COLORADO
Department of Health Care Policy & Financing

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.

Hot Topics

Training License Now Accepted for Ordering, Prescribing or Referring (OPR) Provider Enrollment
In response to provider concerns, the Department will now allow OPR providers with training licenses to enroll with Health First Colorado (Colorado's Medicaid Program). OPR providers enrolling with a training license must use taxonomy 390200000X on the enrollment application to indicate the training license. Training licenses are not accepted for Individual Within a Group (IWG) or billing individual enrollments; full licenses are required.

Denied Claims Do Not Need to Be Adjusted or Sent for Reconsideration
Denied claims do not need to be adjusted or sent as a request for reconsideration. A denied claim can be resubmitted electronically as a new claim once corrections have been made.

EOB 3110 – Claims will Not Deny for Individual Not Being Linked to the Group
Providers have questions about claims with EOB code 3110 for "the rendering provider is not a group member." While it may be unclear on the remittance advice, notations that affiliations are missing **do not cause the claim to deny and are informational only**. Currently, the Department is giving providers an extended grace period to make all necessary updates to their affiliations to avoid future claims denials. If EOB code 3110 appears on a claim, providers should check their affiliations and make sure they are up to date, and check other EOB codes to see why the claim denied. Updated affiliations are currently taking up to three weeks for final approval. **Providers should not submit duplicate update requests.**

Featured Provider Resources

Freqently Asked Questions (FAQs) for Multiple Service Locations: Enrollment and Claims Submission - Now Available
If you have questions about requirements for providers with multiple service locations or how to

enroll and bill for service locations separately, refer to the new FAQ document, Multiple Service Locations: Enrollment and Claims Submission.

How to Update Enrollment Information - Provider Maintenance Provider Web Portal Quick Guide
Refer to the Provider Maintenance Provider Web Portal Quick Guide for detailed, step-by-step illustrated instructions on updating the following enrollment information:

- Provider affiliations
- Provider Specialty and additional taxonomies
- Contact information (including who gets the emails for a provider)
- Opt-out of the Provider Directory
- License and board certification information and updates
- Insurance information
- Network Participation
- Disclosure information
- ACC opt-in changes

Recently Added Issues

There were no new Known Issues posted to the website last week. DXC and the Department are aware of several newly-identified issues and are in the process of developing content to be posted on the Known Issues page as soon as possible.

Recently Updated Issues

Resolved 12/7/17: Claim Denials for Revenue Codes 270, 424, 434, 569, 583, 589 and 780 for EOB 2222 – Policy Not Currently Enforced
Home health provider claims for revenue codes 270, 424, 434, 569 and 589 and Telehealth revenue codes 583 and 780 were denying for EOB 2222 – "Policy not currently enforced."

Some claims with dates of service on or before 6/30/17 were reprocessed on 2/16/18 by DXC; however, the Department and DXC are reviewing the results to determine if additional reprocessing is needed. Claims with dates of service on or after 7/1/17 were not affected and should have processed properly.

Issue resolved 12/7/17

UPDATE 2/15/18: This entry has been updated to reflect completed claims reprocessing.

Claim Denials for Injections Procedure Codes Q9985, Q9986, C9485 and C9489 for EOB 3180 – Procedure Code is Invalid
Procedure codes Q9985 and Q9986 are not being processed for payment. This is causing claim denials for EOB 3180 – "The procedure code is invalid. Correct the procedure code. Refer to the CPT or the HCPCS listing for valid procedure codes." These procedure codes are a part of the quarterly HCPCS update. The Department and DXC are currently working on getting the quarterly HCPCS update codes loaded into the Colorado interChange system. Claims will be reprocessed by DXC.

Claims for procedure codes C9485 and C9489 were previously denied for EOB 3180 – "The procedure code is invalid. Correct the procedure code. Refer to the CPT or the HCPCS listing for valid procedure codes." This issue was resolved on 12/22/17 and claims for procedure codes C9485 and C9489 we reprocessed on 2/9/18.

Issue resolved for procedure codes C9485 and C9489 12/22/17

UPDATE 2/14/18: This entry has been updated to reflect completed claims reprocessing for procedure codes C9485 and C9489.

Retroactive Updates to Eligibility Spans
There is a system issue that 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 may accept this as eligibility verification and render services. The eligibility update will take 2-3 business days to appear in the Colorado interChange. Providers are advised to continue submitting claims to keep them timely and to resubmit affected claims once the member's eligibility has been corrected. Providers **must resubmit** previously submitted claims. For more detailed information, please refer to this fact sheet.

UPDATE 2/12/18: This entry has been updated to clarify that providers **must resubmit** previously submitted claims once the member's eligibility has been corrected.

Recently Resolved Issues

Resolved 2/14/18: DME, PT/OT and Rehabilitation Agency Providers Unable to see Prior Authorization (PA) Modifiers on the Provider Web Portal
Modifiers on the detail lines of the PA records are now viewable on the Provider Web Portal. Providers are no longer required to contact eQHealth Solutions, the ColoradoPAR vendor, for this PA information. **When providers click the Line # of the detail line in question, Web Portal now displays up to four modifiers in the Modifiers field.**

Issue resolved 2/14/18

Resolved 2/14/18: HCBS Providers Unable to see Prior Authorization (PA) Modifiers on the Provider Web Portal
Modifiers on the detail lines of the PA records are now viewable on the Provider Web Portal. HCBS Providers may still require additional information from case managers regarding the amount, scope, and duration of services authorized by the service plan, and should verify all information contained in the service plan before billing. In order to access this functionality, providers must have the client ID and an approved Prior Authorization ID. **When providers click the Line # of the detail line in question, Web Portal now displays up to four modifiers in the Modifiers field.**

Issue resolved 2/14/18

Resolved 2/9/18: DME Claims Denials for A9900 for EOB 2022
Claims for A9900 were denying incorrectly for EOB 2022 – "A National Correct Coding Initiative (NCCI) Medically Unlikely Edit (MUE) that sets when the units of service are billed in excess of established standards for services that a client would receive on a single date of service for a given CPCS/CPT code."

The Department and DXC have resolved this issue. Claims were reprocessed by DXC 2/9/18.

Issue resolved 2/9/18