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.

Known Issues Web Page

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

Take me there!

Hot Topics

Paper Claim Form Signature Requirements

Providers are reminded that signatures are required when sending paper claims. Typed names are **not** accepted. A stamped signature is acceptable. Individual rendering providers do not need to sign; a representative from the group may sign the claim form.

This applies to the Institutional Certification document, the Dental Certification, as well as the signature field on the paper CMS 1500 form. However, all providers should be submitting electronically unless paper claim submission is a work around to a known issue, or they have approval due to submitting less than 5 claims per month.

Reconsiderations do not need to be sent on paper. If a claim denies, the provider should make the necessary corrections and resubmit the claim electronically as a new claim.

Frequently Asked Questions (FAQs) for Multiple Service Locations: Enrollment and Claims Submission - Now Available

We understand that the Multiple Service Locations FAQs caused some confusion. Please note that these FAQs are only applicable to groups and facilities. If you are not a group or facility with multiple locations, you may disregard these FAQs. 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.

Featured Provider Resources

Resource for Non-Emergent Medical Transportation

The Department has developed a NEMT Eligibility Verification and Claims in the New Provider Web Portal webinar and Frequently Asked Questions document. As always, please refer specific questions to the Provider Services Call Center (1-844-235-2387).

Recently Added Issues

Inpatient Claims Reimbursing Incorrectly when "To" and "From" Dates of Service are the Same Day
Inpatient transfer claims are not reimbursing correctly when the "to" and "from" dates of service are the same day.

DXC and the Department are working to resolve the issue.

Claims will be reprocessed by DXC.

Recently Updated Issues

Resolved 1/26/18: 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.

Claims were reprocessed by DXC on 2/16/18 and 2/23/18.

Issue resolved 1/26/18

UPDATE 2/23/18: This entry has been updated to reflect completed claims reprocessing.

Resolved 9/28/17: Claim Denials for EOB 2580 for Hospital Providers and Members with Kaiser Access Plan
The Department and DXC are also aware that some claims were denying incorrectly for EOB 2580 for members with Kaiser Access plan. Kaiser does not reimburse for hospital claims and these should be billed directly to DXC.

Claims were reprocessed by DXC on 10/27/17 and 2/9/18.

Issue resolved 9/28/17

UPDATE 2/22/18: This entry has been updated to reflect completed claims reprocessing.

Resolved 9/28/17: Hospital Provider Claim Denials for E and M Procedure Codes for EOB 2580
The Department and DXC are aware that some claims for all E and M procedure codes were denying incorrectly for hospital providers for EOB 2580. The Colorado interChange was not using diagnosis to determine BHO coverage.

Claims were reprocessed by DXC on 10/27/17 and 2/9/18.

Issue resolved 9/28/17

UPDATE 2/22/18: This entry has been updated to reflect completed claims reprocessing.

Resolved 9/28/17: Claim Denials for Laboratory Codes with BHO-Covered Diagnoses - EOB 2580
Claims for laboratory codes 80047 - 89398 provided to members for the ICD-10 diagnoses listed below were incorrectly denying for Explanation of Benefits (EOB) 2580 – "The services must be billed to the HMO/PHP/BHO listed on the eligibility inquiry." These codes are not part of the BHO contract and need to be billed Fee-for-Service (FFS).

BHO MH Diagnoses Ranges		SUD Diagnoses Ranges	
Start Value	**End Value**	**Start Value**	**End Value**
F20.0	F42.3	F10.10	F10.26
F42.8	F48.1	F10.28	F10.96
F48.9	F51.03	F10.98	F13.26
F51.09	F51.12	F13.28	F13.96
F51.19	F51.9	F13.98	F18.159
F60.0	F63.9	F18.18	F18.259
F68.10	F69	F18.28	F18.959
F90.0	F99	F18.980	F19.16
R45.1	R45.2	F19.18	F19.26
R45.5	R45.82	F19.28	F19.99

Claims were reprocessed by DXC on 10/27/17 and 2/9/18.

Issue resolved 9/28/17

UPDATE 2/22/18: This entry has been updated to reflect completed claims reprocessing.

Recently Resolved Issues

Resolved 1/19/18: Inpatient Claims Denying for EOB 5340 when Billed with ICD 10 Codes Z381, Z384 and Z387

Inpatient claim billed with ICD 10 Codes Z381, Z384 and Z387 as the primary diagnosis were denying for EOB 5340 – "The principal diagnosis is invalid for DRG claims. Correct the principal diagnosis." DXC and the Department have resolved this issue so that these codes can be listed as a primary diagnosis.

DXC reprocessed claims on 2/16/18.

Issue resolved 1/19/18

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