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

Accountable Care Collaborative: Important Information for Primary Care & Behavioral Health Providers Special Provider Bulletin - Now Available
The Accountable Care Collaborative: Important Information for Primary Care & Behavioral Health Providers Special Provider Bulletin (B1800414) was published on 4/17/18 on the Bulletins web page.

This special provider bulletin contains information on provider contracting, resources available on the Accountable Care Collaborative (ACC) Phase II web page, contacting your RAE, and how to stay informed.

Attention - Pediatric Behavioral Therapy Providers: Please refer to this letter for additional clarification to the content published in special bulletin linked above.

Featured Provider Resources

HCBS Claim Denials for PAR When an Approved PAR is On File - EOB 0192 or 5110
This information has been previously published in several sources, including this email, which was sent to HCBS providers on 11/16/17 and posted to the Provider News web page. Please bookmark this link for future reference. This information is being re-published in this week's newsletter as a reminder to providers.

To understand why your claims are denying for a Prior Authorization Request (PAR) despite having an approved PAR on file, it is important to know how the Bridge system works with the Colorado interChange. The Bridge is a system used by case managers to submit Prior Authorization Requests (PARs) to the Colorado interChange. Only after a PAR is approved in the Bridge is it transmitted to the Colorado interChange. It will take at least one day after the PAR is

approved in the Bridge to appear in the Colorado interChange and be available for claims processing. Once the PAR is on file in the Colorado interChange, there is no further interaction between the Bridge and the claim.

When a claim requires a PAR, the Colorado interChange will use a series of criteria to find the matching authorization. Providers do not need to indicate the PAR number on the claim. The system will automatically populate the PAR number on the claim if it finds a match. If a claim denies for a PAR despite an approved PAR being on file, it means the PAR on file does not match all the criteria that is on the claim.

If your claims have denied for either of the following EOBs despite having an approved PAR on file:

- E0B 0192 - "Prior Authorization (PA) is required for this service. An approved PA was not found matching the provider, member, and service information on the claim."
- EOB 5110 - "The prior authorization does not match the services billed on your claim. Please correct services or submit a new prior authorization for the services billed.

One of the following issues may apply:

1. The prior authorization was never fully approved in the Bridge. Check the Provider Web Portal for prior authorization. If there is no approved PAR for the dates of service on the claim, contact the case manager to confirm status in the Bridge.
2. The benefit plan for the member's eligibility has terminated. Please verify member eligibility for the waiver benefit plan prior to submitting claims. If the member does not show an active waiver benefit plan, contact the case manager. A PAR is not a guarantee of member eligibility as the PAR is valid for a span of time (typically one year) and eligibility could change at some point during that span.
3. The PAR units are exhausted. If all units have been billed, the claim will deny. If you believe you need additional units, contact your case manager.
4. The modifiers do not match. Check the billing manuals to make sure you are using the correct modifiers. The Web Portal has been updated to display up to four modifiers on the detail line within the PA record.

Recently Added Issues

Claim Denials for Speech Therapy Procedure Code 92507 for EOB 1030 or 1599
Claims where the billing provider is either type 16 (Clinic - Practitioner) or 48 (Rehabilitation Agency) **and** the rendering provider is type 27 (Speech Therapist - Individual) are incorrectly denying for speech therapy procedure code 92507 for EOB 1030 - "The place of service code is invalid for procedure code" or 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. Affected claims will be reprocessed by DXC.

Clinic Claim Denials for Procedure Code 46220 for EOB 1381 - "No Billing Rule for Procedure"
Clinic claims with procedure code 46220 are denying for EOB 1381 – "No billing rule for procedure."

DXC and the Department are working to resolve the issue. Claims will be reprocessed by DXC.

Recently Resolved Issues

Resolved 4/16/18: Incorrect Dollar Amount for Co-Pay Deduction on Outpatient Claims for General Hospital and Dialysis Providers
General Hospital providers submitting an outpatient claim with date of service on or after 1/1/18 were experiencing a system issue where an incorrect dollar amount ($40.00) was applied as a co-pay deduction when the co-pay deduction should have been $4.00.

Dialysis Center providers submitting an outpatient claim for revenue code 429 with date of service on or after 1/1/18 were also experiencing this system issue where an incorrect dollar amount ($40.00) was applied as a co-pay deduction when the co-pay deduction should have been $4.00.

Claims will be reprocessed by DXC.

Issue resolved 4/16/18