COLORADO
Department of Health Care Policy & Financing

Provider Bulletin

Reference: B2600534

Feb 2026

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Improve health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado.

Did You Know?

An appeal is defined by the Department of Health Care Policy & Financing (the Department) as a legal proceeding.

Providers may instead submit a reconsideration; however, resubmitting the claim as a reconsideration without making any changes may have the same result.

Providers are encouraged to contact the Provider Services Call Center first if a claim is denied so the agent can identify changes that need to be on a resubmission or adjustment.

Call center agents can coordinate with the Department for any policy inquiries or changes on behalf of the provider. Providers can resubmit the corrected claim as a brand-new claim, not a reconsideration or appeal.

All Providers

Timely Filing

Providers have 365 days to submit claims. Providers can keep claims within timely filing by resubmitting every 60 days, if the initial timely filing period of 365 days from the date of service (DOS) has expired. Providers may resubmit within 60 days if an adjustment or recoupment is initiated by the fiscal agent, Gainwell Technologies, or Health Management Systems, Inc. (HMS). Providers must reference the most recent internal claim number (ICN).

Refer to the General Information Manual for more information on Timely Filing.

All Providers Using a Trading Partner

Electronic Data Integration (EDI) Vendor Transition

Providers that use a clearinghouse or billing agent to submit X12 batch transactions on their behalf will need to ensure that the vendor is aware of the changes below.

Electronic Data Integration (EDI) functionality, including batch processing and trading partner enrollment, is transitioning to a new vendor: Edifecs, a Cotiviti business.

These changes are being implemented in three (3) phases.

The initial phase, X12 file naming standards changes, was implemented January 7, 2026.

The next phase is targeted for implementation in the summer of 2026. It includes the following changes:

- New agreement to be signed by trading partners

- New Managed File Transfer (MFT) for trading partners to exchange files with the Department
- New log-in credentials for MFT (to be issued once the agreement has been signed)
- New Trading Partner Enrollment and Testing Site

Multiple training sessions will be scheduled for the new site. Trading partners will receive advance notice of opportunities to register for training beginning in the spring of 2026. More detailed information will be shared in future provider bulletins.

What is staying the same?

- Providers may still use the Provider Web Portal to submit individual claims, maintain enrollment, verify individual eligibility and more.
- Providers will contact the Provider Services Call Center with any questions about claims, the Provider Web Portal or EDI.
- Active trading partners will retain the same trading partner IDs.

The final phase is expected to be implemented in the Fall of 2026.

Refer to the Electronic Data Interchange (EDI) Support web page and Colorado Medicaid Enterprise Solutions (CMES) Transition web page for more information.

All Providers Who Utilize the ColoradoPAR Program

What is the ColoradoPAR Program?

The ColoradoPAR Program is a third-party, fee-for-service Utilization Management (UM) program administered by Acentra Health, Inc. Visit the Colorado Prior Authorization Request Program (ColoradoPAR) web page for more information about the ColoradoPAR Program.

Acentra Provider Satisfaction Survey

The Colorado PAR Provider Survey for Durable Medical Equipment (DME) providers that work with Acentra Health and use the Atrezzo® provider portal opens February 2, 2026, and will remain open through March 13, 2026.

The DME Provider Survey is an opportunity to provide feedback regarding Acentra Health services in processing PARs, customer service, provider education and timeliness.

Acentra will send email reminders with links to complete the survey once it is live.

Interoperability Changes Beginning January 2026

Significant changes in pend and prior authorization request (PAR) timeframes:

Several requirements set forth in the Centers for Medicare & Medicaid Services (CMS) Interoperability and PAR are being implemented as required. The most notable changes impacting providers are highlighted here:

- Pends for additional information **are reduced** from 10 business days to seven (7) calendar days.
- Additional pends on the same PAR will not be extended; all information requested in the initial pend must be supplied, or the PAR will result in a technical denial.
- PARs submitted as Expedited: **no pends or requests for information** will be allowed in order to comply with the rules' requirement for three (3) calendar days. Please ensure all documentation is included with the initial PAR submission.

These changes are required for Acentra Health, Inc. and the Department to be compliant with the Interoperability Turnaround Time Requirements. This will facilitate a faster standard turnaround time for PARs, reducing it to seven (7) calendar days. All PARs, including pends, must be processed within 21 calendar days of initial submission. Visit the CMS Interoperability and Prior Authorization Final Rule web page for more information on the rule.

Long-Term Home Health (LTHH) Prior Authorization Request (PAR) Resumption Information

Prior Authorization Request (PAR) submission requirements for Certified Nurse Aide (CNA):

- Home health agencies are responsible per 10 CCR 2505-10 8.500 for submitting detailed orders on a Plan of Care (POC).
- The Home Health Agency shall indicate a comprehensive list of the **amount, frequency and expected duration** of provider visits for each discipline ordered by the Member's Physician or Allowed Practitioner.
- This shall include the **specific duties, treatments and tasks** to be performed during each visit.

Failure to provide the appropriate level of specificity in the Plan of Care or supporting documentation will result in more pends and adverse determinations.

Refer to the LTHH Plan of Care Rules and Regulations page 48 (8.520.7.D.2.k) for details on the rule requirements for documentation and PAR submission.

Prior Authorization Request (PAR) Submission Training for Acentra

Acentra Health will provide benefit-specific prior authorization request (PAR) submission training for all providers and benefit-specific training for Long-Term Home Health (LTHH). The training dates and times are listed below in Mountain Time:

- Medical Surgical Provider Benefit Training February 11, 2026, at 9:00 a.m.
- Medical Surgical Provider Benefit Training February 11, 2026, at 12:00 p.m.
- Portal Registration and PAR Submission Training February 25, 2026, at 9:00 a.m.
- Portal Registration and PAR Submission Training February 25, 2026, at 12:00 p.m.

PAR submission training sessions are appropriate for all new users and include information on how to submit a PAR using Acentra's provider PAR portal, Atrezzo®.

Contact COProviderIssue@acentra.com with questions or if needing assistance when registering for Atrezzo® training or accessing the portal. Visit the ColoradoPAR Training web page for additional training information.

Behavioral Health Providers

Colorado's Certified Community Behavioral Health Clinic (CCBHC) Updates and Announcements

2026 CCBHC Work in Colorado

The Colorado's Certified Community Behavioral Health Clinic (CCBHC) Planning Grant has been granted a No-Cost Extension (NCE) through June 30, 2026, from the Substance Abuse and Mental Health Administration (SAMHSA). Engagement opportunities are ongoing, to allow stakeholders to contribute input that will shape the future of CCBHCs in Colorado. Access the CCBHC web page for updates. Join the following stakeholder engagement to contribute input that will continue to shape the future of CCBHCs in Colorado:

- **Colorado CCBHC Planning Grant Steering Committee**

This committee meets monthly on the last Monday of each month at 3:00 p.m. MT through May 2026. Topics will include a review of 2025 accomplishments and an overview of plans for 2026. Register to attend.

Health-Related Social Needs Community Webinar on the Final HB23-1300 Feasibility Report

Providers are invited to a webinar on **Wednesday, February 11, 2026, from 10:00 a.m. MT to 11:00 a.m. MT**, to hear the results of the HB23-1300 Feasibility Study.

Colorado House Bill 23-1300, Continuous Eligibility Medical Coverage, directed the Department to study the feasibility of expanding health-related social needs (HRSN) services through Health First Colorado (Colorado's Medicaid program). The Department has engaged stakeholders, examined opportunities and expanded HRSN programs through 1115 waiver authority over the past two years.

The Department partnered with the Colorado Health Institute, a nonpartisan research organization, to author the study. The report examines the costs and benefits of potential expansions related to continuous coverage for Medicaid populations, as well as the need, cost considerations and evidence for HRSN services related to housing, food and nutrition, extreme weather and social and community support. The report also identifies the populations for whom these services are most impactful.

Attend this webinar to learn about the study findings and to review past and upcoming milestones related to HRSN expansions.

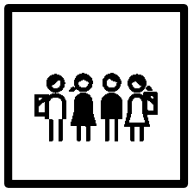
Meeting date and time: Wednesday, February 11, 2026, from 10:00 a.m. MT to 11:00 a.m. MT

- **Intended audiences:** All stakeholders, including nutrition, housing, coverage, violence prevention and other providers, members, advocacy groups and state agencies.

Registration and location: The meeting will be virtual via Zoom. Register in advance or at the start of the webinar. Once registered, a unique link to join the meeting will be received. This link is tied to individual registration and will not work for anyone else.

The meeting recording will be posted to the HRSN web page after the meeting for those unable to attend.

New Policy Statement on Regional Accountable Entity (RAE) Residential Youth Care Coordination



A new Policy Statement is available that identifies the expectations of Regional Accountable Entity (RAE) Care Coordination engagement and participation with and for pediatric members under 21 years of age admitted to residential behavioral health treatment facilities. These expectations will ensure that appropriate and timely care is supported by the Health First Colorado member's care team and enhance access to the full spectrum of Medicaid-covered behavioral health treatment services for members with high-acuity behavioral health needs during and following residential treatment (e.g., Colorado System of Care identification and referrals). The Policy Statement became effective December 8, 2025.

The full Policy Statement is available on the Residential and Inpatient Services web page under Youth Residential Services.

Reminder: Behavioral Health Administration (BHA) License Renewal Required

Behavioral Health Administration (BHA) licenses expire **annually**. It is the provider's responsibility to ensure their license is renewed on time and the updated license is uploaded to the Provider Web Portal. **Claims processing and payment may be interrupted** if the license is expired or not uploaded in the Provider Web Portal.

Providers should verify their license status and documentation to avoid any delays in payment.

Additional information is available on the Provider Enrollment web page. Contact hcpf_bhbenefits@state.co.us with any additional questions or issues.

Reminder: Provider Type and Specialty 64/477 is No Longer Valid

Be advised that Specialty 477 - Substance Use Disorder - Clinics is no longer a valid specialty for Provider Type 64 - Substance Use Disorder (SUD) Continuum, as of December 31, 2025. ***Claims submitted with a date of service (DOS) after December 31, 2025, under Provider Type 64 Specialty 477, will be denied***.

A specialty designating a specific American Society of Addiction Medicine (ASAM) level is needed to keep Provider Type 64 current and in good standing. Refer to the specific specialties on the Find Your Provider Type web page. No further action is needed if the Provider Type 64 enrollment already has a specialty designating an ASAM level. Specialty 477 was automatically removed from provider enrollment on December 31, 2025. Enrollments for Provider Type 64 with no other specialty attached by December 31, 2025, were terminated.

Contact hcpf_bhbenefits@state.co.us with any questions.

Durable Medical Equipment (DME)

Continuous and Bilevel Positive Airway Pressure Devices (CPAP/BiPAP) Policy Reminders

All Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) providers are reminded of the following Continuous and Bilevel Positive Airway Pressure (CPAP and BiPAP) policies:

Initial Requests

- CPAPs and BiPAPs require a trial (rental) period of 30-90 days, in which the member must demonstrate compliance, before a purchase request will be approved.
    - Compliance is defined as usage that is four (4) hours per night on 70% of nights during a consecutive thirty-day period during the approved trial/rental period

- A face-to-face evaluation must be completed within six (6) months of the submission date to discuss the members' diagnosis and need for the PAP. The sleep study must be within the previous 12 months of the prior authorization submission date. Home sleep studies are accepted.
- Questionnaire 8 must be filled out and signed for all members who are over the age of 20. Questionnaire 8 can be found on the Provider Forms web page.
- Orders must be submitted in a timely manner and must specify the type of device that is being requested.
- No supplies may be requested until after the device has purchase approval on file. All supplies are inclusive of the device's trial period and cannot be billed separately.
- CPAPs and BiPAPs require a trial (rental) period of 30-90 days. Members 20 years of age and under may rent for up to six (6) months and provided that they demonstrate increasing compliance a purchase may be approved prior to reaching compliance.

Retrial/Second Trials

If the member does not reach compliance by the end of the trial period, a second trial period may be covered within a one (1) year timeframe at the discretion of the treating physician. A new prescription is required but not a new sleep study.

Replacements and Supply Orders

Policy for CPAP/BiPAP replacement and supplies can be found under the Continuous and Bilevel Positive Airway Pressure Devices (CPAP/BiPAP) section of the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Billing Manual.

Contact Alaina Kelley at Alaina.Kelley@state.co.us with questions.

Mobility Equipment: Make and Model Reminder

To avoid delays in processing prior authorization requests (PARs), all Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) providers are reminded that the

make and model of the wheelchair being requested must be indicated on the PAR and must match the Healthcare Common Procedure System (HCPCS) code being requested. All claims for wheelchairs must be submitted with the serial number of the equipment that was approved on the prior authorization request. Providers must retain record of the serial number for each approved item.

Contact Alaina Kelley at Alaina.Kelley@state.co.us with questions.

Oxygen Contents: Members Receiving Six (6) or More Liters per Minute (LPM) Prior Authorization Notice

Effective for claims received on or after March 1, 2026, providers who are providing six (6) or more liters per minute (LPM) to a member will need to obtain prior authorization approval prior to billing the Healthcare Common Procedure System (HCPCS) codes S8120 and S8121. Questionnaire 16, which can be found on the Provider Forms web page, will need to be completed and submitted with the prior authorization request (PAR). Refer to the Durable Medical Equipment HCPCS Codes web page for more information.

Contact Alaina Kelley at Alaina.Kelley@state.co.us with questions.

Rate Rebalance Notice for A4459 and E2512

The rate of Healthcare Common Procedural Coding System (HCPCS) code A4459 was reduced to $160.85 from $581.45 effective June 1, 2025. The rate was then given the 1.6% across-the-board increase at the old rate of $581.45 rate effective July 1, 2025. The 1.6% increase will be retroactively applied to the correct $160.85 amount making the rate $170.50 from July 1, 2025, through September 30, 2025. The rate was then rolled back to the $160.85 rate effective October 1, 2025. The amount of $420.25 will be recouped for claims with a first date of service (DOS) of July 1, 2025, through September 30, 2025. For claims with a first DOS from October 1, 2025, through February 1, 2026, the amount recouped will be $420.60.

Existing Rate	Corrected Rate	Effective Date and End Date
$581.45		07/01/2024-05/31/2025
$160.85		06/01/2025-06/30/2025
$590.75	$170.50	07/01/2025-09/30/2025
$581.45	$160.85	10/01/2025-02/01/2026

Contact the Provider Services Call Center with any questions.

Home Health Providers

Upcoming Prior Authorization Requirement for Acute Home Health (Pending Medical Services Board Approval)

The Department invites questions about proposed changes to prior authorization requirements for acute home health services. The new prior authorization requirement will apply only to additional acute episodes of care beyond the first 60-day episode. A stakeholder meeting addressing this topic was held on September 16, 2025, and a recording of the meeting can be found on the Acute Home Health Prior Authorization Changes Stakeholder Meeting web page. Stakeholders can submit questions and feedback throughout the rulemaking process by filling out a feedback form, which is available in English and Spanish. Additional updates about the proposed policy will be sent out via future Provider Bulletins.

Contact Devinne Parsons at Devinne.Parsons@state.co.us with any Acute Home Health policy questions.

Contact the Utilization Management (UM) inbox at hcpf_um@state.co.us with any prior authorization operations and submission questions.

Hospital Providers

General Updates

Hospital Specialty Drug Policy: Prior Authorization Update

Approved hospital specialty drugs which are carved out from either the All-Patient Refined Diagnosis Related Group (APR-DRG) or the Enhanced Ambulatory Patient Group (EAPG) payment methodology fall under the Hospital Specialty Drug Policy.

Zevaskyn (prademagene zamikeracel), Healthcare Common Procedure Coding System (HCPCS) code J3389, has been added to the approved hospital specialty drug list effective December 15, 2025. The entire list of specialty drugs subject to this policy are listed on Appendix Z: Hospital Specialty Drugs List.

In addition, and in accordance with the U.S. Food and Drug Administration (FDA) labeling changes, Appendix Z criteria updates have been made for Brineura (cerliponase alfa), HCPCS code J0567.

Member-specific prior authorization requests (PARs) must be submitted directly to the Department at HCPF_PharmacyPAD@state.co.us and approved prior to administration of the specialty drug.

Resources including Appendix Z, coverage standards, request forms and submission requirements are listed on the Physician Administered Drug (PAD) Provider Resources web page under the Hospital Specialty Drug Policy section.

Additional policy information can be found in the Physician-Administered Drugs and Inpatient/Outpatient (IP/OP) Billing Manuals and on the Physician-Administered Drugs Provider Resources web page.

Contact HCPF_PAD@state.co.us with additional questions.

Hospital Stakeholder Engagement Meeting

Bi-monthly Hospital Engagement meetings will be hosted by the Department to discuss current topics regarding ongoing rate reform efforts and operational concerns. Sign up to receive the Hospital Stakeholder Engagement Meeting newsletters.

- The next Hospital Stakeholder Engagement meeting is set for **Friday, March 6, 2026, from 9:00 a.m. to 11:00 a.m. MT** and will be hosted virtually.

Visit the Hospital Stakeholder Engagement Meetings web page for more details, meeting schedules and past meeting materials.

Contact Della Phan at Della.Phan@state.co.us with any questions or topics to be discussed at future meetings. Advanced notice will provide the Facility Rates Section time to bring additional Department personnel to the meetings to address different concerns.

Rural Health Clinic Stakeholder Engagement Meeting

A meeting for Rural Health Clinics (RHCs) has been scheduled for March 5, 2026, from 1:00 p.m. to 2:00 p.m. MT. Topics of discussion will include an overview of the RHC payment methodology for both hospital-based and freestanding RHCs and operational concerns impacting RHC billing or payment.

Visit the Rural Hospital and Rural Health Clinic web page for more details, meeting schedules and past meeting materials.

Contact Andrew Abalos at Andrew.Abalos@state.co.us with any questions or topics requested for discussion at this meeting.

Upcoming Hospital Webinar

A free hospital webinar will be hosted by the Department on February 11, 2026, from 7:30 a.m.-10:00 a.m. MT.

Topics include:

- Key findings within the three (3) legislatively required annual hospital reports released in mid-January 2026
- Updates on the Rural Health Transformation Program
- Impacts to hospitals caused by H.R. 1

This webinar will also include a robust panel discussion with hospital CEOs who will share their perspectives on these topics and ways to work together to navigate this difficult terrain.

Immunization Providers

Immunizations Updates and Reminders

All medically-necessary immunizations are a benefit for all Health First Colorado members without cost sharing. All vaccines that are recommended via shared clinical decision making are a benefit for Health First Colorado members without cost sharing.

Health First Colorado members under 19 years of age are eligible to receive all immunizations available from the federal Vaccines for Children (VFC) Program at VFC-enrolled provider offices. All vaccines that are part of the VFC Program are only reimbursable when administered to members under 19 years of age and when administered by a VFC-enrolled provider using VFC vaccine products. Health First Colorado will not reimburse providers for the cost of vaccines that are available through the VFC Program or for the cost of vaccines that the provider receives at no cost. Providers must enroll with VFC, as well as Health First Colorado, and use VFC vaccines to receive reimbursement for administering vaccines to members under 19 years of age.

Members enrolled in Health First Colorado's Managed Care Organizations (MCO) must receive immunization services through a provider in the MCO's network.

A product code and an administration code must always be included on any claims for vaccination.

Rates can be found in the Immunization Rate Schedule on the Provider Rates & Fee Schedule web page. Further vaccine billing guidance may be found in the Immunizations Billing Manual.

Contact Christina Winship at Christina.Winship@state.co.us with any Vaccine Policy questions. Contact the Provider Services Call Center for assistance with claims and billing.

Laboratory Providers

Updated Unit Limitations and Documentation Requirements for Substance-Specific Confirmatory Tests

Definitive Drug Testing Annual Limits

Effective October 10, 2025, through June 30, 2026:

Adult members are limited to 16 combined units of service for definitive drug testing HCPCS codes G0480, G0481, G0482 and G0483 during the period from October 10, 2025, through June 30, 2026, based on date of service.

Claim Processing:

- Claim EOB 1067 will deny claims submitted on or after October 10, 2025, when the member exceeds the 16-unit limit.
- The Department will review and adjust denied claims during this period to ensure proper system operation.

Exception: Members aged 0–20 may receive additional testing with Prior Authorization when clinically appropriate.

Effective July 1, 2026, Onward:

Adult members are limited to 12 combined units per State Fiscal Year (SFY) (July 1–June 30) for definitive drug testing HCPCS codes G0480, G0481, G0482 and G0483, based on date of service.

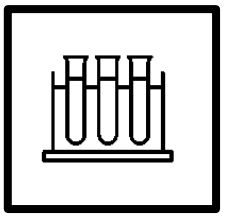
Claim Processing:

- Claim EOB 2364 will count only services provided on or after July 1, 2026, toward the 12-unit SFY limit.

Exception: Members aged 0–20 may receive additional testing with Prior Authorization when clinically appropriate.

Reference: 10 C.C.R. 2505-10, Section 8.660.3.D.

Note: The Medical Services Board (MSB) established a limit of 16 tests per SFY for adults effective October 10, 2025, then reduced this limit to 12 tests on December 12, 2025. Due to operational limitations of processing claims in accordance with a limitation change reducing covered tests from 16 to 12, the 12-test limit will be implemented beginning July 1, 2026. The 16-test limit will be in effect until June 30, 2026.



All documentation, including the order for the drug test, the clinical indication/medical necessity and the lab results must be maintained in the patient's medical record.

Further information can be found in the Laboratory Services Billing Manual.

Contact Sarah Kaslow at Sarah.Kaslow@state.co.us with any questions.

Lactation

Lactation Support Services

Enrolled Certified Registered Nurse Anesthetists (Provider Type 40), Occupational Therapists (Provider Type 28) and Speech Therapists (Provider Type 27) who meet International Board Certified Lactation Consultant (IBCLC), Certified Lactation Counselors (CLCs) and Certified Lactation Educators (CLEs) qualifications per 10 C.C.R. 2505-10 8.732.9 may provide lactation

support services without separate Provider Type 70 (Lactation Consultant) or 71 (Lactation Counselor or Educator) enrollment.

Refer to the Lactation Support Services Billing Manual for more information.

Contact hcpf_maternalchildhealth@state.co.us with any questions.

Obstetrical Care

Prenatal Plus Billing Manual Update

The Prenatal Plus Program Billing Manual has been updated to include new telemedicine guidelines and visit definitions.

Contact HCPF_MaternalChildHealth@state.co.us with questions or concerns about the program.

Pediatric Behavioral Therapy (PBT)

Compliance Update – Registered Behavior Technician (RBT) Certification Requirement

All Applied Behavior Analysis (ABA) providers are reminded that Registered Behavior Technicians (RBTs) must hold an active certification to provide and bill for services under Health First Colorado.

Action Required

The RBT certification compliance deadline has been extended. The previously communicated date of December 12, 2025, (which superseded the August 31, 2025, deadline) is no longer in effect. A new compliance date will be announced in a future provider communication.

Providers are strongly encouraged to bring all staff into full compliance as soon as possible and not wait for the new deadline.

Contact the Provider Services Call Center or Gina Robinson at Gina.Robinson@state.co.us with questions regarding provider requirements.

Pharmacy and All Medication Prescribers

Enhanced Dispensing Fee for Parenteral Nutrition Products

Effective for dates of service beginning January 1, 2026, an enhanced dispensing fee applies to total parenteral nutrition (TPN) pharmacy claims as required by SB 25-084. Pharmacies will

receive an extra $73.21 per TPN claim in addition to their standard dispensing fee (based on total annual prescription volume) and drug ingredient reimbursement.

Billing Instructions:

- Pharmacies must enter Level of Effort (LOE) code 21 in the Drug Utilization Review/Prospective Payment System (DUR/PPS) field to receive the enhanced dispensing fee when submitting TPN claims.
- Claims submitted without LOE 21 will be reimbursed at the standard dispensing fee rate.

Contact Korri Conilogue at Korri.Conilogue@state.co.us with questions.

Health First Colorado Fee-For-Service Pharmacy Benefit Manager (PBM) Change (All Medication Prescribers)

Effective 12:00 a.m. MT, April 1, 2026, Health First Colorado (Colorado's Medicaid program) Fee-for-Service (FFS) claims processing and prior authorization review will be transitioned from the current processor, Prime Therapeutics, to MedImpact Healthcare Systems, Inc.

Prescriber Network: Enrollment in the Health First Colorado FFS program will not change. There is no action for prescribers as MedImpact will use Colorado's existing provider network for the Health First Colorado FFS program. Contact the Provider Services Call Center with any questions.

Electronic Prior Authorization (ePA): MedImpact strongly encourages the use of ePA for submitting prior authorization requests as it is the preferred and most efficient method for processing requests. Prior authorizations are also accepted via fax and phone.

Preferred Drug List (PDL): All existing PDL limits and requirements remain in effect. A copy of the PDL is available on the Pharmacy Resources web page. Pharmacists and prescribing practitioners should contact MedImpact's Pharmacy Help Desk on or after April 1, 2026, for any questions related to the PDL.

Prior Authorization (PA) Form: PA forms have no significant changes. The only change to the PA form is the contact information. The MedImpact PA form should be available on the Pharmacy Resources web page starting March 1, 2026. Pharmacists and prescribing practitioners should contact MedImpact's Prior Authorization Request Desk on or after April 1, 2026, for any questions related to PA requests or the form.
Prior Authorizations (PAs): There is no need to submit a new PA if an active one already exists for the member with Prime Therapeutics, as current active PAs will be transferred to MedImpact.

Fee-For-Service (FFS) Pharmacy Benefit Manager (PBM) Change

Effective at 12:00 a.m. MT, April 1, 2026, Health First Colorado Fee-for-Service (FFS) claims processing and prior authorization review will be transitioned from the current processor, Prime Therapeutics, to MedImpact Healthcare Systems, Inc.

Note: There are no changes to the Bank Identification Number (BIN), Processor Control Number (PCN) or Group, which will result in a seamless transition at the pharmacy. Contact the switch vendor to confirm that claims are being routed correctly to MedImpact if experiencing issues submitting claims on or after April 1, 2026. Contact MedImpact at COFFSTeams@medimpact.com for further assistance if needed.

Upcoming Informational Session: MedImpact will hold an informational session via Teams video conferencing on March 2, 2026, from 9:00 a.m. to 10:00 a.m. MT to facilitate information exchange and answer questions. Join by accessing the link below or dial in by phone.

Join the meeting

Meeting ID: 211 658 154 148 2

Passcode: v7xL3dw6

Dial in by phone

+1 858-252-2734, 594960382# United States

Find a local number

Phone conference ID: 594 960 382#

Provider Network: Enrollment in the Health First Colorado FFS program will not change. There is no action for pharmacies as MedImpact will use Colorado's existing pharmacy network for the Health First Colorado FFS program. Contact the Provider Services Call Center with any questions.

Preferred Drug List (PDL): All existing PDL limits and requirements remain in effect. A copy of the PDL is available on the Pharmacy Resources web page. Pharmacists and prescribing practitioners may contact MedImpact's Pharmacy Help Desk on or after April 1, 2026, for any questions related to the PDL.

Prior Authorization (PA) Form: PA forms have no significant changes. The only change to the PA form is the contact information. The new form with changes will be posted on March 1, 2026. The PA form is available on the Pharmacy Resources web page under Pharmacy Prior Authorization Request. Pharmacists and prescribing practitioners may contact MedImpact's Prior Authorization Request Desk on or after April 1, 2026, for any questions related to PA requests or the form.

Reversals: B3 Claim Rebill is not supported. Claims requiring adjustment must first be reversed and then resubmitted as a new claim.

The procedures for submitting paid pharmacy claims adjustments remain unchanged with this transition and continue to follow the guidelines outlined in the Reversals section of the Pharmacy Billing Manual.

If a claim that is older than 120 days is reversed, it will not be able to be resubmitted. If a claim older than 120 days needs to be reversed and resubmitted, a Request for Reconsideration PHARMACY Form must be completed and submitted to MedImpact. The Request for Reconsideration PHARMACY Form can be found on the Provider Forms page under **Claim Forms and Attachments** section.

Incremental Fills: If greater than 60 days from date written for Schedule II (CII) drugs, claims will deny with Reject Code 650 - Fill Date Greater Than 60 Days from CII Date Prescription Written.

Usual and Customary (U&C): When claims are paid based on the submitted U&C, the U&C value will be represented in the Ingredient Cost Paid (506-F6) field and the Dispensing Fee Paid (507-F7) will be zero (0).

Prescriber Drug Enforcement Administration (DEA) Enforcement: A DEA license, or registration, is a federal license required for healthcare providers to legally prescribe, administer or dispense controlled substances. Prescriber DEA licenses will be edited as follows:

- If the prescriber does not have a valid DEA license on file, claims will deny with Reject Code 44 - Plan's Prescriber Database Indicates the Associated DEA To Submitted Prescriber ID Is Not Found.
- If the pharmacy can verify the DEA license is valid, the pharmacy can utilize one of the following Submission Clarification Codes to override Reject Code 44:
    - 43 = For the prescriber ID submitted, the associated DEA number has been renewed, or the renewal is in progress
    - 45 = For the prescriber ID submitted, the associated DEA number is a valid hospital DEA number with suffix
- If the prescriber does not have a valid DEA license to prescribe controlled substances, claims will be denied with Reject Code 46 - Plan's Prescriber Database Indicates Associated DEA To Submitted Prescriber ID Does Not Allow This Drug DEA Schedule.

Payer Sheet: All electronic pharmacy claims should continue to be submitted in accordance with the National Council for Prescription Drug Programs (NCPDP) version D.0 standard format. MedImpact enforces NCPDP standards according to the *Telecommunication Standard Implementation Guide Version D.Ø*. Fields submitted, even if not required, will be edited according to NCPDP standards and denied with the appropriate NCPDP Reject Codes. Providers can download a complete version of the Health First Colorado D.0 payer sheet from the Pharmacy Resources web page. The payer sheet will be updated to reflect several changes as part of the PBM transition. These changes are noted below and will be effective April 1, 2026. Contact MedImpact at COFFSTeam@MedImpact.com with any questions or clarification.

Note: Pharmacies should consult with their software vendor as soon as possible to determine if, and when, changes need to be made to a pharmacy's billing software or procedures so that no disruption occurs during this transition. Failure by the pharmacy to effect all such changes could lead to Point of Sale (POS) claims rejections.

Additional note: Prime Therapeutics, the current PBMS vendor, will begin enforcing certain NCPDP D.0 standards effective March 1, 2026. These include Missing/Invalid (M/I) Medicaid Indicator Field 360-2B, M/I Patient ZIP/postal code (special characters (e.g., dashes) are not permitted), M/I Patient Street Address (must be entered in all capital letters) and M/I Cardholder Name (first and last name must be all capital letters).

The tables below summarize the key changes pharmacies need to work on to be ready at the implementation date.

Changes to Claim Billing Request Transaction

Segment	NCPDP Field	NCPDP Field Name	MedImpact Value/Situation Defined
Header	103-A3	TRANSACTION CODE	B3 (Rebill) Not supported
Insurance (111 AM) = "04"	303-C3	PERSON CODE	Required When (RW) - Use value printed on card to identify specific person when cardholder ID is for family. A valid value must be submitted. Adding a space or submitting blank will result in the claim being denied with Reject Code 08 – M/I Person Code.
Insurance (111 AM) = "04"	309-C9	ELIGIBILITY CLARIFICATION CODE	RW - needed to clarify member eligibility If submitted, only valid numeric values will be accepted. Other values will result in the claim being denied for Reject Code 14, M/I Eligibility Clarification Code.

Segment	NCPDP Field	NCPDP Field Name	MedImpact Value/Situation Defined
Insurance (111 AM) = "04"	360-2B	MEDICAID INDICATOR	RW - This field will not accept space or values other than a valid two (2)-character state code. If a space or value other than a valid two (2)-character state code the claim will deny for Reject Code 2B, M/I Medicaid Indicator.
Patient (111 AM) = “01”	322-CM	PATIENT STREET ADDRESS	RW- for state/federal/regulatory agency programs. This field does not accept lower case letters. If submitted, it will result in the claim being denied for Reject Code CM, M/I Patient Street Address.
Patient (111 AM) = “01”	323-CN	PATIENT CITY ADDRESS	
Patient (111 AM) = “01”	324-CO	PATIENT STATE/PROVINCE ADDRESS	
Patient (111 AM) = “01”	325-CP	PATIENT ZIP/POSTAL ZONE	RW - Submitted value should only contain numeric characters. A dash is not allowed and claim will be denied for Reject Code CP, M/I Patient Zip/Postal Zone.
Claim (111 AM) = "07"	429-DT	SPECIAL PACKAGING INDICATOR	RW - Required for Long Term Care (LTC) claims for brand oral solid drugs.
Claim (111 AM) = "07"	461-EU	PRIOR AUTHORIZATION TYPE CODE	RW - Required to indicate the need for special handling to override a normal processing rejection.

Segment	NCPDP Field	NCPDP Field Name	MedImpact Value/Situation Defined
Claim (111 AM) = "07"	462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED	RW - Required to indicate the need for special handling to override a normal processing rejection.
Claim (111 AM) = "07"	996-G1	COMPOUND TYPE	RW - Required when billing for compound.
Claim (111 AM) = "07"	147-U7	PHARMACY SERVICE TYPE	RW- Required for Mail Order, LTC and Specialty Pharmacies for proper reimbursement.
Claim (111 AM) = "07"	408-D	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	Required (R) - Dispense as Written (DAW) 0,1,8 and 9 are allowed. All others will deny. DAW 0 cannot be submitted on a multi-source drug with available generics. DAW 1 cannot be submitted on generics or Single Source Brands.
Pricing (111-AM) = "11"	433-DX	PATIENT PAID AMOUNT SUBMITTED	NOT USED: This field is not used for COB billing. Claim will deny if value is other than $0.
Pricing (111-AM) = "11"	438-E3	INCENTIVE AMOUNT SUBMITTED	RW - Required when pharmacy is entitled to a Vaccine Administration fee.
Pricing (111-AM) = "11"	478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	
Pricing (111-AM) = "11"	479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER	
Pricing (111-AM) = "11"	480-H9	OTHER AMOUNT CLAIMED SUBMITTED	

Segment	NCPDP Field	NCPDP Field Name	MedImpact Value/Situation Defined
Pricing (111-AM) = "11"	481-HA	FLAT SALES TAX AMOUNT SUBMITTED	RW - Flat Sales Tax Amount should be submitted when a governing jurisdiction requires the collection of a fixed amount for all applicable prescriptions. Pharmacy is responsible for submission of accurate flat tax values for use in payment calculation. Required when flat sales tax is applicable to product dispensed.
Pricing (111-AM) = "11"	482-GE	PERCENTAGE SALES TAX AMOUNT SUBMITTED	RW percentage sales tax is applicable to product dispensed. NCPDP standard field required if its value has an effect on Gross Amount Due Calculation Pharmacy is responsible for submission of accurate percentage tax values for use in payment calculation. NOTE: For payment of Percentage Tax, all three (3) Percentage Tax fields must be submitted: -Percentage Sales Tax Amount Submitted -Percentage Sales Tax Rate Submitted -Percentage Sales Tax Basis Submitted

Segment	NCPDP Field	NCPDP Field Name	MedImpact Value/Situation Defined
Pricing (111-AM) = "11"	483-HE	PERCENTAGE SALES TAX RATE SUBMITTED	RW sales tax is applicable to product dispensed to provide the rate for use in payment calculation.
Pricing (111-AM) = "11"	484-JE	PERCENTAGE SALES TAX BASIS SUBMITTED	RW sales tax is applicable to product dispensed to provide the basis for use in payment calculation.
Pricing (111-AM) = "11"	430-DU	GROSS AMOUNT DUE	Must summarize according to NCPDP criteria. Ingredient Cost Submitted (4Ø9-D9) + Dispensing Fee Submitted (412-DC) + Flat Sales Tax Amt Submitted (481-HA) + Percentage Sales Tax Amt Submitted (482-GE) + Incentive Amount Submitted (438-E3) + Other Amount Claimed (48Ø-H9) If not equal to gross amount due, then claim will deny for Reject Code R9 - Value in Gross Amount Due Does Not Follow Pricing Formula.
Prescriber (111-AM) = "03"	427-DR	PRESCRIBER LAST NAME	RW - Required to identify the prescriber of the product dispensed.
Prescriber (111-AM) = "03"	368-2P	PRESCRIBER/ZIP POSTAL ZONE	If submitted, it must contain valid value. This field is numeric. A dash or space is not allowed and claim will deny for Reject Code 2P, M/I Prescriber Zip/Postal Zone.

Segment	NCPDP Field	NCPDP Field Name	MedImpact Value/Situation Defined
Coordination of Benefits/Other Payments (111-AM) = "05"	337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Mandatory (M)
Coordination of Benefits/Other Payments (111-AM) = "05"	338-5C	OTHER PAYER COVERAGE TYPE	M
Coordination of Benefits/Other Payments (111-AM) = "05"	339-6C	OTHER PAYER ID QUALIFIER	Required (R) – 03 = BIN Number
Coordination of Benefits/Other Payments (111-AM) = "05"	340-7C	OTHER PAYER ID	R - If no BIN exists due to billing of a non-online payer, please use value 999999 as the BIN of the Other Payer.
Coordination of Benefits/Other Payments (111-AM) = "05"	443-E8	OTHER PAYER DATE	R
DUR/PPS (111-AM) = "08"	473-7E	DUR/PPS CODE COUNTER	R
DUR/PPS (111-AM) = "08"	439-E4	REASON FOR SERVICE CODE	RW - needed to communicate Drug Utilization Review (DUR) information. Allowed Values: • DD = Drug-Drug Interaction • ER = Early Refill • HD = High Dose • PG = Pregnancy If not included, will receive a soft reject that can be overridden in the pharmacy.

Segment	NCPDP Field	NCPDP Field Name	MedImpact Value/Situation Defined
DUR/PPS (111-AM) = "08"	474-8E	DUR/PPS LEVEL OF EFFORT	RW - Payer requirement. Required when needed by plan for proper adjudication.
DUR/PPS (111-AM) = "08"	475-J9	DUR CO-AGENT ID QUALIFIER	Sometimes (S)
DUR/PPS (111-AM) = "08"	476-H6	DUR CO-AGENT ID	S
Compound (111-AM) = "10"	449-EE	COMPOUND INGREDIENT DRUG COST	R
Compound (111-AM) = "10"	490-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	R
Clinical (111-AM) = "13"	491-VE	DIAGNOSIS CODE COUNT	
Clinical (111-AM) = "13"	492-WE	DIAGNOSIS CODE QUALIFIER	
Clinical (111-AM) = "13"	424-DO	DIAGNOSIS CODE	RW - Decimal point should not be included in the International Classification of Diseases (ICD)-10 value. If submitted, only valid numeric values will be accepted. Other values will result in the claim being denied for Reject Code 30, M/I Diagnosis Code.

Change to Claim Response Transaction Accepted/Paid or Duplicate Paid

Segment	NCPDP Field	NCPDP Field Name	MedImpact Value/Situation Defined
Insurance (111-AM) = “25”	524-FO	PLAN ID	
Insurance (111-AM) = “25”	545-2F	NETWORK REIMBURSEMENT ID	

Segment	NCPDP Field	NCPDP Field Name	MedImpact Value/Situation Defined
Insurance (111-AM) = “25”	568-J7	PAYER ID QUALIFIER	
Insurance (111-AM) = “25”	569-J8	PAYER ID	
Status (111-AM) = “21”	987-MA	URL	RW - FUTURE USE
Pricing (111-AM) = “23”	558-AW	FLAT SALES TAX AMOUNT PAID	
Pricing (111-AM) = “23”	559-AX	PERCENTAGE SALES TAX AMOUNT PAID	
Pricing (111-AM) = “23”	560-AY	PERCENTAGE SALES TAX RATE PAID	
Pricing (111-AM) = “23”	561-AZ	PERCENTAGE SALES TAX BASIS PAID	
Pricing (111-AM) = “23”	523-FN	AMOUNT ATTRIBUTED TO SALES TAX	
Pricing (111-AM) = “23”	571-NZ	AMOUNT ATTRIBUTED TO PROCESSOR FEE	
Pricing (111-AM) = “23”	133-UJ	AMOUNT ATTRIBUTED TO PROVIDER NETWORK SELECTION	
Pricing (111-AM) = “23”	134-UK	AMOUNT ATTRIBUTED TO PRODUCT SELECTION / BRAND DRUG	
Pricing (111-AM) = “23”	135-UM	AMOUNT ATTRIBUTED TO PRODUCT SELECTION / NON-PREFERRED FORMULARY SELECTION	
Pricing (111-AM) = “23”	136-UN	AMOUNT ATTRIBUTED TO PRODUCT SELECTION / BRAND NON-PREFERRED FORMULARY SELECTION	
Pricing (111-AM) = “23”	137-UP	AMOUNT ATTRIBUTED TO COVERAGE GAP	

Segment	NCPDP Field	NCPDP Field Name	MedImpact Value/Situation Defined
Pricing (111-AM) = “23”	575-EQ	PATIENT SALES TAX AMOUNT	
Pricing (111-AM) = “23”	574-2Y	PLAN SALES TAX AMOUNT	
Pricing (111-AM) = “23”	148-U8	INGREDIENT COST CONTRACTED / REIMBURSABLE AMOUNT	RW - Returned when payment is based on Patient Responsibility Coordination of Benefits (COB) or Patient Pay Amount.
Pricing (111-AM) = “23”	149-U9	DISPENSING FEE CONTRACTED / REIMBUSABLE AMOUNT	RW - Returned when payment is based on Patient Responsibility COB or Patient Pay Amount.
Pricing (111-AM) = “23”	577-G3	ESTIMATED GENERIC SAVINGS	
Coordination of Benefits/Other Payers (111-AM) = “28”	355-NT	OTHER PAYER ID COUNT	M- Maximum count of three (3)
Coordination of Benefits/Other Payers	338-5C	OTHER PAYER COVERAGE TYPE	M
Coordination of Benefits/Other Payers (111-AM) = “28”	144-UX	OTHER PAYER BENEFIT EFFECTIVE DATE	
Coordination of Benefits/Other Payers (111-AM) = “28”	145-UY	OTHER PAYER BENEFIT TERMINATION DATE	

Changes to Claim Response Transaction Accepted/Rejected

Segment	NCPDP Field	NCPDP Field Name	MedImpact Value/Situation Defined
Insurance (111-AM) = “25”	301-C1	GROUP ID	
Insurance (111-AM) = “25”	302-C2	CARDHOLDER ID	REMOVED
Insurance (111-AM) = “25”	524-FO	PLAN ID	
Insurance (111-AM) = “25”	545-2F	NETWORK REIMBURSEMENT ID	
Status (111-AM) = “21”	987-MA	URL	RW - Future use
Prior Authorization (111-AM) = “26”	498-PY	PRIOR AUTHORIZATIO NUMBER-ASSIGNED	REMOVED
Coordination of Benefits/Other Payer (111-AM) = “28”	355-NT	OTHER PAYER ID COUNT	M- Maximum count of three (3)
Coordination of Benefits/Other Payer (111-AM) = “28”	338-5C	OTHER PAYER COVERAGE TYPE	M
Coordination of Benefits/Other Payer (111-AM) = “28”	144-UX	OTHER PAYER BENEFIT EFFECTIVE DATE	
Coordination of Benefits/Other Payer (111-AM) = “28”	145-UY	OTHER PAYER BENEFIT TERMINATION DATE	

Changes to Claim Reversal Request Transaction

Segment	NCPDP Field	NCPDP Field Name	MedImpact Value/Situation Defined
Insurance (111-AM) = "04"	301-C1	GROUP ID	R - Value submitted on claim should be included on reversal.
Insurance (111-AM) = "04"	306-C6	PATIENT RELATIONSHIP CODE	REMOVED
Claim (111-AM) = "07"	147-U7	PHARMACY SERVICE TYPE	

Changes to Claim Reversal Response Transaction Accepted/Rejected

Segment	NCPDP Field	NCPDP Field Name	MedImpact Value/Situation Defined
Status (111-AM) = "21"	503-F3	AUTHORIZATION NUMBER	RW - When calling Help Desk, this ID is the fastest means to identify the claim.

Claim Reversal Response Transaction Rejected/Rejected

Segment	NCPDP Field	NCPDP Field Name	MedImpact Value/Situation Defined
Status (111-AM) = "21"	503-F3	AUTHORIZATION NUMBER	RW - When calling Help Desk, this ID is the fastest means to identify the claim.

New Billing Requirements for Abortion Medications

Effective for dates of service beginning January 1, 2026, the Department will implement Senate Bill (SB) 25-183, which requires coverage of abortion medication services as a family planning-related service for eligible members.

Billing Instructions

- A diagnosis code must be included in all claims for:
  - Mifepristone (Mifeprex) 200mg
  - Misoprostol (Cytotec) 100mg

- Misoprostol (Cytotec) 200mg

- Claims with a diagnosis code indicating abortion will be paid with state-only funds and are not eligible for federal rebates.
- Claims submitted without a diagnosis code will deny for missing diagnosis.
- Diagnosis codes must reflect the appropriate condition or encounter type in accordance with ICD-10-CM standards.

Example: Z33.2- Encounter for elective termination of pregnancy

Managed Care Carveout

Providers must submit fee-for-service claims for abortion medication for members enrolled in a physical health managed care plan (Denver Health and Rocky Mountain Health Plans).

Contact Korri Conilogue at Korri.Conilogue@state.co.us with questions.

Pharmacy Reimbursement Methodology Update

Effective April 1, 2026, the Department will be updating the outpatient pharmacy reimbursement methodology for covered outpatient drugs.

What is changing:

- **Reimbursement Methodology:**
  - Claims will be reimbursed at the lesser of:
    - Usual & Customary (no dispensing fee) or
    - Average Acquisition Cost (AAC), National Average Drug Acquisition Cost (NADAC), Maximum Allowable Cost (MAC), or Submitted Ingredient Cost (SIC), plus the pharmacy's assigned professional dispensing fee. Previously, MAC applied only when AAC or NADAC were unavailable.

  - Clotting Factor reimbursement methodology is not changing.
- **MAC Rate:**
  - Generic drugs: Wholesale Acquisition Cost (WAC) minus 20% is changing to WAC minus 22%
  - Brand drugs: WAC minus 3.5% is changing to WAC minus 4%
- **Dispensing Fees:**

The two lowest dispensing fee tiers will be reduced from $10.25 to the new rate of $9.93, and $9.31 to the new rate of $8.72.

No action is required by providers. Claims will adjudicate using the updated methodology for dates of service on or after the effective date.

Contact Korri Conilogue at Korri.Conilogue@state.co.us with questions regarding this update.

Pulmicort Flexhaler 90mcg Supply Constraints

Pulmicort Flexhaler (budesonide) has been issued a new National Drug Code (NDC). The prior NDCs have been discontinued by the manufacturer. The new NDCs are associated with Rubicon Holdings (NDC 85612001001 and 85612001101), which is not participating in the Medicaid Drug Rebate Program (MDRP). Health First Colorado can only cover medications which participate in the MDRP. The only remaining MDRP-participating medication, Pulmicort Flexhaler 90mcg from H2 Pharma (NDC 61269050906), is currently on backorder.

The recommendation is to use Health First Colorado's preferred alternatives in this category, which include Arnuity Ellipta (fluticasone furoate), Asmanex HFA (mometasone furoate), Asmanex Twisthaler (mometasone) and QVAR Redihaler (beclomethasone). Additional information regarding inhaled medications can be found on the Preferred Drug List on the Pharmacy Resources web page.

Physician-Administered Drug (PAD) Providers

Prior Authorization (PA) Update

Imaavy (nipocalimab-aahu), Healthcare Common Procedure Coding System (HCPCS) code J9256, and Daxxify (daxibotulinumtoxinA-lanm), HCPCS code J0589, will be added to the list of PADs that require prior authorization in addition to the codes listed in the table below, effective January 1, 2026. In addition, and in accordance with U.S. Food and Drug Administration (FDA) labeling changes, Appendix Y updates have been made for Vyvgart (efgartigimod alfa), HCPCS code J9332, and Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc), HCPCS code J9334. The full list of PADs that require prior authorization can be found in Appendix Y: Physician Administered Drug Medical Benefit Prior Authorization Procedures and Criteria.

J1442	Q5125	J2506	Q5111	Q5127	J9312
Q5101	Q5148	Q5108	Q5122	Q5130	

Providers should ensure that any Health First Colorado member due to receive Imaavy (nipocalimab-aahu) have an approved prior authorization (PA) on file prior to administration. Policy does not usually allow for retroactive PA requests; however, as an exception, the Department will consider retroactive PA requests for J9256 administered on any date of service from January 1, 2026, through March 1, 2026.

Providers must ensure that a member-specific prior authorization request (PAR) is submitted directly to the Department's Utilization Management vendor, Acentra, and approved prior to administration of the PAD.

All PAD PA procedures, clinical criteria and PADs subject to PA requirements can be found in Appendix Y: Physician Administered Drug Medical Benefit Prior Authorization Procedures and Criteria, accessible via the PAD Provider Resources web page.

Additional information regarding PAD PA requirements can be found via ColoradoPAR: Health First Colorado Prior Authorization Request Program and the Physician Administered Drug Provider Resources web pages.

Contact HCPF_PAD@state.co.us with all other PAD questions.

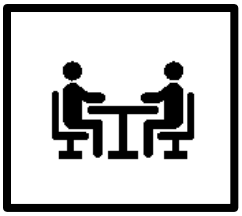
Physician Services

Free Screening, Brief Intervention and Referral to Treatment (SBIRT) Training for Health First Colorado Providers

Free Screening, Brief Intervention and Referral to Treatment (SBIRT) training for Health First Colorado providers is provided through partnership with Peer Assistance Services (PAS), Inc. The SBIRT program promotes prevention and early intervention efforts through in-person, online and virtual training, technical assistance and hands-on SBIRT implementation.

Providers are required to participate in training that provides information about the implementation of evidence-based protocols for screening, brief interventions and referrals to treatment to directly deliver screening and intervention services.

Face-to-face training and consultations are available through various entities such as SBIRT Colorado, Carina Health Network (formerly Colorado Community Managed Care Network) and the Emergency Nurses Association.



Elevate SBIRT and motivational interviewing skills with Peer Assistance Services' new self-paced interactive practice scenarios. Create a free account to access a risk-free practice environment and engage in conversations with a patient about substance use. These simulations use guided prompts to walk through each interaction, improving the delivery and effectiveness of brief interventions.

Register for an upcoming SBIRT training at the PAS training calendar. The shared goal is to promote SBIRT as a standard of care throughout Colorado. Refer to the SBIRT Billing Manual to learn more about best billing practices.

Contact Janelle Gonzalez at Janelle.Gonzalez@state.co.us with questions.

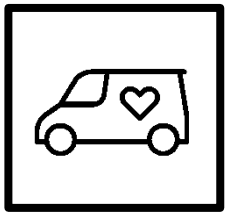
Telehealth

Changes to Medicare's telehealth coverage do not change the Health First Colorado telehealth/telemedicine coverage.

For dually-eligible members with full Health First Colorado benefits, services should continue to be submitted to Medicare before submitting to Health First Colorado, unless otherwise noted in billing manual or Department rule. Health First Colorado will pay based on the Health First Colorado allowable amount for services not covered by Medicare, but which are covered by Health First Colorado. Refer to the Entering Other Insurance or Medicare Crossover Information Quick Guide for more billing information.

Transportation

Non-Emergent Medical Transportation (NEMT) Billing Clarification



The Non-Emergent Medical Transportation (NEMT) Billing Manual on the Billing Manuals web page has been updated to include the following information: ***Providers may bill only the procedure code that corresponds to the vehicle type actually used and the level of service necessary to transport the member to the destination***. This update can be found in the Covered Benefits and Limitations, Standard Forms Required and Procedure Coding sections of the manual.

Contact NEMT@state.co.us with any questions.

Provider Training Sessions

February 2026 Schedule

Providers are invited to sign up for provider training sessions. All sessions are held via webinar on Zoom, and registration links are shown in the calendar below. *The availability of training sessions varies monthly.* Descriptions of available training sessions, calendar registration links and training-specific slide decks are available on the Provider Training web page.

The following training sessions focused on Health First Colorado will be offered in February:

- **Provider Enrollment Training**

Provider enrollment training gives an overview of the Health First Colorado program and guidance on the provider application process including enrollment types, common errors and enrollment with other entities (e.g., DentaQuest, Regional Accountable Entities [RAEs], Health First Colorado vendors). It also provides information on next steps after enrollment.

- Audience: This training is designed for providers at various stages of the initial enrollment process with Health First Colorado.
- Time: One and a half (1.5) hour presentation / half (0.5) hour Q&A

- **Beginning Billing Training**

Beginner billing training provides a high-level overview of member eligibility, claim submission, prior authorizations, Department website navigation, Provider Web Portal use and more. The Department offers two beginner billing trainings: professional claims (CMS 1500) and institutional claims (UB-04).

- Audience: Staff who submit claims, are new to billing Health First Colorado services or who need a billing refresher course should consider attending one of the beginner billing training sessions.
- Time: One and a half (1.5) hour presentation / half (0.5) hour Q&A

- **Billing Training: Medicare and Third-Party Liability**

This focused micro-training addresses billing Medicare and third-party liability (TPL) (e.g., commercial and private insurance) as primary payers, including detailed information on Medicare lower-of pricing logic and timely filing guidelines.

- Audience: This training is not relevant to Home and Community-Based Services (HCBS) and Non-Emergent Medical Transportation (NEMT) providers. This training applies to all other provider types and is recommended after attending beginner billing training.
- Time: One (1) hour presentation / half (0.5) hour Q&A

- **Member Eligibility Training**

This focused micro-training details important aspects of member eligibility from the provider's perspective including eligibility verification, detailed eligibility types, member billing, and using the Provider Web Portal to access this critical information.

- Audience: This training applies to all provider types and is recommended after attending beginner billing training.
- Time: One (1) hour presentation / half (0.5) hour Q&A

Live Webinar Registration

Click the title of the desired provider training session in the calendar to register for a webinar. An automated response will confirm the reservation. Webinars may end early. Time has been allotted for questions at the end of each session.

February 2026				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
2	3	4	5 Billing Training: Medicare & Third-Party Liability 1:30 p.m. - 3:00 p.m. MT	6
9	10 Provider Enrollment Training 11:00 a.m. - 1:00 p.m. MT	11 Member Eligibility Training 1:00 p.m. - 2:30 p.m. MT	12	13
16	17	18 Beginner Billing Training: Professional Claims 9:00 a.m. - 11:00 a.m. MT	19	20
23	24	25	26	27

Note: All training sessions offer guidance for Health First Colorado only. Providers are encouraged to contact the Regional Accountable Entities (RAEs), Child Health Plan *Plus* (CHP+) and Medicare for enrollment and billing training specific to those organizations. Training for the Care and Case Management (CCM) system will not be covered in these training sessions. Visit the CCM System web page for CCM-specific training and resources.

Refer to the Provider Web Portal Quick Guides located on the Quick Guides web page for more training materials on navigating the Provider Web Portal.

Upcoming Holidays

Holiday	Closures
Presidents' Day Monday, February 16, 2026	State Offices and the Provider Services Call Center will be closed. Acentra, AssureCare, DentaQuest, Gainwell Technologies and Prime Therapeutics will be open. Capitation cycles may potentially be delayed. The receipt of warrants and EFTs may potentially be delayed due to the processing at the United State Postal Service or providers' individual banks.

[Provider Services Call Center]

1-833-468-0362