The Colorado Home Care Denial Code Guide

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Colorado Medicaid denial and adjustment codes for home care agencies, explained. From HomeCareBilling.

Colorado Medicaid Denials and Remittances, Explained

A Colorado Medicaid remittance tells you, line by line, what HCPF paid, what it denied and what it took back. Each denied or reduced line carries short codes, and the codes are the only explanation HCPF gives. This guide reads them in plain words, for a home care agency billing Health First Colorado.

Start with how a remittance is put together, because the check total hides most of it: Your Colorado Medicaid Check Looked Fine. So What Was Denied?

Then look up the code on your remittance. Each code page follows the same outline: what it means, why it happens in Colorado home care, how to fix it, and how to prevent it.

- PI-15: authorization missing or invalid
- PI-16 with N821: no matching EVV visit
- OA-18: duplicate claim
- CO-45: charge above the fee schedule, a paid line and not a denial

Before you resubmit anything, HCPF's own advice applies to every code: call the Provider Services Call Center if the cause is unclear, fix what the denial names, and send the corrected claim as a brand-new claim. Resubmitting without a change may get the same result. Billing in general, from prior authorization to timely filing, is in Colorado Medicaid Home Care Billing: The Complete Guide.

Sources

1. HCPF Provider Bulletin B2600540, July 2026 page 7 (Remittance Advice Reports)
2. HCPF Provider Bulletin B2600534, February 2026 page 2 (Did You Know?)
3. X12 Claim Adjustment Reason Codes codes 15, 16, 18 and 45
4. X12 Remittance Advice Remark Codes codes M62, M86 and N821

Your Colorado Medicaid Check Looked Fine. So What Was Denied?

Most owners judge a remittance by one number: the check. If the check is about what you expected, the week went fine. But the check is a net of everything HCPF did to your account that week, and it can be positive while claims were denied and money paid months ago was taken back.

Across the agencies we bill for, 30 of the 37 remittances we reviewed paid a positive check and still denied at least one claim, and 23 of them also took back earlier payments. Nothing in the check total showed either.

Paid, denied and adjusted lines

HCPF reports each week twice. The **remittance advice (RA)** is posted every Monday in the Provider Web Portal and lists every claim processed the week before, in HCPF's own readable format. PDFs go back to March 2017; CSV downloads cover the most recent 10. The **835** is the electronic version: it goes to the billing vendor you contract with, and HCPF keeps it on its server for only 15 days, so whoever receives it must save it.

Every claim line ends one of three ways:

- **Paid** at HCPF's rate. A paid line can still carry a code, such as CO-45, that explains why it paid less than you charged.
- **Denied**: paid zero, with codes that say why.
- **Adjusted**: an earlier claim changed, usually taken back and paid again.

Each code has two parts. The letters are the group: **CO** is "Contractual Obligation", **OA** is "Other Adjustment" and **PI** is "Payor Initiated Reduction". The number is the reason, from the national list of claim adjustment reason codes, and a remark code (a letter and digits, such as N821) often adds detail. The codes Colorado home care agencies see most each have their own page in this guide.

Why a positive check can hide denials

Think of the check as three piles added together:

1. **Claims paid this week**, at HCPF's rate.
2. **Claims taken back.** When HCPF reverses an earlier payment, that money comes out of this week's total.
3. **Adjustments to your account as a whole**, not tied to one claim line.

Denied claims are the missing fourth pile. They pay zero, so they add nothing, and a whole week of one client's services can be denied without the check looking short. Across the agencies we bill for, 15.1% of 2,256 adjudicated claims were denied. Read every line, not the total.

Take-backs booked against your account (PLB)

Adjustments to your account as a whole sit in a section of the 835 called the provider-level adjustment (PLB). Two of its reason codes matter most:

- **WO**, "Overpayment recovery amount": money withheld from this payment to recover an earlier one.
- **CS**, "Adjustment amount, detailed information is provided separately to explain the adjustment."

Across the agencies we bill for, HCPF has booked take-backs as CS adjustments that leave the check positive and carry the amount forward as a balance owed, to be recovered from later checks. So a reversal with nothing withheld this week is not free money. To know how much is at risk, add up the reversed payments themselves; the net of the account adjustments can be close to zero while a large balance is owed.

Reading one claim line by line

For each claim, answer three questions.

Did it pay, pay less, or pay zero? Compare the charge with the payment. Zero is a denial. Less than you charged is a reduction; the codes say which kind.

What do the codes say? Look each one up:

- PI-15: no approved prior authorization (PAR) matches the line.
- PI-16 with N821: no matching EVV visit.
- OA-18: a duplicate of a claim HCPF already processed.
- CO-45: your charge was above the fee schedule. The line was paid; this is not a denial.

Is it a reversal? On the remittances we read, a reversal shows the earlier claim again with its payment taken back, and the corrected claim is often paid on the same remittance. When the corrected claim is denied instead, the old payment is gone with nothing in its place, so match every reversal to a new payment for the same client and dates.

What to do next

- **For a denied claim:** find the cause in its codes. If it is unclear, call the Provider Services Call Center first, so the agent can tell you what has to change. Then send the corrected claim as a brand-new claim, not a reconsideration or an appeal: HCPF defines an appeal as a legal proceeding, and a resubmission without changes may get the same result.
- **For a paid claim that needs a change:** send an adjustment. HCPF asks providers not to void and rebill unless the claim was billed in error or for the wrong member.
- **For a reversal with no new payment:** treat the amount as owed back. When HCPF's fiscal agent starts an adjustment or recoupment, you may resubmit the claim within 60 days.
- **Every week:** keep a copy of every remittance advice. HCPF expects them in your files as proof of timely filing and of the 60-day rule.

Since November 16, 2026, Home Care Billing emails each agency a review of every new remittance: each denied, short-paid and reversed claim grouped by cause, with the next step, and any remittance can be downloaded as a spreadsheet whose rows add up to the deposit.

Sources

1. HCPF Provider Bulletin B2600540, July 2026 page 7 (Remittance Advice Reports)
2. HCPF Provider Bulletin B2600539, June 2026 page 3 (Claim Adjustments)
3. HCPF Provider Bulletin B2600541, August 2026 pages 6-7 (Timely Filing Resubmission Instructions)
4. HCPF Provider Bulletin B2600534, February 2026 page 2 (Did You Know?)
5. X12 Claim Adjustment Group Codes CO, OA, PI
6. X12 Claim Adjustment Reason Codes codes 15, 16, 18 and 45
7. X12 Provider Adjustment Reason Codes CS, WO

PI-15: Authorization Missing or Invalid (Colorado Medicaid)

What it means

PI-15 is two codes. **PI** is the group, "Payor Initiated Reduction". **15** is the reason: "The authorization number is missing, invalid, or does not apply to the billed services or provider." It often comes with the remark code **M62**, "Missing/incomplete/invalid treatment authorization code."

In plain words: HCPF looked for an approved prior authorization (PAR) that covers this line and did not find one that matches it. The national code list now marks reason 15 as deactivated, but it still appears on Colorado remittances: across the agencies we bill for, PI-15 was the most common denial code.

Why it happens in Colorado home care

HCPF requires prior authorization for every home and community-based service. An approved PAR "with the appropriate procedure codes and modifiers" must be on file before you deliver the service and bill it, and each billed service has to correspond to an approved PAR covering the same service, dates and units. Claims without a valid PAR, or over the approved units, deny.

In our experience the PAR usually exists; the line just does not match it:

- **The PAR was revised.** A revised PAR can carry old and new service lines with different start dates and modifiers, and billing one line's code for the other line's weeks denies.
- **The new PAR is not on file yet.** The case manager has approved it, but until it is on file at HCPF, the old PAR is the one that pays.
- **The dates run past the PAR.** Service before its start date or after its end date has nothing to match.
- **A code or modifier differs.** Every modifier on the claim line has to match the PAR line.

How to fix it

1. **Check the PAR number and dates on the claim against the PAR.** Then the code, the modifiers and the units, line by line, until you find the field that differs.
2. **Ask the case manager when the PAR is the problem.** HCPF tells providers to work with case managers to get a PAR's final status. Wait until the corrected or new PAR is on file for those dates.
3. **Fix the claim when the claim was wrong,** and send it as a brand-new claim, not a reconsideration or an appeal. If the cause is unclear, call the Provider Services Call Center first; HCPF warns that a resubmission without changes may get the same result.

Do not bill the client for the gap. HCPF says providers cannot bill members for the denied portion of a PAR or for services beyond what was prior authorized.

How to prevent it

- **Check every batch against the PAR before you send it:** code, modifiers, dates and units on every line.
- **Treat a PAR revision as its own event.** Write down which line covers which weeks.
- **Confirm a new PAR is on file before you bill against it,** and keep billing the old line until then.
- **Contact the case management agency before the service** when you are unsure what is authorized, as HCPF asks.

Home Care Billing checks each line of a batch against the client's authorization before it goes out and warns when the PAR, the procedure code, the dates or the units do not match; when a PI-15 comes back, its denial analysis page tracks the line until it is corrected and resubmitted.

Sources

1. X12 Claim Adjustment Reason Codes code 15 (listed as deactivated)

2. X12 Remittance Advice Remark Codes code M62
3. X12 Claim Adjustment Group Codes PI
4. HCPF Provider Bulletin B2500530, October 2025 page 17 (Prior Authorization Reminder)
5. HCPF Provider Bulletin B2500532, December 2025 pages 12-13 (Reinstatement of Prior Authorization (PAR) System Edits)
6. HCPF Provider Bulletin B2600533, January 2026 page 4 (Member Billing; Prior Authorization Request (PAR) denials)
7. HCPF Provider Bulletin B2600534, February 2026 page 2 (Did You Know?)

PI-16 and N821: EVV Denial (Colorado Medicaid)

What it means

The 835 shows **PI-16** with the remark **N821**; HCPF's own remittance advice shows the same denial as **EOB 3054, "EVV Record Required and Not Found"**. Reason 16 reads "Claim/service lacks information or has submission/billing error(s)", and the remark says which information: "Electronic Visit Verification System visit not found."

In plain words: the line is for a service that requires electronic visit verification (EVV), and HCPF's claims system found no verified visit that matches it. Since February 1, 2022, a claim like that is denied, not paid. PI-16 also comes with other remarks that mean other problems; this page is about N821.

Why it happens in Colorado home care

EVV visits are matched against your claim lines. HCPF's EVV Program Manual says a claim fails to match when one of the points of data in the EVV system was entered wrong, or when the claim was sent before the visit was available for matching. The points it tells you to check:

1. **Billing provider ID.** The billing ID on the claim must match the billing ID of the Sandata (STX) account where the visit is logged. More than one billing ID needs more than one STX account.
2. **Client Medicaid ID.** A mistyped ID on the visit means no match.
3. **Dates of service.** The claim's first and last dates must match the visit's start and end dates.
4. **Service grouping.** The claim's procedure code and modifiers must match the grouped code on the visit. HCPF's EVV Crosswalk of Codes lists them.
5. **Submission date.** Visits go to the claims system nightly, and only verified visits match. A visit is available the day after it is recorded and verified.
6. **Visit status.** A visit with a call-in and no call-out stays in process, and becomes incomplete after 24 hours. Neither is verified.

Live-in caregivers are the other common cause. HCPF does not require EVV for the eligible services a documented live-in caregiver delivers, and each line a live-in caregiver delivered is billed with place of service 99. A line from any other caregiver, for the same client, still needs a verified visit, and place of service 99 requires proof of live-in status.

How to fix it

1. **Pull the remittance** and list every line with N821 or EOB 3054.
2. **Confirm the visit is in Sandata or the caregiver's EVV exemption is on file, then rebill.** In the Provider EVV Portal, find the visit for each line and check the six points above until it is verified. For a live-in caregiver, check that the EVV Exemption Form and its supporting documents are in your files for those dates.
3. **Wait a day.** HCPF says that after you fix an exception and the visit becomes verified, you still wait until the next day to bill.
4. **Rebill the denied line** as a new claim.

One more rule from the manual: if you change an EVV record that already matched a paid claim, void that claim and resubmit it, so the corrected visit matches.

How to prevent it

- **Bill only verified visits,** and never on the day you fixed them.
- **Check the service grouping** on each visit against the code and modifiers you will bill.
- **Keep each live-in caregiver's exemption documents current,** for every client and date range, and bill only that caregiver's lines with place of service 99.
- **When you start billing a new code,** check whether it requires EVV before the first claim.

Home Care Billing flags each claim whose service requires EVV but has no verified visit on its dates before the batch goes out, and leaves place of service 99 lines out of that check, so you can confirm the visit in Sandata first.

Sources

1. X12 Claim Adjustment Reason Codes code 16
2. X12 Remittance Advice Remark Codes code N821
3. HCPF Electronic Visit Verification Program Manual (page last updated October 26, 2026) sections Definitions (Explanation of Benefits (EOB) 3054, In Process, Matched Visit), Billing Integration, Compliance Timeline and Live-in Caregivers
4. HCPF Operational Memo OM 21-075, EVV Claim Edit Timeline pages 1-2

OA-18: Duplicate Claim (Colorado Medicaid)

What it means

OA is the group, "Other Adjustment". **18** is the reason: "Exact duplicate claim/service", a code the national list reserves for the OA group. It often comes with one or two remark codes: **M86**, "Service denied because payment already made for same/similar procedure within set time frame", and **N20**, "Service not payable with other service rendered on the same date."

In plain words: HCPF already processed a claim for this client, this date and this service, and it will not pay the same service twice. Across the agencies we bill for, OA-18 was the third most common denial code.

Why it happens in Colorado home care

An OA-18 is often HCPF doing its job. In our experience it comes from one of three things:

- **Two billing routes.** The same week went out in a file from billing software and was also keyed into the Provider Web Portal, or a new biller started while the old one was still sending claims. One claim pays and the other comes back OA-18.
- **A paid claim sent again as a new claim.** Someone wanted to change a paid claim and sent a fresh one instead of an adjustment. HCPF treats the fresh one as a duplicate, and the original payment stays as it was.
- **A resend after a slow remittance.** A claim did not show on the next remittance, so it was sent again, and then both arrived.

How to fix it

Do not rebill: check that the earlier claim for the same service was paid. Search your remittances for the same client, date of service and procedure code.

- **The earlier claim was paid:** do nothing. The duplicate denial is correct and no money is missing. Mark it resolved so nobody resends it.
- **The earlier claim was paid but was wrong:** send an adjustment to it. HCPF says an update to a previously paid claim can be submitted as an adjustment, and providers should not void the claim and rebill unless it was billed in error or for the wrong member.
- **The earlier claim was denied:** fix the cause of that denial and resubmit it. The OA-18 only told you a claim already existed.
- **You cannot find an earlier claim:** call the Provider Services Call Center before you resubmit, so the agent can identify what needs to change.

How to prevent it

- **Bill each service through one route.** If billing software sends your claims, stop entering the same claims in the portal. When you switch billers, agree on the last date of service the old one sends.
- **Change a paid claim with an adjustment,** never with a new claim.
- **Look on your remittances before you resend anything.**
- **Keep one list of what went out,** by client, date and code, across every route.

Home Care Billing flags the lines of a batch that HCPF may read as duplicates of one another before the batch goes out, so you can review them first.

Sources

1. X12 Claim Adjustment Reason Codes code 18
2. X12 Remittance Advice Remark Codes codes M86 and N20
3. X12 Claim Adjustment Group Codes OA
4. HCPF Provider Bulletin B2600539, June 2026 page 3 (Claim Adjustments)

5. HCPF Provider Bulletin B2600534, February 2026 page 2 (Did You Know?)

CO-45: Charge Exceeds Fee Schedule, Not a Denial (Colorado Medicaid)

CO-45 is not a denial. It means your charge was higher than HCPF's fee schedule for the service, so HCPF paid the line at its own rate and reduced the difference: the line was paid.

What it means

CO is the group, "Contractual Obligation". **45** is the reason: "Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement." The national list's usage note adds that this amount cannot equal the whole charge, which is why CO-45 appears on paid lines and never as the reason a line paid zero.

Across the agencies we bill for, CO-45 was the most common code on paid claims. Most of the time it needs nothing from you; sometimes it is the only sign of a billing mistake.

Why it happens in Colorado home care

On home care remittances, each line is paid at the lower of your charge and HCPF's rate. HCPF names this pricing its "lower-of billed charges payment logic" in its October 2025 provider bulletin (B2500530), where it told behavioral health providers that claims billed below a corrected rate would have to be adjusted by the provider to be paid it. A charge above the rate is cut to the rate with CO-45; a charge below it is paid as billed, with no code to warn you.

Three situations produce CO-45:

1. **Your charge is set above the rate on purpose.** Some agencies bill one round figure for every unit. Every line then shows CO-45, and you are paid the rate either way.
2. **The rate went down and your charges did not.** Health First Colorado cut provider rates by 2.0% across the board for dates of service from July 1, 2026, Community First Choice and the HCBS waivers included. Personal Care outside Denver County (T1019 U2) went from $6.96 to $6.82 per 15-minute unit, so a charge left at $6.96 is cut with CO-45 on every line.
3. **A modifier is missing, so HCPF priced another service.** The fee schedule prices each code and modifier combination. Personal Care in Denver County is billed T1019 U2 HX, at $7.11 per unit from July 1, 2026; leave the HX off and the line is priced as Personal Care outside Denver, $6.82. A charge set at the Denver rate is then above the rate it was priced at, and the money you lost looks like an ordinary CO-45.

How to fix it

Check the client's service rate and the claim's modifiers against HCPF's fee schedule. For each CO-45 line, compare three figures per unit: what you charged, what HCPF paid, and the fee schedule rate for that code and modifiers on that date of service.

- **Paid equals the rate:** nothing to fix. Update your charge if it is out of date, so your books expect what HCPF pays.
- **Paid is below the rate you expected:** the line was priced as another service. Check the modifiers, correct the claim and send it as an adjustment, since the line was paid.

Do not bill the client for the difference. HCPF says members cannot be billed for services Health First Colorado covers.

How to prevent it

- **Update your rates each time HCPF publishes a new fee schedule.**
- **Never charge below the rate.** A line is paid at the lower of the two, and a low charge loses the difference with no code to show it.

- **Check the modifiers that set the rate,** such as HX for a service delivered in Denver County, on every line.

Home Care Billing's remittance review lists a CO-45 line as paid short, not denied, and gives the check above as its next step unless the cut is under 1% of the charge, which it reads as rounding to the fee schedule.

Sources

1. X12 Claim Adjustment Reason Codes code 45 and its usage note
2. X12 Claim Adjustment Group Codes CO
3. HCPF Community First Choice Rates Effective 7/1/2026 page 1 (Personal Care Services)
4. HCPF Provider Bulletin B2600539, June 2026 pages 3-4 (Rate Reductions)
5. HCPF Provider Bulletin B2500530, October 2025 pages 10-11 (Short-Term Behavioral Health: the lower-of billed charges payment logic)
6. HCPF Provider Bulletin B2600533, January 2026 page 4 (Member Billing)

Questions about a denial? Book a call with Mark: https://www.homecarebilling.com/book-a-call