COLORADO
Department of Health Care Policy & Financing

Dear Providers,

This email summarizes additions to the Known Issues & Updates web page from the past two weeks. 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

Member Eligibility Update
Some members who were no longer eligible for coverage still showed eligible in the Provider Web Portal. Members received *this letter* that confirms they have benefits until 3/31/20. After that time, they will no longer have coverage unless they have reapplied and have been determined to be eligible.

Claims for dates of service through 3/31/20 for members that received the letter will be processed and claims that already paid **will not** be recouped. Providers are encouraged to check eligibility for members on each date of service to ensure coverage is active.

CMS Transition Period Ended - Only MBIs Returned for 834 and 271 Transactions
The Centers for Medicare & Medicaid Services (CMS) Transition Period, where providers can use either the Health Insurance Claim Number (HICN) or the Medicare Beneficiary Identifier (MBI) to exchange data and submit claims, ended 12/31/19.

Effective 1/1/20, providers that submit claims where Medicare is the primary payer will have to submit claims using MBIs, regardless of the date the service was rendered. On the 834 and 271 transactions, if a member is enrolled in Medicare, only the current MBI will be returned. If a current MBI is not known for a member, then no Medicare ID will be returned.

For more information about MBIs and exceptions to the MBI deadline, visit the CMS Medicare Beneficiary Identifiers (MBIs) web page and the MBI Health Care Providers & Office Managers web page.

Submitters and trading partners should contact the Provider Services Call Center at 1-844-235-2387 and select option 2 and then option 3 for Electronic Data Interchange (EDI) assistance.

What Will the Revalidation Experience be Like?

- Providers will complete a revalidation application on the Provider Web Portal.
- The revalidation application will be similar to the enrollment application, but simplified.
- Some information will auto-populate, so not all sections will need to be completed.
- A quick guide, a revalidation manual and Provider Services Call Center support will be available before and during the revalidation process.

Visit the Revalidation web page for more information

Featured Provider Resources

Upcoming Holiday - Presidents Day
On Monday, 2/17/20, State Offices, ColoradoPAR Program, DentaQuest and DXC will be closed.

Upcoming holidays are posted to the Provider Resources web page and on the last page of every monthly Provider Bulletin.

How to Bill for Short-Term Behavioral Health Services in the Primary Care Setting
Access has been increased to short-term behavioral health (mental health and substance use disorder) services within the primary care setting as of 7/1/18. The intent of this change is to provide additional access to behavioral health services for short-term episodes of care for low-acuity conditions.
With this change, the first six (6) visits can be billed directly to DXC Technology (DXC) and not the Regional Accountable Entity (RAE).

Allowable Procedure Codes
Only the following procedure codes are reimbursable under the Department's short-term behavioral health services policy:

- 90791--Diagnostic evaluation without medical services
- 90832--Psychotherapy – 30 minutes
- 90834--Psychotherapy – 45 minutes
- 90837--Psychotherapy – 60 minutes
- 90846--Family psychotherapy without patient
- 90847--Family psychotherapy with patient

Additional Information & Resources

- Short-Term Behavioral Health Services in the Primary Care Setting Fact Sheet (available on the Accountable Care Collaborative Phase II web page)
- Verifying Member Eligibility and Co-Pay Provider Web Portal Quick Guide (available on the Quick Guides and Webinars web page)
- Accountable Care Collaborative Phase II web page

Timely Filing and Resubmissions
Providers always have the initial timely filing period of 365 days from the date of service to submit claims. Providers have an additional 60 days from the date of the last remittance advice (RA) to resubmit, if the initial 365-day period has expired. If the date of service is still within 365 days, providers do not need to refile every 60 days.

The previous internal control number (ICN) must be entered on the claim when resubmitting, *if* the date of service is past 365 days.

If a claim was originally submitted within the timely filing guideline and denied or recouped, providers have an additional 60 days from the date of the last RA to resubmit. A resubmission or adjustment of a paid claim must also be within timely filing guidelines.

Resubmissions do not need to be sent as a reconsideration.

Providers are required to resubmit claims every 60 days after the initial timely filing period to keep the claim within the timely filing period, even if the claim denies. 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.

Recently Added Issues

Surgery Providers - Overpayment of Surgery Claims Performed by Assistant Surgeons
Some surgery claims billed with the 80, 81 or 82 modifiers that were paid between 3/1/17, and 3/1/19, were overpaid. Per program policy, these modifiers indicate procedures performed by assistant surgeons and should be reimbursed at 20% of the allowed amount.

Affected claims were reprocessed by DXC and funds were recouped on 1/31/20. This appeared on remittance advices beginning Monday, 2/3/20.

Laboratory Providers - Overpayment of Laboratory Claims Affected by Clinical Diagnostic Laboratory Rate Decrease
Effective 2/10/20, claims with dates of service starting 11/1/19, and having laboratory codes affected by Amendment 19-0028 for Clinical Diagnostic Laboratory rate decreases may appear on remittance advice (RA) as recoupments.

This amendment is to align with Medicare rates in accordance with the Upper Payment Limit published in the January 2020 Provider Bulletin (B2000442).

Recently Resolved Issues

No new Resolved Issues have been posted to the website. DXC and the Department working on several issues and will be adding this information to the Known Issues page in the coming weeks.

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