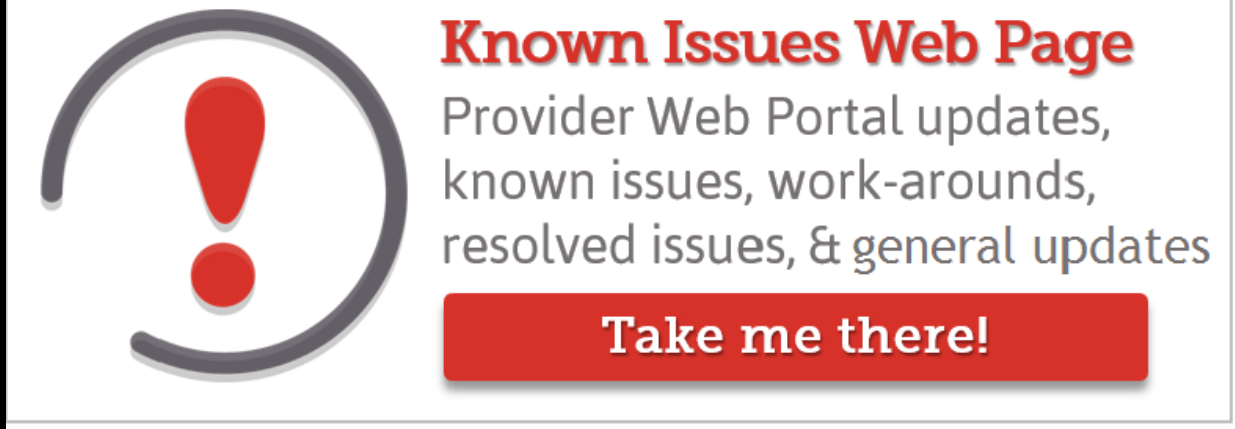
COLORADO
Department of Health Care Policy & Financing

Last Week in Review: Known Issues & Updates web page

Dear Providers,

This email summarizes last week's additions to the Known Issues & Updates web page.

We frequently update our Known Issues & Updates web page, so make sure to check it for updates on a regular basis. Click the button below to visit the Known Issues & Updates web page. Please note that the Known Issues page is not an all-inclusive list of known issues.



Featured Provider Resources

The October Provider Bulletin (B1700404) was published on September 29, 2017, on the Bulletins web page.

New resource documents have been created to help you better understand your claim numbers! The Internal Control Number (ICN) Information Sheet and the Region Code Information Sheet have been posted to the DXC and interChange Resources web page, under Quick Guides - Reading Your Remittance Advice (RA).

Providers are reminded that financial assistance is available to enrolled providers experiencing billing difficulties. If you are an enrolled provider experiencing financial hardship, you can request interim payments by calling the Provider Services Call Center at 1-844-235-2387, selecting option 2 to "speak with an agent" and then option 4 to learn about interim payment options.

Interim payments are paid at 80 percent of a provider's historic weekly payment average over a three-month period prior to March 1, 2017.

Interim payments are meant to give providers temporary financial relief until claims are processed correctly. These payments are not intended to pay outstanding claims billed.

Once claims are processing correctly, an accounts receivable will be set up and these payments will be recouped from future payments. We cannot issue interim payments to providers who are not enrolled or who have not yet completed the revalidation process.

Recently Added Issues

Claim Denials for Injection Procedure Codes Q2050 and Q5101 for EOB 0182
Claims are denying for clinic providers when billed for procedure codes Q2050 and Q5101 for EOB 0182 – "Billing Provider Type and/or Specialty is not allowable for the service billed."

Claims will be reprocessed by DXC.

Claim Denials on Some CLIA Waived Codes
Claims for some CLIA waived codes are incorrectly denying for EOB 3660 – "The service is not within the scope of the billing provider's CLIA certification. Please update the MMIS provider records with the correct CLIA number." The Department and DXC are aware of the issue and working to resolve it.

Claims will be reprocessed by DXC.

For more information on billing CLIA waived codes and the link to a complete list of codes on the CMS website, refer to the article titled "Clinical Laboratory Improvement Amendments (CLIA) Billing" in the July 2017 Provider Bulletin (B1700400).

Recently Updated Issues

Resolved 9/14/17: Claim Denials for Non-Emergent Medical Transportation Providers for EOB 4000 – Member Has Other Insurance
Claims for Non-Emergent Medical Transportation Providers were denying for EOB 4000 – "The member has other insurance. Bill the charges to the other insurance before billing Medicaid. Complete the other insurance payment information fields on the claim and retain a copy of the explanation of benefits."

Claims were reprocessed by DXC on 9/22/17.

Issue resolved 9/14/17

UPDATE 9/25/17: This entry has been updated to reflect completed claims processing.

Recently Resolved Issues

Resolved 9/13/17: Claim Denials for Hospital Providers Due to Admit Date
Claims for Hospital providers were denying when the admit date falls after the "from" date for any of the following EOBs: 1730, 1731, 1393, 1395, 1920, 1930 and 1702. Policy currently allows one day before the admit date to cover bundle/pre-admit services or one day after the "to" date/discharge date on Inpatient claims.

DXC is working on the solution for previously denied claims.

Issue resolved 9/13/17

Resolved 9/18/17: Pediatric Behavioral Therapy Providers
Claims for behavioral therapy procedure codes T1024 and H0046 were suspending for a Prior Authorization Request (PAR) requirement. Until the PARs are converted from the old codes to the new codes, the PAR requirement has been temporarily lifted to allow claims to process. Providers are still responsible for obtaining authorization for new service plans with the new codes. Providers are also responsible to only provide services up to the allowed units on the old codes.

Issue resolved 9/18/17

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