the Usual and Customary charge (U&C)*
- The math for calculating the maximum allowable must be shown. It may be added to the invoice or a separate attachment. Using the above example:
  - $1000 x 1.195 = $1195.00, or
  - $1000 x .195 = $195.00 + $1000 = $1195.00
  - If the full quantity on the invoice was not provided to the member (i.e. a bulk order), a breakdown of the cost per unit multiplied by the quantity provided must be shown. In the instance where a manufacture puts the cost per unit on their invoice, the per unit price calculation does not need to be shown. However, the unit price does need to be multiplied by the quantity provided.
- After verifying the calculation, claims processors will price the claim at the lower of *U&C or (actual invoice cost + the percentage).

***U&C**: What a provider would charge the general public for the product.

Calculations

For manually priced codes, claim processors apply the percentage **last** when calculating the maximum allowable.

For both MSRP and Invoice methodologies, please use caution when multiplying by a percentage. Best practice is to apply the percentage **last**. If your claim has more than one unit on it and you multiply a single unit by the percentage before multiplying by the total units, it is recommended that you retain **no less** than four digits after the decimal. Even with a four-decimal place retention, due to rounding discrepancies, the final total may not be accurate.

Example: B4100 UB

130 units

$0.67 per unit

Percentage applied last: $0.67 x 130 = $87.10

$87.10 x 1.195 = **$104.08**

2 decimal places retained: $0.67 x 1.195 = $0.80

$0.80 x 130 = **$104.00**

4 decimal places retained: $0.67 x 1.195 = $0.8007

$0.8007 x 130 = **$104.09**

Billing Manual Update

The Department is working to update the DMEPOS Billing Manual. Once published, please refer to the Revision Log at the end of the manual for a full list of updates and their associated page numbers.

Reminder to Providers

Claims Must Match Documentation

The Department would like to remind DMEPOS providers that delivery documentation such as delivery tickets and shipping invoices must match the date of service billed and entered on claims pursuant to state and federal audit requests.

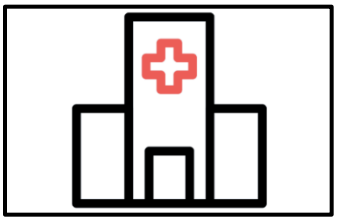
Contact HCPF_DME@state.co.us with questions.

Hospital Providers

General Updates

INPATIENT HOSPITAL

State Requirements to Receive the Medicare Low Volume Payment (LVP) Adjustment in Hospital's Medicare Base Rate



The Bi-Partisan Budget Act of 2018 which was signed into law on February 9, 2018, extended Medicare low-volume hospital payments through 2022. Current low volume payments will continue unchanged requiring less than 1,600 discharges during the fiscal year to qualify. According to the February 28, 2018, **mlnconnects newsletter**, CMS will be re-issuing Table 14 at some point. The Department uses Table 14 to compute the LVP in the Medicare Base Rate which is the starting point for the Medicaid Base Rate. For a provider to receive LVP in the Medicare Base Rate, two things must happen:

1. **Hospitals must be in contact with their Fiscal Intermediaries (Novitas or WPS) as soon as possible to receive Medicare LVP this year (FY 2018):** For hospitals that qualified for the low-volume adjustment in FY 2016-17, this written verification could be a brief letter stating that the hospital continues to meet the low-volume hospital distance criterion as documented in a prior low-volume hospital status request. Again, refer to the **mlnconnects newsletter** for more information.

2. **The State will then have to request updated DRG Disclosures from the fiscal intermediaries in order to officially grant LVP to hospitals** not participating in the CMS Rural Community Hospital Demonstration.

Contact Diana Lambe at Diana.Lambe@state.co.us with further questions.

OUTPATIENT HOSPITALS

Monthly Enhanced Ambulatory Patient Groups (EAPG) Meetings

Starting February 9, 2018, the Department moved the biweekly EAPG Meetings to monthly meetings. These meetings are intended to be an informal discussion where the Department and its hospital providers can

discuss issues relating to billing, payment, and/or the EAPG methodology in general. For recordings of previous meetings, related meeting materials and the current schedule for future meetings, visit the Outpatient Hospital Payment web page. The next meeting will be on May 4, 2018. Please note that there are currently no meetings scheduled for April 2018.

Note: Starting March 30, 2018, EAPG Meetings have been rescheduled to a new time. EAPG Meetings will now be held from 1 - 3 p.m.

Contact Andrew Abalos at Andrew.Abalos@state.co.us or 303-866-2130 for any questions regarding the new EAPG rates or the EAPG methodology in general.

Mass Adjustment of Xerox EAPG Claims Update

The Department and DXC are concluding testing for claims processed through the Xerox legacy system which should have been paid using the EAPG methodology. The Department began reprocessing these claims in mid-March 2018. Due to the claim volume, this process will take several weeks to complete. The Department will be closely monitoring the results to ensure that unexpected takebacks do not occur -- if claims do not process as expected, the Department may delay the reprocessing.

For continuing up to date information regarding the scheduling of mass adjustments on EAPG claims, please review the information found on the Outpatient Hospital Payment web page or attend the Monthly EAPG Meetings.

Contact Andrew Abalos at Andrew.Abalos@state.co.us or 303-866-2130 for assistance in identifying claims which have been adjusted.

Outpatient Cost Settlements

Beginning March 19, 2018, issues and inquires related to Outpatient Cost Settlements will be handled by Andrew Abalos. Contact Andrew Abalos at Andrew.Abalos@state.co.us or 303-866-2130.

SPECIALTY HOSPITALS

Meetings

The next Specialty Hospital Meetings regarding the Budget Neutral Rate will be April 6, 2018, from 1 - 2 p.m. Contact Elizabeth Quaife at Elizabeth.Quaife@state.co.us with questions, concerns or feedback.

For more information, visit the Specialty Hospital section on the Hospital Engagement Meetings web page.

Note: Starting May 4, 2018, the Specialty Hospital Meetings will move to a new time. Specialty Hospital Meetings will be held from 3 - 4 p.m.

ALL HOSPITAL PROVIDERS

Hospital Engagement Meetings

The Department hosted multiple Hospital Engagement Meetings in 2017 to discuss current issues regarding payment reform and operational processing moving forward. The next meeting is scheduled for **Friday, May 4, 2018, from 9:00 a.m. - 12:00 p.m. at 303 E. 17th Ave., Denver, Conference Room 7B & 7C.**

Sign up to receive the Hospital Engagement Meeting newsletters.

Registration for the Hospital Engagement Meetings are no longer required. Participation can be by conference line, webinar and/or in person. The agenda for upcoming meetings will be available on our external website approximately one week in advance of each meeting. Visit the Hospital Engagement Meeting web page for more details and the meeting schedule.

Contact Elizabeth Quaife at Elizabeth.Quaife@state.co.us if you have any questions and/or topics that you would like to be discussed at future meetings. Advanced notice will provide the Department's rates section time to bring additional Department personnel to the meetings to address different concerns.

In-Home Support Services (IHSS) Providers

Rule Changes for In-Home Support Services (IHSS)

The Medical Services Board has approved changes to the rules regarding IHSS effective April 30, 2018. The Department will hold two provider training webinars reviewing the rule changes:

April 17, 2018
10 - 11:30 a.m. MT
Register for the webinar training here

April 19, 2018
2:30 - 4 p.m. MT
Register for the webinar training here

This webinar is intended for IHSS provider agency staff to learn about IHSS rule changes, including the new referral process and updated roles and responsibilities. Advanced registration is required. Only one session needs to be attended.

In conjunction with the rule change, IHSS forms have been updated and are available at Participant Directed Programs – IHSS Forms. IHSS Agencies should use the new versions moving forward.

Contact Erin Thatcher at Erin.Thatcher@state.co.us or 303-866-5788 for more information on IHSS.

Pharmacy and All Medication-Prescribing Providers

April Preferred Drug List (PDL) Announcement

The following drug classes and preferred agents will become effective April 1, 2018:

Atypical Antipsychotics
Preferred products will be: Aripiprazole Tab/ODT/Soln, Clozapine Tab/ODT, Latuda (*with step*), Olanzapine Tab, Quetiapine IR Tab, Risperidone Tab/Soln/ODT, Ziprasidone Cap

Growth Hormone
Preferred products will be: Genotropin, Norditropin

Insulins (Rapid, Short, Intermediate, Long, Mixtures)
Preferred products will be: Novolog Vial/Pen, Humulin R Vial, Humulin N Vial, Levemir Vial/Pen, Lantus (with step), Humulin 70/30 Vial, Humalog 50/50 Vial, Humalog 75/25 Vial, Novolog 70/30 Vial/Pen

Intranasal Corticosteroids
Preferred products will be: Fluticasone propionate, Nasonex (brand name only), Triamcinolone OTC

Leukotriene Modifiers
Preferred products will be: Montelukast Tab/Chewable

Multiple Sclerosis Agents
Preferred products will be: Orals: Gilenya (30 count bottle), Tecfidera, Aubagio; Injectables: Avonex, Betaseron, Rebif, Copaxone 20 mg (brand only)

Neurocognitive Disorder Agents
Preferred products will be: Donepezil 5mg/10mg Tab/ODT, Exelon Patch (brand name only), Memantine Tab

Ophthalmic Allergy
Preferred products will be: Cromolyn, Ketotifen, Pazeo, Lastacaft

Sedative Hypnotics (benzodiazepine and non-benzodiazepine)
Preferred products will be: Eszopiclone, Zaleplon, Zolpidem, Temazepam 15mg and 30mg, Triazolam

Statins and Statin Combinations
Preferred products will be: Atorvastatin, Pravastatin, Rosuvastatin, Simvastatin

The PDL is posted on the Pharmacy Resource web page. Please refer to this for all the detailed prior authorization criteria.

Pharmacy and Therapeutics Committee Meeting:

Tuesday, April 10, 2018
1 - 5 p.m.
303 E. 17th Ave., Denver
7th Floor Conference Rooms A, B & C

The meeting agenda can be found on the Pharmacy and Therapeutics (P&T) web page.

Upcoming Changes for Sedative Hypnotic Medications

Effective April 1, 2018, duplicate therapy for sedative hypnotic medications will not be covered. Only one agent in the sedative hypnotic drug class on the Preferred Drug List will be approved at a time. Patients or providers who are concerned that a benzodiazepine agent prescribed for seizures may not be covered with another sedative hypnotic medication prescribed for sleep should contact the Magellan Rx Management Pharmacy Call Center at 1-800-424-5725 for an override. As a reminder, there is no guarantee of reimbursement if patients choose to pay out-of-pocket for medications with rejected claims at the pharmacy.

Requiring Indications for Growth Hormone Agents

Effective April 1, 2018, growth hormone agents will require a qualifying diagnosis code for coverage. Coverage will be authorized with clinical history of the following ICD-10 diagnosis codes:

- **Q-87** Prader-Willi Syndrome

- **N18, N19** Chronic renal failure or insufficiency
- **K-96** Turner's Syndrome
- **E-23, E-89.3** Hypopituitarism resulting from pituitary disease, hypothalamic disease, surgery, radiation therapy or trauma
- **R-64, B20** Cachexia associated with AIDS
- **Q-87** Noonan Syndrome
- **K-91.2** Short bowel syndrome

Growth hormones will still be subject to verification of preferred or non-preferred product criteria and qualifying diagnoses will be verified in the claims system through AutoPA.

Contact Jeffrey Taylor at Jeffrey.Taylor@state.co.us for additional information.

Drug Utilization Review (DUR) Announcements

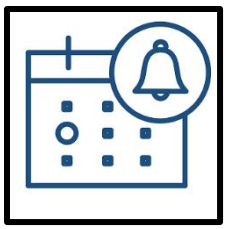
DUR Board Member Position Openings

Do you or somebody you know have a passion for serving Coloradans served by Health First Colorado and availability for a quarterly three-hour meeting where you may contribute your expertise to discussion on medication use criteria for the state of Colorado? If so, the DUR Board is announcing the following openings for new board members:

- One physician board member position
- One pharmacist board member position
- One industry representative board member position

The first meeting will be scheduled in May (date TBD). Contact Brandon Utter at SSPPS.co-dur@ucdenver.edu for more information.

Date of Service (DOS) Reminder



As a reminder, the DOS is the date the prescription was filled by the pharmacy. For auditing purposes, pharmacy providers must be able to substantiate that the DOS submitted on a claim was the date the prescription was filled.

Please see citation to rule for all information that should be included on pharmacy claims:

10 CCR 2505-10, Section 8.800.10.B. Each claim must identify the member, prescribing physician, **date of service**, National Drug Code number of the drug actually dispensed, prescription number, quantity dispensed, days' supply, the Usual and Customary Charge and any other information required by the Department.

Contact Kristina Gould Kristina.Gould@state.co.us with any questions.

Pharmacy Cost of Dispensing Survey

Mercer Health & Benefits LLC (Mercer) is conducting a survey on the cost of dispensing prescription drugs to Health First Colorado members. The Department is required to conduct this survey every two state fiscal

years per the Medicaid State Plan. The survey packets were sent to pharmacy providers in March and the responses are due to Mercer by April 23, 2018. The Department strongly encourages pharmacy providers to participate because the survey findings will be a significant factor in reviewing the dispensing fees currently paid to pharmacies.

Contact Colorado.SMAC@state.co.us with questions related to the survey.

Physician Services

Pricing for Unlisted Surgical Procedure Codes

The Department is aware of pricing issues for unlisted surgery claims and is currently working on a solution to correct the pricing issues. Currently, unlisted surgical procedure codes are pricing at 50 percent of billed charges as an interim solution to this issue. Once the solution is implemented for manually priced surgical services, all claims with DOS on or after March 1, 2017, will be mass adjusted to correct reimbursement. DXC and the Department are working on a resolution.

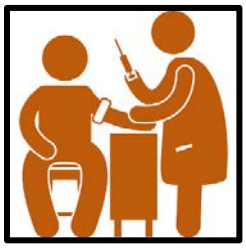
Billing Bilateral Procedures

Effective May 1, 2018, the use of modifier 50 to report bilateral procedures will be changed to reflect National Uniform Billing and Coding standards. Previously the Department required bilateral procedures be reported on two lines, with modifier 50 added to the second line. Beginning May 1, 2018, bilateral procedures will be reported on one line by adding modifier 50 to the appropriate procedure code, using one unit of service.

Reimbursement methodology for bilateral procedures, as well as other requirements in the Medical and Surgical Services Billing Manual, will remain unchanged.

Contact Jesse Durfee at Jesse.Durfee@state.co.us for additional information.

Physician-Administered Drug Rates



The Department will be changing the Physician-Administered Drug rates per the quarterly update requirement. The new rates will take effect for dates of service on or after April 1, 2018. The online fee schedule will be posted before the start of the quarter and can be found under the Physician Administered Drug Fee Schedule drop-down section of the Provider Rates & Fee Schedule web page.

Contact Sam Gosney at Sam.Gosney@state.co.us with questions.

Physician Services, Federally Qualified Health Clinics (FQHC), Rural Health Clinics (RHC), Indian Health Services (IHS) - FQHC

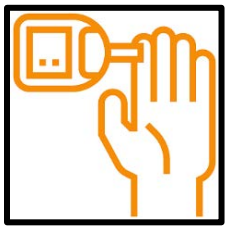
Diabetes Self-Management Education (DSME) Coverage

Providers and entities facilitating or interested in becoming accredited to facilitate DSME, please refer to the previous bulletin article about the program.

The DSME benefit covers:

Up to 10 hours of diabetes-related training within a consecutive 12-month period, which includes:

- One hour for either a group or individual assessment
- Nine hours for group-only diabetes education
- Up to two hours of follow-up training each year after the initial 12-month period



The initial 12-month period begins at the time of submission of the first claim for the benefit. These trainings can be performed in any combination of 30-minute increments.

Information regarding patient eligibility and necessary diagnostic criteria can be found in the DSME Reimbursement Toolkit.

Accreditation

Providers who would like to become involved with DSME and receive reimbursement for services to Health First Colorado members must first become accredited. CMS recognizes two accrediting organizations: (1) American Diabetes Association's Education Recognition Program (ERP), and (2) American Association of Diabetes Educators' Diabetes Education Accreditation Program (DEAP). The Department requires accreditation from one of these two programs.

For more information about each of these programs, please contact the organizations directly:

- Association of Diabetes Educators (Diabetes Education Accreditation Program)
  www.diabeteseducator.org | 1-800-338-3633 or education@aadenet.org
- American Diabetes Association (Education Recognition Program)
  www.diabetes.org | 1-800-DIABETES

Informing the Department of Accreditation

In order to receive reimbursement, the Department must be informed once a provider or entity completes accreditation by either of the two programs listed above. Proof of accreditation must be submitted along with one's Provider ID/Health First Colorado ID and National Provider Identification (NPI).

Reimbursement

Facilities providing DSME can bill using revenue code 0942 and identify the appropriate procedure codes on the claim. Individual providers who render DSME can bill the procedure codes.

The procedure codes for DSME are Healthcare Common Procedure Coding System (HCPCS) codes:

- G0108 (30-minute units, two (2) units per day) for individual counseling
- G0109 (30-minute units, two (2) units per day) for group counseling

Health First Colorado members are only allowed 20 combined units of DSME per year, including up to two combined units of G0108 and up to 18 combined units of G0109.

Per the Fee Schedule, reimbursement is as follows:

- G0108: $40.79
- G0109: $11.20

Accredited DSME Providers Registered with Health First Colorado

American Association of Diabetes Educators	American Diabetes Association
Fort Collins Diabetes Education Program (Banner Health)	Diabetes Self-Management Education Program (San Juan Family Medicine – Multiple Providers)
Loveland Diabetes Education Program (Banner Health)	Axis Health System
Greeley Diabetes Education Program (Banner Health)	La Plata Integrated Health (Axis Health System)
Wray Community District Hospital	Barbara Davis Center for Diabetes (Multiple Providers)
Dr. Elizabeth Kern	University of Colorado Hospital Diabetes Self-Management Program – Central Campus
Barbara Davis Center for Diabetes (Dr. Peter Gottlieb)	Kit Carson County Health and Human Services

Contact Jessica Pekala at Jessica.Pekala@state.co.us or Richard Delaney at Richard.Delaney@state.co.us with questions or to request more information.

Call the Provider Services Call Center at 1-844-235-2387 with any billing questions.

Speech Therapy Providers

Speech Therapy Coverage Determination Notice

Speech therapy using a horse is not a covered State Plan benefit. It is considered experimental and investigational. Providers are prohibited from billing any CPT code for this service.

Complete billing and policy guidance can be found in the outpatient speech therapy manual. Contact Alex Weichselbaum at Alex.Weichselbaum@state.co.us with questions.

Transportation Providers

Hospital Discharge Process

The Department recognizes the challenges with transportation upon discharge from the hospital for many Health First Colorado members.

To assist in the improvement of members' transportation at discharge, please plan as far in advance as possible during the discharge planning process. This includes speaking with the member about using free resources, including family and friends. If free transportation is not available and the member must use Non-Emergent Medical Transportation (NEMT), contact the State Designated Entity prior to discharge to assist in obtaining an NEMT provider available at the time of discharge.

Please remember NEMT is only available if the member has no other means of transportation.

Please contact the State Designated Entity for any questions on the process to arrange NEMT services. For a list of State Designated Entities, visit the NEMT web page.

Hospital Providers in the Veyo Service Area

Reminder: Transportation providers are not required to have wheelchairs on-board their vehicles. If the hospital has a contract with a provider that does carry wheelchairs on-board, that transportation provider can be requested when calling Veyo — there is no need to specify to the agent that the patient needs those items to be provided by the transportation provider. There is no guarantee that the requested provider is available to accommodate the trip, nor a guarantee that a wheelchair-equipped vehicle will be available.

Note: The Veyo Service Area includes Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson, Larimer and Weld Counties.

Upcoming Holidays

Holiday	Closed Offices/Offices Open for Business
Memorial Day – Monday, May 28, 2018	State Offices, DentaQuest, DXC and the ColoradoPAR Program will be closed. The receipt of warrants and EFTs may potentially be delayed due to the processing at the United State Postal Service or providers' individual banks.

DXC Contacts

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

Provider Services Call Center
1-844-235-2387

DXC Mailing Address
P.O. Box 30
Denver, CO 80201