COLORADO
Department of Health Care Policy & Financing

Provider News & Resources

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In This Issue:

License Update Requirement

Federal screening regulations found at 42 CFR § 455.412 require providers to maintain current licenses, without limitations, throughout the term of their agreement. A license update is required when the license on file is expiring soon.

To remain actively enrolled, update the license information in the Provider Web Portal by clicking Provider Maintenance and following the steps under Provider Identification Changes. A copy of the license showing the effective and end dates must be attached.

Refer to the Provider Maintenance - Update License and CLIA Quick Guide located on the Quick Guides web page for more information.

Resolved Known Issue: Speech Therapy Claims Denying EOB 0192, 1599 and 4211

Home and Community-Based Services (HCBS) Providers:

New Denver County and Transportation Codes

Modifier HX is required on some HCBS claims for services provided within the City and County of Denver, effective May 1, 2024. The HX modifier allows providers to bill for prior-authorized HCBS services with Denver County rates without needing to add the HX modifier to the HCBS Prior Authorization Request (PAR). The HX modifier is being added for HCBS services with Denver County rates in a phased approach.

The Adult Day Program Transportation codes for Mileage Bands 2 and 3 on the Complementary and Integrative Health (CIH) waiver changed on May 1, 2024, for services provided outside the City and County of Denver. These changes allowed for the addition of the HX modifier for services provided in Denver without needing to add the HX modifier to HCBS PARs.

Claims billed without the required HX modifier will need to be adjusted.

Refer to the HCBS Billing Manuals on the Billing Manuals web page for information on the updated HCBS codes.

HCBS Providers:

Member Eligibility Benefit Plan Updates

HCBS providers may now see Universal Aid Code "MH" associated with some Waiver Benefit Plans for eligible members when they check a member's eligibility in the Provider Web Portal. The new MH Universal Aid Code replaces thirteen (13) prior aid codes, beginning March 1, 2024.

Waiver Benefit Plans for eligible members may be missing from their Benefits Details list due to a known delay by the counties in determining the benefit plans. Some claims may be denied for EOB 4758 "Billing Provider Type/Specialty Restriction on Procedure Coverage Rule" due to a missing benefit plan in the member's eligibility record.

Members must show a benefit plan as well as the MH code for claims to process correctly. If the benefit plan is missing, HCBS providers may submit a request via this form to update a benefit plan.

HCBS providers should not contact the county or the case manager to update the benefit plan.

Recently Updated Billing Manuals

- Appendix X - HCPCS/NDC Crosswalk for Billing Physician-Administered Drugs
- Federally Qualified Health Center and Rural Health Clinic
- Medical-Surgical
- Telemedicine Billing Manual

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

Resolved Issues

Durable Medical Equipment (DME) Providers:

Resolved 05/23/24: Some Professional Claims for Durable Medical Equipment (DME) Wheelchair Repair Services with Modifier RB Denying for Explanation of Benefits (EOB) 1997

Some professional claims for DME wheelchair repair services with modifier RB were denying incorrectly for EOB 1997 - "The referring, ordering, prescribing or attending provider is missing or not enrolled. Please resubmit with a valid individual National Provider Identifier (NPI) in the attending field."

Affected claims will be reprocessed.

Issue resolved 05/23/24.

Hospital Providers:

Resolved 05/23/24: Some Institutional Claims with Diagnosis Codes F840, F842, F845 with Date of Service 01/01/24 or after were Denying Explanation of Benefits (EOB) 2029

Some institutional claims with diagnosis codes F840, F842, F845 for date of service 01/01/24 or after were denying incorrectly for EOB 2029 - "The Services Must Be Billed to The Members RAE."

Affected claims will be reprocessed.

Issue resolved 05/23/24.

Audiology and Speech Therapy Providers:

Resolved 05/22/24: Some Speech Therapy Claims Denying for Explanation of Benefits (EOB) 0192, 1599 and 4211

Some speech therapy claims submitted on or after 07/01/23 were denying incorrectly with various procedure codes and modifiers, which are listed below.

Procedure Codes

92507 92508 92605 92606 92607 92609
92610 92611 92612 92614 92626 92627
96105 96112 96113 97129 97130

Modifiers

- GN modifier billed along with 96 modifier
- GN modifier billed along with 97 modifier

Explanation of Benefits (EOB) Codes and Descriptions

- 0192 - Prior Authorization (PA) is required for this service. An approved PA was not found matching the provider, member, and service information on the claim.
- 1599 - Rendering Provider Type and/or Specialty is not allowable for the service billed.
- 4211 - Modifier is invalid for procedure code. Read the procedure description. Refer to the Provider Manual, Help Screens, CPT or HCPCS listing for valid modifiers.

Affected claims were reprocessed on 05/24/24.

Issue resolved 05/22/24.