COLORADO
Department of Health Care Policy & Financing

Dear Providers,

This email summarizes additions to the Known Issues & Updates web page from the past week. The Known Issues & Updates web page is frequently updated. Please note that the Known Issues web 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

Discontinued Enrollment Approval Email
Effective October 29, 2018, DXC Technology (DXC) discontinued sending emails that confirmed provider enrollment application approval. Providers will continue to receive the Welcome Letter, which serves as the formal confirmation of enrollment approval and contains the provider's enrollment effective dates, MCD ID and the National Provider Identifier (NPI), if applicable.

Centers for Medicare & Medicaid Services (CMS) Referral Requirements for Physical, Occupational and Speech Therapy (PT/OT/ST) Services
CMS requires a referral for PT/OT/ST services. All Outpatient PT/OT services must have a written order, referral, or prescription by any of the following:

a. Physician (M.D. or D.O.)
b. Physician's assistant
c. Nurse practitioner
d. An approved Individualized Family Service Plan (IFSP) for Early Intervention PT/OT

Physician services do not require an order. Please note that specialists almost always fall under the designation of physicians.

Featured Provider Resources

December Provider Bulletin - Now Available
The December 2018 Provider Bulletin (B1800424) was published on 11/29/18 on the Bulletins web page.

Enrollment Requirement for Managed Care
All providers that render services through Managed Care Organizations (MCOs), including Child Health Plans *Plus* (CHP+) and Regional Accountable Entities (RAEs), need to enroll,

even if they are only seeing CHP members and not Health First Colorado (Colorado's Medicaid program) members. This is necessary because the validity and currency of all provider licenses to perform any service must be screened.

Visit the Provider Revalidation & Enrollment web page for more information.

Recently Added Issues

Ambulatory Surgical Claims Denying when Billed with POS Code 24 (Ambulatory Surgical Center) for EOB 1030
Ambulatory Surgical Center claims for the following procedure codes are denying when billed with place of service code 24 (Ambulatory Surgical Center) for EOB 1030 - "The place of service code is invalid for procedure code."

- 01991 - The Department and DXC are working to resolve the issue. Claims will be reprocessed by DXC.
- 01935 - The Department and DXC are working to resolve the issue. Claims will be reprocessed by DXC.
- 60220 - Issue resolved for this procedure code on 11/28/18. Claims were reprocessed by DXC on 11/30/18.
- 21365 - Issue resolved for this procedure code on 11/28/18. Claims were reprocessed by DXC on 11/30/18.

Recently Updated Issues

Resolved 11/8/18: Inpatient Hospital Claims Paying Incorrectly for Non-Covered Days
Inpatient hospital provider claims where the covered days were less than the total days on the claim and outlier days were paid were paying non-covered days incorrectly due to a miscalculation of outlier days.

Claims were previously reported to have been reprocessed on 11/9/18, however reprocessing was completed by DXC on 11/30/18 and funds may have been recouped.

Issue resolved 11/8/18

UPDATE 11/30/18: This entry has been updated to reflect an updated claims reprocessing date.

Resolved 11/14/18: Ambulatory Surgical Center Provider Claim Denials for EOB 0182 – "Billing Provider Type and/or Specialty is Not Allowable for the Service Billed"
Ambulatory Surgical Center (provider type 44) claims for the procedure codes noted below were denying for EOB 0182 – "Billing Provider Type and/or Specialty is not allowable for the service billed."

This issue was resolved for the following procedure codes on 11/14/18: 15136, 19328, 20912, 21338, 21480, 25116, 25210, 26236, 26525 28050, 28415, 38505, 42145, 43870, 46060, 52300, 54112, 62273, 65210, 67031, 67121, 67141, 67560, 67935, 67950. Claims were reprocessed by DXC on 11/23/18.

Procedure codes 43269 and 45383 are not covered under Health First Colorado (Colorado's Medicaid Program).

Issue resolved 11/14/18

UPDATE 11/26/18: This entry has been updated to reflect completed claims reprocessing.

Resolved 8/8/18: Supply Provider Claim Denials for A9901 for EOB 1178 -

"Service is Not Reimbursable for Date(s) of Service"
Supply provider (type 14) claims for code A9901 were denying for EOB 1178 - "Service is not reimbursable for Date(s) of Service."

It was previously announced in the May 2018 Provider Bulletin (B18004115) that code A9901 should no longer be used for Invoice Manual Pricing, effective for date of service (DOS) 7/1/18. As of DOS 7/1/18, this is a valid denial. However, A9901 should still be payable through DOS 6/30/18, in accordance with Health First Colorado (Colorado's Medicaid Program) policy.

Claims were previously reported to be reprocessed by DXC on 9/14/18. While most claims were reprocessed on that date, it was later identified that crossover claims were not included. Crossover claims affected by this issue will be reprocessed by DXC.

Issue resolved 8/8/18

UPDATE 11/26/18: This entry has been updated to reflect current reprocessing status.

Recently Resolved Issues

Resolved 11/28/18: Clinic Claim Denials for EOB 0182 – "Billing Provider Type and/or Specialty Is Not Allowable for the Service Billed"
Clinic claims for the following procedure codes were denying for EOB 0182 – "Billing Provider Type and/or Specialty is not allowable for the service billed."

- 23473, 23474 (Orthopedic Surgery)
- 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349 and 99350 (Evaluation and Management [E and M])
- 95250, 95251 (Medicine Endocrinology)

Claims were reprocessed by DXC 11/30/18.

Issue resolved 11/28/18

Resolved 11/28/18: Pathology Claims with Procedure Code 88112 Denying for EOB 4211
When billed with a TC modifier or no modifier, procedure code 88112 was denying for EOB 4211 - "Modifier is invalid for procedure code. Read the procedure description. Refer to the Provider Manual, Help Screens, CPT or HCPCS listing for valid modifiers." Per policy, procedure code 88112 can be billed with a TC or 26 modifier, or no modifier indicating the global procedure. The Department and DXC have resolved this issue.

Claims were reprocessed by DXC 11/30/18.

Issue resolved 11/28/18

Resolved 11/8/18: Claims Denied for Procedure Codes 90700 and 98925 – 98928 for EOB 1030 – "The Place of Service Code is Invalid for Procedure Code"
Professional claims billed with Place of Service (POS) 19, 22, 23, 24, 31 or 32 for procedure codes 90700, 98925, 98926, 98927 and 98928 were denied for EOB 1030 – "The place of service code is invalid for procedure code." This issue affected physician services/clinic providers.

Claims were reprocessed by DXC on 11/16/18.

Issue resolved 11/8/18

Resolved 10/29/18: Claims Billed with Certain ICD-10 Diagnosis Codes Denied

for EOB 1530 – "No Billing Rule for Diagnosis"

The majority of new ICD-10 diagnosis codes which became effective 10/1/18 were loaded to the Colorado interChange in September 2018, however approximately 360 ICD-10 codes effective 10/1/18 were loaded at a later date on 10/29/18. As a result, claims billed for any of those 360 codes between 10/1/18 and 10/29/18 were denied for EOB 1530 – "No billing rule for diagnosis."

Claims were reprocessed by DXC on 11/30/18.

Issue resolved 10/29/18

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