COLORADO
Department of Health Care Policy & Financing

Provider Bulletin

Reference: B2500525

July 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?

Providers are reminded to verify the status of licenses on file with Health First Colorado (Colorado's Medicaid program). Some claims are currently denying for Explanation of Benefits (EOB) 3385 – "Provider license not active on date of service."

Licenses can be manually updated through the Provider Web Portal by doing a provider maintenance request. Providers are urged to check the status of provider licenses on file and update as needed. Providers (including Free-standing Birth Centers [FSBCs] licensed through the Colorado Department of Public Health and Environment [CDPHE]) require current, updated licenses for claim reimbursements. Providers must resubmit any previously denied claims once license updates are completed.

All Providers

Fiscal Year 2025-2026 Provider Rate Adjustments

Health First Colorado Across-the-Board (ATB) provider rate increases were approved during the 2024-2025 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 Schedules 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) does 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 Complex Health Needs (CwCHN)
- HCBS – Children's Habilitation Residential Program (CHRP)
- HCBS - Community Mental Health Supports (CMHS)
- HCBS – Complementary and Integrative Health (CIH)
- HCBS - Developmental Disability (DD)
- HCBS - Elderly, Blind and Disabled (EBD)
- HCBS - Supported Living Services (SLS)

A targeted rate increase will be effective for the following HCBS waiver, 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:

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

The Department of Health Care Policy & Financing (the Department) will continue to publish updates as they become effective.

Community Health Workers in Medicaid: Postponed

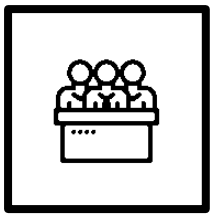
Due to the State's budget shortfall, the Colorado General Assembly passed legislation (SB 25-229) that postpones Health First Colorado reimbursement for Community Health Workers (CHW) until January 1, 2026. The Health First Colorado reimbursement for CHW services will not begin on July 1, 2025. It is anticipated that it will begin around January 1, 2026. Contact HCPF_CHW_Benefit@state.co.us with any questions about the CHW benefit being postponed until January 1, 2026.

Member Correspondence Meetings

A series of quarterly virtual stakeholder meetings are being held by the Department to present information about ongoing improvements to member correspondence.

Department staff will share:

- Updates on improvements being made
- Timelines for making changes
- Plans for future improvements



Attendees will have the opportunity to provide feedback on member correspondence in smaller workgroups. Registered attendees will receive materials to review at least one (1) week in advance of the meeting. Attendees are encouraged to come prepared to provide feedback. Attendees will also be able to submit feedback via a Google form for two (2) weeks following the meeting.

The meetings will be held in English and Spanish. American Sign Language (ASL) interpretation will be provided.

Meeting dates and times (in Mountain Time):

- Thursday, July 17, 2025, 12:00 p.m. to 1:30 p.m.

- Thursday, October 16, 2025, 12:00 p.m. to 1:30 p.m.
- Thursday, January 15, 2026, 12:00 p.m. to 1:30 p.m.

Register for the meetings in advance. A unique link to join the meeting will be received after registering.

A recording may be requested if unable to attend a 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 Ryan Lazo at HCPF_Stakeholders@state.co.us at least one (1) week prior to the meeting to make arrangements.

Contact the Stakeholder Engagement Section at HCPF_Stakeholders@state.co.us with general questions or for more information.

Prevention Services Toolkit

Health First Colorado reimburses for all United States Preventive Services Task Force (USPSTF or Task Force) grade A and B preventive services without cost sharing. The Prevention Services Toolkit has been created to list the procedure codes that may be used in the management of USPSTF A and B recommendations. Reimbursement rates for the procedure codes listed in the toolkit can be found on the Health First Colorado Fee Schedule. It is the provider's responsibility to bill the correct procedure code.

The Task Force works to improve the health of people nationwide by making evidence-based recommendations on effective ways to prevent disease and prolong life. The Task Force assigns each recommendation a letter grade (A, B, C or D grade or I statement) based on the strength of the evidence and the benefits and harms of a preventive service. Additional information about the Task Force and the letter grades can be found on the USPSTF About Us web page.

The Prevention Services Toolkit can be found on the Prevention Services and the U.S. Preventive Services Task Force web page.

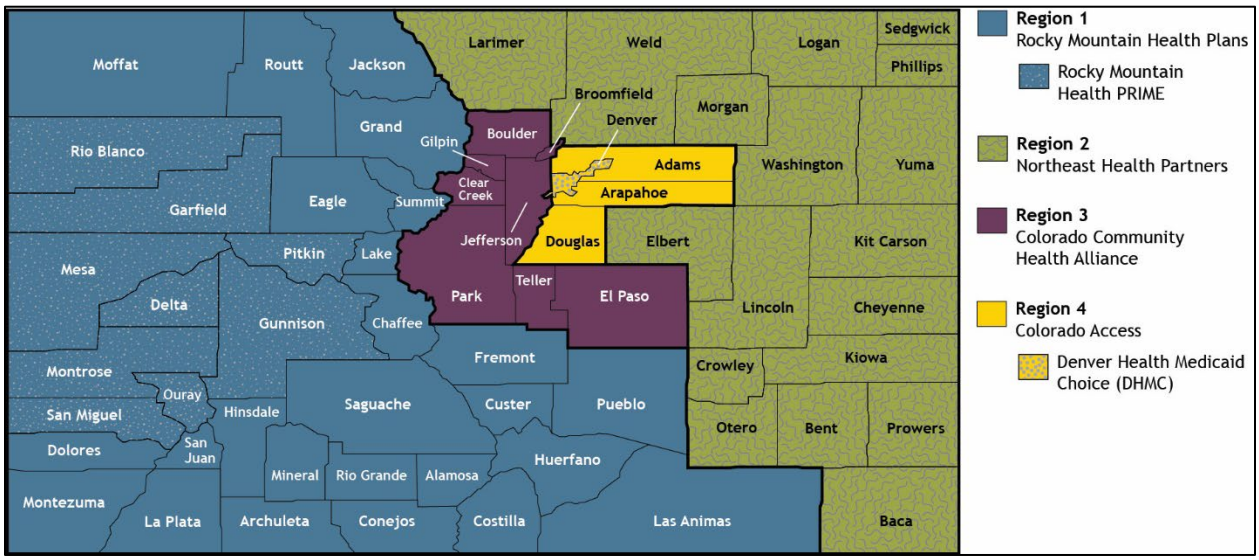
Contact Morgan Anderson at Morgan.Anderson@state.co.us with any questions.

Reminder: Phase III of the Accountable Care Collaborative (ACC) goes live on July 1, 2025

Created in 2011, the Accountable Care Collaborative (ACC) is the primary delivery system for Health First Colorado. Regional Accountable Entities (RAEs) are responsible for promoting member health and well-being by administering the capitated behavioral health benefit,

establishing and supporting networks of providers and coordinating medical and community-based services for members in the region.

Current contracts with the RAEs, referred to as Phase II, will end on June 30, 2025. New contracts, referred to as Phase III, will launch on July 1, 2025. As part of this transition, the number of RAEs will be reduced from seven (7) to the following four (4) regions:



Complete the Accountable Care Collaborative (ACC) Phase III Triage Center form if experiencing an urgent or critical issue as part of the transition to ACC Phase III. System-wide issues impacting multiple providers will be documented in the ACC Phase III Change Management Issues and Resolutions Log once identified.

Contact the appropriate RAE with questions about this transition, including questions about member attribution and payment.

Other Resources:

- Factsheets available on the ACC Provider and Stakeholder Resource Center web page:
    - ACC Phase III Member Attribution
    - ACC Phase III Primary Care Medical Provider (PCMP) Payment Structure
    - ACC Phase III Care Coordination Tiers
    - ACC Transition of Care Policy
- Resources available on the ACC Member Messaging Resource Center web page:
    - ACC Phase III Member Communications Toolkit
    - Regional Organization 101 Factsheet
    - Link to the ACC Phase III 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.

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

Important dates for Prior Authorization Request (PAR) resumption for Long-Term Home Health Therapies

The soft launch period has concluded, and the PAR process for Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST) services is now fully active. All Home Health Agencies (HHAs) are required to submit at least 10% of their Long-Term Home Health (LTHH) therapy caseload for PARs each month. This submission rate should continue until all cases have undergone medical necessity reviews, with all PARs fully submitted no later than May 4, 2026. Refer to Operational Memo 25-033 for detailed information on the timeline, expectations and enforcement of the reinstated PAR requirements and medical necessity review process.

Go-Live for PARs of Registered Nurse (RN) and Certified Nursing Assistant (CNA) services is planned for August 1, 2025. There will be additional steps needed to meet PAR requirements for LTHH CNA, LTHH RN and Private Duty Nursing (PDN):

Skilled Care Acuity Assessment and Nurse Assessor

- The Skilled Care Acuity Assessment will be completed by Telligen (the Nurse Assessor vendor), and the associated Recommendation Letter will be required when submitting a PAR for LTHH CNA, LTHH RN and PDN services. Reference the Training section below for associated training dates. Visit the Nurse Assessor web page for more information. **Note:** The Skilled Care Acuity Assessment and Recommendation Letter are required when submitting a PAR as part of the clinical documentation to be considered with the rest of the body of evidence for the PAR. The Recommendation Letter does not constitute a medical necessity determination and does not directly authorize services. It serves as a supporting document within the full clinical review.
    - Before a PAR can be submitted, the HHA or Case Manager must first submit a referral for a Nurse Assessor. After the assessment is completed, the Skilled Care Acuity Assessment and Recommendation Letter will be made available and must be included with the PAR submission.
- The new Skilled Care Acuity Assessment will replace all previously used acuity tools in the PAR process for skilled services. This includes both the 2003 pilot PDN Acuity Tool and the Pediatric Assessment Tool (PAT).

Reference Operational Memo OM 25 - 037 and Operational Memo OM 25 - 036 for more details. Communication will continue via the Memo Series, and stakeholders may submit questions to HomeHealth@state.co.us.

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

Nurse Assessor Referral Training Web Page

Provider Type	Training dates, times and registration link	Description
Authorized User Training with Telligen * All entities who will submit referrals must attend this training.	• Presentation • Webinar Recording	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	• Webinar Recording	This session is designed to provide Hospital Case Managers and Discharge Planners with the necessary knowledge to submit a referral, including specific instances when hospital staff would be appropriate to submit referrals.
Case Managers, CMAs and RAEs	• July 15, 2025, 9:00 a.m. - 10:00 a.m. • July 17, 2025, 9:00 a.m. - 10:00 a.m.	These sessions are designed to provide Case Managers, CMAs and RAEs with the necessary knowledge and skills to successfully submit an assessment referral using Qualitrac on behalf of a member.
HHAs and Providers	• July 17, 2025, 3:00 p.m. - 4:00 p.m. • July 22, 2025, 9:00 a.m. - 10:00 a.m.	These sessions are designed to provide HHAs and providers with the necessary knowledge and skills to successfully submit an assessment referral using Qualitrac on behalf of a member.

Provider Type	Training dates, times and registration link	Description
Members and Legal Representatives	• July 28, 2025, 2:00 p.m. - 3:00 p.m.	This session is designed to assist members and their legal representatives in understanding how to navigate the 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 Training web page.

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

Prior Authorization Request (PAR) Submission Training for Acentra

Acentra Health will provide general Prior Authorization Request (PAR) submission training for all providers and benefit-specific training for Long-Term Home Health (LTHH) in July. The training dates and times are listed below in Mountain Time:

- LTHH Open Hours - July 1, 2025, at 3:00 p.m.
- LTHH Open Hours - July 9, 2025, at 9:00 a.m.
- LTHH Training - July 16, 2025, at 12:00 p.m.
- LTHH Training - July 22, 2025, at 9:00 a.m.
- Portal Registration and PAR Submission - July 23, 2025, at 9:00 a.m.
- Portal Registration and PAR Submission - July 23, 2025, 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 Health'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

Certified Community Behavioral Health Clinics (CCBHCs) Planning Grant Project Stakeholder Engagement Opportunities

The Behavioral Health Administration (BHA) and the Department continue to learn from stakeholders while working together on the Certified Community Behavioral Health Clinics (CCBHCs) Planning Grant Project. Feedback is being sought from all stakeholders, including providers, advocates, those who receive behavioral health services and their families. Join any of the following stakeholder engagement opportunities. All times are listed in Mountain Time.

Monthly CCBHC Stakeholder Meetings are held on the last Wednesday each month from 1:00 p.m. to 2:00 p.m.
The Department and BHA host a monthly public meeting for all stakeholders to review progress and share input on CCBHC Planning Grant efforts. The forum is open to members, providers, individuals with lived experience and their families, advocates, state agencies, managed care entities and anyone interested in learning more about the CCBHC model in Colorado. Register in advance to attend the monthly CCBHC Stakeholder Meeting.

Monthly CCBHC Steering Committee (CCBHC-SC) Meetings are held on the last Monday each month from 3:00 p.m. to 4:00 p.m.

A CCBHC Steering Committee (CCBHC-SC) meets monthly to provide input throughout the CCBHC planning process. CCBHC-SC meetings are open for public observation with time reserved for comments and questions. Register in advance to attend the monthly CCBHC Steering Committee Meeting.

The CCBHC-SC is guided through contractor consultation, state leadership, stakeholder feedback and the work of the following subcommittees:

- **Prospective Payment System and Finance Subcommittee**
  - Meetings are held on the third Wednesday each month at 2:00 p.m.
  - Register in advance to attend Prospective Payment System and Finance Subcommittee meetings.
- **Certification and Provider Readiness Subcommittee**
  - Meetings are held on the first Tuesday each month at 2:00 p.m.
  - Register in advance to attend Certification and Provider Readiness Subcommittee meetings.
- **Quality Measure Data Management Subcommittee**
  - Meetings are held on the third Tuesday each month at 2:00 p.m.

- Register in advance to attend Quality Measure Data Management Subcommittee meetings.

Subcommittees will include subject matter experts from clinics and organizations who render care to the CCBHC Planning Grant's populations of focus and Colorado's priority populations, as well as urban, rural and frontier communities, to ensure CCBHC-SC and subcommittees are reflective of Colorado's geographic and cultural diversity.

All CCBHC meetings are open to the public. The feedback and participation of all stakeholders from all levels and perspectives is appreciated.

Colorado System of Care Implementation Plan Release

The Colorado System of Care (CO-SOC) Implementation Plan Version 1.0 is now available on the Improving Intensive Behavioral Health Services for Medicaid (IBHS) web page.
The Implementation Plan was created as part of the G.A. et al v. Bimestefer (1:21-cv-02381) Settlement Agreement regarding Medicaid coverage for children in need of Intensive Behavioral Health Services (IBHS). The Implementation Plan, as outlined in the Settlement Agreement, is the Department's plan for implementing a model based on clinical best practices and evidence-supported practices for delivering IBHS to Medicaid members as determined by the Department in consultation with the Consultant and Plaintiffs' Counsel.

All stakeholders, families and community partners are encouraged to stay informed. Sign up for the Colorado System of Care (CO-SOC) for Children and Youth Behavioral Health newsletter. Visit the Improving Intensive Behavioral Health Services for Medicaid (IBHS) web page for meeting links, agendas, updates and resources. Email questions and comments to HCPF_CO_SOC@state.co.us.

Important Updates About Behavioral Health Crisis Services in Colorado

The 988 Colorado Mental Health Line will become the primary way to connect to free emotional, mental health or substance use support 24/7 as a result of Colorado Senate Bill (SB) 25-236. Get connected and learn more at 988Colorado.com.

What does this mean for the Colorado Crisis Services (CCS) line? Beginning July 1, 2025, individuals contacting the Colorado Crisis Services line at 1-844-493-8255 or via text at 38255 will be connected to receive services via 988 Colorado.

What are the impacts to the CCS Peer Support Line? Starting July 1, 2025, individuals seeking peer support services can call 988. The peer support line that is currently accessed through Colorado Crisis Services will continue to be available during the consolidation process. Individuals are encouraged to make the transition to 988.

When can more updates be expected? The 988 team is providing monthly updates on the 988 Colorado Crisis Services web page until the transition is complete. A monthly 988 Colorado newsletter has been launched, and the first one was sent the second week of June. Sign up to receive the newsletter. Contact the 988 team at 988Colorado@state.co.us with any questions.

Medicaid Sustainability: Behavioral Health and Managed Care Actions Memo

The Medicaid Sustainability: Behavioral Health and Managed Care Actions Memo was prepared by the Department to share expectations for the coming 2025-2026 fiscal year to maintain alignment with the Medicaid Sustainability Framework with the Regional Accountable Entity (RAE) managed care entities. This memo helps frame the Department's policy strategies to successfully navigate Colorado's fiscal challenges, as well as the evolving Federal Medicaid funding threats, for all stakeholders. It is critical at this time that the Department evaluates and monitors the impact of the implemented changes on Medicaid behavioral health cost trends and the shared Medicaid Sustainably Framework and goals. The Medicaid Sustainability Memo can be accessed on the Department's Behavioral Health web page. Contact HCPF_BHBenefits@state.co.us with any questions.

Stakeholder Engagement Forum: 1115 Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED) Demonstration

Please join the Department for the Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) Stakeholder Engagement Forum. This will be a monthly forum and creates a stakeholder engagement opportunity to inform implementation planning for the SMI/SED demonstration under Colorado's 1115 Waiver.

Interested stakeholders are encouraged to sign up in advance.

The National Correct Coding Initiative (NCCI)

Beginning July 1, 2025, the Department is requiring Regional Accountable Entities (RAEs) to implement all National Correct Coding Initiative (NCCI) edits. The Centers for Medicare & Medicaid Services (CMS) created NCCI to reduce improper payments stemming from incorrect coding and billing practices. NCCI prevents reimbursement for inappropriate combinations of

Current Procedural Terminology (CPT) codes. The following are the three (3) types of NCCI edits:

- **Add-on Code (AOC)** edits ensure add-on codes are not billed without a primary procedure code.
- **Medically Unlikely Edits (MUEs)** prevent inappropriate payments when services are reported with an unusually high number of units of service.
- **Procedure to Procedure (PTP)** edits prevent code pairs that should not be reported together on the same date of service.

Beginning October 1, 2025, the Department is instituting *Colorado-specific* MUEs and PTPs. The Department anticipates communicating the details of these edits in July 2025.

Visit the CMS NCCI for Medicaid web page for more information on NCCI edits.

Durable Medical Equipment (DME) Providers

General Updates

Continuous Glucose Monitors (CGM): Reminder

All Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) providers are reminded that procedure codes A4238 and A4239 are limited to one (1) unit of service per one (1) month of supply per federal limits. Refer to the DMEPOS HCPCS Table for additional guidance.

Continuous Glucose Monitors (CGM): Fee-for-Service Billing and Managed Care Plans

Beginning November 1, 2025, all Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) providers who supply CGMs and CGM supplies will need to submit fee-for-service claims for **all** members who are enrolled in a physical health managed care plan (Denver Health and Rocky Mountain Health Plans). This is a change from the current carve-in method for CGMs supplied to children.

Additionally, beginning November 1, 2025, all professional claims submitted for CGM products and supplies must include the National Drug Code (NDC) of the product (unless an NDC is not assigned to it) in addition to the Healthcare Common Procedure Coding System (HCPCS) procedure code. The DMEPOS Billing Manual will be updated to contain a crosswalk of CGM products and related NDCs and HCPCS as a reference. Providers must indicate the NDC that appears on the actual product when billing for the item and should not rely on the billing manual crosswalk. Providers may begin submitting NDC numbers on CGM claims at any time prior to November. Additional information will be released in the coming months.

House Bill 22-1290 Compliance Reminder for Complex Rehabilitative Technology (CRT) Providers

As a reminder, CRT providers should have submitted repair metrics data for the period December 1, 2024, through May 31, 2025, by June 30, 2025. Submit this data to HCPF_DME@state.co.us to comply with House Bill 22-1290, 10 CCR 2505-10 8.590.5.E.3.a.

Across-the-Board (ATB) Provider Rate Increase and Manually Priced Percentages

The Joint Budget Committee approved a 1.6% Across-the-Board (ATB) rate increase for all Health First Colorado benefits beginning July 1, 2025, during the 2024-2025 legislative session. This rate increase applies to manually priced claims that follow the Manufacturer's Suggested Retail Price (MSRP) less or invoice acquisition plus methods only.

Method/Source	2025 Increase (1.6% Increase)
Durable Medical Equipment	
MSRP less	13.56%
Invoice acquisition cost plus	24.45%
Prosthetics	
MSRP less	13.56%
Invoice acquisition cost plus	24.45%

Covered Benefit: Human Milk Fortifier Products

Human Milk Fortifier products are now a covered benefit using Healthcare Common Procedure Coding System (HCPCS) code B4155. Effective June 1, 2025, these products can be provided with Health First Colorado as the primary payer instead of using the Women, Infants and Children (WIC) program. Providers are encouraged to reference Colorado Specific Guidelines for these products.

Documentation for Wheelchairs

All Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) providers are reminded that thorough and proper documentation should be submitted to support the need for a requested wheelchair, including any **environmental challenges** that the member may experience. Refer to the Wheelchair Benefit Coverage Policy for more information.

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

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

Changes to Short-Term Behavioral Health (STBH) and Integrated Care Billing

Effective July 1, 2025, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) should bill all Short-Term Behavioral Health (STBH) visits to the appropriate Regional Accountable Entity (RAE). Additionally, FQHCs and RHCs may be reimbursed by Health First Colorado for Health Behavior Assessment & Intervention (HBAI) and Collaborative Care Model (CoCM) codes at the encounter rate. These sessions will not require a covered behavioral health diagnosis and should be billed to the Department using the 900-revenue code. Integrated care services (HBAI and CoCM) at FQHCs and RHCs will follow standard reimbursement policies, including those outlined in 10 CCR 2505-10 8.700.

Refer to the FQHC/RHC billing manual for further details regarding billing for STBH and integrated care services. Contact HCPF_IntegratedCare@state.co.us with questions.

Primary Care Fund Supplemental Payment

The maximum total payment amount for the Primary Care Fund Program shall be $38,248,473 for State Fiscal Year 2025-2026.

Contact Daniel Harper at Daniel.Harper@state.co.us or 303-866-4427 for more information.

Home and Community-Based Services (HCBS) Providers

2025 Direct Care Worker Base Wage Attestation Compliance

All Home and Community-Based Services (HCBS) providers delivering any of the base wage qualifying services must complete the 2025 Workforce Report and attach a completed 2025 Base Wage Attestation Form. A link to the 2025 Workforce Report and instructions for submission will be sent to the email address on file in the Provider Web Portal. Visit the Direct Care Workforce Base Wage web page to find base wage qualifying services and information about this requirement.

The 2025 Workforce Report and the 2025 Base Wage Attestation Form will be available on July 1, 2025, and are due by August 31, 2025. HCBS service providers that do not meet reporting or base wage requirements are subject to audit, corrective action, suspension of claims or recoupment. All HCBS providers that have not submitted the required attestation form will be posted publicly and claim payment suspensions will start on September 15, 2024.

Refer to the Direct Care Workforce Base Wage Frequently Asked Questions (FAQs) on the Direct Care Workforce Base Wage web page or contact HCPF_BaseWage@state.co.us with any questions.

Home and Community-Based Services (HCBS) Billing Manual Updates – Services Transitioning to Community First Choice (CFC)

Certain services currently available on the Home and Community-Based Services (HCBS) waivers will gradually transition to Community First Choice (CFC) between July 1, 2025, and June 30, 2026. From July 1, 2026, those services will only be available through CFC. The billing manuals have been updated to indicate which services will be transitioning away from the HCBS waivers in July 2026.

Transitions will occur at members' Continued Stay Reviews. Providers are advised to continue billing in accordance with approved service plans for members during the transition year.

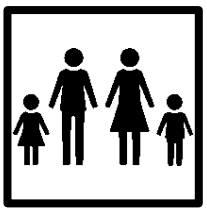
Community First Choice

Effective July 1, 2025, CFC provides select HCBS and service delivery options to Health First Colorado members who meet the eligibility criteria.

Providers may already be eligible to serve CFC members and are encouraged to review the Community First Choice Billing Manual to confirm.

CFC does not create a new eligibility category under Health First Colorado and does not increase the financial eligibility threshold for members seeking Long-Term Care. Members must either be eligible for Health First Colorado or an HCBS waiver, receiving at least one (1) waiver service per month and meet an institutional Level of Care (LOC) as determined by a Case Management Agency (CMA) to be financially eligible for CFC. LOC determinations are made annually by the CMA using the state prescribed LOC assessment.

CFC services are available to members of all ages and are not based on disability or diagnosis. The receipt of CFC services is not permitted in institutional settings such as nursing facilities and hospitals. The services must be provided by certified Health First Colorado providers when a member chooses to receive services under CFC.



Service planning, Prior Authorization creation and case management for CFC members are provided by CMAs in the same manner HCBS members are supported.

Receipt of CFC services does not prohibit members from receiving services across other Health First Colorado programs or authorities, such as HCBS waiver programs. Members may receive HCBS services on one (1) waiver at the same time as CFC as long as the services are not duplicative. Such members must meet all required targeting criteria for each waiver to be eligible, as well as the receipt of one (1) monthly waiver service.

A new billing manual for CFC has been posted on the Department's Billing Manuals web page under the dropdown "HCBS and CFC." Providers seeking additional information about CFC are

advised to consult the Community First Choice Option web page, review Released Memos and read Provider Bulletins to stay informed.

Community First Choice (CFC)

Community First Choice (CFC), also known as 1915(k), is an optional Medicaid program that allows states to offer select home and community-based attendant services and supports to eligible members on the State Plan, expanding these long-term care services to more Health First Colorado members.

Promoting self-direction, relocation out of institutions and person-centered practices are significant goals of CFC. Members will have the option to self-direct attendant care services or to receive services through an agency. CFC gives members access to service delivery models that allow for controlling budget, selecting and dismissing attendants and providing training for the people who provide care. By expanding these options, members will experience greater choice and control over how services are received.

The CFC option provides an increase in Federal matching payments to states for CFC service expenditures. The Department is currently working to implement CFC by **July 1, 2025,** with the authority from Senate Bill 23-289.

The Centers for Medicare & Medicaid Services (CMS) approved the CFC State Plan Amendment in December 2024.

Most providers who are already enrolled to serve members on the Home and Community-Based Services (HCBS) waivers will be credentialed to serve CFC members and should continue to work with each member's Case Management Agency (CMA) to obtain Prior Authorizations and Service Plans for CFC Members. Providers should review the posted Community First Choice Billing Manual to identify the appropriate services that can be billed under CFC.

The only provider requirements that are changing under CFC are for Personal Care services and impacted providers should review "PM 25-001" linked below for more information.

Community First Choice (CFC) Resources:

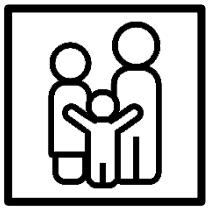
- Community First Choice (CFC) Fact Sheet - February 2025
  - Spanish Version - CFC Fact Sheet - February 2025
- Community First Choice (CFC) Frequently Asked Questions (FAQs) - Updated May 22, 2025
- Community First Choice (CFC) web page

Community First Choice (CFC) Provider Resources:

- HCPF OM 25-030: Community First Choice (CFC) Operational Memo - Updated May 20, 2025 (direct link)

- HCPF PM 25-001: Upcoming Licensure Requirement for Personal Care Service Providers Under Community First Choice (direct link)
- Community First Choice (CFC) Billing Manual

Children with Complex Health Needs (CwCHN) Waiver



The Children with Complex Health Needs (CwCHN) waiver will be a new waiver that encompasses the current Children's Home and Community-Based Services (CHCBS) waiver member population and the Children with Life-Limiting Illness (CLLI) waiver member population. The services on the new CwCHN waiver will be the same as the current CLLI waiver services with the addition of the Wellness Education Benefit. Eligibility will be expanded to capture both the current CHCBS and CLLI waiver populations. Members who currently receive In-Home Support Services (IHSS) through the CHCBS waiver will receive the benefit through Community First Choice (CFC), including continued access to parent caregiver. **This waiver will be implemented July 1, 2025.**

Children with Complex Health Needs (CwCHN) Waiver Resources:

- Children with Complex Health Needs (CwCHN) Waiver Fact Sheet - February 2025
  - Spanish Version - CwCHN Waiver Fact Sheet - February 2025
- Children with Complex Health Needs (CwCHN) web page

Children with Complex Health Needs (CwCHN) Provider Resources:

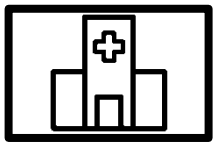
- HCPF OM 25-024: Children with Complex Health Needs (CwCHN) Waiver Operational Memo (direct link) for more details regarding billing
- Upcoming – Children with Complex Health Needs (CwCHN) Billing Manual

Hospitals

Hospital Stakeholder Engagement Meetings

Bi-monthly Hospital Stakeholder 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, July 11, 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) 2025-2026 Inpatient (IP) Base Rates 30-Day Review

In mid-June, the Department sent an email to hospital stakeholders notifying them when the Fiscal Year (FY) 2025-2026 Inpatient (IP) Base Rates, effective July 1, 2025, were posted to the Inpatient Hospital Payment web page for the 30-day review period.

The FY 2025-2026 IP REBASING HIPAA version Excel workbook detailing how rates effective July 1, 2025, were created was presented to hospitals during the extra June 13, 2025, Hospital Stakeholder Engagement Meeting.

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 RHC payment methodology for both hospital-based and freestanding RHCs and operational concerns impacting RHC billing and payment.

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

CPT Codes 97550, 97551 and 97552 for Outpatient Hospitals

Current Procedural Terminology (CPT) codes 97550, 97551 and 97552 for caregiver training were opened in error for outpatient hospital claims beginning January 1, 2024. Effective July 1, 2025, these codes are closed. Outpatient hospital claims may continue to pay for these codes until the implementation of the Enhanced Ambulatory Patient Grouping (EAPG) version 3.18 update and related reprocessing has been completed.

The EAPG version 3.18 update has been discussed during the Hospital Stakeholder Engagement Meetings. Visit the Hospital Stakeholder Engagement Meetings web page to review webinar recordings of the meetings.

Contact Jessica Short at Jessica.Short@state.co.us and Diva Wood at Diva.Wood@state.co.us with questions or concerns.

Supplemental Payment Information

Family Medicine Residency Program Supplemental Payment

The maximum total payment amount for the Family Medicine Residency Program shall be $5,166,153 for State Fiscal Year 2025-2026.

State University Teaching Hospital Supplemental Payment

The maximum total payment amount for the State University Teaching Hospital Program shall be $1,324,017 for State Fiscal Year 2025-2026.

Rural Family Medicine Residency Development Supplemental Payment

The maximum total payment amount for the Rural Family Medicine Residency Development Program shall be $3,000,000 for State Fiscal Year 2025-2026.

Pediatric Major Teaching Supplemental Payment

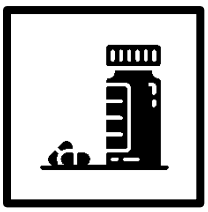
The maximum total payment amount for the Pediatric Major Teaching Program shall be $13,455,012 for State Fiscal Year 2025-2026.

Contact Daniel Harper at Daniel.Harper@state.co.us or 303-866-4427 for more information.

Physician-Administered Drug (PAD) Providers

Change to Appendix X - HCPCS/NDC Crosswalk for Billing Physician-Administered Drugs

Effective July 1, 2025, the Outpatient Hospital Carve Out (OPHCO) benefit descriptor on Appendix X - HCPCS/NDC Crosswalk for Billing Physician-Administered Drugs, the Healthcare Common Procedure Coding System (HCPCS) and National Drug Code (NDC) Crosswalk, will change to Hospital Specialty Drug (HSD). This change aligns the benefit descriptor with the policy name update.



The Crosswalk provides guidance on valid and reimbursable HCPCS/NDC combinations covered under the Physician-Administered Drug (PAD) benefit and pertains to claims billed on the CMS 1500 professional claim form, the UB-04 institutional claim form and 837P/837I batch transactions.

Providers must bill for the NDC and quantity of the PAD administered to the member, and the PAD must be used for a United States 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. All information regarding the PAD benefit can be found on the PAD Resources web page. All respective PAD, Hospital Specialty Drug, 340B and IP/OP Hospital policies apply.

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

Physician-Administered Drug (PAD) 2025 Quarter 3 Rate Update

The Physician-Administered Drug (PAD) rates for the third quarter of 2025 have been updated. The new rates are effective July 1, 2025, and are posted to the Provider Rates & Fee Schedule web page under the Physician Administered Drug Fee Schedule section.

Physician Services

Anesthesia Code 00126 Retroactive Rate Update

The rate of Anesthesia Code 00126 will be retroactively adjusted from $28.63 to $21.11 in alignment with all anesthesia rates being rebalanced according to 2024-2025 legislative appropriations. Claims for dates of service between July 1, 2024, through June 30, 2025, will be reprocessed. Refer to the Health First Colorado Fee Schedule for rates as they become effective.

Contact the Provider Services Call Center with any questions.

Colorado Medicaid eConsult Update

Health First Colorado providers can access a free, secure statewide electronic consultation platform via ColoradoMedicaidConsult.com. The eConsult platform allows Primary Care Medical Providers (PCMPs) to consult electronically with specialists, often reducing the need for in-person referrals for members.

Effective July 1, 2025, Colorado Medicaid eConsult will expand to support specialty-to-specialty consultations. This enhancement will broaden the existing PCMP user role to a general “submitter” role, allowing specialists (including MDs/DOs, Nurse Practitioners [NPs] and Physician Assistants [PAs]) to initiate eConsults as treating practitioners.

The Telemedicine and eConsult Billing Manual will be updated to reflect these changes, enabling third-party platforms to implement and submit claims for specialty-to-specialty reimbursement. Refer to the Telemedicine and eConsult Billing Manual for full details on updated criteria and reimbursement policies.

Contact the eConsult team at HCPF_eConsult@state.co.us for more information about this feature. Contact Safety Net Connect (SNC) at ColoradoSupport@safetynetconnect.com for assistance with platform access and additional technical support.

Getting Started with Colorado Medicaid eConsult:

Practices can complete the Practice Enrollment Form to begin the enrollment process or attend an upcoming Monthly Program Overview Webinar from 12:30 p.m. to 1:00 p.m. Mountain Time for more information.

Contact ColoradoSupport@safetynetconnect.com with any questions.

eConsult Reimbursement:

Refer to the Telemedicine and eConsult Billing Manual for details on eConsult reimbursement.

Upcoming Learning Opportunities:

Safety Net Connect is excited to offer an upcoming free Continuing Medical Education (CME)-accredited webinar designed to keep providers informed on key clinical topics. This session is open to all healthcare professionals interested in enhancing their knowledge and practice.

August 14, 2025, at 12:00 p.m.
Topic: Assessment of Liver Function
Presented by: Board Certified Gastroenterologist Dr. Alicia Lieberman

Deepen understanding of liver health and diagnostic approaches in gastroenterology.

Assessment of Liver Function Registration Link

Additional information:

Visit the eConsult Platform web page for more information or email the eConsult team at HCPF_eConsult@state.co.us.

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.

Pre-Screening Tools for Screening, Brief Intervention and Referral to Treatment (SBIRT)

Effective June 1, 2025, the Parents, Partner, Past and Present (4Ps) and Parents, Peers, Partner, Past and Present (5Ps) pre-screening tools are approved for the Screening, Brief Intervention and Referral to Treatment (SBIRT) benefit. These pre-screening tools are designed to identify substance use risks, particularly in pregnant and postpartum populations, and support early intervention efforts. The integration of the 4Ps and 5Ps will enhance the ability to screen for alcohol, tobacco and drug use, as well as related behavioral health concerns, ensuring that at-risk individuals receive timely brief interventions and referrals to appropriate care. Refer to the Screening, Brief Intervention and Referral to Treatment (SBIRT) Program Billing Manual for more information.

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

Supplemental Payment Information

University of Colorado School of Medicine Physician and Professional Services Supplemental Payment

The maximum total payment amount for the University of Colorado School of Medicine Physician and Professional Services Supplemental Payment shall be $224,561,814 for State Fiscal Year 2025-2026. Of the maximum total amount, up to $112,280,907 are Federal funds retained by the University of Colorado School of Medicine for their role serving as a critical safety net for Colorado Medicaid beneficiaries as agreed to between the Department and the University of Colorado School of Medicine.

Primary Care Fund Supplemental Payment

The maximum total payment amount for the Primary Care Fund Program shall be $38,248,473 for State Fiscal Year 2025-2026.

Contact Daniel Harper at Daniel.Harper@state.co.us or 303-866-4427 for more information.

Radiology & Imaging Providers

Guidance for Addressing Technical Denials for Imaging Prior Authorization Requests (PARs)

A high volume of technical denials for imaging Prior Authorization Requests (PARs) continues to be seen. In May 2025, 270 PARs for these services were placed in pending status due to missing or invalid information. These requests were not corrected within the required timeframe and resulted in technical denials.

Common causes of technical denials include:

- Incomplete Health First Colorado member information
- Inaccurate dates of service
- Missing or incorrect diagnosis codes
- Incorrect Current Procedural Terminology (CPT) codes
- Insufficient documentation of medical necessity

To avoid technical denials:

- Verify all member information is complete and accurate before submitting
- Double check that dates of service match documentation
- Include all relevant diagnosis codes
- Confirm CPT codes are appropriate for the requested service
- Provide clear documentation supporting medical necessity

Resources and Support:

Contact COProviderIssue@acentra.com with questions or for assistance with PAR submissions. Refer to the ColoradoPAR Training web page for PAR training materials. Refer to the Laboratory Services Billing Manual for information on laboratory services.

Contact Sarah Kaslow at Sarah.Kaslow@state.co.us with questions on radiology and imaging.

Speech Therapy Providers

Inaccurate Provider Web Portal Display for Speech Therapy Units

The Provider Web Portal is displaying inaccurate units available for speech therapy services. Claims are being processed correctly but the totals displayed in the Provider Web Portal are inaccurate.

Providers are encouraged to contact Acentra to begin the prior authorization process even if all units have not been utilized.

New Coverage for Adult Habilitative Speech Therapy Services Begins July 1, 2025

Effective July 1, 2025, Health First Colorado will cover habilitative speech therapy services for eligible adult members when medically necessary. The allotment of 12 speech therapy sessions 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.

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

Any questions regarding PARs may be directed to HCPF_UM@state.co.us.

Telemedicine Providers

Remote Patient Monitoring

Effective July 1, 2025, Remote Patient Monitoring (RPM) will be a covered benefit. RPM is the continuous use of technology to track a patient's clinical data, enabling early detection of health changes and timely medical interventions to prevent emergency intervention or inpatient hospitalization.

Refer to the Telemedicine and eConsult Billing Manual for procedure codes and additional information. Contact Sahara Karki at Sahara.Karki@state.co.us for more information.

Transportation Providers

Non-Emergent Medical Transportation (NEMT) Coding Changes

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

- Healthcare Common Procedure 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).
  Note: All NEMT providers must begin using this code for billing mileage for non-ambulance and non-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 Health First Colorado.

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 in both English and Spanish.

Span Billing for Non-Emergent Medical Transportation (NEMT)

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

Claims must 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.

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

Transdev Health Solutions 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 Health Solutions 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 Health Solutions for all billing and may not submit claims directly to the Department. Changes to billing status are not being made. Contact NEMT@state.co.us with any additional 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 changes. Contact NEMT@state.co.us with any questions.

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. They will otherwise not be reimbursed for services provided on or 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. 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 Fall 2025.

More details will be given as the enrollment period gets closer. Information will be provided in the Provider Bulletins available on the Provider Bulletin web page.

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 expired document associated with them, 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 (current broker) 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 Required Practices

Providers **must** upload a single file folder for each driver and vehicle on their roster when submitting credentialing documents in the Transdev Health Solutions (current broker) ProCredEx system. Each folder **must** 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.

Note that Transdev Health Solutions will reject any file submissions that are missing all required documents. Providers may resubmit again with a complete file if this rejection occurs.

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

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.

Non-Emergent Medical Transportation (NEMT) Coverage Limitation for Home and Community-Based Services (HCBS)

Per rule 10 CCR 2505-10 8.014.6.A.12, NEMT trips for Home and Community-Based Services (HCBS) are **not** covered benefits. Transportation for HCBS must be provided by Non-Medical Transportation (NMT) providers.

Non-Emergent Medical Transportation (NEMT) Provider Requirements: NEMT providers must verify destination eligibility using the Find a Doctor Tool before scheduling trips. If the destination provider is listed as "Home & Community (HCBS)," the trip is not covered and should not be provided.

To provide Non-Medical Transportation (NMT) services for HCBS waiver members, providers must:

- Complete a separate enrollment application specifically for Non-Medical Transportation (NMT) services (Provider Type 36)

- Bill Non-Medical Transportation (NMT) services under the appropriate Provider ID (not the Provider ID used for Non-Emergent Medical Transportation [NEMT])

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

Provider Training Sessions

July 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 July:

- Beginner Billing Training for Professional Claims
- Beginner Billing Training for Institutional Claims
- Provider-Specific Training: Clinic Practitioners (Provider Type 16)
- Billing Training: Medicare and Third-Party Liability

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.*

Please read the descriptions below to determine appropriate training sessions for provider types.

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 specific provider types.

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.

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.

July 2025				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
	1	2 Beginner Billing Training: Institutional Claims (7/2/25) 9:00 a.m. - 11:30 a.m.	3	4

July 2025				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
7	8 Provider-Specific Billing Training: Clinic Practitioner (7/8/25) 9:00 a.m. - 11:30 a.m. Billing Training: Medicare & Third-Party Liability (7/8/25) 1:00 p.m. - 2:30 p.m.	9	10 Beginner Billing Training: Professional Claims (7/10/25) 1:00 p.m. - 3:30 p.m.	11
14	15	16	17	18
21	22	23	24	25
28	29	30	31	

Upcoming Holidays

Holiday	Closures
Independence Day July 4, 2025	State Offices, Acentra Health, AssureCare, DentaQuest, Gainwell Technologies, 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