COLORADO
Department of Health Care Policy & Financing

Dear Providers,

This email summarizes the past week's additions to the Known Issues & Updates web page. 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.

Known Issues Web Page

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

Take me there!

Hot Topics

Receiving an ERA X12 835 - Providers Must Assign Transactions via the Provider Web Portal
In order for a provider or their clearinghouse to receive an ERA X12 835, each associated provider will need to assign these transactions in the Provider Web Portal. For more information on how to sign up to receive an ERA X12 835, please refer to the Updating Your ERA X12 835 Information - Provider Web Portal Quick Guide.

While RAs are automatically posted to the provider's web portal account, ERA X12 835s will **only** be created and delivered if the provider has followed the appropriate steps to assign the ERA X12 835 to the trading partner ID. The ERA X12 835 needs to be assigned to the trading partner ID prior to the financial cycle running. **The 835 files will not be reposted or recreated if this step is not followed.** Providers will instead need to use the Remittance Advice (RA) as an alternative solution.

Note: Providers are not required to use the ERA X12 835 transaction and this information may not apply if a clearinghouse is not used for billing and report retrieval.

Update to Billing Provider ID Requirements on Batch Submissions
Previously, if a submitter used identical information in Loop 2310C N3 and N4 and Loop 2010AA N3 and N4 for the billing provider information, the file would not receive a compliance error.

As of 5/18/18, this has been corrected to comply with the X12 standards and users will receive an error if the two fields have identical information.

Contact EDI services at 1-844-235-2387, option 3 for more information.

Featured Provider Resources

New Provider Web Portal Quick Guide: Updating Additional Third-Party Liability

(TPL) Information
The new Provider Web Portal Quick Guide: Updating Additional Third-Party Liability (TPL) Information has been published to the Provider Resources web page. This quick guide provides detailed, step-by-step instructions on how to add TPL information for a member who has TPL coverage that is not listed in the Provider Web Portal and how to update/terminate existing coverage.

Recently Added Issues

DME Claims with HCPCS Codes S8120 and S8121 Denying for EOB 1178
Claims for oxygen contents HCPCS S8120 and S8121 with TG modifier for members using ventilators or oxygen in nursing facilities are denying for EOB 1178 "Service is not reimbursable for Date(s) of Service."

DXC and the Department are working to resolve the issue.

Claims will be reprocessed by DXC.

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, are not automatically crossing over from COBA to the Colorado interChange.

The Department is working to resolve the issue. Providers are advised to submit Crossover claims for QMB Only Clients directly to DXC until the issue is resolved.

Recently Updated Issues

Resolved 6/6/18: Behavioral Therapy Provider Claim Denials for EOB 0678 – "Billing Provider Type and Specialty Not Allowable for Rendering Provider"
Claims were denying for Behavioral Therapist providers for EOB 0678 – "Billing Provider Type and Specialty is not allowable for the Rendering Provider" when:

- the billing provider type on the claim was 25 with a rendering provider type of 84; *OR*
- the billing provider type on the claim was 83 with a rendering provider type of 24

These provider type combinations should be allowable per program policy.

Claims were reprocessed on 6/15/18.

Issue resolved 6/6/18

UPDATE 6/15/18: This entry has been updated to reflect completed claims reprocessing.

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 and S5160 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 issue has now been resolved for T2029 only. S5160 and A9900 have not yet been resolved; the Department and DXC are working to correct them.

No action is necessary for providers at this time. Updates will be provided when the issue has been completely resolved.

Claims will be reprocessed by DXC. Claims have not yet been reprocessed for any of the

three affected procedure codes.

UPDATE 6/15/18: This entry has been updated to reflect issue resolution for procedure code T2029 only.

Recently Resolved Issues

Resolved 6/14/18: Claim Denials for Eye Surgery Codes 66982 & 66984 for EOB 0101 or 1010
Claims for eye surgery procedure code 66984 were denying for EOB 0101 – "This is a duplicate service" or EOB 1010 – "This is a duplicate item that was previously processed and paid" when:

- 66984 was billed with modifier 54; ***AND***
- a separate claim for eyeglasses was billed with modifier 55

Claims for 66982 billed with modifier 54 were also denying for EOB 0101 or EOB 1010; however, the issue was resolved for 66982 on 12/10/17.

Claims for both 66982 and 66984 were reprocessed by DXC on 6/15/18.

Issue resolved 6/14/18

Resolved 6/13/18: Retroactive Updates to Eligibility Spans
The Colorado interChange was not processing some retroactive changes to a Health First Colorado (Colorado's Medicaid Program) and Child Health Plan *Plus* (CHP+) member's eligibility span. The Colorado interChange is now receiving the changes from the CBMS eligibility system. This issue has now been resolved.

If a member still believes an update to their eligibility information is necessary, the process is the same as it would have been with the Xerox legacy system; the member must call the Health First Colorado Member Contact Center to initiate the correction. In some cases, the member may be redirected to the county technician if additional information is needed to fulfill the eligibility requirements.

Issue resolved 6/13/18

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