COLORADO
Department of Health Care Policy & Financing

Last Week in Review: Known Issues & Updates web page

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.

Known Issues Web Page

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

Take me there!

Hot Topics

Common Reasons for Claim Denials and Suspends
The Department and DXC recently published a list of common reasons for claim denials and suspends.

Common reasons for claim suspends are as follows:

EOB 0101 - Possible duplicate: practitioner to practitioner.
Explanation: This may be a duplicate claim, but not all parameters for an exact duplicate are met, so the claim must be reviewed by DXC to determine if it is a duplicate.
Estimated Time for Processing: 30 days

EOB 4000 - "The client has other insurance. Bill the charges to the other insurance before billing Medicaid. Complete the other insurance payment information fields on the claim and retain a copy of the explanation of benefits."
Explanation: The client has other insurance. Medicaid is always the payer of last resort. The claim must be sent to the primary carrier first. Due to a system defect claims must be reviewed to determine if the TPL information was entered on the claim.
Estimated Time for Processing: One week

EOB 6172 - "Multiple Surgery Review"
Explanation: The department and DXC are currently working to implement a more efficient process.
Estimated Time for Processing: Current backlog anticipated to be resolved in the next few weeks

EOB 2013 - "Claim Processed With Closest Elig Span-Deny" OR **EOB 2690** – "Claim processed with closest eligibility span."
Explanation: The client is currently not eligible.
Estimated Time for Processing: This claim will be recycled after 15 calendar days. If after the 15 days the client is still not eligible for the DOS, the claim will deny.

EOB 0653 - "Claim requires manual pricing. Please attach invoice for medical services."
Explanation: This claim requires manual processing by DXC to price.
Estimated Time for Processing: 30 days

NOTE: If claims are over 60 days from the date of receipt, please notify the DXC Provider Services Call Center at 844-235-2387 so they can be escalated for processing.

This list has been posted to the Known Issues & Updates web page under the General Updates section, near the top of the page, along with a list of common reasons for claim denials.

Featured Provider Resources

New training materials Beginning Billing Workshop CMS 1500 and Beginning Billing Workshop UB-04 have been posted to the Provider Training web page, under the Billing Training and Workshops section.

As a reminder, please verify member eligibility for Health First Colorado (Colorado's Medicaid Program) and Child Health Plan *Plus* (CHP+) via the Provider Web Portal prior to submitting claims. You can also search for Prior Authorization Request (PAR) status on the web portal; however, a PAR is not a guarantee of member eligibility as the PAR is valid for a span of time and eligibility can change at some point during that span.

For more information on checking member eligibility, refer to the Verifying Member Eligibility Quick Guide.

The Provider Services Call Center (1-844-235-2387) hours are as follows:

- 7 a.m. – 5 p.m. MT Monday, Tuesday & Thursday
- 10 a.m. – 5 p.m. MT Wednesday & Friday

The Provider Services Call Center utilizes the time between 7 a.m. and 10 a.m. on Wednesdays and Fridays to return calls to providers.

Refer to the Provider Services Call Center Information Sheet for more details. This information has also been posted under the General Updates section of the Known Issues & Updates web page for future reference.

Visit the DXC and interChange Resources web page for helpful information and reference documents such as Provider Web Portal Quick Guides, interChange FAQs, and notable changes related to the transition from the previous MMIS to the new Colorado interChange system.

If you are receiving this email, you are already signed up to receive Provider Bulletins and general announcements. If you would also like to receive emails specific to your provider type, you can sign up here.

Keeping your contact information up to date in the Provider Web Portal will also help to ensure that you receive emails specific to your organization's claims.

Many of the emails sent out to providers are also posted on the Provider Resources web page under the Emails to Providers heading. Please note that this is not an all-inclusive list of emails sent to providers, as some contain sensitive information and therefore are not made available to

the public.

Recently Added Issues

Claims Denying for Clinic Providers with Place of Service Code 24 (Ambulatory Surgical Center) for EOB 1030 - Place of Service Code is Invalid for Procedure Code
Claims for clinic providers are denying when billed with place of service code 24 (Ambulatory Surgical Center) for EOB 1030 - "The place of service code is invalid for procedure code."

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

Claim Denials for Laboratory Codes with BHO-Covered Diagnoses - EOB 2580
Claims for laboratory codes 80047 - 89398 provided to members for the ICD-10 diagnoses listed below are incorrectly denying for Explanation of Benefits (EOB) 2580 – "The services must be billed to the HMO/PHP/BHO listed on the eligibility inquiry." These codes are not part of the BHO contract and need to be billed Fee-for-Service (FFS).

BHO MH Diagnoses Ranges		SUD Diagnoses Ranges	
Start Value	**End Value**	**Start Value**	**End Value**
F20.0	F42.3	F10.10	F10.26
F42.8	F48.1	F10.28	F10.96
F48.9	F51.03	F10.98	F13.26
F51.09	F51.12	F13.28	F13.96
F51.19	F51.9	F13.98	F18.159
F60.0	F63.9	F18.18	F18.259
F68.10	F69	F18.28	F18.959
F90.0	F99	F18.980	F19.16
R45.1	R45.2	F19.18	F19.26
R45.5	R45.82	F19.28	F19.99

The Department and DXC are working to resolve this issue. Affected claims will be reprocessed by DXC.

Hospital Provider Claim Denials for E and M Procedure Codes for EOB 2580
The Department and DXC are aware that some claims for all E and M procedure codes are continuing to deny incorrectly for hospital providers for EOB 2580. The Colorado interChange is not using diagnosis to determine BHO coverage. DXC is working to resolve this issue.

Recently Resolved Issues

Resolved 9/15/17: Claims Overpaid or Were Not Denied Appropriately
Claims processed between 9/6/17 and 9/13/17 were either paid when they should have denied, or paid in full when they should have had a portion of the payment reduced. This issue affected all provider types. Affected claims will be reprocessed and funds will be recouped. Provider will be notified via email at least one week prior to any recoupments.

Issue resolved 9/15/17

Resolved 9/14/17: Viewing HCBS PARs in the Colorado interChange System
HCBS providers were previously unable to view a member's Prior Authorization Request (PAR) status in the Provider Web Portal. This issue has now been resolved. The Department and DXC Technology (DXC) have implemented a system enhancement to the Colorado interChange to allow providers to view a member's PAR status in the web portal.

Resolved 9/14/17: Claim Denials for Non-Emergent Medical Transportation

Providers for EOB 4000 – Member Has Other Insurance
Claims for Non-Emergent Medical Transportation Providers were denying for EOB 4000 – "The member has other insurance. Bill the charges to the other insurance before billing Medicaid. Complete the other insurance payment information fields on the claim and retain a copy of the explanation of benefits."

Claims will be reprocessed by DXC.

Issue resolved 9/14/17