COLORADO
Department of Health Care Policy & Financing

Provider News & Resources

March 21, 2022 Issue 45

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Featured Provider Web Portal Quick Guide:

Upcoming Holidays:

Memorial Day - Monday, May 30

State Offices, the ColoradoPAR Program, DentaQuest and Gainwell Technologies will be closed.

Delayed Member Notification of Health First Colorado Eligibility

It is not effective to rely solely on the member notifying the provider of their eligibility. Billing statements, or collection agencies should also not be the only means of obtaining eligibility information.

Providers are expected to take appropriate and reasonable action to identify Health First Colorado (Colorado's Medicaid program) eligibility within 365 days (timely filing guidelines). Some examples of appropriate action include:

- Reviewing past medical and accounting records for eligibility and billing information for services provided
- Requesting eligibility information from the referring provider or facility where the member was seen
- Contacting the member by phone and by email and by mail
- Verify eligibility via the Provider Web Portal or via batch

If the timely filing period expires because the provider is not aware that the member is Health First Colorado eligible, the fiscal agent is not authorized to override timely filing.

Provider Enrollment: Application Fees, Fingerprinting, Site Visits

Application fees, fingerprinting, and site visits are required for enrollment. If any of these requirements were waived for the Public Health Emergency (PHE), they will be required to continue enrollment.

Refer to the New Provider Specialties for COVID-19 Long-Term Temporary Enrollment communication under the Enrollment News and Updates section on the Provider Enrollment web page for more information.

Electronic Visit Verification (EVV) Denials

Providers are reminded that all claims requiring the use of EVV will encounter a pre-payment review. **Information such as the Medicaid ID, Dates of Service, Group Code and Provider ID must be consistent between the visit records and claims**. Claims without necessary EVV records may deny with Explanation of Benefits (EOB) 3054 "EVV Record Required and Not Found".

If a denial is received for missing EVV:

1. Check for missing records in Sandata and submit a manual entry, if needed.
2. Check for incomplete or unverified visits in Sandata and adjust records, if needed.

When the above step(s) have been completed:

1. **Wait 24 hours** for the visit to transmit to Colorado interChange.
2. **After 24 hours**, visits are available for matching and can be re-billed or adjusted.

It is recommended providers review the Best Practices for Recording and Billing with Electronic Visit Verification (EVV) document. Refer to the February 2022 Provider Bulletin (B2200475) for more information.

Reminder: Reconsiderations & Appeals

Denied claims do not need to be sent as a request for reconsideration. A denied claim should be corrected and resubmitted electronically as a new claim.

Resubmissions should not be sent on paper, even if the claim has surpassed the 365-day timely filing period or if the claim has previously denied.

Contact the Provider Services Call Center with questions on how to correct denied claims, timely filing or other billing and policy concerns regarding a formal appeal.

Featured Provider Web Portal Quick Guide: New Functionality to Remove Delegates

A provider may remove a delegate under the Add New Delegate/Office Staff tab or under the Linked Registered Delegate/Office Staff tab. A delinked or removed delegate will no longer act on behalf of that provider location.

Refer to the Removing a Delegate section in the Delegates Quick Guide for step-by-step instructions.

Visit the Quick Guides web page to locate all published Provider Web Portal Quick Guides.

Recently Published Billing Manuals

- Appendix X - HCPCS and NDC Crosswalk for Billing Physician-Administered Drugs
- Pharmacist Services Billing Manual

Visit the Billing Manuals web page to locate all published billing manuals.

Resolved Issues

Resolved 3/18/22: Home & Community-Based Services (HCBS) Claims for H0038, S5130, T1019 and T2016 Paid at Incorrect Rate - Specialties 656, 666, 664, 652, 673 and 674

Some HCBS claims subject to the Denver Minimum Wage rate for procedure codes H0038, S5130, T1019 and T2016 for dates of service on or after 1/1/21 were not being reimbursed at the correct rate. Some member profiles in the Colorado Benefits Management System (CBMS) were missing county of residence data.

Affected claims were reprocessed 3/18/22.

County of residence is based on information in the member's profile in the Colorado Benefit Management System, which is then transmitted to the Colorado interChange.

Issue resolved 3/18/22

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