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.

Hot Topics

Service Limits, Prior Authorizations and the Early and Periodic Screening Diagnostic and Treatment (EPSDT) Benefit
There are no service limits for members up to age 20. The EPSDT benefit process is available for children and youth that need services or supplies above a standard limit. Providers can add additional units to a Prior Authorization Request (PAR) which is submitted to eQHealth. Exceptions may be granted based on documentation of medical necessity. Approved PARs will be sent to the Colorado interChange to allow providers to submit claims for payment.

For procedure codes that do not show as covered in the fee schedule, visit the EPSDT link on the eQHealth website for more information on how submit a PAR.

Policy Update Requiring a Prior Authorization Request (PAR) for Back Surgery and Other Select Surgical Codes
Effective 4/1/19, back surgery and other select surgical codes will require a PAR through the Department's PAR vendor, eQHealth Solutions. Codes requiring a PAR will be noted in Appendix M - Procedures Requiring Prior Authorization, available on the Billing Manuals web page under the Appendices drop-down section. A PAR can be requested utilizing the online PAR portal, eQSuite®.

Visit the ColoradoPAR website for more information, including training opportunities for utilizing eQSuite®, the specific codes requiring a PAR, and other provider resources.

Contact the ColoradoPAR Program at co.pr@eqhs.org or 1-888-801-9355 with any questions regarding the prior authorization process.

Featured Provider Resources

March Provider Bulletin - Now Available

The March 2019 Provider Bulletin (B1900428) was published on 2/28/19 on the Bulletins web page.

Provider Forms Web Page
The Provider Forms web page is a valuable resource for Health First Colorado (Colorado's Medicaid Program) providers. Providers are encouraged to familiarize themselves with the forms housed on this web page and bookmark the page for future reference.

The Provider Forms web page houses forms for the following needs:

- Affidavit of Lost Warrant
- Claim Forms and Attachments
- Colorado Choice Transitions
- Critical Incident Reporting System for HCBS Members
- Durable Medical Equipment Authorization Questionnaires
- Federally Qualified Health Centers
- Fingerprinting
- Fraud Reporting
- Home Health
- Long-Term Services and Supports Case Management Tools
- Pharmacy
- Post-Eligibility Treatment of Income (PETI Authorizations)
- Prior Authorization Requests
- Provider Enrollment & Updates
- Sterilization Consent

Recently Added Issues

Physical and Occupational Therapy (PT/OT) Claim Denials for Explanation of Benefits (EOB) 0182 - "Billing Provider Type and/or Specialty Not Allowable Service Billed" and EOB 1599 - "Rendering Provider Type and/or Specialty Not Allowable for Service Billed"
PT/OT claims with an appropriate rendering provider type 17 (Physical Therapist) or 28 (Occupational Therapist) and a billing provider type 25 (Non-Physician Practitioner – Group) are incorrectly denying for EOB 0182 – "Billing Provider Type and/or Specialty is not allowable for the service billed" and EOB 1599 – "Rendering Provider Type and/or Specialty is not allowable for the service billed."

DXC and the Department are working to resolve this issue.

Claims will be reprocessed by DXC.

Recently Updated Issues

Resolved 2/22/19: Pediatric Behavioral Therapy Claims Denying for Explanation of Benefits (EOB) 2030 – "The Services Must be Billed to Denver Health Medicaid Choice Plan"
Pediatric Behavioral Therapy claims were denying for EOB 2030 - "The services must be billed to Denver Health Medicaid Choice plan." Denver Health does not cover pediatric behavioral therapy claims.

Claims were reprocessed by DXC on 3/1/19.

Issue resolved 2/22/19

UPDATE 3/1/19: This entry has been updated to reflect completed claims reprocessing.

Resolved 2/22/19: Pediatric Behavioral Therapy Claims Denying for Explanation of Benefits (EOB) 2029 - "The Services Must Be Billed to the Member's RAE"
Pediatric Behavioral Therapy Claims were denying for EOB 2029 - "The services must be billed to the member's RAE." Regional Accountable Entities (RAEs) do not cover Pediatric Behavioral Therapy and claims should be billed directly to DXC.

Claims were reprocessed by DXC on 3/1/19.

Issue resolved 2/22/19

UPDATE 3/1/19: This entry has been updated to reflect completed claims reprocessing.

Recently Resolved Issues

Resolved 2/27/19: Claim Resubmissions Denying for Timely Filing
Some claims resubmitted after a previous adjustment were incorrectly denying for EOB 1786 – "The date of service date is out of timely filing" in the following scenario:

- The claim is submitted by the provider within timely filing guidelines and paid.
- DXC Technology (DXC)/Department adjusts the claim that is past 365 days from the original date of service, which can possibly result in a recoupment of funds.
- The provider resubmits the claim within 60 days from the date of the remittance advice (RA), using the Internal Control Number (ICN) of the adjustment.

Claims will be reprocessed by DXC; however, if the claim is urgent, providers should contact the Provider Services Call Center at 1-844-235-2387.

Note: Claims that are still within 365 days and have been adjusted can be resubmitted without the adjustment ICN.

Issue resolved 2/27/19

Resolved 2/27/19: Durable Medical Equipment (DME) Claim Denials for E0936 RR for EOB 4211
Claims for E0936 billed with the RR modifier were incorrectly denying for EOB 4211 – "Modifier is invalid for procedure code." The Department's policy allows for E0936 to be billed with the RR modifier.

Providers are advised to resubmit affected claims.

Issue resolved 2/27/19

Resolved 2/27/19: Behavioral Therapy (Provider Type 84) Claims with Place of Service (POS) 12 Denying for EOB 0182 and/or EOB 1030
Behavioral therapy (provider type 84) claims billed with POS 12 were denying for one or both of the following EOBs:

- EOB 0182 – "Billing Provider Type and/or Specialty is not allowable for the service billed."
- 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 3/1/19.

Issue resolved 2/27/19

Resolved 2/28/19: Home & Community Based Services (HCBS) Waiver Claims for Procedure Code T1017 Denying for Explanation of Benefits (EOB) 3280 - "The Members Age is Invalid for this Procedure Code"
HCBS Waiver Claims for procedure code T1017 were denying for EOB 3280 "The members age is invalid for this procedure code. Verify the members birth date." The age range for procedure code T1017, targeted case management, was modified to include ages 0 – 18 for the CES (HCBS Children's Extensive Support Waiver) Benefit Plan. The age range was previously 3 – 18.

Claims were reprocessed by DXC on 3/1/19.

Issue resolved 2/28/19

Resolved 3/1/19: COBA Claims for Members with QMB Only Are Not Automatically Crossing Over
Some claims for services provided to members that have Qualified Medicare Benefits (QMB) only, with no Title XIX coverage, were not automatically crossing over from COBA to the Colorado interChange.

Issue resolved 3/1/19

Resolved 3/1/19: Nursing Facility Claim Denials for Explanation of Benefits (EOB) 0101 - "This Is a Duplicate Service"
Some nursing facility claims were incorrectly denying for EOB 0101 – "This is a duplicate service." The Department's policy allows for the discharging facility to bill through the discharge date and the admitting facility to bill for the admit date, which can allow the same date to appear on both claims.

Claims will be reprocessed by DXC.

Issue resolved 3/1/19

Please do not reply to this email; this address is not monitored.