COLORADO
Department of Health Care Policy & Financing

Provider News & Resources

July 11, 2022 Issue 52

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Featured Resources:

July 2022 Provider Bulletin (B2200480)

Upcoming Holidays:

Labor Day -

Did You Know?

Switch to Mailchimp

Email communications sent by Gainwell Technologies on behalf of the Department of Health Care Policy & Financing (the Department) have switched from Constant Contact to the email management application Mailchimp. Affected emails include the monthly bulletin, the weekly newsletter, announcements about known issues, and other general communications.

Providers may notice the Mailchimp footer on emails. Providers will continue to receive the same email communications they received prior to the switch.

Revalidation Reminder

Providers are reminded of the requirement to submit revalidation applications according to their scheduled due date.

Claims are currently not being denied or suspended if revalidation has not been completed. However, providers are strongly encouraged to submit their

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

Revalidation Dates Spreadsheet on the Revalidation web page.

Reminder: Verify License Status

Providers are reminded to keep licenses up to date. If a provider has recently received a notification about an expired license, the status can be confirmed by logging into the Provider Web Portal to verify the license status and update licenses as applicable.

1. Login into the Provider Web Portal. **Note**: Delegates have limited access, check with your administrator if your access allows updating capabilities for licensing.
2. Select **Provider Maintenance**, twice.
3. Click on **Provider Identification Changes**.

Result: All applicable licenses that are on file and associated with the portal account will display.

Refer to the Provider Maintenance - Update License Quick Guide for more information.

Ordering, Prescribing, Referring (OPR) Claim Identifier Project - Update

Effective July 1, 2022, the Department will begin a soft enforcement of the federal requirement 42 CFR § 455.440 that claims for certain types of services contain the National Provider Identifier (NPI) of the provider who ordered the service, and that the NPI is actively enrolled with Health First Colorado.

The OPR claim edits will initially be set to "pay and report" instead of "deny". This will allow providers to analyze their claim Remittance Advice and identify which claims are missing the required OPR NPI number. The Department will continue to monitor claims and keep providers notified of changes.

Refer to the June 2022 Provider Bulletin (B2200479) for more information.

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.

Claims Editing Bypass for Gender Restrictions

Many procedures that are restricted to a member's assigned sex at birth are still medically necessary after legally changing their gender. Currently, these claims must be reprocessed to bypass the gender edits. Effective June 29, 2022, these claims are processed through interChange when the following billing guidance is used with gender-specific procedures that conflict with the member's identified gender:

- **CMS-1500/837P claims:** Providers should enter the KX modifier to the appropriate line item.
- **UB-04/837I claims:** Providers should enter condition code 45 to indicate a procedure is medically necessary despite a gender conflict.

The Gender-Affirming Care Services Billing Manual was updated to include the new KX modifier and condition code 45.

Note: This communication was previously published in the July 2022 Provider Bulletin (B2200480)**.**

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

It is not necessary to attach a copy of the EOB for all claims that have a Third-Party Liability (TPL) or Medicare as the primary insurance. TPL and Medicare information should be reported directly on the claim. All claims should be filed electronically, even if there is a primary payer.

Providers have an additional 120 days from the Medicare EOB date to submit the claim to remain within the timely filing guidelines. Claims with a TPL for commercial insurance must

be submitted to Health First Colorado within 365 days.

An EOB is only necessary when submitting a TPL claim that requires prior authorization, where the TPL has paid at zero and the entire amount has been applied to the deductible. Prior authorization is not required from Health First Colorado if the TPL has paid as primary.

Note: This does not apply to physician-administered drugs.

Recently Published Billing Manuals

- Appendix X - HCPCS and NDC Crosswalk for Billing Physician-Administered Drugs
- Early Intervention Program
- Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
- Durable Medical Equipment HCPCS Codes
- Family Planning Benefit Expansion for Special Populations
- Federally Qualified Health Center/Rural Health Center (FQHC/RHC)
- Gender-Affirming Care Services
- HCBS - Adult - BI, CMHS, and EBD
- Medical and Surgical Services
- Pharmacy Billing Manual
- Physician-Administered Drugs (PAD)
- Residential Child Care Facility (RCCF)

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

Known Issues

Institutional Claims for Diagnosis Codes Z28310, Z28311, Z2839 Denying for Explanation of Benefits (EOB) 3014 EAPGS - "Diagnosis is either invalid for date(s) of service or requires greater specificity" and Enhanced Ambulatory Patient Grouping (EAPG) Error Code 3102 - "Secondary Diagnosis"

Some institutional claims for the diagnosis codes listed below are denying for EOB 3014 - "EAPGS Diagnosis is either invalid for date(s) of service or requires greater specificity" and Enhanced Ambulatory Patient Grouping (EAPG) Error Code 3102 - "Secondary Diagnosis".

- Z28310 - Unvaccinated for COVID-19
- Z28311 - Partially vaccinated for COVID-19
- Z2839 - Other under-immunization status

Approval from the Centers for Medicare and Medicaid Services (CMS) was received to implement EAPG version 3.16. Once implemented, claims will be reprocessed in the upcoming weeks. More information will be published in future communications.

Resolved Issues

Resolved 07/01/2022

Ambulatory Surgical Center (ASC) Claims for Procedure Code 36561 Paying at Incorrect Rate

Some ASC claims for procedure code 36561 were being paid at the incorrect rate of $1,813.06. The correct ASC grouper rate is $1,831.06. Providers are requested to continue to bill usual and customary charges or the correct rate of $1,831.06.

Affected claims were reprocessed on 07/01/22.

Issue resolved 07/01/22.

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