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

Child Health Plan *Plus* (CHP+) Update
On December 21, 2017, the Joint Budget Committee approved Governor John Hickenlooper's request for one-time, short-term funding to extend funding of CHP+ **through February 28, 2018**, if Congress does not act to renew federal funding.

The Department is currently working to update CHP+ policy, operations and communications guidance, and is continuing to monitor federal activity on the CHP+ program.

Stay Informed
- Visit CO.gov/HCPF/FutureCHP
- Sign up for the future of CHP+ newsletter

If Congress does not act to renew federal funding, what will be the end of CHP+ in Colorado?
If Congress does not act, the CHP+ program will end February 28, 2018.

Can individuals still apply for CHP+ in February 2018?
Yes, new applications for CHP+ will be accepted through February 28, 2018. Although the CHP+ program will end after February 28, 2018, if Congress does not renew federal funding, counties and eligibility sites will continue to process all new applications. Individuals who apply by February 28, 2018, may be eligible for CHP+ for the month of February 2018.

Will there be any changes to CHP+ benefits or eligibility in February?
No, there will be no changes to CHP+ benefits or eligibility in February 2018. CHP+ members should continue going to the doctor, and CHP+ children should continue going to the dentist.

Will CHP+ redetermination packets stop going out?
No, redetermination letters will continue to be mailed and processed in January and February 2018. This information is needed to accurately determine the members' eligibility.

Do CHP+ members still need to pay the enrollment fee?

Yes, CHP+ members who owe an enrollment fee need to continue to pay the fee by the deadline listed in their letter.

Only Paid Claims Can Be Voided - Provider Web Portal Void Claim Option Appears Only on Eligible Claims
The void claim option on the Provider Web Portal will only appear on eligible claims. Only paid claims can be voided and the most recent paid Internal Control Number (ICN) must be used to adjust or void. For more instructions on how to adjust or void a claim, refer to the Copy, Adjust or Void a Claim Quick Guide on the Web Portal. As a reminder, providers should be submitting all claims electronically. Please see the November 2017 Provider Bulletin (B1700406) for information on submitting claims with attachments.

Denied claims do not need to be adjusted or sent as a request for reconsideration. A denied claim can be resubmitted electronically as a new claim once corrections have been made.

Featured Provider Resources

January Provider Bulletin - Now Available
The January Provider Bulletin (B1700409) was published on 12/29/17 on the Bulletins web page.

How to Copy, Adjust or Void a Claim in the Provider Web Portal
Refer to the Copy, Adjust or Void a Claim Provider Web Portal Quick Guide for detailed, step-by-step instructions on how to copy, adjust or void a claim in the Provider Web Portal.

The Provider Web Portal Quick Guides cover a variety of topics and are available on the DXC and interChange Resources web page under the "Quick Guides" drop-down.

Co-Payment Policy Updates
The Department is implementing two policies related to co-payments. You can find details about each of the policies in the December Provider Bulletin (B1700407) (pages 4 and 5) and the December Special Provider Bulletin - Co-payment Policy Updates (B1700408).

The Department has also recorded an informational webinar. This webinar explains each policy and provides guidance and resources for providers and pharmacies.

Providers must verify eligibility and co-payment information at each visit. For instructions on how check a Health First Colorado member's eligibility and co-payment requirement, review this quick guide.

Sign Up for Provider Email Communications
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 us 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 News and Implementations web page, under the "Emails to Providers" heading. Please be aware that this is not an all-inclusive list of emails sent to providers, as some contain specific provider-type information and therefore are not relevant to every provider.

Recently Added Issues

Claims Suspending for HCPCS 2018 Procedure Codes
Claims are suspending when billed for HCPCS 2018 procedure codes for EOB 0000 - "This claim/service is pending for program review."

Claims will be reprocessed by DXC once the HCPCS 2018 procedure codes and the billing rules have been loaded into the Colorado interChange system.

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. DXC, the Department and eQHealth (Colorado PAR) are working to resolve the issue.

PAR approval does not serve as a timely filing waiver. Claims will be reprocessed by DXC.

UPDATE 12/26/17: This entry has been updated to note that claims will be reprocessed by DXC.

Resolved 12/13/17: Incorrect Claim Payments for Nursing Facility Providers on Crossover Claims
Part A crossovers were paying the full coinsurance and deductible instead of using the "lower of" pricing logic. Part B crossovers were paying at zero when they should have paid the coinsurance and deductible.

Claims are being reprocessed by DXC in several stages. The first stage of claims reprocessing had results showing on RAs from the week of 12/4-12/8/17. The second stage of claims reprocessing occurred on 12/20/17. DXC is continuing to reprocess affected claims and will update this entry as each stage is completed.

Issue resolved 12/13/17

UPDATE 12/29/17: This entry has been updated to reflect claims reprocessing updates.

Resolved 11/22/17: Modification to the Source of Nursing Facility Patient Liability Data
For nursing facility claims received on or after 3/1/2017, Patient Liability was calculated using data from the Colorado Benefits Management System (CBMS). It has been determined the claim data from Value Code 31 (Patient Liability Amount) is generally more accurate; therefore, the Colorado interChange system has been updated to calculate Patient Liability using the Value Code 31 data submitted on the claim.

The first stage of claims reprocessing occurred on 12/8/17. The second stage of claims reprocessing occurred on 12/15/17.

Issue resolved 11/22/17

UPDATE 12/29/17: This entry has been updated to reflect an additional round of completed claims reprocessing.

Recently Resolved Issues

Resolved 12/23/17: Claim Denials for Injection Procedure Codes Q2050 and Q5101 for EOB 0182
Claims were denying for clinic providers when billed for procedure codes Q2050 and Q5101 for EOB 0182 – "Billing Provider Type and/or Specialty is not allowable for the service billed."

Claims on or after date of service 7/1/2017 were reprocessed on 11/2/2017. The codes have now been updated to encompass dates of service from 1/1/2017 to 7/1/2017. DXC will reprocess these additional claims.

DXC and the Department are still researching claims for date of service 10/1/2016 -1/1/2017.

Issue resolved 12/23/17

Resolved 12/19/17: Claim Denials for Procedure Code S5161 for EOB 1544 – Procedure is Not Billable with Client's Benefit Plan

HCBS provider claims for procedure code S5161 were denying for Explanation of Benefits (EOB) Code 1544 – "Procedure is not billable with client's benefit plan."

Claims will be reprocessed by DXC. As a reminder, please verify member eligibility as claims could still appropriately deny if the member is not eligible on the waiver plan.

Issue resolved 12/19/17

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