COLORADO
Department of Health Care Policy & Financing

OPERATIONAL MEMO

TITLE:	**PROVIDER REQUIREMENTS FOR ASSISTING IN THE COORDINATION OF BENEFITS**
SUPERSEDES NUMBER:	
EFFECTIVE DATE:	**NOVEMBER 19, 2021**
DIVISION AND OFFICE:	**MEDICAID OPERATIONS OFFICE**
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Purpose and Audience:

The purpose of this Operational Memo is to inform all Health First Colorado (Colorado's Medicaid Program) providers of their obligation to effectively communicate coordination of benefits requirements to Health First Colorado members who have primary third-party insurance.

Information:

Background

Under Section 25.5-4-301(1)(a)(I), C.R.S., no member "shall be liable for the cost or the cost remaining after payment by Medicaid, Medicare, or a private insurer of medical benefits authorized by Title XIX of the social security act[]." Further, under paragraph G in the provider participation agreement, a "Provider shall not bill supplemental charges to the client, except for amounts designated as co-payments by the Department."

Section 25.5-4-301(1)(a)(III)(A), C.R.S., states that when a third party is primarily liable for the payment of a member's medical assistance benefits, prior to receiving medical care, the member is required to comply with the protocols of this liable third party, which includes using providers within the third party's network or receiving a

referral from the member's primary care physician. If a member fails to comply with the protocols of the liable third party, this Section allows the member to be held personally liable for the cost of the medical care the third party would have otherwise been liable to pay.

Provider Obligation to Assist Members in the Coordination of Benefits

While members with third-party primary insurance are required to coordinate their benefits with their primary insurance company, all providers must communicate with the members to assist in this required coordination of benefits. Outside of those emergency treatments where communicating with the member upfront about insurance is not possible, prior to providing services to the member, providers shall inform the member if they are out of network for the member's primary third-party insurance.

Additionally, prior to billing a member personally for the member's failure to coordinate benefits and comply with the protocols of the third-party insurance, providers must, at a minimum, make the following instructive communication attempts to the member, all of which must be documented in writing. Each communication attempt shall clearly convey the specific actions the member must take in order to effectively coordinate the member's benefits so as to enable the provider to bill the third-party primary insurance.

1) Call and speak with the member. If the member does not answer the phone call, leave a detailed voice message.
2) If the provider has the member's email address, send the member an email.
3) Send a certified letter to the member by mail, addressed to the member's last known address.

Providers shall not send a bill to a member before or during the process of making the above required communication attempts. If these required communication attempts have been completed, documented in writing, and if the member has still not coordinated benefits as needed for the provider to bill the third-party insurance, then, not prior to 30 days following the mailing date of the certified letter, the provider may bill the member for failure to comply with the protocols of the member's third-party insurance, in accordance with Section 25.5-4-301(1)(a)(III)(A), C.R.S.

Failure to Comply

A provider's failure to make the above-described communication attempts prior to billing a member with third party primary insurance, and to document said attempts in writing and make them available to the Department upon request, will be considered illegal billing in violation of Section 25.5-4-301, C.R.S., and will result in the Department taking action against the provider consistent with Section 25.5-4-301 and 10 C.C.R. 2505-10, Section 8.076.

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