COLORADO
Department of Health Care Policy & Financing

Provider Bulletin

Reference: B2500532

Dec 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?

Medicare replacement plans must be reported as "Medicare" on claims, and not as "third-party liability (TPL)." Refer to the Entering Other Insurance or Medicare Crossover Information Quick Guide for more information. Health First Colorado (Colorado's Medicaid program) should always be the payer of last resort.

Providers cannot bill members for co-pays or deductibles assessed by third-party resources. Providers cannot bill members for the difference between commercial health insurance payments and the billed charges when Health First Colorado does not make an additional payment.

All Providers

Important Revalidation Requirements

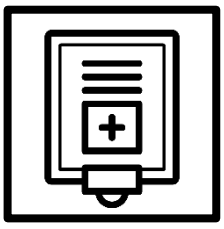
Providers are encouraged to review the Provider Revalidation Dates Spreadsheet posted on the Revalidation web page to confirm revalidation dates. This file is updated weekly and can be used to verify active enrollment for any provider. All providers are reminded that they must revalidate enrollment every five (5) years per federal mandate from the Centers for Medicare and Medicaid Services (CMS). All Provider IDs must be actively enrolled and revalidated with Health First Colorado for claims to be paid per rule 42 CFR § 455.410(b).

Claims will deny if providers have not revalidated by the deadline. ***Providers should not re-enroll if past the revalidation date***.

The link for revalidation remains on the Provider Web Portal account associated with the provider for six (6) months after the revalidation date. **If the revalidation link is no longer available, contact the Provider Services Call Center for next steps. Do not start a new application.**

Non-Emergent Medical Transportation providers that did not comply before the deadline may not revalidate. The moratorium for Non-Emergent Medical Transportation new enrollments was approved by the CMS and will be in effect until at least March 31, 2026.

Streamlining Initial Decisions for the Appeals Process Stakeholder Survey



The Colorado Department of Health Care Policy & Financing (the Department) invites questions about proposed changes to streamline the appeals process for Initial Decisions that have no exceptions, requests for transcripts or requests for extension of time filed within 18 days of the mailing of the Initial Decision.

The proposed rule streamlines the current appeals process as follows:

Parties have 18 calendar days to respond with a challenge when an Initial Decision is mailed out. They can do this by:

- Filing exceptions (formal objections),
- Requesting a transcript,
- Asking for an extension of time.

If no one files any of those within the 18 calendar days:

- The Office of Appeals has up to 12 more calendar days to review the case if they choose to.
- If they do not choose to review it, the Initial Decision automatically becomes the Final Agency Decision after 30 calendar days from the date it was originally mailed.

If Exceptions or Extensions are filed or transcripts are requested within the 18 calendar days:

- If **exceptions or requests for transcripts or extensions** are filed within the 18 calendar days, the case follows the normal appeal process. This means the Office of Appeals will issue a Final Agency Decision within 90 calendar days of the original hearing request, the opposing party has 10 calendar days to respond and the Appeals Officer reviews the case and issues a Final Agency Decision.
- If someone asks for a **transcript**, they automatically get 45 extra calendar days (from the original deadline) to file their exceptions.
- This timeline might change if an expedited hearing was requested or if an extension was granted.

Comments and questions on the proposed rule can be submitted through the Stakeholder Survey. Input will help the Department understand the impact on appeals. The survey takes 5-10 minutes to complete.

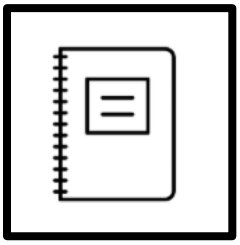
Email Russell Zigler at Russ.Zigler@state.co.us with questions about the proposed policy or the stakeholder engagement survey.

Community Health Workers (CHW) in Medicaid: Postponed until January 1, 2028

The Department wants to provide an update regarding Health First Colorado reimbursement for Community Health Worker (CHW) services. Given the acute budget crisis the state of Colorado faces, the Governor extended and amended Executive Order D25 014 on October 31, 2025, making additional State Fiscal Year 2025-26 (FY2025-26) reductions, which include an additional delay to the Health First Colorado CHW benefit until January 1, 2028. The Health First Colorado reimbursement for CHW services will not begin on January 1, 2026, but will instead begin on January 1, 2028.

Contact HCPF_CHW_Benefit@state.co.us with any questions about the CHW benefit being paused until January 1, 2028.

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 January 2026. Visit the National Correct Coding Initiative (NCCI) Edits web page for more information.

Pharmacy Benefit Management System (PBMS) Transitioning

The Department is transitioning components of its Pharmacy Benefit Management System (PBMS) from Prime Therapeutics (formerly Magellan) to MedImpact.

What providers should know:

- The Opioid Risk module is not changing and will continue to be managed by OpiSafe.
- MedImpact will implement and manage four (4) new PBMS modules:
    - The core PBMS (February 2026)
    - Rebate (launched October 2025)
    - Preferred Drug List (launched October 2025)
    - Real-Time Benefit Tool (February 2026)
- Contact information for the PBMS, including the call center phone number, fax number and the mailing address for paper claims will change. Information will be provided closer to the transition date and be available on the Provider Contacts web page.
- The Bank Identification Number/Processor Control Number (BIN/PCN) for pharmacy claim submission will remain the same. Pharmacies will continue to submit their claims as usual.

Why is the PBMS vendor changing?

Prime Therapeutics' contract expires this winter and the Department is required by state and federal regulations to solicit competitive bid proposals from vendors on a regular basis.

Through a competitive bid process, the Department selected MedImpact to implement four (4) of the five (5) PBMS modules. Visit the Colorado Medicaid Enterprise Solutions Transition web page for more information.

Provider Web Portal Login Reminders

User Inactivity and Timeouts

The Provider Web Portal allows up to 15 minutes of inactivity. If left idle for 15 minutes, the system will automatically log the user out. To regain access, the user may immediately return to the login page and enter the credentials.

Unlock a User Account

A user may become temporarily locked out. This is commonly due to multiple attempts using wrong password. The account will automatically unlock after approximately 15 minutes, at which point the user may attempt to log in again using the correct credentials.

Visit the Quick Guides web page for additional Provider Web Portal navigation information.

All Providers Who Utilize the ColoradoPAR Program

What is the ColoradoPAR Program?

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

Interoperability Changes Beginning in January 2026

Significant changes in Pend and Prior Authorization Request (PAR) timeframes:

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

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

These changes are required for Acentra Health Inc. and the Department to be compliant with the Interoperability Turnaround Time Requirements. These changes will facilitate a faster turnaround time for PARs overall and decrease administrative burden for all parties once implemented. Visit the CMS Interoperability web page for more information on the rule.

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

Go-Live for Prior Authorization Requests (PARs) of Registered Nurses (RNs) and Certified Nursing Assistant (CNA) services was August 1, 2025

The requirement to submit a Skilled Care Acuity Assessment and Recommendation letter is currently on pause. Review the LTHH CNA, LTHH RN and Private Duty Nursing (PDN) PAR requirements located on the ColoradoPAR Training web page.

Prior Authorization Request (PAR) Submission Training for Acentra

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

- Private Duty Nursing Benefit Training December 10, 2025, at 9:00 a.m. MT
- Private Duty Nursing Benefit Training December 10, 2025, at 12:00 p.m. MT
- Portal Registration and PAR Submission Training January 7, 2026, at 9:00 a.m. MT
- Portal Registration and PAR Submission Training January 7, 2026, 12:00 p.m. MT

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.

Reminder: Enhanced Standard Assessment

Effective November 15, 2025, all children and youth being considered for residential treatment (Qualified Residential Treatment Program [QRTP], Psychiatric Residential Treatment Facility [PRTF] or Out-of-State High-Intensity Residential Treatment [OSHIRT]) will be required to undergo an Enhanced Standardized Assessment (ESA) for initial Health First Colorado coverage authorization. This applies when residential services are to be reimbursed directly by the Department. Continuing stay approval will also be required for periods of treatment longer than 30 days.

As of November 15, 2025, any child already in an episode of care in a QRTP or a PRTF will receive an initial 30-day approval. OSHIRT reviews will continue their regular 30-day review

cadence. Continued stay reviews will begin December 15, 2025, and occur every 30 days thereafter.

Refer to Operational Memo 25-032: Utilization Management and Assessment Requirements for Qualified Residential Treatment Providers (QRTP) and Psychiatric Residential Treatment Facilities (PRTF) for further information.

Refer to the ColoradoPAR Training web page for information about Utilization Management, Prior Authorization and Continuing Stay Reviews.

Contact Christina Winship at Christina.Winship@state.co.us with policy or enrollment questions.

Contact Acentra at coproviderregistration@acentra.com with questions regarding Utilization Management.

Behavioral Health Providers

Certified Community Behavioral Health Clinics (CCBHC) Planning Grant Updates

CCBHC Planning Grant Year-End Updates

The 2025 calendar year is ending along with the grant timeline for the Colorado 2025 Certified Community Behavioral Health Clinics (CCBHC) Planning Grant. CCBHC Planning Grant team members from both the Department and the Behavioral Health Administration (BHA) are working to finalize required activities and objectives.

Reminders for end of year CCBHC communications and stakeholder engagement:

- December workgroup meetings and public forums have been cancelled due to increased scheduling conflicts.
- The next CCBHC Steering Committee meeting will take place on January 26, 2026, from 3:00 p.m. – 4:00 p.m. MT. Register through Zoom or on the CCBHC Planning Grant web page.

CCBHC Planning Grant No-Cost Extension Request

The joint state agency team has submitted a request for a CCBHC Planning Grant No-Cost Extension (NCE). If granted, the NCE would allow federal resources to continue into 2026, supporting ongoing efforts of CCBHC work in Colorado. Decisions on NCE requests are anticipated by December 30, 2025.

CCBHC Planning Grant Memorandums

Continue to check the Behavioral Health Administration (BHA) Memorandum web page for updated memorandums and communications regarding planned policies and infrastructure for CCBHC services in Colorado. CCBHC Memorandum #2 is now available for review. This memo highlights certification details, known and anticipated certification timelines and provides access to the Provider Readiness Assessment.

Providers and stakeholders are encouraged to explore the CCBHC Planning Grant web page for additional details and reference materials.

New Frequently Asked Questions (FAQ) on National Correct Coding Initiative (NCCI) Edits and Colorado Medically Unlikely Edits (CO MUEs)

The National Correct Coding Initiative (NCCI) edits and Colorado Medically Unlikely Edits (CO MUEs) Frequently Asked Questions (FAQ) have been released. NCCI edits and MUEs were created to reduce improper payments stemming from incorrect coding and billing practices. NCCI prevents reimbursement for inappropriate combinations of Current Procedural Terminology (CPT) codes.

This FAQ includes answers to many of the questions received from providers related to the NCCI and CO MUEs. The FAQ and details about CO MUEs and NCCI policy are available on the Behavioral Health Policies, Standards, and Billing References web page. Email hcpf_bhbenefits@state.co.us with any additional questions.

New Statewide Funding Opportunities to Address the Opioid Crisis

The Colorado Attorney General's Office and the Colorado Opioid Abatement Council (COAC) have announced **up to $23 million in new statewide opioid abatement funding** available through two (2) grant opportunities:

- **Resilient Colorado Grant** – Focused on community-based prevention, recovery and leadership initiatives that strengthen Colorado's behavioral health and recovery systems.
    - **Application due December 18, 2025**
- **Round 4 Infrastructure Funding Opportunity** – Prioritizes capital or operational investments in rural, underserved or disproportionately impacted communities, and encourages collaborative or multi-organization proposals.
    - **Application due January 14, 2026**

Note that funding from these opportunities come from national opioid settlements and must be used for forward-looking opioid abatement strategies. Review the full list of Approved Uses.

Prior Authorization and Retrospective Reviews for Outpatient Psychotherapy

The Regional Accountable Entities (RAEs) have been directed to develop strategies to ensure that only medically necessary psychotherapy services are being paid. **This is to address the unmanageable growth in outpatient psychotherapy and includes an expectation that the RAEs create prior authorization and retroactive review processes looking specifically at outpatient psychotherapy that exceeds 24 sessions in a 12-month period.** This applies across all provider types and to any combination of the following impacted psychotherapy codes: 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90846, 90847, 90849 and 90853.

The Governor's Executive Order removed the prohibition on prior authorization review (PAR) of services, restoring it as an option available to the RAEs. However, there is **no requirement** that utilization management be performed in a **specific way**. It may be through prior authorization review (PAR), but an alternate process such as retrospective review or pending payment may be considered. RAEs will look at their tools to determine what process makes the most sense for their region and will implement unique approaches based on the needs of their networks. If providers are only rendering medically necessary services, they will see no change to their reimbursement.

This policy is necessary to address problematic utilization trends and avoid service cuts that could limit member access to essential services.

Join the Independent Provider Network (IPN) Forum with any questions regarding this policy on Friday, December 5, 2025, at 1:00 p.m. MT. Register via Zoom. Behavioral health policies are available on the Behavioral Health Policies, Standards, and Billing References web page.

Providers with Essential Safety Net Provider (ESNP) Designation: New Options Available in the Provider Web Portal During Revalidation

Essential Safety Net Providers (ESNPs) will see new fields in the Provider Identification panel and a new ESNP attachment type in the Attachments and Fees panel when completing Provider Revalidation activities in the Provider Web Portal. These options have previously only been available when completing Provider Maintenance activities. Refer to the Provider Revalidation Manual or Provider Revalidation Quick Guide on the Revalidation web page for further details.

Durable Medical Equipment

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

Complex Rehabilitative Technology (CRT) providers are reminded that they must submit repair metrics data by December 31, 2025, for the period of June 1, 2025, through November 31, 2025. Providers must send data to HCPF_DME@state.co.us to comply with House Bill 22-1290, 10 CCR 2505-10 8.590.5.E.3.a.

Home and Community-Based Services (HCBS)

Electronic Visit Verification: Temporary Pause of the Provider Portal EVV Exemption Process for Live-In Caregivers

A temporary pause in the Electronic Visit Verification (EVV) exemption process for live-in caregivers in the Provider Web Portal has been announced (Operational Memo 25-068).

This pause is intended to reduce administrative burden while the Department works with stakeholders and Gainwell Technologies to refine and improve the exemption process.

What Providers Need to Know

- Do not submit new exemption requests for live-in caregivers through the Provider Web Portal until further notice.
- Providers must maintain complete EVV exemption documentation for all active live-in caregivers, including:
    - The EVV Attestation of Exemption Form, located on the Provider Forms web page under the Provider Enrollment and Update Forms drop-down menu.
    - All required supporting documentation.
- Providers remain responsible for ensuring exemption records are accurate, current and available for audit and must be renewed annually.
- Continue to use the following when billing for services provided by an exempt live-in caregiver:
    - Place of Service (POS) 99 or Condition Code (CC) 23, as applicable.
    - Claims without live-in caregiver documentation in the Provider Web Portal will post informational EOB 3056 but will still pay.

- Providers should continue to use EVV for all services that do not qualify for the live-in caregiver exemption.

The Department is working with stakeholders and the fiscal agent to design an improved exemption process. A specific implementation timeline has not been determined. The Department will communicate updates as soon as they become available.

Email EVV@state.co.us with any questions. Visit the EVV Program web page for program updates and additional resources.

Extraordinary Cleaning Services Excluded from EVV

Operational Memo 25-039, issued July 1, 2025, introduced Extraordinary Cleaning as a new Home and Community-Based Services (HCBS) waiver benefit under the Supported Living Services (SLS) and Children's Extensive Support (CES) waivers.

Extraordinary Cleaning services are not subject to Electronic Visit Verification (EVV). This determination reflects the nature of the service and how it is delivered under the waivers.

What Providers Need to Know

- EVV is not required for Extraordinary Cleaning services.
- Providers and case management agencies must continue to document service delivery in accordance with waiver requirements and case management protocols.
- EVV requirements continue to apply to all other Personal Care and Homemaker services.
- This clarification supports accurate EVV usage and reduces administrative burden for excluded services.

Background

Extraordinary Cleaning became an available service for members enrolled in the SLS and CES waivers under OM 25-039. The benefit provides specialized cleaning, disinfection and sanitization tasks that maintain a safe and hygienic environment for members whose health or disability creates a need for such supports.

Email EVV@state.co.us with questions about EVV requirements. Email HCPF_PDP@state.co.us with questions about program details for the Extraordinary Cleaning waiver benefit.

Long-Term Care Employer Reporting for Care Worker Tax Credit

Starting in 2025, all long-term care employers must report total hours worked by each eligible direct care worker in Colorado to the Department of Revenue (DOR) by January 31 each year. Failure to file on time may result in a $500.00 penalty.

Who is Covered:

- Employers providing home and community-based services, nursing facility care or certified home care agency services.
- Eligible direct care workers, excluding Certified Nursing Assistants (CNAs), who provide hands-on personal care or services to individuals receiving long-term care in Colorado and who have worked at least 720 hours during the tax year.

What to Report:

- Worker's name, Social Security Number or Tax Identification Number and total hours worked during the calendar year.

Visit the DOR website to learn how to file and the Direct Care Worker Tax Credit Frequently Asked Questions for additional information.

Reinstatement of Prior Authorization (PAR) System Edits

System edits that require a **valid Prior Authorization Request (PAR)** on file for payment of Home and Community-Based Services (HCBS) are being reinstated.

These system edits were temporarily paused as part of the Long-Term Services and Supports (**LTSS) Stabilization Actions** to ensure timely payments and continued access to care during periods of system transition. Normal claim validation rules will resume as system stability is restored and Case Management Agencies (CMAs) are creating PARs timely.

Provider Requirements

Providers are required to verify that a member is eligible to receive HCBS prior to providing services. All HCBS services **must be authorized with an approved PAR** before they are delivered and billed.

- Verify **member eligibility** in the Provider Web Portal before providing services.
- Confirm that each billed service corresponds to an **approved PAR** covering the same service, dates and units.
- **Contact the Member's Case Management Agency (CMA)** prior to service delivery if there is uncertainty about service authorization.
- Claims billed for services without a valid PAR, or that exceed approved service units, will be **denied** once system edits are reinstated.

Provider Action Steps

1. **Confirm Authorizations:**
   Work with the CMA to ensure all active members have valid PARs in place covering all services and units.

2. **Review Billing Practices:**
   Reconcile claims to confirm that all services align with approved PARs prior to submission.
3. **Verify Eligibility:**
   Continue verifying member eligibility before each service encounter in the Provider Web Portal.

Key Takeaway

By **January 2026**, it is anticipated that all temporary LTSS stabilization system flexibilities are scheduled to end. Claims billed for services without a valid, approved PAR — or that exceed approved units — will deny. This transition restores standard claim processing and ensures that all HCBS services are properly authorized prior to delivery.

Provider Resources

- Provider Services Call Center
- LTSS Stabilizing Actions

The Department appreciates providers' continued partnership and commitment to ensuring quality care for Health First Colorado members as the Department transitions away from stabilization and returns to normal operations.

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, January 9, 2026, from 1:00 p.m. to 3:00 p.m. MT** and will be hosted virtually.

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

Contact 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.

Billing Guidance Reminders

Birthing Parent and Newborn Billing

- Services for the birthing parent and baby must be billed on separate claims under the identification number of each member.

Covered/Non-covered Days

- Total days on the claim are calculated as the days between Admission and To Date of Service (TDOS)
- Value codes indicate the quantity of covered and non-covered days
  - Value Code 80: covered days
  - Value Code 81: non-covered days
- Occurrence Span Code 74
  - Used to report the from and through dates at a non-covered level of care or leave of absence (LOA) during an otherwise covered stay

Refer to the Inpatient/Outpatient Billing Manual for billing guidance.

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

Elimination of the 1.6% Across the Board (ATB) Rate Increase Effective October 1, 2025

On August 28, 2025, Governor Polis signed Executive Order D25 014, that reduces General Fund expenditures to bring Colorado's budget into balance for the current fiscal year, State Fiscal Year 2025-26 (FY 2025-26). An email was sent to hospital stakeholders in September to review the 30-day posting of new hospital rates for this change. Impacted rates include:

- Inpatient APR-DRG hospital base rates
- Outpatient EAPG hospital base rates
- Per Diem Specialty & Psychiatric hospital base rates

Contact Diana.Lambe@state.co.us with any questions relating to inpatient hospital rates.
Contact Sean.Paschke@state.co.us with any questions relating to outpatient hospital rates.
Contact Della.Phan@state.co.us with any questions relating to rehabilitation, long-term acute care or psychiatric hospital rates.

Implementation of Various Outpatient Hospital Enhanced Ambulatory Patient Grouper Rate Updates Effective July 1, 2025

The Department is working with its fiscal agent on the implementation of various rate changes impacting outpatient hospital claims effective July 1, 2025. Rate changes include the

1.6% increase to Enhanced Ambulatory Patient Grouper (EAPG) base rates effective July 1, 2025, through September 30, 2025, the implementation of EAPG version 3.18 and the rate reduction to the 340B drugs paid through the EAPG methodology.

The EAPG version update is currently scheduled for completion within the fourth quarter of the calendar year. All impacted outpatient hospital claims will be identified and reprocessed to pay using the correct rates and version upon completion.

Contact Sean.Paschke@state.co.us with any questions relating to outpatient hospital rates.

Outpatient Hospital Specialty Drug Payment Rate Reduction

On October 31, 2025, Governor Polis extended and amended Executive Order D25 014, making additional reductions to General Fund expenditures to bring Colorado's budget into balance for the current fiscal year, State Fiscal Year 2025-26 (FY 2025-26). Per the amended Executive Order, the Department will reduce the outpatient hospital specialty drug reimbursement rate from 97% to 100% of invoiced cost to 92% of invoiced cost. The reduced rate is anticipated to be effective April 1, 2026, pending approval of the related State Plan.

Refer to Appendix Z for a listing of drugs currently carved out from hospital payment methodologies. Contact Andrew.Abalos@state.co.us and Della.Phan@state.co.us with questions.

Rural Health Clinic Stakeholder Engagement Meeting

A meeting for Rural Health Clinics (RHCs) has been scheduled for January 8, 2026, from 1:00 p.m. to 2:00 p.m. MT. 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.

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

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

Vagus Nerve Stimulator Reimbursement

Assessment is underway to determine current reimbursement levels for Vagus Nerve Stimulator devices within the EAPG methodology are creating access to care barriers. This is related to the postponement of Senate Bill 25-121, which was intended to raise reimbursement for the device.

Hospitals and their providers are encouraged to contact HCPF_HospitalRegulatory@state.co.us with any concerns related to existing reimbursement levels for this device.

Pharmacy

Enhanced Dispensing Fee for Parenteral Nutrition Products

Starting January 1, 2026, an enhanced dispensing fee will apply to total parenteral nutrition (TPN) pharmacy claims as required by SB 25-084. Pharmacies will receive an extra $73.21 per TPN claim in addition to their standard dispensing fee (based on total annual prescription volume) and drug ingredient reimbursement.

Billing Instructions:

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

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

New Billing Requirements for Abortion Medications

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

Billing Instructions

- A diagnosis code must be included on all claims for:
    - Mifepristone (Mifeprex) 200m
    - Misoprostol (Cytotec) 100mg
    - Misoprostol (Cytotec) 200mg
- Claims with a diagnosis code indicating abortion will be paid with state-only funds and are not eligible for federal rebates.
- Claims submitted without a diagnosis code will deny for missing diagnosis.
- Diagnosis codes must reflect the appropriate condition or encounter type in accordance with ICD-10-CM standards.

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

Managed Care Carveout

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

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

Pharmacy and All Medication Prescribers

Preferred Drug List Status and Criteria Changes: Humira (Adalimumab) & Mounjaro (Tirzepatide)

Effective January 1, 2026, Humira will be changed to non-preferred status on the Preferred Drug List (PDL). Current utilizers will need prior authorization to continue using Humira after this time. New adalimumab biosimilars will be available as preferred when this change occurs.

Effective January 1, 2026, preferred adalimumab products will include Yuflyma (adalimumab-AATY) syringe and auto injector, Adalimumab-AATY syringe and pen, Adalimumab-ADBM pen, Adalimumab-AACF syringe, Amjevita (adalimumab-ATTO) syringe and autoinjector and Cyltezo (adalimumab-ADBM) pen and syringe. These changes will be published on the PDL available on the Pharmacy Resources Page by December 1, 2025. Refer to the PDL or contact Prime Therapeutics at 800-424-5725 for more information and prior authorization criteria.

Effective January 1, 2026, prior authorization requests for members currently stabilized on Mounjaro (tirzepatide) 7.5 mg, 10 mg, 12.5 mg, or 15 mg product strengths may receive approval for one (1) year to allow for continuation of therapy with the prescribed Mounjaro (tirzepatide) product strength. Prior authorization requests occurring on or after this effective date for all other non-preferred products in the "GLP-1 Analogues" PDL drug class will be subject to meeting non-preferred drug criteria listed for the requested product on the PDL.

Preferred Drug List (PDL) Announcement of Preferred Products

Changes will be made for the following PDL classes, effective January 1, 2026:

PDL Drug Class	Moved to Preferred	Moved to non-preferred
Antihistamines/ Decongestant Combos	• **Cetirizine-pseudoephedrine ER tablet**	none
Epinephrine (self-administered) Products	• **Auvi-Q Auto-Inject** • **Epinephrine Auto-Inject (all manufacturers)** • **Neffy Spray**	none

PDL Drug Class	Moved to Preferred	Moved to non-preferred
Newer Hereditary Angioedema (HAE) Products	• **Icatibant syringe** • **Orladeyo capsule** • **Takhzyro vial and syringe**	• **Cinryze - kit** • **Firazyr syringe**
Immune Globulins	• **Bivigam IV liquid** • **Cutaquig SQ liquid** • **Gammaked IV/SQ liquid**	• **Hizentra vial and syringe**
Targeted Immune Modulators (TIMs)	• **Yuflyma (adalimumab-AATY) syringe and autoinjector** • **Adulimumab-AACF (CF) syringe** • **Amjevita (adalimumab -ATTO) syringe and autoinjector** • **Imuldosa (ustekinumab-SLRF) syringe** • **Selarsdi (ustekinumab-AEKN) syringe** • **Steqeyma (ustekinumab-STBA) syringe** • **Xeljanz XR tablet**	• **Hadlima (adalimumab-BWWD) all forms** • **Humira (adalimumab) all forms**

No changes will be made for the following PDL classes:

PDL Drug Class	PDL Drug Class
Human Immunodeficiency Virus (HIV) Treatments	Anti-Herpetic Agents – Oral, Topical
Hepatitis C Virus Treatments	Fluoroquinolones - Oral
Methotrexate Products	Newer Generation Antihistamines
Inhaled Beta2 Agonists (Short & Long-Acting)	Intranasal Rhinitis Agents
Inhaled Corticosteroids & Combinations	Leukotriene Modifiers
Phosphodiesterase Inhibitors (PDEIs)	Inhaled Anticholinergics & Combinations
Antibiotics, Inhaled	Ribavirin Products

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 at 800-424-5725 with questions regarding rejected claims or prior authorization.

Prescriber Tool and Prescriber Tool Alternative Payment Model (APM) Update – Webinar Recording Now Available

A recorded overview of the Prescriber Tool and the Prescriber Tool Alternative Payment Model (APM) for program year three (3) is now available:

- The Prescriber Tool and Prescriber Tool APM Webinar

The Prescriber Tool is a powerful resource available directly within many Electronic Health Record (EHR) system workflows, giving providers seamless access to vital member pharmacy benefit information. This tool has integrated features such as e-prescribing, Real-Time Benefits Inquiry (RTBI) and electronic prior authorizations to deliver transparency and efficiency at the point of care. Providers can make faster, more informed decisions with instant access to medication coverage details and lower-cost therapeutic alternatives—improving care while managing rising pharmaceutical costs.

The Prescriber Tool APM Year 3 started in October 2025. The APM is designed to incentivize use of the Prescriber Tool and promote pharmacy benefit compliance and cost efficiency when possible. The Prescriber Tool APM shares a portion of the pharmacy program savings generated, if any, from prescriber use of the Prescriber Tool and Preferred Drug List (PDL) compliance rates among participating practices.

Refer to the following resources for more information:

- The Prescriber Tool Project web page
- The Prescriber Tool APM web page
- The Prescriber Tool and Prescriber Tool APM Webinar

Physician-Administered Drug (PAD) Providers

Prior Authorization Update

Effective January 1, 2026, the Healthcare Common Procedure Coding System (HCPCS) codes listed in the table below will be added to the list of PADs that require prior authorization (PA).

J1442	Q5125	J2506	Q5111	Q5127
J9312	Q5101	Q5108	Q5122	Q5130

Certain PADs administered in a non-outpatient hospital office or clinic setting fall under the PAD PA policy. PADs requiring a PA are listed on Appendix Y: Physician Administered Drug Medical Benefit Prior Authorization Procedures and Criteria.

The providers subject to this policy bill claims on the professional claim type (CMS 1500 or 837P electronic format). Providers must ensure a member specific PA request is submitted to

Acentra Health through the Atrezzo® portal and an approval is received prior to administering the PAD to the member.

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

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

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

Physician Services

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

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

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

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

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

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

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

Telehealth Services Coverage

On October 1, 2025, Medicare reverted to its pre-pandemic coverage of telehealth services. Medicare's change to its telehealth coverage does not change Colorado Medicaid's telehealth/telemedicine coverage.

Services for dually eligible members (members having both Medicare and Health First Colorado coverage) with full Health First Colorado benefits should continue to be submitted to Medicare first unless otherwise noted in billing manual or Department rule. If the service is not covered by Medicare, but is covered by Health First Colorado, Health First Colorado will pay based on the Health First Colorado allowable amount. Refer to the Entering Other Insurance or Medicare Crossover Information Quick Guide for more billing information.

Colorado Medicaid eConsult Update

Health First Colorado providers can access a free, secure statewide electronic consultation platform via ColoradoMedicaideConsult.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 has expanded to support specialty-to-specialty consultations. This enhancement broadens the existing PCMP user role to a general "submitter" role, allowing specialists (including Medical Doctors [MDs]/Doctors of Osteopathic Medicine [DOs], Nurse Practitioners [NPs] and Physician Assistants [PAs]) to initiate eConsults as treating practitioners.

The Telemedicine and eConsult billing manual was 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.

eConsult Reimbursement

Refer to the Telemedicine and eConsult Billing Manual on the Billing Manuals web page for additional information.

Speech Therapy

Billing for Alternative Augmentative Communication (AAC) Device Trials and Use

Augmentative and Alternative Communication (AAC) Codes in Speech Therapy for Device Trials and Therapy:

In accordance with American Speech Language-Hearing Association (ASHA) guidance, Current Procedural Terminology (CPT) codes **92606-92609** should be used to bill for AAC services related to the evaluation, trial and therapy associated with speech-generating devices (SGDs) and non-speech generating devices.

- **CPT 92607**: Used for the **initial evaluation(s)** of a patient's suitability for an AAC device, including assessment of communication needs and determining appropriate device features.
- **CPT 92608**: Used for **each additional hour** required to complete the AAC evaluation(s) or device trial(s). This includes any extended assessment or data collection needed to determine device efficacy.
- **CPT 92609**: Used for **treatment and training** with the *selected* device after the evaluation phase. This code covers direct therapy to teach the member how to effectively utilize the **speech-generating device** for functional communication.
- **CPT 92606:** Used for a **non-speech generating device**, with program and modification, and training the member of its appropriate use.

ASHA clarifies that a **trial of an AAC device** may be billed under **92607/92608** as part of the evaluation process when determining the most appropriate device for a member. Once a specific device has been selected and the focus shifts to teaching or practicing device use, **92609** should be billed for therapy with a speech-generating device, which includes modifying or programming, or 92606 for therapeutic services for the use of a Non-Speech Generating Device, which includes programming and modification.

Providers must document the purpose and scope of each session clearly, noting whether the session involves evaluation/trial activities (92607–92608) or device-based therapy (92606/92609), meaning working with the member on how to use the device itself and/or are modifying and programming it for their use.

According to the National Correct Coding Initiative (NCCI), providers can bill CPT codes 92606 or 92609 with 92507 on the same date of service when documentation shows medical necessity and clearly distinguishes the two (2) services. When billing both 92609 (speech-generating device-related services) and 92507, providers can attach modifier 59 to indicate the separate services.

When submitting a prior authorization request (PAR) for CPT codes 92606 or 92609, providers may include documentation (via the request or additional case notes in the UM vendor's provider portal) confirming that the member has completed the AAC trial, selected the device for ongoing therapy and is awaiting the receipt of the device. This documentation helps prevent gaps in the member's care.

Email Devinne.Parsons@state.co.us with questions related to Outpatient Speech Therapy policy.

Email HCPF UM at hcpf_um@state.co.us with questions related to the PAR process and submission.

Therapy Providers

Policy Clarification for Certified Nurse Midwives (CNM) as an Allowed Ordering, Prescribing, Referring (OPR) Provider

Certified Nurse Midwives ***are*** allowed to order, prescribe and refer within the Outpatient Physical, Occupational and Speech Therapy benefits.

Effective July 1, 2022, the Department started soft enforcement of the federal requirement 42 CFR § 455.440 that claims for certain types of services contain the National Provider Identifier (NPI) of the provider who ordered the service, and that the NPI is actively enrolled with Health First Colorado. Outpatient Physical, Occupational and Speech Therapy requires an ordering NPI to be both indicated and validated on the claim submissions.

Providers are required to enter the NPI of the ordering provider into the following locations for claim submission. This field may be labeled as "Referring Provider" in the Provider Web Portal.

Professional claims

- For paper claims use field 17.b
- Electronic submissions use loop 2420 with qualifier DK (Ordering), DN (Referring), or DQ (Supervising)

Institutional claims

- The Attending Provider field (#76) or the Other ID fields (#78 or #79) for both paper and electronic claims
- Providers should refer to their applicable UB-04 billing manuals for guidance on how each field is used

Providers should contact the Provider Services Call Center for assistance with claim submission.

Contact Devinne.Parsons@state.co.us with questions regarding Outpatient Physical, Occupational and Speech Therapy policy.

Transportation Providers

Non-Emergent Medical Transportation (NEMT) Updates

XL and/or Bariatric Wheelchair Transports

Effective November 1, 2025, Non-Emergent Medical Transportation (NEMT) providers will no longer use A0434 for XL or Bariatric Wheelchair Transports. XL and Bariatric wheelchair

services are covered if two (2) attendants are used for assisting the member with loading and unloading.

- Bill A0130 + U9 modifier for the service of XL or Bariatric wheelchair transportation using two (2) attendants.

- Wheelchair Van transportation services only using one (1) attendant are billed using A0130 with no modifier.

NEMT Rural Mileage Edit and 25+ mile trips statewide

Effective September 30, 2025, a revision to the 25-mile rule (10 CCR 2505-10 8.014.4.A) was implemented for NEMT in rural communities.

Key Changes

- **Increased Mileage Limit**: The daily roundtrip mileage limit increased from 52 miles to 125 miles for members residing in designated rural counties.
    - This change reflects the geographic challenges of large and sparsely populated counties.
    - It is intended to improve access to care for rural members while supporting local NEMT providers.
    - Trips more than 125 miles round trip are still covered but can only be provided under certain circumstances and require certain documentation on the claim. Both are details in the Non-Emergent Medical Transportation (NEMT) Billing Manual.
- **Eligibility**: Eligibility for the expanded limit is based on the member's county of residence.
    - A list of qualifying counties is found below and is posted in the NEMT Billing Manual.
    - ***No new forms or processes are required. Existing state issued standard trip logs and the 25-mile forms remain in effect. Both can be found on the Provider Forms web page***.
- **Claims Review**:
    - NEMT claims billed for procedure codes A0425, S0215 or S0209 will be suspended for review if billed units exceed 125 (for designated rural counties).
        - Claims billed for more than 125 miles for members in these rural counties must have attached the required forms (Standard Trip Log and 25 Mile Form) detailed in the NEMT Billing Manual and found on the Provider Forms web page under the Claim Forms and Attachments dropdown menu.
        - Designated Rural Counties: Alamosa, Archuleta, Bent, Chaffee, Cheyenne, Clear Creek, Conejos, Costilla, Crowley, Custer, Delta, Dolores, Fremont,

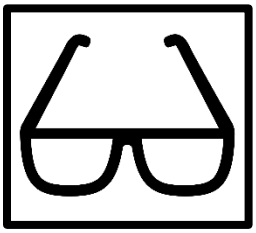
Gilpin, Grand, Gunnison, Hinsdale, Huerfano, Jackson, Kiowa, Lake, Lincoln, Logan, Mineral, Moffat, Montrose, Morgan, Otero, Ouray, Park, Phillips, Pitkin, Rio Blanco, Rio Grande, Routt, Saguache, San Juan, San Miguel, Sedwick, Washington.

NEMT Span Billing

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.

Vision Providers



Eyeglass Coverage

Eyeglasses coverage is limited to one (1) or two (2) single or multifocal vision clear plastic or polycarbonate lenses with one (1) frame. The Current Procedural Technology (CPT) codes of *either* V2020 *or* V2025 should be used in eyeglass frame claims.

Glasses coverage is limited to one (1) or two (2) single or multifocal vision clear plastic or polycarbonate lenses with one (1) frame every 24 months for members aged 21 and up. Eyeglasses for adult members are benefits following eye surgery only.

Coverage for members under 21 limited to one (1) or two (2) single or multifocal vision clear plastic or polycarbonate lenses with one (1) frame when medically necessary. Replacement is a covered service when there is a change in prescription, a loss, or when repair exceeds the cost of replacement.

Rates can be found on the Provider Rates & Fee Schedule web page. Further vision services billing guidance can be found in the Vision Services Billing Manual.

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

Women's Health, Family Planning

Abortion Coverage

The coverage of abortion-related services will expand in compliance with SB25-183 for the following eligibility categories, effective for Dates of Service beginning January 1, 2026:

- Health First Colorado (TXIX), including Cover All Coloradans
- Emergency Medicaid Services (EMS), also referred to as the "Emergency Medical and Reproductive Health Care Program"
- Child Health Plan *Plus* (CHP+)

Approved abortion codes listed below will be reimbursed with state-only funds for members enrolled in the above programs, regardless of circumstance. Members will not be subject to member deductibles, copayments, or coinsurance for these services and may not be billed for these services (CO Rev Stat §25.5-4-301).

CHP+ providers must submit their claims to their CHP+ Managed Care Organization (MCO) for manual reconciliation reimbursement.

Providers must submit separate claims for any services **not specific** to abortion care; non-abortion services must **not** be included on the abortion-related claim and may be denied and subject to recoupment (clawback) if improperly bundled.

Elective abortions are identified via diagnosis code Z33.2; no additional documentation is required for reimbursement of elective abortion-related services. Current system restrictions limiting abortion coverage to cases of incest, rape, or life endangerment will be removed, effective January 1, 2026.

Beginning January 1, 2026, providers are no longer required to append Modifier 52 to CPT code S0199 to identify telemedicine services that were used to deliver any component of the abortion bundle. Telemedicine may be used for one (1) or more components of S0199 (e.g., patient counseling, follow-up consultation, or confirmation of pregnancy). The Department will release future guidance regarding appropriate telemedicine informational modifiers for claim submission.

Treatment for Non-Viable Pregnancy

The Department will continue to seek federal match regarding treatment related to non-viable pregnancies. No documentation is required for reimbursement on non-viable pregnancy treatment. When a member receives treatment for a non-viable pregnancy condition, an appropriate diagnosis code (listed below) is required:

- O00.0-O00.9, Ectopic Pregnancy
- O01.0-O01.9, Hydatidiform mole
- O02.0-O02.9, Other abnormal products of conception
- O02.1, Missed Abortion (incomplete miscarriage)
- O03.0-O03.9, Spontaneous Abortion

- O08.0-O08.9, Complications following ectopic and molar pregnancy

Abortion and Pregnancy-Related Procedure Codes

The following CPT codes are covered for abortion and pregnancy-related services:

59840	59841	59850
59851	59852	59855
59856	59857	01964
01965	01966	58120
59100	59812-59830	S0199
S0190	S0191	

Surgical Procedure Codes

10A07Z6	10A07ZZ
10A07ZW	10A00ZZ
10A07ZX	10A08ZZ

The Obstetrical Care Billing Manual will reflect these changes on January 1, 2026.

Email Devinne Parsons at Devinne.Parsons@state.co.us with any questions regarding Abortion policy.

Contact Amanda Carlson at Amanda.Carlson@state.co.us with any questions regarding the Family Planning Expansion Groups

Email Amy.Ryan@state.co.us any questions regarding Child Health Plan *Plus*.

Contact the Provider Services Call Center with questions about provider enrollment.

Provider Training Sessions

December 2025 Schedule

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

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

- **Beginner Billing Training**

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

use and more. The Department offers two (2) beginner billing trainings: professional claims (CMS 1500) and institutional claims (UB-04).

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

Time: Two (2) hour presentation / half (0.5) hour Q&A

- **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.

  Audience: This training is not relevant to Home and Community-Based Services (HCBS) and Non-Emergent Medical Transportation (NEMT) providers. This training applies to all other provider types and is recommended after attending beginner billing training.

  Time: One (1) hour presentation /half (0.5) hour Q&A

Live Webinar Registration

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

December 2025				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
1	2	3 Billing Training: Medicare & Third-Party Liability 10:00 a.m. to 11:30 a.m. MT	4 Beginner Billing Training for Professional Claims (CMS 1500) 1:00 p.m. to 3:30 p.m. MT	5
8	9	10	11	12
15	16	17	18	19
22	23	24	25	26
29	30	31		

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

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

Upcoming Holidays

Holiday	Closures
Thanksgiving Day **Thursday, November 27, 2025**	State Offices, Acentra, AssureCare, DentaQuest, Gainwell Technologies and the Provider Services Call Center will be closed. Prime Therapeutics will be open.
Day After Thanksgiving **Friday, November 28, 2025**	State Offices, Acentra and DentaQuest will be closed. AssureCare, Gainwell Technologies, Prime Therapeutics and the Provider Services Call Center will be open. Capitation cycles may potentially be delayed. The receipt of warrants and EFTs may potentially be delayed due to the processing at the United State Postal Service or providers' individual banks.

Provider Services Call Center

1-833-468-0362