COLORADO
Department of Health Care Policy & Financing

Provider Bulletin

Reference: B2500518

Jan. 2025

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Did You Know?

Claims will be denied beginning January 1, 2025, if providers do not revalidate.

Providers must resubmit any denied claims if the revalidation is completed after the due date. The Provider Revalidation Dates spreadsheet, listing all providers and their revalidation dates, is posted on the Revalidation web page under "Revalidation Resources". Providers are reminded to submit their revalidation applications by their listed due date. New applications, revalidations and enrollment updates are currently being processed by Department of Health Care Policy & Financing's (the Department) fiscal agent within five (5) business days on average.

Improve health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado.

All Providers

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and Visit Allowances

Well-Child Visits for Members Under Age 21

Health First Colorado (Colorado's Medicaid program) does not impose a limit on the number of well-child visits per calendar year or within any 365-day period for members under the age of 21. This policy aligns with the Bright Futures Periodicity Schedule.

For example, if a child misses a scheduled well-care visit and has another visit scheduled earlier than usual within the same calendar year or 365-day period, both visits are permitted.

Contact Gina Robinson at Gina.Robinson@state.co.us with questions or for clarification.

Reminder: EPSDT Benefits for Members Under Age 21

Providers play a crucial role in leveraging EPSDT benefits to optimize health outcomes and ensure timely, comprehensive care for members under the age of 21.

Federal law (42 U.S.C. § 1396d(r)) mandates that Medicaid programs, including Health First Colorado, provide EPSDT services for members under the age of 21.

Key details about EPSDT benefits:

- **Broad Coverage:** EPSDT ensures coverage for any medically necessary service to "correct or ameliorate" a condition identified during screening, even if the service is not covered for adults or included in the Colorado State Medicaid Plan (Health First Colorado).
- **Definition of Ameliorate:** "Ameliorate" includes improving, maintaining or preventing the worsening of a health condition and avoiding additional health issues.
- **Robust Benefits:** EPSDT benefits for individuals under the age of 21 are more comprehensive than adult Medicaid benefits and include a unique medical necessity definition.
- **Provider Role:** Services must be prescribed by an enrolled treating provider and may require prior authorization.

Health First Colorado is required to provide or arrange for all necessary treatments, directly or through appropriate referrals.

Refer to 10 CCR 2505-10 § 8.280.4.E or contact the EPSDT team at HCPF_EPSDT@state.co.us for additional information.

Feasibility Study - Coverage of Housing & Nutrition Services

House Bill 24-1322 directs the Department to assess whether it is feasible to expand certain housing and nutrition services through Health First Colorado that address members' Health-Related Social Needs (HRSN). If any components are found to be budget neutral, the Department must seek federal authorization no later than July 1, 2025.

It has been determined that certain services are feasible based on ongoing expansion work, and an amendment request was submitted to add certain HRSN services to the 1115 Substance Use Disorder (SUD) waiver in Summer 2024. While there is significant supporting evidence for the rest of the components and some infrastructure in Colorado, the budget is difficult to estimate and would exceed federal financial requirements. There are also timeline constraints that make pursuing additional amendments at this time difficult. The feasibility of expansions will continue to be estimated in a future study, HB23-1300 "Continuous Eligibility Medical Coverage," due by the start of 2026.

Read the full study and find webinar materials on the HRSN web page. Contact HCPF_HRSN@state.co.us for more information.

Health First Colorado and Child Health Plan *Plus* (CHP+) Will Expand to Cover Children and Pregnant People Regardless of Immigration Status

All Colorado children ages 18 and younger and pregnant people living in Colorado, no matter their immigration status, will soon be able to obtain full health coverage through Health First Colorado and Child Health Plan *Plus* (CHP+) through Cover All Coloradans.

These members will have access to full Health First Colorado and CHP+ benefits and may seek services from a provider without additional action needed by providers.

What does this mean for providers?

Expectations and requirements for providers are the same for these members as any other member. Current processes such as checking eligibility and submitting claims will not change. Providers do not need to bill differently for these members.

The expected impact to providers is limited to a potential increase in patients seeking services. These new members may not speak English as their first language. Providers are reminded that they need to provide language access to members for their medical services. The Regional Accountable Entities (RAEs) can assist with accessing translation or interpretation services if needed.

How do people enroll for coverage?

Individuals eligible for coverage through Cover All Coloradans can apply by completing the paper application or electronically by visiting the Program Eligibility Application Kit (PEAK) application form and by utilizing all traditional application resources.

Visit the Cover All Coloradans: Health Benefits for Children and Pregnant Persons web page for more information. Contact HCPF_CoverAllCO@state.co.us with any questions.

Provider Enrollment Application Fee for Calendar Year 2025

Certain providers are required by the Affordable Care Act (ACA) to remit an application fee when applying to be part of the Health First Colorado provider network. The Centers for Medicare & Medicaid Services (CMS) sets the fee annually. This fee is assessed at initial enrollment, revalidation and change of ownership, as required, and is assessed in full for each service location enrolled in Health First Colorado.

The Provider Enrollment application fee has been set at $730 for the 2025 calendar year.

Provider Services Call Center Transition Coming This Spring

The Department announced that management of the Provider Services Call Center will transition from Gainwell Technologies (Gainwell) to OptumInsight (Optum) beginning in Spring 2025 when Gainwell's contract expires.

What does this mean?

Gainwell currently manages the Provider Services Call Center and assists providers with claims submissions and billing questions, member eligibility, provider enrollment assistance and the Provider Web Portal.

This vendor change will only apply to the Provider Services Call Center that providers call for the above inquiries. The Care and Case Management (CCM), Dental, Pharmacy and Electronic Visit Verification (EVV) call centers will not change. Visit the Provider Contacts web page for a complete list of assistance resources. More information will be shared about changes as the transition approaches. Some changes will include:

- A new phone number
- Ability to avoid waiting on hold by having an agent call back in order of the queue
- Ability to provide valuable feedback about a call during an after-call survey

Will the Provider Web Portal or Colorado interChange change?

No, Gainwell will continue as the vendor managing the Colorado interChange and Provider Web Portal. Gainwell and Optum will work together closely to ensure high quality resolution to provider questions and concerns.

Why is the Provider Services Call Center vendor changing?

The Department is required by state and federal regulations to solicit competitive bid packages from vendors on a regular basis.

The Department believes this transition will enhance member preventive service options and capabilities for providers and is committed to minimizing disruptions and keeping providers informed as the transition nears. Visit the Colorado Medicaid Enterprise Solutions (CMES) Transition web page for more information.

Reminder: Update Address for Internal Revenue Service (IRS) Form 1099 in Provider Web Portal

Providers are encouraged to ensure the IRS 1099 form mailing address on file with Health First Colorado is accurate by January 1, 2025. Providers may add, view or modify the IRS 1099 form mailing address through the Provider Maintenance option in the Provider Web Portal. A confirmation letter will be sent to all linked provider service locations when an update is completed.

The letter will contain:

- The provider service location ID (Health First Colorado Provider ID)
- Information about the user who completed the change
- Details of the address changes made (previous and new)

Note: The IRS 1099 form mailing address is linked to the associated tax ID. If multiple provider IDs share the same tax ID, and one provider changes the 1099 address, that address will change for all providers with that tax ID.

Visit the Provider Maintenance - Provider Web Portal Quick Guide web page and view Address Changes for instructions on how to update an address in the Provider Web Portal.

All Providers Who Utilize the ColoradoPAR Program

What is the ColoradoPAR Program?

The ColoradoPAR Program is a third-party, fee-for-service (FSS) Utilization Management (UM) program administered by Acentra Health, Inc. Visit the Colorado Prior Authorization Request Program (ColoradoPAR) webpage for more information about the ColoradoPAR Program.

Acentra Health Provider Training

Acentra Health will provide general PAR submission training for all providers and benefit-specific training for Pediatric Long-Term Home Health providers beginning in January 2025. General PAR submission training is appropriate for all new users and includes information on how to submit a PAR using Acentra's provider PAR portal, Atrezzo®. The training dates and times are listed below in Mountain Time (MT).

- PAR Submission Training January 13, 2025, 12:00 p.m.
- PAR Submission Training January 14, 2025, 8:30 a.m.
- PAR Submission Training January 16, 2025, 3:00 p.m.
- Pediatric Long Term Home Health Training January 21, 2025, 3:00 p.m.
- Pediatric Long Term Home Health Training January 23, 2025, 12:00 p.m.

- Pediatric Long Term Home Health Training January 27, 2025, 12:00 p.m.
- Pediatric Long Term Home Health Training January 29, 2025, 8:30 a.m.
- Long-Term Home Health Open Hours February 4, 2025, 9:00 a.m.
- Long-Term Home Health Open Hours February 6, 2025, 12:00 p.m.
- Long-Term Home Health Open Hours February 13, 2025, 9:00 a.m.

PAR submission training is appropriate for all new users and includes information on how to submit a PAR using Acentra's provider PAR portal, Atrezzo®.

Contact COProviderIssue@acentra.com with questions or if needing assistance when registering for Atrezzo® training or accessing the portal. Visit the ColoradoPAR Training web page for additional training information.

Adverse Determination Options: Reconsideration and Peer-to-Peer (P2P) Process

What options do providers have for an Adverse Determination, also known as a PAR Denial?

Providers can request a PAR Reconsideration for any adverse determination (see page 61 in the Acentra Provider Manual). A Reconsideration request must be submitted to Acentra Health within 10 business days of the initial denial. Providers may upload additional supporting documentation for the case. Ordering providers may request a P2P review within 10 business days of the review determination after an adverse decision (see page 61 in the Acentra Provider Manual). A P2P allows the ordering provider to discuss the case with an Acentra Health physician reviewer, provide clarification or additional information, or to gain a clearer understanding of why a request was denied. The P2P process provides a dedicated scheduler to confirm a mutually agreed upon date and time for the P2P call to take place. These calls are most helpful when new information is provided.

Contact either the Colorado PAR Program UM Team at HCPF_UM@state.co.us or Acentra Provider Relations COProviderIssue@acentra.com with questions or for assistance.

Diagnostic Imaging PAR (Prior Authorization Request) Update

Current Procedural Terminology (CPT) 78431 (Myocardial imaging with positron emission tomography (PET) and computed tomography (CT) scan, perfusion study)

- A mismatch between a code available for PARs in the billing manual and within Atrezzo® was identified and corrected.
- As of December 1, 2024, PARs are now available within the Atrezzo® portal for this code. Claims should no longer be denied for not having a PAR if an appropriate PAR is submitted and approved.

Inpatient Hospital Transitions (IHT) (Formerly Inpatient Hospital Review Program [IHRP 2.0])

IHT (formerly Inpatient Hospital Review Program [IHRP 2.0]) went live on September 9, 2024, and its role in the Hospital Transformation Program (HTP) was finalized on October 1, 2024. The Joint Operating Committee (JOC) meetings will continue to be facilitated throughout the first quarter of 2025. Hospitals providing IHT are encouraged to attend the JOC meetings to ask questions, discuss workflows and troubleshoot issues. Contact HCPF_UM@state.co.us to be included on the meeting invite if attending for the first time. The remaining JOC meetings will be on January 2, 2025, February 4, 2025, and March 13, 2025, at 1:00 MT.

A Question and Answer document specific to IHT and the HTP is available on the IHT web page for reference.

Contact the Colorado PAR Program UM Team at HCPF_UM@state.co.us or Acentra Provider Relations at COProviderIssue@acentra.com with any additional questions.

Long-Term Home Health – Prior Authorization Request (PAR) Resumption Information

The federal requirement for Pediatric Long-Term Home Health (PLTHH) PARs is planned to be reinstated by April 6, 2026, as mandated by 42 CFR 456.6(a). The implementation will follow a phased, gradual approach to ensure a smooth transition and to minimize disruptions for providers.

The first phase of this PAR Resumption Plan is the **voluntary Soft Launch** of PAR requirements for the following Home Health services:

- Physical Therapy (PT)
- Occupational Therapy (OT)
- Speech Therapy/Speech-Language Pathology (ST/SLP)

The Soft Launch period will begin on February 3, 2025, and will remain available until the Maintenance of Eligibility (MOE) requirement for Colorado is lifted by the Centers for Medicare and Medicaid Services (CMS), but not before May 1, 2025. Given the uncertainty of the end date, Home Health Agencies (HHA) are strongly encouraged to avoid delays in submitting therapy PARs for review to the UM vendor, Acentra Health. Denials will not be issued and services will not be interrupted during the Soft Launch. Submission trends will be monitored, and educational support to providers will be provided as needed. Further information, including the timeline for reinstating PAR requirements for all PLTHH services (e.g., Registered Nurse [RN] and Certified Nurse Assistant [CNA] services) are outlined in Operational Memo HCPF-OM 24-060.

- Refer to the Acentra Health Provider Training section above for dates, times and training registration for instructor-led PLTHH-specific PAR training via webinar; LTHH office hours; and general PAR submission training.

Reminders for Pends and Adverse Determination Options

Pends:

Providers have 10 business days to respond to a pend issued by Acentra Health. If there is no response to the pend, the case will be technically denied for lack of information.

Adverse Determinations:

The provider then has 10 business days to request a PAR Reconsideration or a Peer-to-Peer (P2P) Review after the date on the denial letter. If the provider does not request a reconsideration or peer-to-peer review within that timeframe, a new PAR will need to be submitted.

Contact either the Colorado PAR Program UM Team at HCPF_UM@state.co.us or Acentra Health Provider Relations at COProviderIssue@acentra.com with questions or for assistance.

Behavioral Health Providers

State Plan or B3 Modifiers on Behavioral Health Claims

All first position modifiers which indicated a State Plan (SP) service or a "B3" service (e.g. HE, HF, HJ, HK, HM, HQ, HT, TM, TT, U4) were deleted from the State Behavioral Health Services (SBHS) Billing Manual on January 1, 2024.

Regional Accountable Entities (RAEs) have been instructed to deny claims that include the SP or B3 modifiers on claims in the first position in the coming weeks.

Resubmit a new or corrected claim without the SP or B3 modifier if a claim denial is received.

American Society of Addiction Medicine (ASAM) 4th Edition Transition Survey for 3.2-Withdrawal Management (WM) Providers

Behavioral Health Administration (BHA) and the Department are in need of specific information about agency transition plans in regard to the ASAM 4th Edition changes that will affect ASAM 3.2-Withdrawal Management (WM) facilities. Information submitted through the ASAM 4th Edition Transition Survey for 3.2-WM Providers will be compiled, reviewed and addressed with agencies and will help identify supports needed across the state.

This survey will gather information about the proposed option of expanding the crisis services continuum by building in a receiving center-type model. Facilities would evolve to become combined Walk-In-Crisis (WIC) and Crisis Stabilization Units (CSUs) with withdrawal management protocols. Agencies can review the comparison document of current WM-WIC-CSU requirements to help inform consideration of this proposal.

Providers should submit the ASAM 4th Edition Transition Survey for 3.2-WM Providers by close of business on January 15, 2025, to allow for review and action to occur early in the new year.

This information will also be accepted by email at CDHS_BHARuleFeedback@state.co.us.

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

Clarification on Billing Behavioral Health Evaluation and Management (E/M) Procedure Codes

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) must soon submit one (1) claim using revenue code 900, including the appropriate evaluation and management (E/M) code(s), to Health First Colorado for members receiving fee-for-service (FFS) behavioral health E/M services.

A visit that includes FFS behavioral health E/M services and other behavioral health services should include ***all*** behavioral health services in the visit on the claim billed to Health First Colorado.

FQHCs and RHCs should submit claims to the appropriate Regional Accountable Entity (RAE) when billing for E/M consultation codes 99242 through 99245. Refer to Appendix E of the State Behavioral Health Services Billing Manual for information on when it is appropriate to use these consultation codes.

FQHCs and RHCs can receive one (1) encounter payment for a behavioral health visit for a single patient in one day per 10 CCR 25-05-10 8.700.

Updated language can be found in the Federally Qualified Health Center and Rural Health Clinic billing manual.

Home and Community-Based Services (HCBS)

Enhanced Required Home and Community-Based Services (HCBS) Provider Training

Newly enrolling HCBS providers have been required since August 13, 2021, to watch recorded online training about the enrollment process and complete a quiz to demonstrate understanding of the content.

The Provider Enrollment and Revalidation online training webinar has been updated and expanded. The updated training includes a comprehensive review of the Department's HCBS

enrollment and revalidation process, the Colorado Department of Public Health and Environment (CDPHE) certification and licensure process, best business practices for HCBS providers and important information about the Settings Rule.

Revalidating providers will soon be required to complete the training as well. Certification of completion will be generated at the end of the training module and must be attached to new and revalidation applications. Applications without a certificate attached may be denied or returned to the provider.

Refer to Operational Memo 24-061 located on the 2024 Memo Series Communication web page for more information on the training. Contact HCPF_HCBS_Questions@state.co.us with any questions.

Home and Community-Based Services (HCBS) Waiver, Program of All-Inclusive Care for the Elderly (PACE), Adult Long-Term Home Health Providers

Colorado Direct Care Training is now available on Colorado's Direct Care Careers platform

The **Colorado Direct Care Training** (ARPA 1.03 Standardized Core Curriculum and Specialization) curriculum is now available on the Direct Care Careers platform. This training is designed for providers working in a variety of care settings and with different populations and uses a flexible "universal worker" approach. Over 30 modules are available for HCBS providers to use in their onboarding and annual training and for individuals interested in learning more about caregiving. The Direct Care Careers platform is also available for providers to advertise open positions to job-seekers and for individual users to access a variety of Colorado-specific resources related to supporting members.

Learn more about how to sign up for the Direct Care Careers platform through these videos:

- Individual Sign-Up: Direct Care Careers Colorado Demonstration for Applicants
- Consumer-Direct Attendant Support Services (CDASS): Direct Attendant Direct Care Careers Colorado Demonstration for CDASS
- Provider Sign-Up: Direct Care Careers Colorado Demonstration for Providers

Contact HCPF_BaseWage@state.co.us with questions on how to access the training modules or the Direct Care Careers platform.

Retroactive Rate Increase and Direct Provider Payment

An American Rescue Plan Act (ARPA) Home and Community-Based Services (HCBS) **retroactive rate increase for select services** is anticipated to be implemented, pending approval from the Joint Budget Committee (JBC).

Providers **must** submit all claims for the time period July 1, 2024, through December 31, 2024, **no later than February 28, 2025,** to receive the subsequent payment based on this

rate increase. Providers are encouraged to submit claims for this time period as soon as possible, following billing requirements.

Statewide Home and Community-Based Services (HCBS) Service Code Changes beginning January 1, 2025

Providers are advised of statewide changes in billing practices and service codes relative to Denver Minimum Wage Regional Pricing.

Claims adjudication will no longer be based on the member's county of residence on file beginning January 1, 2025. Providers serving members eligible for Home and Community-Based Services (HCBS) with dates of service on or after January 1, 2025, should bill either the Denver rate or the non-Denver (standard) rate based on where the service was rendered.

Providers should add the HX modifier as described on the Rate Schedules when billing services rendered within Denver. The HX modifier will not appear on HCBS Prior Authorization Requests (PARs). These claims no longer need to be submitted with the procedure code T2034 or include the valid Denver ZIP code of the service location to the claim 'Note' field.

Some statewide standard HCBS service codes are changing soon to accommodate the Denver Minimum Wage Regional Pricing changes. Case managers must use the new HCBS service codes when adding services to PARs with service line start dates of January 1, 2025, or later. All existing PAR lines impacted by these standard HCBS code changes will automatically be revised. Case managers may need to manually revise PARs if the units need to be adjusted on these PAR lines. HCBS providers should contact case managers if PAR revisions are required to adjust units based on service utilization.

Refer to the HCBS Fee Schedules on the Provider Rates and Fee Schedules web page for more information on these code changes. The HCBS Billing Manuals will be updated on the Billing Manuals web page shortly.

Update Regarding the Department's Actions to Support Long-Term Services and Supports (LTSS) Members and Providers

Resolving the billing issues for services to LTSS members is a priority for the Department. The information below is a reminder and follow-up to information previously distributed. Continue to follow the actions below:

1. Continue to render previously authorized services to members for service dates on or after July 1, 2023, even if the HCBS Benefit Plan or Prior Authorization Request (PAR) is no longer there. Providers should bill within timely filing guidelines for all services rendered. The Benefit Plan will be manually created and added to the member's eligibility, and the claim will be reprocessed.
2. Resubmit previously denied or suspended claims monthly. Claims will be reprocessed as new system fixes are implemented. There may be additional issues related to a

member's eligibility determination or a missing Benefit Plan that can cause a claim to be denied or suspended. System fixes are being implemented to mitigate these payment impediments.

3. Do not contact a county or Case Management Agency (CMA) to resolve claims processing issues. Contact the Provider Services Call Center.

There is a process to review provider claim submissions for accuracy, request additional documentation on questionable claims and recoup payments if they were paid incorrectly.

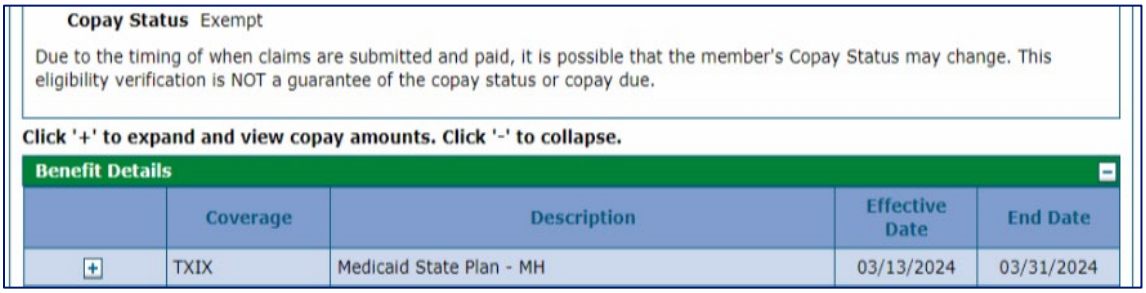
Member Eligibility Verification: Waiver Benefit Plan

Providers can see when a member has the HCBS Aid Code and Level of Care (LOC) for HCBS services in the Provider Web Portal.

In the screenshot below from the Provider Web Portal Eligibility Verification screen, the member has the 'MH' aid code for HCBS LOC and the Medicaid HCBS Benefit Plan, but there is no HCBS Benefit Plan (e.g., Elderly, Blind and Disabled [EBD]).

This means the member is eligible for HCBS but the specific Medicaid HCBS Benefit Plan has not yet been created in the interChange.

Refer to the Provider Web Portal Eligibility Verification Quick Guide for more guidance.



Previously reported and implemented strategies:

1. Claims may be processed for previously approved services for a specific member even if there is not an active PAR in the system.
2. Member HCBS Benefit Plans are being extended if an existing HCBS Benefit Plan or an existing HCBS PAR is not found. Providers should verify eligibility to identify the member's current HCBS Benefit Plan and check for a PAR to determine what services are authorized for the member. The provider should continue to provide and bill for the services that were previously authorized for the member if the HCBS Benefit Plan (e.g., the Benefit Plan only shows 'MH') or PAR is not found.

Current and future strategy:

1. The Department implemented another strategy to mitigate terminations for missing LOC determinations, until further notice. When eligibility is determined, a 12-month extension will be applied to the current LOC end date and will not terminate eligibility with that extension. This will help resolve provider payment issues associated with lapses in LOC determinations.

2. Starting with September 2023 renewals, the Department temporarily paused terminations for most reasons (unless the termination was for a member who moved out of state or passed away) for two (2) months past the LTSS member's original termination date. In March 2024, the Department began to manually reinstate eligibility for all LTSS members when their eligibility was set to end and prevented impacted members from being terminated from Health First Colorado.

    - The manual process that has been in place since March 2024 will no longer be in use.
    - Terminations with a temporary pause for 60 days after the termination date for Long-Term Care (LTC), Buy-In Program for Working Adults with Disabilities (WAwD) and Buy-In Program for Children with Disabilities (CBwD) soon will be implemented.
    - This 60-day extension will apply for most termination reasons, not just procedural ones, allowing members extra time to submit their renewal packets with supporting documents and to work with their eligibility technician to resolve any issues with their case. There are specific termination reasons that will not be eligible for this 60-day extension, including:
        - Death
        - Incarceration
        - No longer a Colorado resident
        - Withdrawal from the program
    - During this period, an initial letter will be sent to members informing them that their termination has been paused, explaining the reasons for this pause and what they need to do as next steps.
    - Eligibility will automatically be re-evaluated in the second month of the extension.
        - Ongoing eligibility will be approved if a member meets all eligibility requirements and submits the necessary documentation.
        - Eligibility will terminate at the end of the 60 days if a member does not meet the eligibility requirements or fails to provide the required information.
    - Members will receive a formal Notice of Action before the end of the 60-day period that outlines whether they remain eligible or if their eligibility will end, along with information about their appeal rights.
    - If a member has been determined to no longer meet eligibility, they are entitled to a 90-day reconsideration period which begins at the end of eligibility (after the end of the 60-day extension). During this 90-day reconsideration period, if the member is able to submit all of the required paperwork or work with an eligibility technician to resolve any issues with the case and is then deemed eligible, their eligibility will be reinstated for their original termination date.

What will appear in the Provider Web Portal:

Providers may see adjusted claims on the Remittance Advice (RA) statements.

- If a claim is paid without a PAR on file, the claim will be automatically reprocessed once there is an applicable PAR. Providers will see that the claim was adjusted and paid on the RA, but no additional payment will be issued.
- All billed services are expected to align with an approved PAR. The Department has not determined a date for when the PAR edits will be set back to Deny when a service is not matched to a PAR at this time.
- If a claim is suspended or denied because of a missing HCBS Benefit Plan or PAR, it will be reprocessed based on the new HCBS Benefit Plan or PAR when those become available.
- If a claim is suspended with a service that will only pay if the rate is on the PAR, the service will either be manually priced or will be reprocessed based on the new Benefit Plan or PAR when those become available.

Denied or suspended claims:

Claims may be denied for other reasons. If a service was previously paid, the service would be denied for duplicate service edits.

Providers may anticipate larger RA statements, which include adjusted claims. This is necessary to get payments to providers in a timely manner.

Impact to providers:

Providers will see a net increase in reimbursements. This should continue as stabilization efforts continue.

The Department is committed to overcoming these challenges through focused actions, partnership, transparency and communication. Visit the new Stabilizing Eligibility & Case Management for Long-Term Services & Support (LTSS) Members webpage to learn more.

Use the escalations form to notify the Department of members who are experiencing difficulty with the eligibility renewal process.

Providers should contact the Fiscal Agent's Provider Services Call Center with questions about denied claims or other issues with billing or verifying member eligibility. Claims questions submitted via the webform will be redirected to the Provider Services Call Center.

Hospice Providers

Rate Update Effective October 11, 2024, Through June 30, 2025

Guidance and approval from the Centers for Medicare and Medicaid Services (CMS) regarding the Hospice rate update effective October 11, 2024, through June 30, 2025, is being awaited. Federal Fiscal Year (FFY) 2024-2025 Hospice rates will be effective October 11, 2024, instead of October 1, 2024, due to an error. Reimbursement for the dates of service October 1, 2024,

through October 10, 2024, will reflect the Fiscal Year (FY) 2023–2024 Hospice Fee Schedule on the Provider Rates and Fee Schedule web page.

The Department will update the Hospice rates once this communication is received. Reimbursement should reflect updated rates for all claims billed for dates of service on or after October 11, 2024. The Hospice Fee Schedule effective October 11, 2024, through June 30, 2025, will be posted to the Provider Rates and Fee Schedule web page under the Hospice category upon implementation of the rates.

It is anticipated the Hospice rates will align with the state fiscal year to reflect the approved across-the-board rate changes appropriated by the Joint Budget Committee.

Hospital Providers

General Updates

Hospital Stakeholder Engagement Meetings

Bi-monthly Hospital Stakeholder Engagement Meetings will be hosted by the Department to discuss current topics regarding ongoing rate reform efforts and operational concerns. Sign up to receive the Hospital Stakeholder Engagement Meeting newsletters.

- The next Hospital Stakeholder Engagement Meeting is set for **Friday, January 10, 2025, from 1:00 p.m. to 3:00 p.m. MT** and will be hosted virtually.

Visit the Hospital Stakeholder Engagement Meeting web page for more details, meeting schedules and past meeting materials. Calendar Year 2025 meeting dates have been posted.

Contact Della Phan at Della.Phan@state.co.us with any questions or topics to be discussed at future meetings. Advanced notice will provide the Facility Rates Section time to bring additional Department personnel to the meetings to address different concerns.

All Patient Refined-Diagnosis Related Group (APR-DRG) Version 40 Update

Version 40 of the APR-DRG methodology and its associated weight table has been updated. Claims with a last date of service on or after October 1, 2024, will be reprocessed with a retroactive claims adjustment.

Visit the Inpatient Hospital Payment web page to locate the weight tables that will be implemented. Visit the Hospital Stakeholder Engagement Meetings web page to review webinar recordings of the meetings.

Email Diana Lambe Diana.Lambe@state.co.us and Andrew Abalos at Andrew.Abalos@state.co.us with questions or concerns.

Outpatient Hospital Providers

Health First Colorado as Secondary Payer Pricing Logic Update

The application of Other Insurance (OI), also known as Third-Party Liability (TPL), to claims where Health First Colorado is the secondary payer is not accurate for claims priced under the Enhanced Ambulatory Patient Group (EAPG) methodology. The OI payments are not being fully applied to the claim prior to Health First Colorado making payment as secondary payer.

The system logic will be updated as of January 8, 2025, so EAPG claims with OI are priced correctly by deducting the total prior payments from the Health First Colorado allowed amount. Providers can reference the Third-Party Liability section of the General Provider Information Manual for additional information and a claim example.

Contact ThirdParty_Liability@state.co.us with any questions.

Laboratory Service Providers

Newly Covered Benefit Current Procedural Terminology (CPT) 81513

CPT code 81513 will soon be a covered benefit under Health First.

Contact Sarah Kaslow at Sarah.Kaslow@state.co.us with any questions.

Nursing Facilities

Nursing Facility Swing Bed Rate Upcoming

The nursing facility swing bed rate is required to be updated annually by Department rule 10 CCR 2505-5 §8.443.and "shall be determined as the state-wide average class I nursing facilities payment rate on January 1 of each year."

The updated swing bed rate is $284.42. The rate has been updated in the Colorado interChange, and claims reimbursement should soon reflect the updated rate for dates of service.

Physician-Administered Drug (PAD) Providers

Physician-Administered Drug (PAD) Billing Unit Requirements

Claims billed for PADs should be submitted with accurate Healthcare Common Procedure Coding System (HCPCS) units, National Drug Code (NDC) units and units of measure.

Providers should bill for one (1) HCPCS unit and the amount of NDC units administered to the member for miscellaneous PAD procedure codes, including but not limited to J3490, J3590 and J9999. These codes may be manually priced based on the NDC units administered to the member and require an invoice to be attached to the claim.

Temporary, pass-through and permanent PAD procedure codes should be billed for both the appropriately converted HCPCS units and the amount of NDC units administered to the member.

Reference the HCPCS/NDC Crosswalk (Appendix X) to convert to HCPCS units. The HCPCS description quantity and unit of measure must be utilized to convert and bill for accurate HCPCS units.

Examples:

Miscellaneous PAD Procedure Code	
PAD	Cosentyx
Amount administered to the member	125 mg
HCPCS	J3590
HCPCS Description	Unclassified Biologics
NDC	00078116861
NDC Description	Cosentyx 125 mg / 5 mL vial
HCPCS units to be billed [Amount of PAD administered divided by HCPCS unit description]	1
NDC units to be billed	5 mL

Permanent PAD Procedure Code	
PAD	Medroxyprogesterone
Amount administered to the member	150 mg
HCPCS	J1050
HCPCS Description	Injection, medroxyprogesterone acetate, 1 mg
NDC	67457088700
NDC Description	Medroxyprogesterone acetate 150 mg/mL
HCPCS units to be billed [Amount of PAD administered divided by HCPCS unit description]	150 mg / 1 mg = 150
NDC units to be billed	1 mL

Pass Through PAD Procedure Code	
PAD	Aponvie
Amount administered to the member	32 mg
HCPCS	C9145
HCPCS Description	Injection, aprepitant, (aponvie), 1 mg
NDC	47426040101
NDC Description	Aponvie 32 mg / 4.4 mL vial
HCPCS units to be billed [Amount of PAD administered divided by HCPCS unit description]	32 mg / 1 mg = 32
NDC units to be billed	4.4 mL

Additional information may be found on the PAD Provider Resources web page. Contact HCPF_PAD@state.co.us with any policy questions.

Quarter 1 Rate Update 2025

The Physician Administered Drug (PAD) rates for the first quarter of 2025 have been updated. The new rates will soon be effective and are posted to the Provider Rates & Fee Schedule web page under the Physician Administered Drug Fee Schedule section.

Pharmacies and All Medication Prescribers

Opioid Medication Updates

Xtampza ER, Nucynta IR and Nucynta ER will no longer be participating in the Medicaid Drug Rebate Program (MDRP). These medications are currently preferred products but will no longer be a covered benefit on January 1, 2025. Visit the Pharmacy Resources web page for a list of opioid products on the Preferred Drug List to consider as alternatives.

Prescriber Tool Alternative Payment Model (APM) Update

The Prescriber Tool Alternative Payment Model web page has been updated for Program Year 2, including a list of eligible practices searchable by Practice Business Name or National Provider Identifier (NPI). The slides and recording from October 2024's webinar discussing the

updates being made to Year 2 can also be found on the Prescriber Tool Alternative Payment Model web page.

Program Year 2 for Prescriber Tool APM began in October 2024. The activity window begins in January 2025. Eligible providers should look for an email in mid-January 2025 with a link to complete the activities required and be eligible for payment.

The Prescriber Tool APM is an upside-risk-only program designed to incentivize increased and consistent use of the Prescriber Tool by Health First Colorado providers receiving Fee-for-Service (FFS) payments for their outpatient pharmaceutical claims, specifically the Real-Time Benefits Inquiry (RTBI) module, and prescription of preferred medications where clinically appropriate.

Contact HCPF_PharmacyAPM@state.co.us with any questions.

Physicians, Clinic Providers

Free Screening, Brief Intervention and Referral to Treatment (SBIRT) Training for Health First Colorado Providers

Free SBIRT training for Health First Colorado providers is provided through partnership with Peer Assistance Services, Inc. (PAS). PAS has provided SBIRT training and support since 2006. The SBIRT program promotes prevention and early intervention efforts through in-person, online and virtual training; technical assistance; and hands-on SBIRT implementation.

In order to directly deliver screening and intervention services, providers are required to participate in training that provides information about the implementation of evidence-based protocols for screening, brief interventions and referrals to treatment. Face-to-face trainings and consultations are available through various entities such as SBIRT Colorado, Colorado Community Managed Care Network and the Emergency Nurses Association.

Visit the PAS training calendar to register for an upcoming training. The shared goal is to promote SBIRT as a standard of care throughout Colorado. Refer to the SBIRT Billing Manual to learn more about best billing practices.

Contact Janelle Gonzalez at Janelle.Gonzalez@state.co.us with questions.

Physician Services

Bariatric Surgery Rule Revision Stakeholder Meetings

Stakeholders are invited to participate in a series of virtual meetings to discuss revising the bariatric surgery rule. These meetings will build on feedback from earlier sessions, where stakeholders expressed a preference to revise the rule rather than remove or leave it unchanged.

Department staff will provide an overview of the current rule, present proposed revisions based on feedback and open the floor for discussion to gather stakeholder input.

Meeting Dates:

- **Meeting 1:** Thursday, January 23, 2025, 9:30 a.m.–12:30 p.m. MT
- **Meeting 2:** Thursday, March 13, 2025, 9:30 a.m.–12:30 p.m. MT

Location: Virtual via Zoom. **Register in advance**

Meeting Accommodation and Language Access Notice: Auxiliary aids and services for individuals with disabilities and language services for individuals whose first language is not English may be provided upon request. Notify HCPF_Stakeholders@state.co.us at least one week prior to the meeting to make arrangements.

Visit the Bariatric Surgery Rule Change Consideration web page or contact HCPF_Stakeholders@state.co.us for more information.

Colorado Medicaid eConsult Update

Health First Colorado providers have access to a free and secure statewide electronic consultation platform through ColoradoMedicaideConsult.com. eConsult allows Primary Care Medical Providers (PCMPs) to communicate electronically with Specialty Providers, frequently eliminating the need for in-person referrals for members.

Available Specialties for clinical guidance include:

Adult Specialties (21): Addiction Medicine, Allergy and Immunology, Cardiology Dermatology, Endocrinology, Gastroenterology, Hepatology, Geriatric Medicine, OB/Gynecology, Hematology/Medical Oncology, Infectious Disease, Nephrology, Neurology, Orthopedics, Otolaryngology (ENT), Pain Medicine, Physical Medicine/Rehabilitation, Psychiatry, Pulmonology/Sleep Medicine, Rheumatology, Urology

Pediatric Specialties (16): Allergy and Immunology, Cardiology, Dermatology, Developmental Pediatrics, Endocrinology, Gastroenterology, Hematology/Oncology, Infectious Disease, Nephrology, Neurology, Orthopedics, Otolaryngology (ENT), Psychiatry, Pulmonology, Rheumatology, Urology

Specialty Update: Adult OB/GYN specialists are available to respond to eConsults for adult and adolescent patients aged 14 and above.

Getting Started with Colorado Medicaid eConsult:

Practices can complete the Practice Enrollment Form to begin the enrollment process or attend an upcoming Monthly Program Overview Webinar from 12:30 p.m. to 1:00 p.m. MT for more information.

Contact ColoradoSupport@safetynetconnect.com with any questions.

eConsult Reimbursement:

Refer to the Telemedicine Billing Manual for details on eConsult reimbursement.

Additional information:

Visit the eConsult Platform web page for more information or email the eConsult team at HCPF_eConsult@state.co.us.

Therapy Providers

Stable and Facility Fees in Therapies Using Hippotherapy as a Treatment Tool

Providers delivering hippotherapy, also known as equine movement, as a treatment tool may not charge members any stable fees or facility fees when delivering hippotherapy within outpatient physical therapy, outpatient occupational therapy and outpatient speech therapy. Providers who have charged any members for stable or facility fees related to this covered service must cease doing so immediately. Contact Devinne Parsons at Devinne.Parsons@state.co.us with any outpatient therapy policy questions.

Vision Providers

Ordering, Prescribing and Referring (OPR) Claim Identifier Mandate

In the coming months, Health First Colorado will begin editing vision services claims for compliance with federal OPR regulations (42 CFR § 455.440).

The following providers are eligible to **order, prescribe or refer** vision services when enrolled with Health First Colorado and licensed by the Colorado Department of Regulatory Agencies (DORA) or the licensing agency of the state in which they do business: Optometrists, Ophthalmologists and Physicians.

The following providers are eligible to **render** vision services when enrolled with Health First Colorado and licensed by DORA or the licensing agency of the state in which they do business: Optometrists, Ophthalmologists and Opticians.

The OPR provider indicated on the claim **must** be actively enrolled with Health First Colorado (42 CFR § 455.410(b)). The claim will be denied if the indicated provider is not actively enrolled

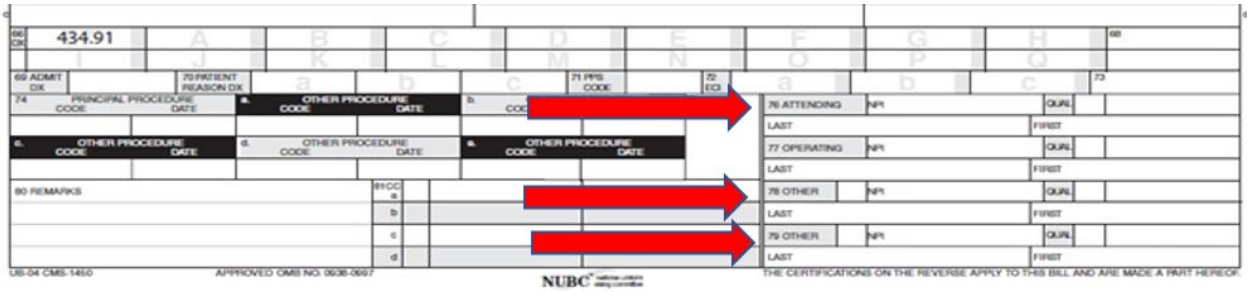
It is important for OPR providers to understand the implications of failing to enroll in Health First Colorado. Providers who render services to Health First Colorado members based on the order, prescription or referral from an OPR provider will not be reimbursed for such items or services unless the OPR provider is enrolled.

Vision providers are reminded to include the OPR providers on claims and to ensure the OPR provider is currently enrolled with Health First Colorado. The OPR field on the CMS 1500

professional claim form is 17b and in fields 76-79 on the UB-04 institutional claim form. This field may be labeled as Referring Provider in the Provider Web Portal. Claims with services requiring OPR provider(s) will post Explanation of Benefits (EOB) 1997- "The referring, ordering, prescribing or attending provider is missing or not enrolled. Please resubmit with a valid individual National Provider Identifier (NPI) in the attending field," if the OPR provider is not enrolled with Health First Colorado.

Below is a visual example of the CMS 1500 claim form with an indicator of where the NPI number should be populated:

UB-04 outpatient hospital claims would populate the required NPI in the attending provider field (#76) or the Other ID field (#78 or #79). The following is a visual example of where the OPR NPI must be populated:



The OPR mandate is not currently denying claims for missing OPR NPIs. However, missing OPR NPIs will result in claims denials beginning April 1, 2025.

Providers are highly encouraged to sign up to receive Department communications.

Contact the Provider Services Call Center with questions about claim denials. Contact Christina Winship at Christina.Winship@state.co.us with questions on policy.

Refer to the Vision Care and Eyewear Manual for more information on billing vision claims.

Refer to the Claim Identifier Project web page for more information about OPR requirements.

Women's Health

Prenatal Plus Program Billing Manual Update

The Prenatal Plus Program billing manual has been updated to include clarifying language for billing behavioral health services and Cover All Coloradans eligibility, which will provide coverage for children, pregnant and postpartum people who would be eligible for Health First Colorado and CHP+ if not for immigration status.

Contact HCPF_MaternalChildHealth@state.co.us with questions or concerns about the program.

Provider Training Sessions

January 2025 Schedule

Providers are invited to sign up for a provider training session. Training sessions focused on Health First Colorado are offered:

- Provider Enrollment
- Beginner Billing: Professional Claims (CMS-1500)
- Beginner Billing: Institutional Claims (UB-04)
- Intermediate Billing: All Claim Types

All sessions are held via webinar on Zoom, and registration links are shown in the calendar below. The availability of training sessions varies monthly.

Provider Enrollment

Provider enrollment training is designed for providers at various stages of the initial enrollment process with Health First Colorado. It provides an overview of the program and guidance on the provider application process, including enrollment types, common errors and enrollment with other entities (e.g., DentaQuest, Regional Accountable Entities [RAEs], Health First Colorado vendors). It also provides information on next steps after enrollment. Note that it does not provide guidance on revalidation for already enrolled providers.

Beginner Billing Training

There are two (2) beginner billing training sessions offered. One (1) is for providers who submit professional claims (CMS 1500), and the other is for providers who submit institutional claims (UB-04). These training sessions are identical except for claim submission specifics.

Click "Which Beginner Billing Training Do I Need?" on the Provider Training web page to find training aligned to provider type.

Beginner billing training provides a high-level overview of member eligibility, claim submission, prior authorizations, Department website navigation, Provider Web Portal use and more.

Staff who submit claims, are new to billing Health First Colorado services or who need a billing refresher course should consider attending one of the beginner billing training sessions.

Intermediate Billing Training

Intermediate billing training covers claims processing and Remittance Advice (RA) via the Provider Web Portal and batch, secondary billing with commercial insurance and Medicare, attachment requirements, timely filing, suspended claims, adjustments and voids, reconsiderations, resubmissions and more.

Provider-Specific Training

Provider-specific training sessions cover topics unique to providers. Visit the Provider Training web page for information on upcoming provider-specific training.

Note: These sessions offer guidance for Health First Colorado only. Providers are encouraged to contact the Regional Accountable Entities (RAEs), Child Health Plan *Plus* (CHP+) and Medicare for enrollment and billing training specific to those organizations. Training for the Care and Case Management (CCM) system will not be covered in these training sessions. Visit the CCM System web page for CCM-specific training and resources.

Refer to the Provider Web Portal Quick Guides located on the Quick Guides web page for more training materials on navigating the Provider Web Portal.

Live Webinar Registration

Click the title of the desired provider training session in the calendar to register for a webinar. An automated response will confirm the reservation.

Note: Webinars may end early. Time has been allotted for questions at the end of each session.

January 2025				
Monday	Tuesday	Wednesday	Thursday	Friday
		1	2	3
6	7	8 Provider Enrollment Training 10-11:30 a.m.	9 Beginner Billing Training: Institutional Claims (UB-04) 9 – 11 a.m.	10
13	14 Beginner Billing Training: Professional Claims (CMS 1500) 9 - 11:30 a.m.	15	16	17
20	21	22	23 Intermediate Billing Training 9-10:30 a.m.	24
27	28	29 Beginner Billing Training: Professional Claims (CMS 1500) 8:30-11 a.m.	30	31

Upcoming Holidays

Holiday	Closures
New Year's Day Wednesday, January 1	State Offices, AssureCare and the ColoradoPAR Program will be closed. Capitation cycles may potentially be delayed. The receipt of warrants and EFTs may potentially be delayed due to the processing at the United State Postal Service or providers' individual banks. Gainwell Technologies and DentaQuest will be open.
Martin Luther King Jr. Day Monday, January 20	State Offices, Gainwell Technologies, DentaQuest, AssureCare and the ColoradoPAR Program will be closed. Capitation cycles may potentially be delayed. The receipt of warrants and EFTs may potentially be delayed due to the processing at the United State Postal Service or providers' individual banks.

Gainwell Technologies Contacts

Provider Services Call Center
1-844-235-2387

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