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.

Hot Topics

Billing Health First Colorado (Colorado Medicaid) Members for Services
It is important that all healthcare providers know that Health First Colorado members cannot be billed for services covered by Health First Colorado.

Providers are responsible for determining if a patient has Health First Colorado coverage before services are rendered.

At the state level, Colorado law (C.R.S. 25.5-4-301(II)), provides that no Health First Colorado member shall be liable for the cost, or the cost remaining after payment by Health First Colorado, Medicare, or a private insurer, of medical benefits authorized under Title XIX of the Social Security Act. This law applies whether or not Health First Colorado has reimbursed the provider, whether claims are rejected or denied by Health First Colorado due to provider error, and whether or not the provider is enrolled in the Colorado Medical Assistance Program. This law applies even if a Health First Colorado member agrees to pay for part or all of a covered service.

Please note that **providers should not send overdue Health First Colorado member accounts to collection agencies**, unless the billing is for a non-covered service and the member has reneged on a written payment agreement.

Visit the Policy Statement: Billing Health First Colorado Members for Services web page for more information.

Timely Filing Requests
Load letters or other timely filing requests are not necessary when the claim is submitted within 365 days from the date of service. Providers always have the initial 365 days to submit a claim. Referencing the previous claim number or attaching a timely filing override is only needed if the initial timely filing period has expired.

Featured Provider Resources

March Provider Bulletin - Now Available
The March 2020 Provider Bulletin (B2000445) was published on 2/28/20 and is available on the Bulletins web page.

New Benefit for HCBS-CES Waiver Providers - Youth Day Services
Youth Day Services for youth ages 12-17 enrolled in the Home and Community Based Services - Children's Extensive Support (HCBS-CES) waiver can now be added to members' service plans. Providers need to discuss with families and case managers when to distinguish between Youth Day and Respite.

The Youth Day Services Specialty (751) has been added to existing CES-Respite Providers' enrollment profiles retroactive to February 1, 2020.

Current CES-Respite Providers are eligible through this waiver. Providers need to discuss with families and case managers when to distinguish between Youth Day Services and Respite Services for billing. Providers should follow the billing codes and rates for each service, as outlined in the HCBS-IDD Billing Manual available on the Billing Manuals web page under the HCBS drop-down section.

The following procedure codes are available for Group (T2027 U7 HQ) and Individual (T2027 U7). A limit of ten (10) hours per member per day for these services (in any combo of group/individual units) applies. There is no Individual-Per Diem for Youth Day.
Youth Day Services (Individual) T2027 U7
- Reimbursed at $5.70 per 15 minute Unit

Youth Day Services (Group) T2027 U7 HQ
- Reimbursed at $1.90 per 15 minute Unit

Contact Kathleen Homan at Kathleen.Homan@state.co.us with questions or concerns related to CES – Youth Day or CES – Respite.

Sign Up for Provider Email Communications
Recipients of this email are already signed up to receive Provider Bulletins and general announcements. To receive emails specific to provider type, sign up by selecting the email list(s) that best apply.

Keeping provider contact information up to date in the Provider Web Portal will also help to ensure that providers receive emails specific to their organization's claims. The email address associated with the mailing address in the Web Portal will be used for provider communications. For instructions on how to access and update the email address on file, refer to the Provider Maintenance Provider Web Portal Quick Guide, available on the Quick Guides and Webinars web page.

Looking for a recent newsletter or email? Weekly newsletters and many of the emails sent out to providers are also posted on the Provider News web page.

Recently Added Issues

Upcoming Reprocessing of Third Party Liability (TPL) Recoupments
The reprocessing of multiple claims identified for recoupment by Health Management Systems (HMS), the Department's Third Party Liability (TPL) vendor, has been delayed within Colorado interChange. These claims have identified the member as having commercial insurance or third party liability which should be billed primary.

DXC and the Department are working to resolve this issue. DXC will reprocess affected claims and recoup funds in several stages throughout the month of March. It is anticipated that recoupments will be completed by the end of March 2020.

Recently Updated Issues

Durable Medical Equipment (DME) Claim Denials for EOB 5110
Claims billed for procedure code A4225 are incorrectly denying for EOB 5110 - "The prior authorization does not match the services billed on your claim. Please correct services or submit a new prior authorization for the services billed." This procedure code does not require a prior authorization.

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

UPDATE: This issue was previously published including procedure codes L8691 and L8692. These procedure codes **do require** prior authorization and the known issue has been updated to remove L8691 and L8692.

Recently Resolved Issues

Resolved 2/25/20: Pharmacy Claim Denials for Procedure Code K0554 With Modifier NU for Explanation of Benefits (EOB) 4211 – "Modifier Is Invalid for Procedure Code and EOB 0182 – "Billing PT/PS Restriction on Proc Billing Rule"
Pharmacy claims for procedure code K0554 with modifier NU were denying for EOB 4211 – "Modifier is invalid for procedure code" and EOB 0182 – "Billing PT/PS Restriction on Proc Billing Rule."

Claims will be reprocessed by DXC.

Issue resolved 2/25/20

Resolved 2/26/20: Long Term Acute Care (LTAC), Rehabilitation (Rehab) and Spine/Brain Injury Treatment Specialty Hospital Hospitals Changed to Per Diem Reimbursement
Effective 7/1/19, Long Term Acute Care (LTAC) Hospitals and Rehabilitation (Rehab) hospitals changed from All Patient Refined – Diagnosis Related Groups (APR-DRG) reimbursement to per diem reimbursement. Colorado interChange was updated to reflect the change on 2/26/20, and claims submitted after 2/26/20 will process accordingly.

Providers are responsible for billing claims which encompass dates of service before and after the 7/1/19 implementation date. An interim solution for how providers should submit these claims is being developed. Once complete, future communications will be posted to the Inpatient Hospital Per Diem Reimbursement Group web page.

DXC will reprocess all affected claims with an admit and discharge date on or after 7/1/19.

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