COLORADO
Department of Health Care Policy & Financing

Provider News & Resources

January 20, 2026 Issue 137

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All Providers

Known Issues:

Did You Know? Provider Load Letters

A load letter is not intended to provide proof of eligibility. Providers must verify eligibility and not rely on member notification.

The purpose of the load letter is to allow providers to submit claims outside of the 365-day timely filing period if the member was retroactively enrolled. Load letters will only be granted for cases where the member's eligibility was backdated.

If a member's eligibility has been updated within 365 days from the Date of Service (DOS), providers can resubmit the claim and no load letter is needed.

Reconsiderations and Appeals

An appeal is a formal legal process which

Denied Incorrectly

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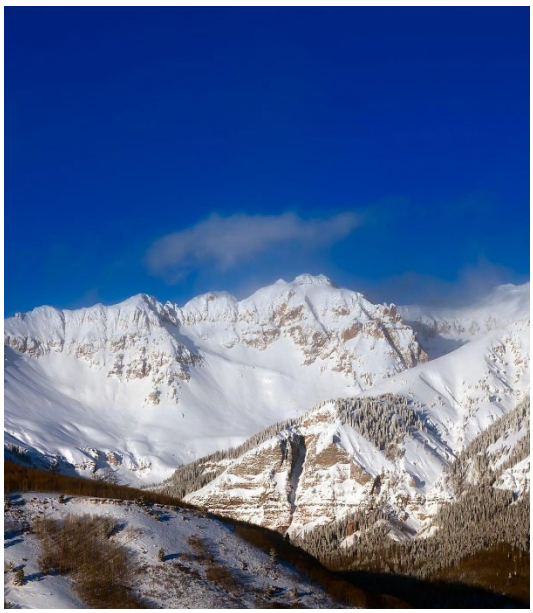
is costly for the provider and the Department of Health Care Policy & Financing (the Department). Providers are encouraged to resubmit new claims instead of filing an appeal or reconsideration. Denied claims do not need to be sent as a request for reconsideration. Claims may be corrected and resubmitted electronically as a new claim.

Providers may receive assistance with their billing questions and policy concerns by contacting the Provider Services Call Center, who will work with the Department to find a resolution.



Claims for Healthcare Common Procedure Coding System (HCPCS) 2026 Procedure Codes Suspending for Explanation of Benefits (EOB) 0000

Claims billed with a Healthcare Common Procedure Coding System (HCPCS) 2026 procedure code may begin suspending for EOB 0000 - "This claim/service is pending for program review" beginning January 1, 2026. The Colorado interChange is being updated with the 2026 HCPCS billing codes based on the Centers for Medicare & Medicaid Services' (CMS) annual release of deletions, changes and additions.

Claims will be released from suspense once the update is complete. Providers are reminded to check the Provider Rates and Fee Schedule web page before billing to ensure the codes are a covered benefit. All codes must be reviewed for medical necessity, prior authorization coverage standards and rates before the codes are reimbursable.

Electronic Data Interchange (EDI): File Naming Information for Providers that Use a Trading Partner

Effective January 7, 2026, standardized file naming conventions for X12 files are in use. Providers should contact their trading partner to confirm their trading partners are using the new X12 file naming standards. File naming conventions may be reviewed on the X12 File Naming Standards Quick Guide web page.

New file names for response and acknowledgement files, such as the Electronic Remittance Advice (ERA), are now in use. Please ensure your vendor has adjusted their system to retrieve reports before reports expire. Providers may also obtain a copy of the Remittance Advice (RA) on the Provider Web Portal if unable to obtain a copy from their vendor.

Contact the Provider Services Call Center with any questions.

Pharmacy Providers

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

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

Note: There are no changes to the Bank Identification Number (BIN), Processor Control Number (PCN) and Group which will result in a seamless transition at the pharmacy.

Upcoming Informational Sessions: To facilitate information exchange and answer questions, MedImpact will hold an informational session via Microsoft Teams on March 2, 2026, from 9:00 a.m. to 10:00 a.m. Mountain Time to facilitate information exchange and answer questions. Join by accessing the link below or dial in by phone.
Join the Meeting
Meeting ID: 211 658 154 148 2
Passcode: v7xL3dw6

Dial in by phone
+1 858-252-2734, 594960382# United States, Del Mar
Find a local number
Phone conference ID: 594 960 382#

Recently Updated Billing Manuals and Fee Schedules

Billing Manuals

- Ambulatory Surgery Centers (ASC)
- Children's Habilitation Residential Program (CHRP) Waiver Program
- Home and Community Based Services (HCBS) - Denver Minimum Wage Regional Pricing Appendix
- Laboratory Services
- Non-Emergent Medical Transportation (NEMT)

Visit the Billing Manuals web page to locate all published manuals.

Fee Schedules

- CwCHN, CHCBS, CHRP (effective January 1, 2026)
- DD, SLS, CES (effective January 1, 2026)

Visit the Provider Rates and Fee Schedule web page to locate all published fee schedules.

Known Issues

Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) Providers

Some Institutional Claims with Revenue Code 900 Denied Incorrectly

Some Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) institutional claims for behavioral health services with revenue code 900 and a Date of Service (DOS) on or after 7/1/2025 denied incorrectly for Explanation of Benefits (EOB) 2028 – "BH REV 900 REQUIRES BH PROC."

Affected claims will be reprocessed.

A resolution is in process.

Pediatric Behavioral Therapy (PBT) Providers

Prepayment Reviews may be Required for Some Pediatric Behavioral Therapy (PBT) Providers

Beginning 2/1/26, the Department of Health Care and Finance (the Department) will conduct prepayment reviews of some Pediatric Behavioral Therapy (PBT) providers.

Reviews will focus on specific PBT coding. Review parameters will be posted publicly once finalized. Individual providers that are asked to participate in prepayment reviews will

receive a direct notice from the Department prior to 2/1/26 that outlines the scope of the review and provides general instructions.

Substance Use Disorder (SUD) Providers

Resolved 1/15/26: Some Substance Use Disorder (SUD) Providers were Incorrectly Disenrolled

Some Substance Use Disorder (SUD) providers were incorrectly disenrolled from Health First Colorado (Colorado's Medicaid program).

Specialty 477 for Substance Use Disorder Clinics is no longer a valid specialty for Provider Type 64 - Substance Use Disorder (SUD) Continuum after December 31, 2025. Refer to the specific specialties on the Find Your Provider Type web page. Enrollments for Provider Type 64 with no other specialty attached by December 31, 2025 were terminated.

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

Issue resolved 1/15/26.

Behavioral Health

Resolved 1/14/26: Some Claims for Short Term Behavioral Health Services were Denying for Explanation of Benefits (EOB) 2029

Some claims for Short Term Behavioral Health services for procedure codes 90791, 90832, 90834, 90837, 90846, 90847 were denying for EOB 2029 - "The Services Must Be Billed to the Members RAE."

Affected claims were reprocessed on 9/3/24.

Issue resolved 1/14/26.

Pharmacy Providers

Resolved 1/7/26: Some Continuous Glucose Monitor (CGM) Claims May Have Paid at an Unexpected Rate

Some professional claims for Continuous Glucose Monitors (CGMs) with a Date of Service (DOS) on or after 11/1/2025 may have paid at an unexpected rate when billed with procedure codes A4238, A4239, A9277, A9276, A9277 or E2103, with no modifier or with a modifier of U1, U2 or U3.

Affected claims were reprocessed 1/9/26.

Issue resolved 1/7/26.

Featured Resources

Updating Electronic Funds Transfer (EFT) Information Quick Guide

An Electronic Funds Transfer (EFT) is required for:

- All in-state and border provider groups, clinics and facilities
- Individual providers who are not affiliated with a group, excluding Physician Assistants and Non-Physician Practitioners (RNs)

A provider is required to submit an EFT document through provider enrollment on the Provider Web Portal. Once the update is submitted via the enrollment portal, a specialist will review the submission, process the update and establish EFT. Paper checks will be sent until EFT has been established.

Each time bank information changes, a new EFT document must be submitted. Reference the Updating Electronic Funds Transfer (EFT) Information Quick Guide on the Quick Guides web page.

Provider Trainings

Provider Training Opportunities in January and February

Providers are invited to sign up for provider training sessions. All sessions are held via webinar on Zoom, and registration links are shown 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.

Intermediate Billing Training
Register for this session: Friday, January 23, 2026, at 10:00 a.m. - 12:00 p.m. MT

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

Billing Training: Medicare & Third Party Liability
Register for this session: Thursday, February 5, 2026, at 1:30 p.m. - 3:00 p.m. MT

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

Provider Enrollment Training
Register for this session: Tuesday, February 10, 2026, at 11:00 a.m. - 1:00 p.m. MT

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

Member Eligibility Training

Register for this session: Wednesday, February 11, 2026, at 1:00 p.m. - 2:30 p.m. MT

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