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

Reminder: Request for Reconsideration is Not Necessary for Denied Claims
Providers are reminded that denied claims do not need to be adjusted or sent as a request for reconsideration. A denied claim should be resubmitted electronically as a new claim once corrections have been made. Resubmissions should not be sent on paper, even if the claim has surpassed the 365-day timely filing period.

Timely Filing Period Extended to 365 Days - Effective 6/1/18
Do you still have questions on the new timely filing rules?
Effective 6/1/18, the timely filing period has been extended to 365 days. For questions, please reference the Timely Filing Frequently Asked Questions (FAQs), located on the Provider FAQ Central web page.

Claims with Primary Medicare or Other Insurance/Third Party Liability (TPL)
Providers who receive payment from Medicare or other insurance/TPL no longer need to attach the Explanation of Benefits (EOB) to the electronic claim. Providers have an additional 120 days from a Medicare payment or denial and must include the Medicare or TPL EOB date on the claim. Providers must keep the EOB and supporting documentation on file. Claims with commercial insurance/TPL must be received within 365 days with no additional extension.

Note: This timely filing extension does **not** apply to behavioral health claims submitted through the Behavioral Health Organization (BHO), dental claims submitted through DentaQuest or pharmacy (point of sale) claims submitted through Magellan; however, Durable Medical Equipment (DME) claims are subject to the updated 365-day timely filing policy.

Featured Provider Resources

June Provider Bulletin - Now Available
The June Provider Bulletin (B1800417) was published on 5/31/18 on the Bulletins web page.

Update to General Provider Information Manual

The General Provider Information Manual has been updated. Refer to the revision log at the end of the manual for a complete list of changes.

Recently Added Issues

Prior Authorization Revisions for Procedure Codes T2031 and T2033

Case managers are temporarily unable to revise PAR lines with codes T2031 (Alternative Care Facility) and T2033 (Supported Living Program). This may allow claims to pay higher than the approved daily rate that is listed on the PAR. This may potentially cause the total approved dollars to be exhausted before the end of the certification period, and before all units are utilized.

The Department and DXC are aware of the issue and are working to resolve it. No action is necessary for case managers or providers at this time.

Behavioral Therapy Provider Claim Denials for EOB 0678 – "Billing Provider Type and Specialty Not Allowable for Rendering Provider"

Claims are 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 is 25 with a rendering provider type of 84; OR
- the billing provider type on the claim is 83 with a rendering provider type of 24

These provider type combinations should be allowable per program policy. The Department and DXC are working to resolve this issue.

Claims will be reprocessed by DXC.

Recently Updated Issues

Medical PAR Revisions, Reconsiderations or PARs with Amended Status Not Showing Fully Approved

Some PAR revisions, reconsiderations or any PAR with Amended status are not showing fully approved in the interChange. The line items of the PAR must show approved or approved with revisions in order for the claims to pay. PAR approval does not serve as a timely filing waiver.

Updates have been made in the Colorado interChange and eQ Health has resent PARs to the interChange. The Department is currently working to identify all affected PARs, and most of these have been corrected.

Claims will be reprocessed by DXC; however providers may resubmit if they have a corrected PAR.

UPDATE 6/1/18: This entry has been updated to note progress made towards issue resolution.

Recently Resolved Issues

Resolved 5/25/18: DME Oxygen Rental Denials for Procedure Code E1390 with Place of Service Nursing Home

Claims for DME oxygen for procedure code E1390 billed with modifier TT were denying for EOB 4211 - "Modifier is invalid for procedure code." Modifier TT should not have been billed for this procedure code after 12/31/17. Providers should have bill procedure code E1390 with modifier RR after 12/31/17; however, these claims were denying for EOB 2590 - "Bill Medicare first and complete the Medicare information fields on the claim." It is not necessary to bill Medicare for place of service 31 or 32 (Nursing home). If Place of service is 11 (home),

then Medicare must be billed first.

Providers are advised to resubmit affected claims.

Issue resolved 5/25/18

Resolved 5/24/18: Claim Denials for Laboratory Codes for EOB 2580
Some claims for procedure codes 80047-89398 were incorrectly denying for EOB 2580 – "The services must be billed to the HMO/PHP/BHO listed on the eligibility inquiry."

Claims were reprocessed by DXC 5/25/18.

Issue resolved 5/24/18

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