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.

Known Issues Web Page

Provider Web Portal updates, known issues, work-arounds, resolved issues, & general updates

Take me there!

Hot Topics

There is a system issue which prevents the Colorado interChange from processing some **retroactive changes** to a Health First Colorado (Colorado's Medicaid Program) and Child Health Plan *Plus* (CHP+) member's eligibility span.

If a member believes a fix to their eligibility information is necessary, the process is the same as it would have been with the old MMIS; the member must call the Health First Colorado Member Contact Center to initiate the correction.

If the member has already contacted the Member Contact Center and obtained the Proof of Insurance, the provider can accept this as eligibility verification in good faith and render services. The eligibility update will take 2-3 business days to appear in the Colorado interChange system. Once the fix is made, the provider can verify eligibility in the Provider Web Portal and will be able to submit or resubmit claims for services to the member. The Proof of Insurance does not need to be attached to the claim as proof of eligibility.

For more detailed information, please refer to this fact sheet.

Featured Provider Resources

Interim Payment Frequently Asked Questions (FAQs)
Q: Who qualifies for an interim payment?
A: Any enrolled provider who is receiving 80% or less of historic (pre-interChange) payments can qualify. Consideration can be given for new providers who have enrolled since go-live.

For more FAQs about interim payments, refer to the new Interim Payments FAQ document, located on the DXC and interChange Resources web page.

Update to Appendix X - HCPS and NDC Crosswalk for Billing Physician-Administered Drugs

Appendix X was recently updated with the latest HCPS and NDC Crosswalk for Billing Physician-Administered Drugs. Appendix X is published on the Billing Manuals web page under the Appendices section.

Recently Added Issues

Nursing Facility and ICF/IID Provider Claim Denials When Room and Board Billed on Same Dates as Therapy for EOB 0101 – Duplicate Service

Claims for nursing facility provider types 20 and 21 are denying for EOB 0101 – "This is a duplicate service" when room and board (inpatient – revenue code 100 series) are billed on the same dates as therapy (outpatient – revenue code 400 series).

DXC and the Department are working to fix this issue. Affected claims will be reprocessed by DXC.

Delivery, Antepartum and Postpartum Care Claims Denied for EOB 1030 when the Place of Service (POS) is 12 (Home)

Claims for procedure codes 59400, 59409, 59410, 59610, 59612, 59614, 59425, 59426, and 59430, billed with Place of Service (POS) 12 – Home, may incorrectly deny for Explanation of Benefits (EOB) 1030 - "Place of Service restriction on proc billing rule." Home births may be performed by physicians and certified nurse-midwives carrying malpractice insurance that covers home births.

The Department and DXC are working to resolve the issue. Affected claims will be reprocessed by DXC.

Claim Denials for Vaccine Procedure Codes for EOB 1552 and EOB 1030

Some claims for vaccine procedure codes are denying for Explanation of Benefits (EOB) 1552 -"This procedure is age restricted. Member's age does not fall within the approved range." and EOB 1030 - "The place of service code is invalid for procedure code."

The Department and DXC are currently reviewing to ensure the appropriate place of service and age ranges are assigned.

Pediatric Behavioral Therapy Claims Suspended or Denied for Duplicate, for Procedure Code H0046, Modifier TJ

Pediatric Behavioral Therapy claims billed with both procedure codes H0046 (without modifier TJ) and H0046 (with modifier TJ) are incorrectly denying when both procedure codes are billed for the same day for EOB 0101 – "This is a duplicate service."

DXC and the Department are working to fix this issue.

Claims will be reprocessed by DXC.

Recently Updated Issues

Resolved 10/6/17: Claims Denying for Birth Center Providers with Place of Service (POS) 25 (Birth Center) for EOB 0182

Claims with certain procedure codes for Birth Center Providers (Specialty 58 and 116) were denying when billed with POS 25 (Birth Center) for EOB 0182 – "Billing Provider Type and/or Specialty is not allowable for the service billed."

Claims were reprocessed by DXC on 10/13/17.

Issue resolved 10/6/17

UPDATE 10/17/17: This entry has been updated to reflect completed claims reprocessing.

Recently Resolved Issues

Resolved 9/27/17: Physician and Clinic Provider Claims Denied for Procedure Code J9301 for EOB 1381 – No Billing Rule for Procedure
Claims for physician and clinic providers were denying for procedure code J9301 for EOB 1381 – "No billing rule for procedure."

Claims were reprocessed by DXC on 9/29/17.

Issue resolved 9/27/17

Resolved 10/13/17: Claim Denials for DME and Physician Services for Sleep Studies with Place of Service 12
Claims were denying for sleep studies with place of service 12.

Claims were reprocessed by DXC on 10/18/17.

Issue resolved 10/13/17

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