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

Ordering, Prescribing or Referring (OPR) Application Not Required for Individual Within a Group (IWG) Providers with Prescriptive Authority
Providers with prescriptive authority who are enrolled as an active IWG (rendering provider) may be prescribers. They are **not** required to complete an additional OPR application. OPR enrollments are for providers who do not submit payment directly to Medicaid but only prescribe, refer or order for Medicaid members. Submitting an OPR application with the same Social Security Number (SSN) as a previously enrolled IWG may result in the application being denied as a duplicate or in denied claims.

3-Day Override on Claims for Emergency Medication Dispensing
In an emergency situation, the Department will place a 3-day override on a claim written by an unenrolled prescriber so that the member can obtain the medication(s) that they need. **This will mirror the current override process.** Please refer to Appendix P for more information on the override process.

Individual Providers Enrolling with a Social Security Number (SSN) May Only Have One Medicaid ID
Providers with any of the following individual types may only have **one** application associated to a SSN, even if they provide services in multiple locations:

- Billing individuals
- Individuals within a group (IWG)
- Ordering, prescribing and referring (OPR) providers

An additional application for any of the individual types above **with the same SSN and same NPI as a previous application** (regardless of whether the individual type is the same as on the previous application) may result in the application being denied as a duplicate or denied claims. Individuals may affiliate with multiple groups in different locations.

Reminder: Verify Member Eligibility Before Rendering Services
Before rendering services, the provider should verify the member's eligibility to ensure that the member is eligible for benefits. Providers should retain documentation of the verified eligibility for billing purposes.

It is critical for providers to always check the eligibility response at each visit as eligibility may change.

Refer to the General Provider Information Billing Manual, located under the General Provider Information drop-down section on the Billing Manuals web page, for more information.

Alternative Benefit Plan Member Must Have Medicaid State Plan (TXIX) Coverage to Be Eligible for Services
The Alternative Benefit Plan (ABP) is an extended plan which must be accompanied by Medicaid State Plan (TXIX) coverage. If the member does not have TXIX coverage, they are not eligible for services and claims will be denied for EOB 3261 - "The procedure code currently is not a benefit for date of service billed. Refer to the CPT or the HCPCS listing for valid procedure codes."

Providers should verify coverage under Benefit Details (example shown here) on the Provider Web Portal before rendering services. For detailed, step-by-step instructions on verifying member eligibility, refer to the Verifying Member Eligibility - Provider Web Portal Quick Guide, available under the Quick Guides section on the interChange Resources web page.

Featured Provider Resources

Frequently Asked Questions: Tax Year 2017 1099-MISC Forms
For Tax Year 2017 providers may receive **two** 1099 Miscellaneous Income (1099-MISC) forms from the State of Colorado due to implementation of the Colorado interChange in March 2017. Specifically, if a provider was enrolled in Colorado Medicaid for the period January - February 2017, they will receive a 1099-MISC form from the State of Colorado, Office of the State Controller. Providers enrolled in Colorado Medicaid for the period March - December 2017 will receive a 1099-MISC form from the Department of Health Care Policy & Financing (the Department). The amounts shown on the 1099s are what the Department has reported to the IRS.

DXC and the Department recently published a list of Frequently Asked Questions (FAQs) and answers pertaining to this issue, available on the Provider FAQ Central web page under the 2017 1099-MISC Tax Forms drop-down section.

February Provider Bulletin - Now Available
The February Provider Bulletin (B1800410) was published on 1/31/18 on the Bulletins web page.

Recently Added Issues

Voiding Claims via the Provider Web Portal Denying for Atypical HCBS Providers for EOB 1960 – "No Provider Billing Indicator Found"
HCBS providers who do not use an NPI (atypical providers) are currently not able to successfully void a claim using the Provider Web Portal. While the portal may display a message stating that the claim was successfully voided, the system is erroneously creating the claim without the billing provider ID, causing claim denials for EOB 1960 - "No Provider Billing Indicator Found. Please make sure the billing provider has been revalidated and that you are using the correct billing provider service location."

DXC and the Department are working to resolve the issue. For questions, please contact the Provider Services Call Center (1-844-235-2387).

Recently Updated Issues

HCBS Claim Denials for Procedure Codes A9900, S5160 and T2029 for EOB 0653 – "Claim Requires Manual Pricing. Please Attach Invoice for Medical Services"
HCBS claims are suspending for procedure codes A9900, S5160 and T2029 for EOB 0653 - "Claim requires manual pricing. Please attach invoice for medical services." However, please note that HCBS providers are **not** required to submit an invoice. Once the correct rate source is identified, claims will no longer deny for manual pricing.

The Department and DXC are working to fix the issue. No action is necessary for providers at this time. Updates will be provided when a resolution is reached.

Claims will be reprocessed by DXC.

UPDATE 2/2/18: This entry has been updated to include S5160 and to clarify that no action is needed from providers at this time.

Resolved 12/23/17: Claim Denials for Injection Procedure Codes Q2050 and Q5101 for EOB 0182
Claims were 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 on or after date of service 7/1/17 were reprocessed on 11/2/17. The codes have now been updated to encompass dates of service from 1/1/17 to 7/1/17. DXC will reprocess these additional claims for procedure code Q2050. All claims for procedure code Q5101 have been reprocessed.

Claims for dates of service 10/1/16 - 1/1/17 for procedure code Q5101 were reprocessed by DXC on 1/11/2018.

Issue resolved for Q2050 on 1/10/18

Issue resolved for Q5101 on 12/23/17

UPDATE 2/2/18: This entry has been updated to reflect issue resolution for both Q2050 and Q5101 and completed claims reprocessing for Q5101.

Resolved 1/19/18: Claims Denying for Procedure Code J2407 for EOB 1178 - "Service is not Reimbursable for Date(s) of Service"
Claims were denying for procedure code J2407 for EOB 1178 - "Service is not reimbursable for Date(s) of Service."

Claims were reprocessed on 1/26/18.

Issue resolved 1/19/18

UPDATE 1/30/18: This entry has been updated to reflect completed claims reprocessing.

Recently Resolved Issues

Resolved 1/25/18: Claim Denials Non-Emergent Medical Transportation (NEMT) Procedure Codes A0431, A0430 and A0140 for EOB 1030 - "Place of Service Code is Invalid for Procedure Code"
Claims were denied for NEMT procedure codes A0430 and A0431 when billed with place of service (POS) 42 for EOB 1030 - "The place of service code is invalid for procedure code. Correct the place of service code. Refer to the Provider Manual or Help Screens for valid place of service codes."

Claims were denied for NEMT procedure code A0140 when billed with POS 41 for EOB 1030 - "The place of service code is invalid for procedure code. Correct the place of service code. Refer

to the Provider Manual or Help Screens for valid place of service codes."

Claims were reprocessed by DXC on 2/2/18.

Issue resolved 1/25/18

Resolved 1/8/18: Claim for Revenue Code 434 Paying at the Incorrect Rate
Home health provider claims for revenue code 434 were not paying the current rate. The Department and DXC have fixed this issue.

Claims with dates of service on or after 7/1/17 will be reprocessed by DXC.

For a complete list of current rates, please refer to the Home Health Rate Schedule.

Issue resolved 1/8/2018