COLORADO
Department of Health Care Policy & Financing

Provider Bulletin

Reference: B2500524

June 2025

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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?

The grace period on claims payment for Ordering, Prescribing and Referring (OPR) Providers has ended; claims for the following provider types will deny if the referring provider is not actively enrolled with Health First Colorado (Colorado's Medicaid program).

- Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)
- Home Health and Private Duty Nursing
- Pediatric Personal Care
- Radiology and Imaging services
- Laboratory services
- Physical, Occupational, and Speech Therapy services (outpatient)
- Audiology services
- School Health Services Program (physical, occupational, and speech therapy services)
- Outpatient Hospital-based therapies, radiology and imaging services, and laboratory services
- Vision Care and Eyewear services
- Doula services
- Lactation Support Service

Refer to the Ordering, Prescribing and Referring Claim Identifier Project web page for more information.

All Providers

EOB 3110 - Claims Will Not Deny for Individual Not Being Linked to the Group

Some providers have questions about claims with Explanation of Benefits (EOB) code 3110: "The rendering provider is not a group member." Notations that affiliations are missing do not cause claims to deny and are *informational only*.

The Department is giving providers an extended grace period to make all necessary updates to their affiliations to avoid future claims denials. If EOB code 3110 appears on a claim, providers should check their affiliations and make sure they are up to date and check other EOB codes to see why the claim was denied.

Updated affiliations are currently taking up to five (5) days for final approval. Providers should not submit duplicate update requests.

Reminder: Provider License Status

Some claims are currently being denied for no license on file. Practitioner licenses expired with the Department of Regulatory Agencies (DORA) on April 30, 2025. Some licenses were automatically updated. Providers may have an active license with DORA but the license may not be on file with Health First Colorado.

If an exact match for the provider's name is not found, the license must be manually updated through the Provider Web Portal by the provider to avoid claim denials. The grace period for this issue has ended and claims that previously were paid may now be denied. Providers are urged to check the status of the individual's provider license on file and update as needed.

Refer to the Update Licenses and Clinical Laboratory Improvement Amendments (CLIA) Quick Guide for information on how to update licenses.

Community Health Workers (CHW) in Medicaid: Postponed

The Department of Health Care Policy & Financing (the Department) wants to provide an update regarding Health First Colorado reimbursement for Community Health Worker (CHW) services. Due to the State's budget shortfall, the Colorado General Assembly passed legislation (SB 25-229) that postpones CHW Health First Colorado reimbursement until January 1, 2026. The Health First Colorado reimbursement for CHW services will not begin on July 1, 2025, but will instead begin on January 1, 2026. Contact HCPF_CHW_Benefit@state.co.us with any questions about the CHW benefit being paused until January 1, 2026.

Fiscal Year 2025-2026 Provider Rate Adjustments

Health First Colorado Across-the-Board (ATB) provider rate increases were approved during the 2024-25 legislative session and are effective for dates of service beginning July 1, 2025. All rate adjustments are subject to Centers for Medicare & Medicaid Services (CMS) approval prior to implementation. The fee schedules located on the Provider Rates and Fee Schedule web page will be updated to reflect the approved 1.6% ATB rate increases. Rates will be updated in the Colorado interChange for dates of service beginning July 1, 2025.

The 1.6% ATB increase for Home and Community-Based Services (HCBS) waivers do not require CMS approval. Claims with dates of service on or after July 1, 2025, will be reimbursed at an increased rate for providers for the following waivers:

- HCBS - Brain Injury (BI)
- HCBS - Children's Extensive Supports (CES)
- HCBS - Children's Home and Community-Based Services (CHCBS)
- HCBS - Children with Life Limiting Illness (CLLI)
- HCBS – Children's Habilitation Residential Program (CHRP)
- HCBS - Community Mental Health Supports (CMHS)

- HCBS – Complementary and Integrative Health (CIH)
- HCBS - Developmental Disabilities (DD)
- HCBS - Elderly, Blind and Disabled (EBD)
- HCBS - Supported Living Services (SLS)

A targeted rate increase will be effective for the following HCBS services, effective July 1, 2025:

- Targeted Case Management, Per Member Per Month

Rates will also be adjusted to align across waivers with the implementation of the Community First Choice (CFC) waiver. The following services will be aligned across waivers effective July 1, 2025:

- Health Maintenance Activities
- Personal Care Services
- Homemaker, Basic and Enhanced
- Consumer-Directed Attendant Support Services (CDASS) Homemaker
- CDASS Personal Care Services

The Department will continue to publish updates as they become effective.

Help Shape the Future of Health First Colorado: Apply to Join the Medical Care Advisory Committee (MCAC)

The Department is recruiting for the Medical Care Advisory Committee (MCAC).

In 2024, the Centers for Medicare & Medicaid Services (CMS) updated federal requirements (42 CFR 431.12) directing states to establish and operate a public Medicaid Advisory Committee.

This new committee will play an important role in improving quality of care, advancing health equity and strengthening Health First Colorado services across Colorado.

Individuals are being sought with relevant experience in health care or advocacy who:

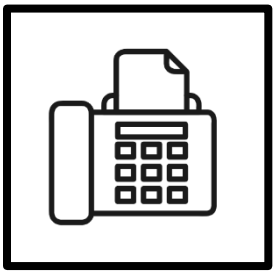
- Serve or represent Health First Colorado members
- Have demonstrated leadership or expertise in their field
- Are open to diverse viewpoints
- Have a desire to improve Health First Colorado services for all members

Applications are open from May 12, 2025, to July 1, 2025.

Learn more about the committee and eligibility requirements on the Medical Care Advisory Committee web page.

Individuals are encouraged to apply or to share this opportunity with others who may be interested.

Provider Services Call Center Virtual Hold



The Provider Services Call Center is currently experiencing higher-than-average wait times. To reduce wait times, providers can select the new "virtual hold" option to hang up the phone while keeping their place in line and receive a call back when an agent is available. The system is unable to call back numbers with extensions. Providers are encouraged to use the new automated phone system for self-service instead of holding for an agent. Providers can verify:

- Payment history
- Claims status and associated EOB codes
- Member eligibility

National Correct Coding Initiative (NCCI) Notification of Quarterly Updates

Providers are encouraged to monitor Centers for Medicare & Medicaid Services (CMS) for updates to National Correct Coding Initiative (NCCI) rules and guidelines. Updates to the procedure-to-procedure (PTP) and medically unlikely edit (MUE) files are completed quarterly with the next file update available July 2025. For more information, visit the National Correct Coding Initiative (NCCI) Edits web page.

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.

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

Pediatric Long-Term Home Health (LTHH) Prior Authorization Requests (PARs) have been on pause since February 8, 2022. Prior authorization is a federal requirement per 42 CFR 456.3; the Department intends to fully reinstate the PAR requirement by April 6, 2026. Implementing Pediatric LTHH PARs will follow a gradual, phased-in approach to allow a smooth transition and avoid overwhelming providers.

Soft Launch:

- Pediatric Long-Term Home Health (LTHH) Therapies
    - Physical Therapy (PT)

- Occupational Therapy (OT)
- Speech Therapy/Speech-Language Pathology (ST/SLP) services

The first phase of the PAR Resumption Plan, the **voluntary Soft Launch period**, started **February 3, 2025**, and will remain in effect until **June 30, 2025**. Home Health Agencies (HHAs) are strongly encouraged to avoid delaying the submission of therapy PARs for review.

The **Soft Launch** is a phase during which providers can submit PARs for review by Acentra Health. During this period, the outcome of the PARs **will not impact the current status of members' benefits**. The Department will actively monitor submission progress throughout the Soft Launch period and provide education to providers when necessary.

Important dates for PAR resumption, Pediatric Home Health Therapies

- July 1, 2025
  - Go-Live for PT, OT and ST/SLP PARs
  - Providers will be required to submit PARs for medical necessity review using a phased-in approach. **Detailed instructions and timelines will be communicated prior to the start of the Go-Live period through an Operational Memo (OM).**

Go Live for RN and CNA services is planned for July 1, 2025. Additional guidance on specific dates and expectations coming soon.

Note: There will be a new PAR requirement for LTHH Certified Nursing Assistant (CNA) and Registered Nurse (RN) services:

Skilled Care Acuity Assessment and Nurse Assessor

- **NEW!** The Skilled Care Acuity Assessment (completed by Telligen, the Nurse Assessor vendor), will be required when submitting a PAR for LTHH RN and CNA services. Reference the Training section below for associated training dates. Visit the Nurse Assessor web page for more information.

Reference Operational Memo 24-060 for more details. Communication will continue via the Memo Series, and stakeholders may submit questions to the HomeHealth@state.co.us inbox.

Verbal Order Requirement Reminders

In cases where a verbal order is issued, it must be properly documented, contain all necessary components and be signed by the ordering Physician or Approved Practitioner before Prior Authorization Request (PAR) submission. Providing services without a valid order violates Medicaid and Medicare regulations and PAR submission requirements. To ensure compliance with both federal and Health First Colorado regulations (10 CCR 2505-10, Section 8.520), verbal orders must include the following components:

- Service discipline(s) requested
- Frequency and duration
- Name of the individual giving the order
- Name of the individual receiving the order
- Date and time the order was given
- Dated signature of the healthcare professional at the Home Health Agency (HHA) who took the order

These requirements align with the Medicare Program Integrity Manual sections 30.2.3 (specificity of orders), 30.2.6 (use of verbal orders) and 30.2.9 (alternative signatures, such as electronic signatures). The Medicare Benefit Policy Manual (Chapter 7, Section 30.2.1) provides further guidance on these requirements. Failure to follow these guidelines may result in pends for additional information or delays in PAR processing.

Medical Necessity of Oral Liquid Nutrition Supplementation

An increase in Prior Authorization Request (PAR) submissions has been noted for Oral Liquid Nutrition Supplementation. These are only considered medically necessary when a patient cannot meet their nutritional needs through their regular diet alone and require additional nutrients to maintain or improve their health. The medical necessity of the oral liquid nutrition supplementation must be clearly documented in the request.

Medical Necessity is defined in 10 C.C.R. 2505-10, Section 8.076.1.8.

Prior Authorization Request (PAR) Submission Training for Acentra

Beginning in April 2025, 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:

- Pediatric LTHH Therapies Go Live - June 3, 2025, 12:00 p.m.
- LTHH Training - June 4, 2025 - 9:00 a.m.
- LTHH Training - June 9, 2025 - 3:00 p.m.
- Pediatric LTHH Therapies Go Live - June 10, 2025 - 9:00 a.m.
- LTHH Training - June 12, 2025 - 12:00 p.m.
- LTHH Training - June 17, 2025 - 3:00 p.m.
- LTHH Open Hours - July 1, 2025 - 3:00 p.m.
- LTHH Open Hours - July 9, 2025 - 9:00 a.m.
- Portal Registration and PAR Submission Training - June 11, 2025 - 9:00 a.m.
- Portal Registration and PAR Submission Training - June 11, 2025 - 12:00 p.m.
- Portal Registration and PAR Submission Training - June 6, 2025 - 3:00 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.

Important Training Dates:

Hospital Discharge Planners and Case Managers, Case Management Agencies (CMAs), Regional Accountable Entities (RAEs), and Home Health Agencies (HHAs)

Nurse Assessor Referral Training:

Provider Type	Training dates, times, and registration link	Description
***Authorized User Training with Telligen; All entities who will submit referrals must attend this training**	• June 10, 2025, from 9:00 a.m. to 10:00 a.m. Mountain Time • June 12, 2025, from 3:00 to 4:00 p.m. Mountain Time	Each agency or facility designates **one (1) or two (2) individuals** as authorized officials. These officials are responsible for **setting up Qualitrac access** for users within their facility. This training will guide participants through the necessary steps to set up user access within Qualitrac.
Hospital Case Managers and Discharge Planners	June 5, 2025, from 1:00 p.m. to 1:50 pm Mountain Time Or dial: (US) +1 267-574-0397 PIN: 183 801 810#	This session is designed to provide Hospital Case Managers and Discharge Planners the necessary knowledge and skills to successfully submit an assessment referral using Qualitrac. This will include specific instances where hospital staff would be appropriate to submit referrals.
Case Managers (RAEs and CMA staff)	Coming Soon	This session is designed to provide Case Managers the necessary knowledge and skills to successfully submit an assessment referral using Qualitrac.
Providers (HHAs)	Coming Soon	This session is designed to provide Home Health Agency staff the necessary knowledge and skills to successfully submit an assessment referral using Qualitrac.
Members and Legal Representatives	Coming Soon	This session is designed to assist members and their legal representatives in understanding how to navigate the

Provider Type	Training dates, times, and registration link	Description
		Connect Member Portal when submitting a nurse assessment referral. The training will provide clear, accessible guidance to ensure an efficient and successful submission process.

*Recordings of all Nurse Assessor-related training sessions will be available on the Nurse Assessor web page.

Note: The Authorized User Training must be completed for each entity or agency who wishes to submit a referral via Qualitrac. (Members will be able to submit via another mechanism that does not require this step.)

Coordination of Care for Speech and Occupational Therapy Providers

Demonstration of coordination of care and documentation that services are not being duplicated is required when a member is participating in both occupational and speech therapy.

The most common area in which this is seen is **feeding therapy**, when goals pertain to *oral motor or sensory*.

Submitting the current therapy plan of the other provider with the active Prior Authorization Request (PAR) to show no overlap in goals or duplication of services will reduce pends and delays in care to the member. Both therapy providers should collaborate in supplying the other provider's therapy plan for their members to ensure services are not delayed in either modality.

Refer to the Speech Therapy Billing Manual on the Billing Manual web page.

Note: Non-Covered Services #22. Therapy that replicates services that are provided concurrently by another type of therapy is not covered. Particularly, occupational therapy which should provide different treatment goals, plans, and therapeutic modalities from speech therapy.

Adult Habilitative Speech Therapy Expansion Update

Effective July 1, 2025, Health First Colorado will cover adult habilitative speech therapy services for eligible adult members when medically necessary. The condition of 12 sessions of speech therapy before a Prior Authorization Request (PAR) is required is applicable for this population. Appropriate modifiers indicating habilitative services (GN+96) are required on all

PARs. This benefit will be subject to the same PAR requirements as other Speech Therapy services. Refer to the Speech Therapy Billing Manual for specific requirements.

Behavioral Health Providers

Article Correction: Fee-for-Service Physician-Administered Drugs (PADs)

The May 2025 Provider Bulletin article for Fee-for-Service Physician-Administered Drugs (PADs) stated:

Long-Acting Injectable Antipsychotic (LAIs) medications may be administered in any setting (e.g., pharmacy, clinic, office or member home) and billed to the pharmacy or medical benefit as most appropriate and in accordance with all Health First Colorado billing policies.

This should read:

Long-Acting Injectable medications (LAIs) *for the treatment of Mental Health or Substance Use Disorders* may be administered in any setting (e.g., pharmacy, clinic, office or member home) and billed to the pharmacy or medical benefit as most appropriate and in accordance with all Health First Colorado billing policies.

Clarification for Substance Use Disorder (SUD) Continuum Providers on Terming Specialty Type 64/477

On July 1, 2024, new Specialty Types were added under Provider Type (PT) 64 (Substance Use Continuum) to align with Behavioral Health Administration (BHA) Endorsements for each American Society of Addiction Medicine (ASAM) level of care. This allows the Department and Regional Accountable Entities (RAEs) to accurately track network adequacy for all Substance Use Disorder (SUD) levels of care.

Ensure that PT 64 enrollments include a Specialty Type for each ASAM level of care endorsement on BHA licenses by June 15, 2025. Submit a maintenance request through the Provider Web Portal to add a Specialty Type to the PT 64 enrollment. The Provider Maintenance Quick Guide explains how to submit a maintenance request.

The list of ASAM level of care Specialty Types can be referenced on the Department's Find Your Provider Type webpage under Substance Use Disorder (SUD) Continuum.

Specialty Type 477 is not associated with an ASAM level of care and is therefore being discontinued. It is not possible for a provider to remove a Specialty Type via a maintenance request. Once all SUD Continuum providers have added the necessary ASAM level of care Specialty Type(s), the 477 Specialty Type will be end-dated in the system.

Correction for content mentioned in April newsletter: The Department will not be denying claims with dates of service after June 30, 2025, when billed by Provider Specialty Type 64/477. This policy may be revisited in the future.

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

Certified Community Behavioral Health Clinic (CCBHC) Feedback Survey and Update

Behavioral Health Administration (BHA) and the Department continue to work on the collaborative Certified Community Behavioral Health Clinic (CCBHC) Planning Grant Project. Learning from our stakeholders is an important part of the planning grant process. We are seeking feedback from all stakeholders, including providers, advocates, members and their families. A CCBHC Feedback Survey has been launched to help facilitate this.

Complete this 2-minute survey to provide feedback. Feedback may be provided anonymously, but providers are encouraged to provide contact information in case the Department has follow-up questions. The survey is available on the CCBHC Planning Grant web page.

Refer to the CCBHC Planning Grant web page or contact HCPF_BHBenefits@state.co.us for more information.

Mental Health Transitional Living Homes Informational Memo Released

An Informational Memo (IM 25-007) about Mental Health Transitional Living Homes (MHTL) was released February 14, 2025. The purpose of this Informational Memo is to inform all service providers, case management agencies, members and interested stakeholders about the differences between MHTL homes Level 1 (Transitional Living) and Level 2 (Supported Therapeutic Transitional Living).

The MHTL Informational Memo can be accessed on the Department's 2025 Memo Series Communication web page. Contact HCPF_BHBenefits@state.co.us with any questions.

Adult Behavioral Health Residential Billing Modifiers

Adult Mental Health Residential (Provider Type 96) Providers must now use First Position Modifiers when billing for Adult Behavioral Health Residential services, as outlined on page 61 of the April 2025 SBHS Billing Manual:

- HB - Used for Adult Mental Health Residential
- U2 - Used for Adult Mental Health Transitional Living Level 2 Homes
- U3 - Used for Adult Eating Disorder Residential Treatment

Contact HCPF_BHBenefits@state.co.us for more information.

Known Issue: Comprehensive Safety Net Provider Fee-for-Service (FFS) Claims Denial

Comprehensive Safety Net Provider (CSNP) (Provider Type 78) fee-for-service (FFS) claims are currently denying due to system implementation delays. CSNPs may continue to submit FFS claims and they will be reprocessed once system updates are complete in Fall 2025. The Regional Accountable Entities (RAEs) are aware of this issue and have been advised of the process for reprocessing their claims. All CSNP claims will bypass timely filing.

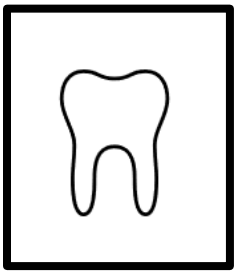
Contact HCPF_BHBenefits@state.co.us with any further questions.

Dental Providers

Oral Surgeons: Procedure Code J0585

Procedure code J0585 does not currently require prior authorization when administered in and billed by an outpatient hospital on an Institutional claim form (UB-04 or 837I).

Hospital Specialty Drug policies, procedures and prior authorization requirements can be found on Appendix Z – Hospital Specialty Drugs on the Billing Manual web page.



A member-specific prior authorization must be on file prior to administration of the drug to a Health First Colorado member for all Hospital Specialty Drugs. Providers must bill for the National Drug Code (NDC) of the Physician-Administered Drug (PAD) administered to the member, and the PAD must be used for a U.S. Food and Drug Administration (FDA) approved indication or an indication that is supported by certain compendia identified in section 1927(g)(1)(B)(i) of the Social Security Act and in accordance with the manufacturer labeling.

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

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

Reminder: Pulse Oximeters

All Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) providers are reminded that procedure code E0445 with modifier U1 should be used for fingertip pulse oximeters, and modifier U2 should be used for tabletop pulse oximeters. Refer to the DMEPOS Healthcare Common Procedural Coding System (HCPCS) Table in the Durable Medical Equipment HCPCS Codes on the Billing Manuals web page for additional guidance.

Rate Update for A4459

A rate adjustment will be effective June 1, 2025, due to a procedure code description change for HCPCS A4459. Previously A4459 encompassed a pump and 15 catheters. Due to the April 1, 2025, update the description has been changed to include only the pump. All catheters are to be billed separately on HCPCS A4453. Updated reimbursement rates can be found on the Health First Colorado Fee Schedule.

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Billing Manual Updates

The Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Billing Manual has been updated. Refer to the revision log at the bottom of the manual for the May 2025 updates.

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

Home and Community-Based Services (HCBS) Providers

Home and Community-Based Services (HCBS) Provider Contact Information Update for 2025 Base Wage Reporting Compliance

Home and Community-Based Services (HCBS) providers are required to ensure accurate contact information is on file with the Department in preparation for 2025 HCBS Direct Care Worker Base Wage Reporting which begins July 1, 2025.

Provider Agencies are encouraged to sign up for the Office of Community Living Long-Term Services and Supports Newsletter, join the mailing list for the Monthly Notices of Released Memos and review the Provider Bulletins to stay informed on

Base Wage reporting. Contact HCPF_BaseWage@state.co.us to provide feedback and suggestions on the reporting process.

Confirm agencies' contact information via the Provider Web Portal and follow the step-by-step instructions found in the Provider Maintenance Quick Guide on or before June 6, 2025.

Refer to the Direct Care Workforce Base Wage web page for more information.

Buy-In Program for Working Adults with Disabilities Update

The Health First Colorado Buy-In Program for Working Adults with Disabilities allows adults with a qualifying disability to "buy into" Health First Colorado. Members who work and earn too much to qualify for Health First Colorado may qualify for the Buy-In Program.

Changes to how Health First Colorado members enroll into the Working Adults with Disabilities Buy-In Program were originally planned to become effective in June 2025. The decision was made to delay the planned changes to the Working Adults Buy-In program by at least one year.

The changes would have specifically impacted Health First Colorado members who also receive services through HCBS waivers. The changes had been communicated to stakeholders via various newsletters, communication channels, stakeholder meetings, and notices sent out over the last several months. The Department has become aware of system errors and escalations since reinstating monthly premiums. These are actively being monitored and diligently mitigated.

Refer to the Health First Colorado Buy-In Program For Working Adults With Disabilities web page for more information about the Health First Colorado Buy-In Program for Working Adults with Disabilities.

Working Adult Buy-In members and advocate questions should be directed to the Colorado Medical Assistance Program (CMAP) at 1-(800) 711-6994.

Hospice Providers

Rate Update Effective October 11, 2024 – June 30, 2025

Centers for Medicare & Medicaid Services (CMS) approval regarding the Hospice rate update effective October 11, 2024, through June 30, 2025, is still pending. The Hospice Fee Schedule will be updated once approval is received.

Reimbursement should reflect updated rates for all claims billed for dates of service on or after October 11, 2024. The updated fee schedule will be posted to the Provider Rates and Fee Schedule web page under the Hospice category upon implementation of the rates.

Hospital Providers

General Updates

Hospital Stakeholder Engagement Meetings

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, June 13, 2025, from 1:00 p.m. to 3:00 p.m. Mountain Time** and will be hosted virtually.

Visit the Hospital Stakeholder Engagement Meeting web page for more details, meeting schedules and past meeting materials. **Calendar Year 2025 meeting dates have been posted**.

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.

Fiscal Year (FY) 25-26 Inpatient (IP) Base Rates

The Fiscal Year (FY) 25-26 Inpatient (IP) Base Rates Health Insurance Portability and Accountability Act (HIPAA) Stakeholder Workbook detailing how rates effective July 1, 2025, have been created will be presented to hospitals during the extra June 13, 2025, Hospital Stakeholder Engagement Meeting.

In mid-June, the Department will send out an email to hospital stakeholders notifying them when the FY 25-26 IP Base Rates effective July 1, 2025 have been posted to the Inpatient Hospital Payment web page for the 30-day review period. Contact Diana Lambe and Andrew Abalos with any questions or concerns.

Rural Health Clinic (RHC) Stakeholder Engagement Meeting

A meeting for Rural Health Clinics (RHCs) has been scheduled for July 10, 2025, from 1:00 p.m. to 2:00 p.m. Mountain Time. Topics of discussion will include an overview of the Rural Health Clinic payment methodology for both hospital-based and freestanding RHCs and operational concerns impacting RHC billing or payment.

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

Pediatric Behavioral Therapy Providers

Provider Type Transition

Pediatric Behavioral Therapy providers who are still enrolled in Provider Type 25, note that the billing codes associated with pediatric behavioral therapies will be closed for provider type 25 as of June 30, 2025.

Contact Martina Schmidt at Martina.Schmidt@state.co.us for assistance enrolling in an approved provider type to ensure payments continue to be received for services. Add **Provider Type Transition** to the subject line. Contacting as soon as possible before June 30, 2025, will ensure a smooth transition and minimize disruptions to practices.

Refer to the Pediatric Behavioral Therapies billing manual or contact Gina Robinson at Gina.Robinson@state.co.us for more information.

Pharmacy Providers

Pharmaceutical Rate Methodology Update

Effective September 1, 2025, the pharmaceutical rate methodology will be updated with a revised calculation of Maximum Allowable Cost (MAC) rates.

Note: This is an update from the previously published 8/15/2025 effective date.

MAC rates will be calculated as follows:

- The generic drug MAC rate will be Wholesale Acquisition Cost (WAC) minus 20 percent.
- The brand name drug MAC rate will be WAC minus 3.5 percent.

Visit the Provider Rates & Fee Schedules web page under the Pharmacy Rate List section for more information regarding outpatient pharmacy reimbursement rates.

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

Pharmacy and All Medication Prescribers

Liraglutide (Generic Victoza) Status Update

Effective May 9, 2025, generic Liraglutide pens were moved to preferred status on the Preferred Drug List (PDL), in addition to the existing preferred products, to help offset an identified supply disruption of other clinical options.

Refer to the PDL at Health First Colorado Preferred Drug List. Contact the Prime Therapeutics Help Desk at 1-800-424-5725 with questions regarding rejected claims or prior authorization.

Preferred Drug List (PDL) Announcement of Preferred Products

Changes will be made for the following PDL classes, effective July 1, 2025

PDL Drug Class	Moved to Preferred	Moved to Non-Preferred
Buprenorphine - injectable- *New State Drug Class*	**Brixadi, Sublocade**	none
Pulmonary Arterial Hypertension (PAH)	**Remodulin**	none
Anti-Psoriatic- oral & topical	**Calcipotriene Foam and Ointment, Calcipotriene/Betamethasone Ointment**	none
Immunomodulators - topical	**Eucrisa, Opzelura**	none
ACEI/ARB Combination Products	**Quinapril/HCTZ, Telmisartan/HCTZ**	none
Rosacea	**Azelaic Acid**	**Mirvaso**
Steroids - topical	**Fluocinolone Acetonide Solution**	**Oralone**
Hemorrhoidal, anorectal and related topical anesthetic agents	**Lidocaine Cream**	**Hydrocortisone/ Pramoxine Cream**
Non-Biologic ulcerative colitis agents	**SF Rowasa**	none

No changes will be made for the following PDL classes:

PDL Drug Class	PDL Drug Class
Tetracyclines	Benign Prostatic Hypertrophy
Statins & combinations	Bile Salts
Movement disorder agents	GI motility, Chronic
Anti-Emetics – oral & non-oral	Oral Isotretinoins
H. pylori	Pancreatic Enzymes
Erythropoiesis stimulating agents	Anti-coagulants
Alpha, beta and calcium Channel Blockers	Anti-platelets
Lipotropics: Bile acid sequestrants, fibrates & other agents	Colony Stimulating Factors
Renin inhibitors and combinations	Acne-Topical

PDL Drug Class	PDL Drug Class
Proton pump inhibitors	

Additional prior authorization criteria for all preferred and non-preferred medications can be found on the Health First Colorado Preferred Drug List. Contact the Prime Therapeutics Help Desk at 1-800-424-5725 with questions regarding rejected claims or prior authorization.

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. PAS has provided SBIRT training and support since 2006. The SBIRT program promotes prevention and early intervention efforts through in-person, online and virtual training; technical assistance; and hands-on SBIRT implementation.

In order to directly deliver screening and intervention services, 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. Face-to-face trainings and consultations are available through various entities such as SBIRT Colorado, Colorado Community Managed Care Network and the Emergency Nurses Association.

Visit the PAS training calendar to register for an upcoming training. 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.

Qualified Residential Treatment Program (QRTP) and High-Intensity Pediatric Residential Treatment Facility (PRTF) Providers

Prior Authorization and Nomenclature Stakeholder Meeting

Qualified Residential Treatment Program (QRTP) and High-Intensity Pediatric Residential Treatment Facility (formerly Psychiatric Residential Treatment Facility) (PRTF) providers are invited to attend a meeting regarding proposed updates to utilization management and ongoing stay requirements for QRTP and PRTF. Upcoming changes to nomenclature for out-of-state providers will be shared. There will be time for policy questions and clarification.

Date and Time: Wednesday, June 18, 2025, from 1:00 p.m. to 2:30 p.m. Mountain Time
Intended Audiences: QRTP and PRTF providers, members, advocacy groups, other impacted communities

Register in advance or at the start of the webinar. Once registered, a confirmation email with information to join the webinar will be received.

The meeting recording will be posted on the QRTP/PRTF Prior Authorization and Nomenclature Stakeholder Meeting web page after the meeting.

Meeting Accommodation and Language Access Notice

Auxiliary aids and services for individuals with disabilities and language services for individuals whose first language is not English may be provided upon request. Notify the meeting organizer Ryan Lazo at Ryan.Lazo@state.co.us or the or the Civil Rights Officer at hcpf504ada@state.co.us at least one (1) week prior to the meeting to make arrangements.

Las ayudas y servicios auxiliares para individuos con discapacidades y servicios de idiomas para individuos cuyo idioma materno no sea inglés pueden estar disponibles por solicitud. Comuníquese con organizador de reuniones; Ryan Lazo; o con el oficial de derechos civiles a hcpf504ada@state.co.us al menos una (1) semana antes de la reunión para hacer los arreglos necesarios.

Speech Therapy

New Coverage for Adult Habilitative Services

Effective July 1, 2025, Health First Colorado will begin covering adult habilitative speech therapy services for adult members when medically necessary. This policy change supports members acquiring, retaining and improving communication skills essential for daily functioning. These services are included in the policy that allows for 12 sessions of speech therapy before a Prior Authorization Request (PAR) is required. All speech therapy providers are reminded that the appropriate modifiers indicating habilitative services (GN+96) are required on all claims and PARs.

Contact Devinne Parsons at Devinne.Parsons@state.co.us with any questions regarding the outpatient speech therapy policy.

Contact HCPF_UM@state.co.us with any questions regarding PARs.

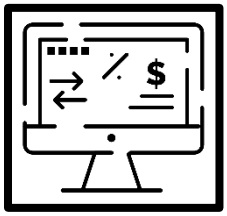
Transportation Providers

Non-Emergent Medical Transportation (NEMT) Billing Codes and Rate Changes

Effective July 1, 2025, all Non-Emergent Medical Transportation (NEMT) providers must follow these billing and coding changes:

- Healthcare Common Procedural Coding System (HCPCS) **A0425** is to be used only for ambulance trip mileage. It is no longer used for non-ambulance trip mileage.
- HCPCS **S0215** is to be used only for all NEMT provider trips that are non-ambulance and non-wheelchair van mileage. It will be priced at $3.00 per unit (per mile). All NEMT providers must begin using this code for billing mileage for non-ambulance and wheelchair trips with dates of service on and after July 1, 2025.
- HCPCS **S0209** is to be used only for wheelchair van trip mileage. It will have a rate increase to $3.00 per unit (per mile).

Effective July 1, 2025, **HCPCS A0425 is no longer covered for non-ambulance trips**. Providers who continue to use HCPCS A0425 for non-ambulance trip mileage will be subject to overpayment recovery which may result in termination for cause from the Health First Colorado program.



Enrollment with Statewide Broker Beginning Fall 2025

Beginning January 1, 2026, the Non-Emergent Medical Transportation (NEMT) program will have a statewide broker. This means that all NEMT services will be scheduled and reimbursed through the statewide broker.

Providers who want to continue providing NEMT services after January 1, 2026, must enroll with the statewide broker. Otherwise, they will not be reimbursed for services they provide on and after January 1, 2026.

The statewide broker will be required to enroll and contract with all enrolled NEMT providers who are valid and in good standing, and there will not be a limit on the number of providers who can enroll with the statewide broker. Provider enrollment and contracting with the statewide broker will begin in the Fall 2025.

More details will be given as the enrollment period gets closer. More information will be provided in the coming months and will be included in Provider Bulletins available on the Provider Bulletin web page.

Updates to Required Non-Emergent Medical Transportation (NEMT) Forms

Updates have been published to the required Non-Emergent Medical Transportation (NEMT) trip forms found on the Provider Forms web page under the Claim Forms and Attachments

drop-down menu. A new standardized form for NEMT Consent and Liability Release for Minors is now available.

Non-Emergent Medical Transportation (NEMT) Operational Memo – Verifying Benefit Eligibility

A new Operational Memo (OM25-028) has been published to instruct Non-Emergent Medical Transportation (NEMT) providers of the required procedures for verifying member benefit eligibility and documenting transportation requests. Following the procedures of this memo is mandatory for all NEMT providers outside of the current broker network (e.g., providers who do not receive trip assignments from the broker and who submit claims directly to the Department).

Contact Courtney Sedon at Courtney.Sedon@state.co.us with any questions.

Span Billing

Span billing (grouping multiple lines with separate dates of service on one [1] claim) is ***not*** allowed for transportation providers.

Claims are to be submitted with one (1) date of service per claim. The From Date of Service (FDOS) needs to be the same as the To Date of Service (TDOS), which is one (1) date of service per claim. The mention of "line" in the manual is advising providers that both the FDOS and the TDOS fields need to be completed with a single date of service. If there are separate codes being billed for the same date of service, an additional line should be added to the claim for the same date of service only.

Credentialing - Completion and Updating

Providers must credential any driver or vehicle used to supply billable Non-Emergent Medical Transportation (NEMT) services. If a driver or vehicle previously credentialed has any document associated with them that expires, the driver or vehicle must be brought back into compliance within 30 days of expiration by uploading the document in ProCredEx with a valid date.

All providers must continue to upload their monthly Office of Inspector General (OIG) and System of Award Management (SAM) Exclusion Screenings to ProCredEx.

The Department and Transdev Health Solutions are making a change to the process for vehicle inspections for brand new vehicles. All vehicles purchased brand new with proof of the vehicle never being put into service from a dealership, distributor, manufacturer or retrofitter will be eligible for a virtual vehicle inspection. These virtual vehicle inspections are only available for brand new vehicles.

Credentialing with ProCredEx Best Practices

Providers should upload a single file folder for each driver and vehicle on their roster when submitting credentialing documents in the Transdev Health Solutions ProCredEx system. Each folder should contain all relevant documents for that specific driver or vehicle. This streamlined approach enables faster and more accurate credential processing for both providers and Transdev Health Solutions review agents.

Contact Mattew Paswaters at Mattew.Paswaters@state.co.us with any questions.

Billing Status Changes

Billing status changes will be delayed and further reviewed due to fraud, waste and abuse concerns of Non-Emergent Medical Transportation (NEMT) services billing in addition to the moratorium currently in effect regarding NEMT provider enrollment. The Department will not be allowing any NEMT provider to add billing capabilities. Do not call the Provider Services Call Center with these questions as they cannot make these changes. Contact NEMT@state.co.us with any questions.

Non-Emergent Medical Transportation (NEMT) Billing Guidelines for the Denver County Areas

Transdev is responsible for administering Non-Emergent Medical Transportation (NEMT) in nine (9) Colorado counties: Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson, Larimer and Weld. Transdev utilizes the least costly, medically appropriate means of transportation for each member and arranges those transportation services. Transdev Health Solutions is the Department's State Designated Entity as its contracted NEMT broker.

All providers within these nine (9) counties must contract with Transdev for all billing and may not submit claims directly to Gainwell Technologies. Changes to billing status are not being made. Contact NEMT@state.co.us with any additional questions.

Women's Health

Lactation Support Services Billing Update

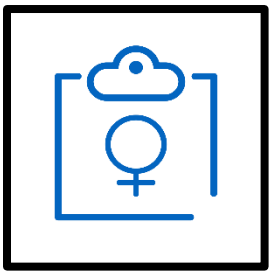
Claims billed with the lactation support services procedure code S9443 are denying for Explanation of Benefits (EOB) 2022 – "A National Correct Coding Initiative (NCCI) Medically Unlikely Edit (MUE) that sets when the units of service are billed in excess of established standards for services that a member would receive on a single date of service for a given CPCS/CPT code."

A second position modifier and corresponding rate have been added to procedure code S9443 to reflect the time spent in direct member contact. More information on how to use the second modifier can be found in the updated Lactation Support Services Billing Manual.

Providers may update denied claims with the new modifiers and resubmit them electronically as new claims.

Issue resolved 4/25/2025.

Lactation/Doula Cross-Billing



International Board Certified Lactation Consultants (IBCLC), Certified Lactation Counselors (CLC) or Certified Lactation Educators (CLE) enrolled as lactation support service providers who meet Doula qualifications per 10 C.C.R. 2505-10 8.734.4 may provide Doula services without separate Provider Type 79 enrollment. Enrolled Doula providers who meet IBCLC, CLC, or CLE qualifications per 10 C.C.R. 2505-10 8.732.9 may provide lactation support services without separate Provider Type 70 or 71 enrollment.

Refer to the Lactation Support Services and Doula billing manuals for further information.

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

Provider Training Sessions

June 2025 Schedule

Providers are invited to sign up for provider training sessions. The following training sessions focused on Health First Colorado will be offered in June:

- Beginner Billing Training for Institutional Claims
- Intermediate Billing Training

All sessions are held via webinar on Zoom, and registration links are shown in the calendar below and on the Provider Training web page. *The availability of training sessions varies monthly.*

Provider Enrollment

Provider enrollment training is designed for providers at various stages of the initial enrollment process with Health First Colorado. It provides an overview of the 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. Note that it does not provide guidance on revalidation for already enrolled providers.

Beginner Billing Training

There are two (2) beginner billing training sessions offered. One (1) is for providers that submit professional claims (CMS 1500), and the other is for providers that submit institutional claims (UB-04). These training sessions are identical except for claim submission specifics.

Click "Which Beginner Billing Training Do I Need?" on the Provider Training web page to find training aligned to provider type.

Beginner billing training provides a high-level overview of member eligibility, claim submission, prior authorizations, Department website navigation, Provider Web Portal use and more.

Staff who submit claims, are new to billing Health First Colorado services or who need a billing refresher course should consider attending one (1) of the beginner billing training sessions.

Intermediate Billing Training

Intermediate billing training covers claims processing and Remittance Advice (RA) via the Provider Web Portal and batch, secondary billing with commercial insurance and Medicare, attachment requirements, timely filing, suspended claims, adjustments and voids, reconsiderations, resubmissions and more.

Billing Training: Medicare and Third-Party Liability

This focused 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.

Note: This training is not relevant to Home and Community-Based Services (HCBS) and Non-Emergent Medical Transportation (NEMT) providers.

Provider-Specific Training

Provider-specific training sessions cover topics unique to providers.

Note: These 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.

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.

Note: Webinars may end early. Time has been allotted for questions at the end of each session.

June 2025				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
2	3 Intermediate Billing Training Tuesday, June 3, 2025 9:00 – 11:00 a.m.	4	5 Beginner Billing Training: Institutional Claims Thursday, June 5, 2025 9:00 - 11:30 a.m.	6
9	10	11	12	13
14	15	16	17	18
21	22	23	24	25
28	29	30		

Upcoming Holidays

Holiday	Closures
Juneteenth June 19, 2025	State Offices, Acentra, AssureCare, DentaQuest, and Optum will be closed. 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. Acentra, Gainwell and Prime Therapeutics will be open.
Independence Day July 4, 2025	State Offices, Acentra, AssureCare, DentaQuest, Gainwell, Optum and Prime Therapeutics will be closed. Capitation cycles for managed care entities may potentially be delayed. The receipt of warrants and EFTs may potentially be delayed due to the processing at the United States Postal Service or providers' individual banks.

Provider Services Call Center
1-833-468-0362