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The Department of Health Care Policy & Financing (the Department) recognizes that this past year has brought significant changes for providers. Based on the provider questions most frequently submitted to the Department and DXC Technology (DXC), the Department has published this special bulletin as a helpful resource. In addition to answering the most frequently-asked provider questions, this bulletin also serves as a collection of previously published important information, with links to the original sources.

Providers and billing agents are encouraged to print out this bulletin as a reference for some of the key questions of the past year's transition to the new Colorado interChange system.

## Claims Submission

### **Do Not Send Reconsiderations for Denied Claims**

Originally published in [November 2017 Provider Bulletin \(B1700406\)](#) - "Did You Know?"

Reconsiderations are not required for denied claims. The provider can make the necessary corrections and resubmit as a new claim. The resubmission does not need to be billed on paper. If corrections are not made to the originally denied claim, a re-bill will still deny.

## Electronic Submission of Claims with Attachments

Originally published in [September 2017 Provider Bulletin \(B1700403\)](#) - "Claim Submission Method for Claims with Attachments"

Providers are advised to submit all claims electronically (including claims with attachments) through the [Provider Web Portal](#).

The only exception to this is for providers submitting less than five (5) claims per month (in this instance, the provider must submit a [request form](#)).

For information about using the Provider Web Portal, refer to the available quick guides located on the visit the [Quick Guides and Webinars web page](#).

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## Provider Web Portal Void Claim Option Appears Only on Eligible Claims

Originally published in "[Last Week in Review](#)" Newsletter (January 2, 2018) - under "Hot Topics" (same title as above)

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 - Provider Web Portal Quick Guide](#). 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 (page 3). 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.



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## When to Attach Explanation of Benefits (EOB) on Third Party Liability (TPL) and Medicare Claims

Originally published in "[Last Week in Review](#)" Newsletter (March 19, 2018) - under "Hot Topics" (same title as above)

It is not necessary to attach a copy of the EOB for all claims that have a TPL or Medicare primary. TPL and Medicare information should be reported directly on the claim. An EOB is only necessary when submitting a TPL or Medicare claim that is outside timely filing; then the EOB may serve as a timely filing waiver. As a reminder, all claims, including TPL and Medicare claims, should be filed electronically, even if there is a primary payer.

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## Unique National Provider Identifiers (NPIs): Making Claim Submission Easier

Originally published in [September 2017 Provider Bulletin \(B1700403\)](#) - "National Provider Identifier (NPI) Numbers" and [December 2016 Provider Bulletin \(B1600390\)](#) - "Did You Know?"

Providers are strongly encouraged to obtain and use a unique billing NPI for every location address and provider type enrolled as a Health First Colorado (Colorado's Medicaid Program) and Child Health Plans *Plus* (CHP+) provider. To obtain a separate NPI, contact NPI at 800-465-3203.

Providers may get EOB 1473 - "Multiple Provider Locations Found for Billing Provider" as a reason for claim denial if each location address and provider type within one organization do not have a unique NPI. If sharing an NPI with more than one (1) group provider type or location address, then additional steps are needed to ensure proper claims adjudication. A unique nine (9) digit zip code or taxonomy code is required to identify the Health First Colorado billing provider ID.

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## Paper Claim Form Signature Requirements

Originally published in ["Last Week in Review" Newsletter \(February 26, 2018\)](#) - under "Hot Topics" (same title as above)



Providers are reminded that signatures are required when sending paper claims. Typed names are not accepted. A stamped signature is acceptable. Individual rendering providers do not need to sign; a representative from the group may sign the claim form.

This applies to the [Institutional Certification](#) document, the Dental Certification, as well as the signature field on the paper CMS 1500 form. However, all providers should be submitting electronically unless paper claim submission is a work around to a known issue, or they have approval due to submitting less than five (5) claims per month.

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## Claims Paid with "0" Date

Originally published in [August 2017 Provider Bulletin \(B1700401\)](#) - "Did You Know?"

Occasionally, claims will appear as "Paid" (with a Paid date of "0") in the Provider Web Portal but not on the Remittance Advice (RA). This is due to the claim being flagged by a prepayment cycle. The claim is being reviewed before it is released. This process may take a few weeks.

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## Suspended Claims

Originally published on the [Known Issues & Updates web page](#) - under "General Updates" (same title as above)

Please be aware that suspended claims will only appear once on the RA. The top reasons for suspended claims are:

- EOB 1786 (Timely Filing) - Estimated Time for Processing: 20 business days
- EOB 0101 (Duplicate) - Estimated Time for Processing: 30 days
- EOB 4000 (Third Party Insurance) - Estimated Time for Processing: One week
- EOB 6172 (Multiple Surgery) - Estimated Time for Processing: 30 days

- **EOB 2013 (Eligibility)** - 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 (Manual Pricing)** - Estimated Time for Processing: 30 days

**Note:** If claims are over 60 days from the date of receipt, please notify the [Provider Services Call Center](#) so they can be escalated for processing.

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## "Lower of" Pricing Logic for Rate Increases

Originally published in [April 2018 Provider Bulletin \(B1800412\)](#) - "Did You Know?"

If the Department implements rate increases, claims that were already billed with and paid at a rate lower than the new rate cannot be adjusted for the higher rate. The Department will always use the "lower of" pricing logic. Providers are advised to bill their usual and customary charges.

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## Rates and Fee Schedules

Originally published in "[Last Week in Review](#)" [Newsletter \(March 19, 2018\)](#) - under "Featured Provider Resources" ("[Updates Rates & Fee Schedules](#)")

Not all codes are listed on the Health First Colorado Fee Schedule, so providers are advised to check [all fee schedules](#) which apply to their billing practices. If a code is not listed on the Health First Colorado Fee Schedule, it may be listed on a benefit-specific fee schedule.

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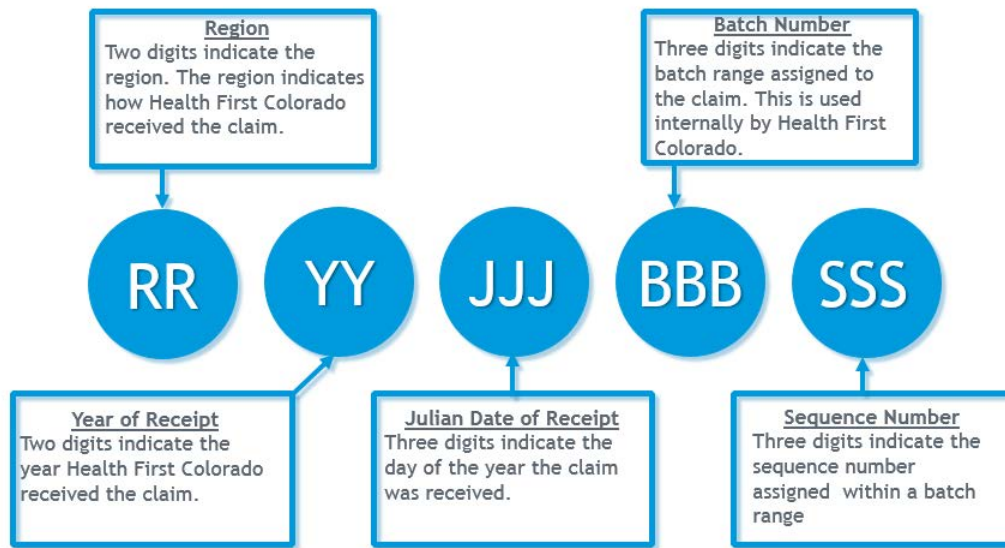
## Finding Information About Your Submitted Claims (What Is an ICN?)

Originally published in [December 2017 Provider Bulletin \(B1700407\)](#) - "Did You Know?"

In the Colorado interChange, each claim is assigned an ICN. Besides assisting a customer service agent with locating a specific claim, the ICN can help identify some information about the claim.

- What type of claim is it?
  - The first two (2) digits of the ICN (referred to as the "region code") identifies the type of claim it is. [Here's a list of region codes and their corresponding claim types](#)\*
- When did the fiscal agent receive the claim?
  - After the region code, the ICN lists five (5) digits which correspond to the [Julian date](#)\* on which the claim was received by the fiscal agent.

- The other numbers in the ICN are used by claims processing staff to identify other information about the claim.



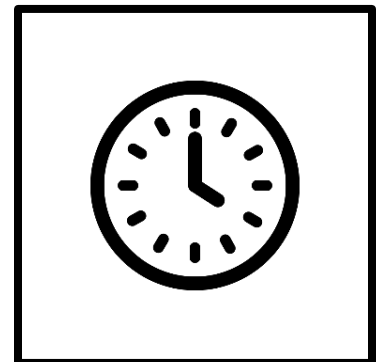
\*Find these resources on the [Quick Guides and Webinars web page](#).

## Timely Filing

Originally published in [December 2017 Provider Bulletin \(B1700407\)](#) - "Timely Filing Frequently Asked Questions (FAQs)"

The Department and DXC receive many questions related to timely filing and have published frequently asked questions on the [Provider FAQ Central web page](#) about the topic that may be helpful in understanding the policy. Here are some important basics about timely filing:

- Providers always have **at least 240 days** from the date of service (DOS) to submit the claim. A timely filing waiver is only needed if the dates of service have exceeded 240 days.
- Providers are required to resubmit claims every 60 days after the initial timely filing period (240 days from DOS) to keep the claim within the timely filing period (even if the claim denies). The previous ICN must be referenced on the claim.
- Providers who receive payment from Medicare or other insurance (third party liability/TPL) should attach the EOB to the claim when submitting it through the Provider Web Portal, only if the initial 240 days has expired.



**Waiting for prior authorization or correspondence from the Department or the fiscal agent is not an acceptable reason for late filing. Phone calls and other correspondence are not proof of timely filing. The claim must be submitted, even if the result is a denial or rejection.** Issues, including billing agent, software failure, or clearinghouse to transmit accurate and acceptable claims or failure to identify transmission errors in a timely manner, need to be resolved between the provider and the billing agent, software vendor, or clearinghouse. If the original timely filing period expires, the next submission must be received within 60 days of the last adverse action. The following are examples of adverse action:

- Fiscal agent correspondence (including form letters) that identifies specific claims
- Claims that have been date-stamped by the fiscal agent or the Department and returned to the provider
- Provider enrollment letter for initial enrollment approval or a backdate approval (affiliations or updates are not acceptable reasons for late filing)
- Load letter for eligibility backdate
- Affidavit of delayed notification of member eligibility

Claims that are not able to be submitted within the 240-day guideline, but have one (1) of the above documents attached to the submission, will be reviewed by the fiscal agent. Further information on timely filing can be found in the [General Provider Information Billing Manual](#).

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## **Provider Enrollment**

### **Ordering, Prescribing or Referring (OPR) Application Not Required for Individual Within a Group (IWG) Providers with Prescriptive Authority**

Originally published on the [Provider Revalidation & Enrollment web page](#) (same title as above)

Providers with prescriptive authority who are enrolled as an active IWG (rendering provider) may be prescribers. They are not required to complete an additional OPR application. OPR enrollments are for providers who do not submit payment directly to Health First Colorado but only prescribe, refer or order for Health First Colorado members. Submitting an OPR application with the same Social Security Number (SSN) as a previously enrolled IWG may result in the application being denied as a duplicate or in denied claims.

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### **Individual Providers Enrolling with an SSN May Only Have One Medicaid ID**

Originally published in "[Last Week in Review](#)" Newsletter (February 5, 2018) - under "Hot Topics" (same title as above)

Providers with any of the following individual types may only have one application associated to an SSN, even if they provide services in multiple locations:

- Billing individuals
- Individuals within a group (IWG)
- Ordering, prescribing and referring (OPR) providers

An additional application for any of the individual types above with the same SSN and same NPI as a previous application (regardless of whether the individual type is the same as on the previous application) may result in the application being denied as a duplicate or denied claims. Individuals may affiliate with multiple groups in different locations.




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### **Department Grace Period for Updating Provider Affiliations**

Originally published in [March 2017 Provider Bulletin \(B1700396\)](#) - "Are You Getting One of the Following Claim Messages?"

Although providers may see EOB code 3110, this is informational. Providers are encouraged to update affiliation information on the Provider Web Portal (for instructions, refer to the [Provider Maintenance - Provider Web Portal Quick Guide](#)), but a claim will not deny for missing affiliation information at this time.

Affiliation update requests are currently taking up to three (3) weeks for final approval. Providers should not submit duplicate update requests.

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## **Member Eligibility**

### **Retroactive Updates to Member Eligibility Files**

Originally published on the [Known Issues & Updates web page](#) - under "All Provider Types" ("Retroactive Updates to Eligibility Spans")

There is a system issue that prevents the Colorado interChange from processing some retroactive changes to a Health First Colorado and CHP+ member's eligibility span.



If a member believes a fix 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 at 1-800-221-3943 to initiate the correction.

If the member has already contacted the Member Contact Center and obtained the Proof of Insurance, the provider may accept this as eligibility verification and render services. The eligibility update will take 2-3 business days to appear in the Colorado interChange. Providers are advised to continue submitting claims to keep them timely and to resubmit affected claims once the member's eligibility has been corrected. Providers must resubmit previously submitted claims.

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## **Alternative Benefit Plan**

Originally published on the [Known Issues & Updates web page](#) - under "All Provider Types" ("Alternative Benefit Plan Member Must Have Medicaid State Plan [TXIX] Coverage to Be Eligible for Services") and "[Last Week in Review](#)" Newsletter (February 15, 2018) - under "Hot Topics" ("Alternative Benefit Plan Member Must Have Medicaid State Plan [TXIX] Coverage to Be Eligible for Services")

The Alternative Benefit Plan (ABP) is an extended plan which must be accompanied by Medicaid State Plan (TXIX) coverage. If the member does not have TXIX coverage, they are not eligible for services and claims will be denied for EOB 3261 - "The procedure code currently is not a benefit for date of service billed. Refer to the CPT or the HCPCS listing for valid procedure codes."

Providers should verify coverage under Benefit Details on the Provider Web Portal before rendering services. For detailed, step-by-step instructions on verifying member eligibility, refer to the [Verifying Member Eligibility - Provider Web Portal Quick Guide](#).

## **DXC Contacts**

### **DXC Office**

Civic Center Plaza  
1560 Broadway Street, Suite 600  
Denver, CO 80202

### **Provider Service Call Center**

1-844-235-2387

### **DXC Mailing Address**

P.O. Box 30  
Denver, CO 80202