COLORADO
Department of Health Care Policy & Financing

Provider Bulletin

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Jan 2026

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

Did You Know?

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.

All Providers

All Providers Who Use a Trading Partner

File Naming Changes for Trading Partners

A trading partner is an entity that submits X12N transactions such as batch claim files or batch eligibility inquiries for providers. This entity could be a clearinghouse, a software vendor or a billing agent.

N**ew file naming requirements will be required beginning January 2026.** Trading Partners must review the X12 File Naming Standards Quick Guide web page and should have implemented the new file name structure.

Provider Action Required

Providers who use a vendor or a clearinghouse to batch bill must contact them immediately to confirm they are using the new X12 file naming standards.

Implementation Timeline and Response file name changes

Beginning January 8, 2026, trading partners will begin receiving new file names for response and acknowledgement files such as the Electronic Remittance Advice (ERA). Providers should confirm with their vendors that system updates have been completed, so these reports can be retrieved before they expire.

Providers may also obtain a copy of the propriety Remittance Advice (RA) on the Provider Web Portal.

Contact the Provider Services Call Center with any questions.

Claims for 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.

Drug Testing Medical Necessity Standards

The Laboratory Services Billing Manual was updated in December 2025 to establish specific criteria for when drug testing is considered medically necessary and the specific documentation requirements.

All providers, including laboratories, clinics and substance use disorder treatment practices, who perform and bill for drug testing procedures must follow these policies by **February 1, 2026.** Claims for dates of service on or after February 1, 2026, will be reviewed against these standards. The Department of Health Care Policy & Financing (the Department) encourages providers to review and implement these standards promptly to ensure compliance with existing requirements found in 10 CCR 2505-10 8.076.

This policy refines the broad medical necessity requirement for services to be provided in accordance with generally accepted professional standards for health care in the United States and with the existing laboratory services requirements. Most relevant are the existing policies that require:

- The services have been ordered by a licensed healthcare professional pursuant to the Ordering, Prescribing and Referral policies found in the Laboratory Services Billing Manual and the Ordering, Prescribing, and Referring Claim Identifier Project web page.
- The services are performed to diagnose conditions and illnesses with specific symptoms.
- The services are not routine diagnostic tests performed without apparent relationship to treatment or diagnosis for a specific illness, symptom, complaint or injury.

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

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

Keep Claims within Timely Filing

Providers can keep claims within timely filing by resubmitting every 60 days after the initial timely filing period of 365 days from the date of service (DOS). The previous Internal Control Number (ICN) must be referenced on the claim if the claim is over 365 days. Providers may resubmit within 60 days using the previous ICN if an adjustment is done by the fiscal agent. Visit the Frequently Asked Questions (FAQs) and Billing Resources web page and click the Timely Filing drop-down menu for more information.

Member Billing

Providers are responsible for determining Health First Colorado (Colorado's Medicaid program) coverage before services are rendered. Members cannot be billed for services covered by Health First Colorado.

Providers cannot bill members in the following circumstances:

Delayed notification of eligibility from the member

It is the provider's responsibility to verify eligibility on every date of service. Providers can verify eligibility via the Provider Web Portal, the virtual agent and Batch 270 through in-house software or a clearinghouse.

Providers not enrolled with Health First Colorado do not have access to Health First Colorado eligibility information but should ask if individuals have coverage before providing services. The provider should encourage a member to work with an enrolled provider if the member states Health First Colorado coverage.

Provider is not enrolled with Health First Colorado

Members cannot be billed if the provider chooses not to enroll as a provider for and receive payment from Health First Colorado.

Providers can enroll after services have been rendered to a member. The provider must complete the enrollment process and submit claims within a timely manner. Current timely filing guidelines require submitting claims within 365 days of the date of service.

Prior Authorization Request (PAR) denials

Providers cannot bill members for services rendered but not prior authorized due to lack of information on a Prior Authorization Request (PAR). A Technical/Lack of Information denial does not mean the services are not covered.

Providers also cannot bill members for the denied portion of a PAR or any services rendered beyond what is prior authorized. If a PAR is partially approved, it is considered covered.

Third-Party Liability (TPL) balances, co-pays and deductibles

Providers cannot bill members for the difference between billed charges and the amount reimbursed by the Third-Party Liability (TPL) and Health First Colorado. The provider also

cannot bill members for co-pay or deductibles assessed by a TPL. This information can be found in the General Provider Information Manual, located on the Billing Manuals web page.

Providers are reminded that Health First Colorado is always the payer of last resort. If a member has coverage through a Third-Party Liability (TPL), such as a commercial or individual policy, the provider must utilize the TPL as the primary payer.

Claim denials

System-related denials, such as billing errors or being outside timely filing, are not acceptable reasons to bill members.

Retroactive member eligibility

Providers should return any collected fees to the member, minus any required co-pay(s), and bill Health First Colorado for covered services if the member gains eligibility retroactively.

Providers may obtain a timely filing waiver from the Department if the claim is out of timely filing.

If the covered service requires a Prior Authorization Request (PAR), the Department may direct its Utilization Management (UM) contractor to process a retroactive PAR if the provider submits all required documentation. This does not guarantee the PAR will be approved or the claim paid.

Providers shall not send overdue Health First Colorado member accounts to collection agencies, unless the billing is for a non-covered service and the member has reneged on a written payment agreement with the provider. Visit the Policy Statement: Billing Health First Colorado Members for Services web page for more information.

Payment may be collected from or billed to a Health First Colorado member ***only*** if:

A member is **not enrolled in Health First Colorado** on the date of service.

Service is not covered by Health First Colorado and the member was made aware prior to receiving the service. The provider must enter into a written agreement with the member under which the member agrees to pay for items and services that are non-reimbursable by Health First Colorado (C.R.S. § 25.5-4-301(1)(a)(I)). Questions regarding whether a service is covered by Health First Colorado may be referred to the Provider Services Call Center.

Note that providers may only collect co-pays from members with primary Medicaid coverage (§ 8.754.1).

Refer to the Policy Statement: Billing Health First Colorado Members for Services for more information.

Pharmacy Benefit Management System (PBMS) Transitioning

Components of the Department's Pharmacy Benefit Management System (PBMS) are being transitioned from Prime Therapeutics (formerly Magellan) to MedImpact. In October 2025, the

Rebate module and Preferred Drug List module were implemented by MedImpact. The core PBMS module and Real-Time Benefit Tool module implementations are anticipated for April 2026.

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 (anticipated April 2026)
  - Real-Time Benefit Tool (anticipated April 2026)
  - Rebate (launched October 2025)
  - Preferred Drug List (launched October 2025)
- 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. The information will be 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 Enrollment Application Fee for Calendar Year 2026

Certain providers are required by the Affordable Care Act (ACA) to remit an application fee when applying to be part of the Health First Colorado provider network. The Centers for Medicare & Medicaid Services (CMS) sets the fee annually. This fee is assessed at initial enrollment, revalidation and change of ownership, as required, and is assessed in full for each service location enrolled in Health First Colorado.

The Provider Enrollment application fee has been set at $750 for the 2026 calendar year.

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 January 2026

Significant changes in Pend and Prior Authorization Request (PAR) timeframes will be occurring. 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 highlighted here:

- Standard PAR request shall be completed within seven (7) calendar days.
- Expedited PARs must be completed within 72 hours.
- A Pend Authorization Request 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 in compliance with the rule requirement for three (3) calendar days. Ensure all documentation is included with the initial PAR submission.

These changes are required for Acentra Health Inc. and the Department of Health Care Policy & Finance (the Department) to be compliant with the new CMS Interoperability Rule. These changes will facilitate a faster turnaround time for PARs overall and decrease administrative burden for all parties once implemented. Visit the CMS web page for more information on the rule.

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

Reminders for PAR submission requirements for Certified Nurse Aide (CNA):

- When submitting Plans of Care (POCs) for CNA services, the Home Health Agency shall indicate a comprehensive list of the amount, frequency and expected duration of provider visits for each discipline ordered by the Member's Ordering Physician or Allowed Practitioner. The POC must also detail the specific duties, treatments and tasks to be performed during each visit, as well as all services and treatments to be provided under the POC.
    - It is recommended providers include a task breakdown of each CNA task and the time it takes to perform at the visit to ensure easier justification of the time requested.
    - Every task listed in the POC must be supported by clinical documentation demonstrating why the task requires the skills of a CNA.

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

Reference the Home Health Services Rules and Regulations for details on the rule requirements for documentation and PAR submission.

Prior Authorization Request (PAR) Submission Training for Acentra

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

- Acute Home Health Benefit Training January 14, 2026, at 9:00 a.m.
- Acute Home Health Benefit Training January 14, 2026, at 12:00 p.m.
- Portal Registration and PAR Submission Training January 7, 2026, at 9:00 a.m.
- Portal Registration and PAR Submission Training January 7, 2026, 12:00 p.m.

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

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

Ambulatory Surgery Center (ASC)

January 2026 Updates to Allowed Procedures

The addition of the following surgical procedures as allowed ASC procedures has been reviewed and approved, effective January 1, 2026, for dates of service January 1, 2026, and later.

ASC Group 1					
10005	50387	50389	53451	55876	64561

ASC Group 2	
57295	58356

ASC Group 8					
50080	50575	50580	51535	52649	54650
57282	57283	57287	63020	63030	

ASC Group 9		
50081	55880	63047

The Ambulatory Surgery Center (ASC) billing manual has been updated accordingly.

Contact Chris Lane at Chris.Lane@state.co.us with any questions.

Behavioral Health Providers

Access to Behavioral Health Services for Individuals under Age 21 Report

A report has been submitted by the Department to the General Assembly on access to behavioral health services for individuals under the age of 21 years. This report provides an analysis of utilization of a limited set of behavioral health services covered under Health First Colorado that went into effect July 1, 2024, per Senate Bill 23-174.

Read the full report on the Legislator Resource Center.

Behavioral Health (BH) Peer Support Professional Certification Requirements: Attestation Required January 1, 2026

The State Medicaid Director letter #07-011 indicates that states must determine the minimum training and certification criteria for professionals delivering peer support services in a behavioral health context. The Department follows the definitions of training and certification requirements for Peer Support Professionals in Behavioral Health Administration (BHA) rule. In alignment with the Medicaid Sustainability Memo published in June 2025, agencies must sign and submit this attestation to their Regional Accountable Entity (RAE) or RAEs by January 1 annually, indicating that all Behavioral Health Peer Support Professionals are either certified or are in the process of becoming certified. Additional information is posted on the Behavioral Health Policies, Standards and Billing References web page under the section titled Behavioral Health Peer Support Policy.

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

Certified Community Behavioral Health Clinic (CCBHC) Ongoing Work

2026 CCBHC Work in Colorado

Certified Community Behavioral Health Clinic (CCBHC) work continues in Colorado into the 2026 calendar year. The CCBHC Planning Grant project team has requested a No-Cost Extension to expand resources from the 2025 CCBHC Planning Grant year into 2026. The Colorado CCBHC project team will continue work regarding exploration of the CCBHC model in Colorado with or without the extension, though work and project plans may need to be modified if the extension is not granted to Colorado.

Updates on the status of the extension request will be shared at the next CCBHC Stakeholder Engagement event on Monday, January 26, 2026, at 3:00 p.m. MT.

Register for the meeting to attend.

PPS Financial Guardrail Discussion

The Department and Behavioral Health Administration (BHA) are currently developing a Prospective Payment System (PPS) Guardrails Plan and seeking feedback from partners.

A PPS is a flexible, advanced reimbursement model that ties payment to daily encounters instead of to individual services. It is provider-specific and based on each provider's unique cost structure, designed to cover a safety net provider's actual cost of services.

The Guardrails Plan will detail the structure of the PPS payment, financial and data reporting requirements and quality requirements. It will also explain the monitoring and oversight processes and potential impacts of noncompliance.

The draft plan will be shared publicly in early 2026.

The first stakeholder session is scheduled for January 23, 2026, from 11:00 a.m. to 12:00 p.m. MT. Register in advance via Zoom. Additional methods for submitting feedback and input will be made available soon.

Health First Colorado Behavioral Health Rendering Provider Oversight (RPO) Policy: Final Version Posted - Attestation Due January 1, 2026

Appreciation is extended to everyone who took the time to submit feedback and ask clarifying questions regarding the Health First Colorado Behavioral Health Rendering Provider Oversight (RPO) policy. Participation was invaluable in shaping clear, effective policies that support both providers and members.

The final version of the RPO Policy and a document answering Frequently Asked Questions are now available on the Behavioral Health Policies, Standards and Billing References web page.

All Health First Colorado enrolled providers who are subject to this policy must submit the attestation annually by January 1 to any Regional Accountable Entity (RAE) the billing provider is contracted with, confirming adherence to rules and standards outlined in the policy.

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

New Frequently Asked Questions (FAQ) on Prior Authorization and Retrospective Reviews for Outpatient Psychotherapy Released

A Frequently Asked Questions (FAQ) on Prior Authorization and Retrospective Reviews for Outpatient Psychotherapy has been released to answer the questions received from providers, advocates and legislators about the recent guidance for the Regional Accountable Entities (RAEs) on utilization management of outpatient psychotherapy services. In the guidance, RAEs were directed to develop strategies to address the unmanageable growth in outpatient

psychotherapy and ensure services are medically necessary. This included an expectation that the RAEs establish processes to review outpatient psychotherapy that exceeds 24 sessions in a state fiscal year (July through June).

The FAQ provides additional information about the scope and goals of the policy and will assist the RAEs and providers in implementing the change. The FAQ and related RAE Transmittal guidance are posted in the Resources section of the Behavioral Health web page.

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

New Regional Accountable Entity (RAE) Network Management Provider Memo Released

A Regional Accountable Entity (RAE) Network Management Provider Memo has been released. The memo details how the RAEs will focus their provider recruitment and network expansion efforts based on regional need and quality of care. Instead of offering a contract to any willing provider, RAEs will prioritize providers that fill network gaps and are able to demonstrate quality outcomes when building their networks.

Find the RAE Network Management Provider Memo in the Resources section of the Behavioral Health web page.

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

Reimbursement for Electroconvulsive Therapy (ECT)

Effective January 1, 2026, Regional Accountable Entities (RAEs) will begin outreaching and adjusting contracts for Electroconvulsive Therapy (ECT). Effective April 1, 2026, the Department will enforce the revised reimbursement requirements detailed below for ECT.

- ECT-related anesthesia must be incorporated into the reimbursement rate for ECT. 00104, Anesthesia for Electroconvulsive Therapy, will be phased out for use under the capitated behavioral health benefit.
- ECT cannot be reimbursed outside of per diem payments for inpatient psychiatric services.

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

Reminder for Providers to Reference the Current Billing Manual

Ensure that the most up-to-date State Behavioral Health Services (SBHS) Billing Manual is utilized by selecting the manual from the State Behavioral Health Services Billing Manual web page. This will ensure the most accurate billing information.

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

SUD Residential Levels of Care Utilization Management

In January 2021, members began receiving expanded Substance Use Disorder (SUD) services through the 1115 waiver. To support the rollout of these new benefits, the Department implemented minimum length of stay requirements. These requirements were designed to provide Regional Accountable Entity (RAE) education and ensure a smooth transition. Over the past four (4) years, meaningful progress has been made in expanding access and improving service delivery.

Effective March 1, 2026, the Department will remove the minimum length of stay requirements. This change empowers RAEs to authorize treatment durations that meet each member's unique needs, which aligns to a core principle of The American Society of Addiction Medicine (ASAM) criterion that treatment should be individualized based on patient needs and preferences.

If a RAE requires a prior authorization review (PAR) for residential or inpatient SUD treatment, the RAE must allow providers up to 24 hours post admission to request authorization.

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

Sunsetting H0006, Alcohol and/or Drug Service - Case Management

Procedure code H0006, Alcohol and/or Drug Service - Case Management, is sunsetting effective December 31, 2025, and will no longer be reimbursed. The services covered under this Substance Use Disorder (SUD) specific code can be delivered more generally under other existing behavioral health case management codes.

Refer to the State Behavioral Health Services Billing Manual for other case management procedure codes.

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

Durable Medical Equipment

Continuous Glucose Monitor (CGM) Updates

Beginning November 1, 2025, CGMs are billed to the pharmacy benefit ***or*** as a professional claim. All professional claims submitted for CGM products and supplies must include the National Drug Code (NDC) of the product, the proper Healthcare Common Procedure Coding System (HCPCS) procedure code, and modifier combination when submitting a claim. The Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Billing Manual will be updated to contain a crosswalk of the CGM product, HCPCS and modifiers that must be used when submitting claims.

CGMs that do not have an NDC or a Wholesale Acquisition Cost (WAC) must be submitted as a professional claim and **require** Questionnaire 20 to be submitted with the prior authorization request (PAR) and to the claim. Questionnaire 20 can be found on the Provider Forms web page under the Durable Medical Equipment, Prosthetics, Orthotics & Supplies (DMEPOS) Forms drop-down.

A new prior authorization request (PAR) will be required for CGMs that are billed to the pharmacy benefit.

Managed Care Carveouts

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 prior carve-in method of CGMs supplied to children.

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

House Bill 24-1327: Physical Therapists Prescribing Medical Equipment

House Bill 24-1327 was passed during the 2024 Legislative Session to authorize a licensed physical therapist to directly recommend and prescribe Durable Medical Equipment (DME) to a Health First Colorado member without requesting the prescription from a licensed physician. Additional information can be found on the Ordering, Prescribing and Referring web page.

Contact Devinne Parsons at Devinne.Parsons@state.co.us with questions regarding Physical Therapy policy.

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

As a reminder, Complex Rehabilitative Technology (CRT) providers should have submitted repair metrics data for the period June 1, 2025, through November 31, 2025, by December 31, 2025. Providers must send data to HCPF_DME@state.co.us to comply with 10 CCR 2505-10 8.590.5.E.3.a. While data submitted after the deadline will still be accepted, providers are strongly encouraged to submit as soon as possible to support timely review and processing.

Wheelchair Mounted Robotic Arms: Updated Policy

Effective November 25, 2025, Wheelchair Mounted Robotic Arms (WMRA) are being reviewed on a case-by-case basis under the Department's medical necessity criteria, which can be found at 10 CCR 2505-10 8.076.8. These devices are generally considered experimental or

investigational because available clinical evidence is insufficient to demonstrate clinically meaningful benefit, functional improvement or reduction in caregiver burden. Requests for coverage will typically be denied as not medically necessary unless the provider submits compelling, member-specific clinical evidence demonstrating that the device meets Colorado's medical necessity criteria.

For members under 21, consistent with Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements at 42 U.S.C. § 1396d(r), WMRA devices may be covered when medically necessary to correct or ameliorate a physical or mental condition, even if not otherwise covered for adults. Such requests will be subject to prior authorization with individualized review. This policy can be found in the Wheelchair Benefit Coverage Policy.

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

Home and Community-Based Services (HCBS)

Long-Term Care Employer Reporting for the Direct Care Worker Tax Credit

Effective Tax Year 2025, all long-term care employers must report the total hours worked by each eligible direct care worker in Colorado to the Department of Revenue (DOR) by January 31 of each year.

Failure to file by the deadline may result in a $500 penalty.

Who Must Report

Long-term care employers include:

- Home and Community-Based Services (HCBS) Providers (Provider Type 36)
- Nursing Facilities (Provider Types 20 and 21)
- Certified Home Care Agencies (Provider Type 10)

Eligible Services

The following hands-on services and supports fall under eligible services for this tax credit:

- Adult Day Services
- Alternative Care Facility
- Behavioral Services
- Consumer Directed Attendant Support Services (CDASS)
- Community Connector
- Day Treatment
- Extraordinary Cleaning
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IDD)
- Intermediate Care Facilities Nursing Facility (ICF-NF)
- In-Home Support Services (IHSS)

- Independent Living Skills Training
- Life Skills Training
- Mentorship
- Mental Health Transitional Living Homes
- Pediatric Personal Care
- Personal Care
- Prevocational Services
- Residential Habilitation (Group Residential Services and Supports [GRSS], Individual Residential Services and Supports [IRSS])
- Respite
- Specialized Habilitation
- Supported Community Connections
- Supported Employment
- Supported Living Program
- Therapeutic Respite
- Transitional Living Program
- Youth Day Services
- Youth Mentorship

Who Is Covered

- Employers who provide HCBS services, nursing facility care or certified home care agency services.
- Eligible direct care workers (excluding Certified Nursing Assistants [CNAs] are individuals who:
    - Provide hands-on personal care or services to long-term care recipients in Colorado
    - Worked at least 720 hours during the tax year.

What Employers Must Report

For each eligible direct care worker, employers must submit:

- Worker's name
- Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN)
- Total hours worked during the calendar year

Additional Information

Visit the Department of Revenue's Long Term Care Employer Report web page to learn how to file. Refer to the Direct Care Worker Tax Credit Frequently Asked Questions for additional information.

Nurse Assessor Program Ending

The Department is announcing the end of the Nurse Assessor Program for Health Maintenance Activities (HMA), Private Duty Nursing (PDN) and Long-Term Home Health (LTHH), as outlined in HCPF Operational Memo 25-075.

Key Points for Providers

- Effective immediately, no new HMA referrals should be submitted to Telligen. Only scheduled HMA assessments will be completed through December 24, 2025.
- Beginning December 22, 2025, Case Managers resumed full responsibility for determining and authorizing HMA hours using the Direct Care Services Calculator (DCSC).
- PDN and LTHH will not return to the Nurse Assessor program. Providers must continue submitting all prior authorization requests (PARs) and clinical documentation to Acentra.

Home Health Agencies should continue providing care per physician-ordered Plans of Care and follow existing PDN/LTHH processes to prevent service gaps.

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 **Friday, January 9, 2026, from 1:00 p.m. - 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.

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.

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

The Department has worked 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 was scheduled for completion within the fourth quarter of calendar year 2025. All impacted outpatient hospital claims are in the process of being identified and reprocessed to pay using the correct rates and version.

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

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. Postponement of Senate Bill 25-121, which was intended to raise reimbursement for the device, has created some access to care barriers.

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

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

Managed Care

Reminder: Claims Submission Compliance

This is a reminder that providers who submit claims to a Regional Accountable Entity (RAE) or Managed Care Organization (MCO), including Child Health Plan *Plus* (CHP+) MCOs may need to take action to continue receiving reimbursement for providing covered services to Health First Colorado and Child Health Plan *Plus* (CHP+) members. RAEs and MCOs will begin rejecting or denying claims on a rolling basis for providers who:

1. Have used incorrect information during enrollment in the Medicaid Management Information System (MMIS)
2. Submit claims with information that does not match the National Provider Identifier (NPI), Provider Type and/or Taxonomy Codes in MMIS

Providers may resubmit the claims to their RAE/MCO with information that matches MMIS or once they have corrected their information in MMIS. Refer to the November 2025 Provider Bulletin and the Managed Care Compliance fact sheet for more information. Providers should contact their RAE/MCO with questions about whether they may be impacted by these upcoming changes or for help on making the appropriate changes to their claims.

Nursing Facilities

Anesthesia Providers: Duplicate Billing of Services Rendered by a Certified Registered Nurse Anesthetist (CRNA) Supervised by an Anesthesiologist

When services are rendered by a CRNA who is supervised by an anesthesiologist, the procedure will only be paid once. If the services are billed by both the CRNA and the anesthesiologist, the second claim will be denied as a duplicate.

Contact Chris Lane at Chris.Lane@state.co.us with questions regarding anesthesia policy.

Nursing Facility Swing Bed Rate Effective January 1, 2026

Code of Colorado Regulations 10 CCR 2505-5, §8.443.1. E. requires the nursing facility swing bed rate be updated annually and "shall be determined as the state-wide average class I nursing facilities payment rate at January 1 of each year."

The updated swing bed rate effective January 1, 2026, is $288.78. The rate has been updated in the Colorado interChange and claims reimbursement should reflect the updated rate for dates of services on or after January 1, 2026.

Skilled Nursing Facilities (SNFs) and Hospice Providers: Elevated Risk Levels

Starting in January 2026, Skilled Nursing Facilities (SNFs) that were enrolled or revalidated on or after January 1, 2023, and Hospice providers enrolled on or after January 1, 2024, will start receiving letters explaining elevation to **high-risk** levels, which requires additional enrollment screening, fingerprint-based background checks and a site visit. This is pursuant to federal rule 42 C.F.R. § 455.434 and Colorado rule 10 C.C.R. 2505-10: 8.125.12.

The letter will list owner or provider individuals that will be required to comply:

- Fingerprints **must** be obtained from one (1) of the approved fingerprinting sites.
- There are fingerprinting sites throughout Colorado. It should not be necessary to travel more than 40 miles to get fingerprinted.
- Individuals are responsible for paying the fingerprinting fee.
- The ***original*** Applicant Fingerprinting must be completed. Hard copies, photocopies, faxes and emails of the Applicant Fingerprint Card **will not be accepted**.
- Most individuals only need to get fingerprinted once, but the Department may ask for more if needed.
- It takes approximately 30 business days to process fingerprints.

More communications to enrolled SNFs and Hospice providers will be made within the upcoming weeks.

- Providers are reminded to maintain updated contact information on their profile in the Provider Web Portal.
- Refer to the Employment and Background Checks web page of the Colorado Bureau of Investigation (CBI) website for additional information and a list of approved fingerprinting site locations.
- Refer to the Enrollment Frequently Asked Questions (FAQs) on the Provider Enrollment web page for information regarding the fingerprinting process.
- Providers may contact the Provider Services Call Center to check site visit or fingerprinting requirements statuses.

Physician-Administered Drugs

Hospital Specialty Drug Policy: Prior Authorization Update

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

Ryoncil (remestemcel-L-rknd), Healthcare Common Procedure Coding System (HCPCS) code J3402, has been added to the approved hospital specialty drug list effective November 3, 2025. The entire list of specialty drugs subject to this policy are listed on Appendix Z: Hospital Specialty Drugs List.

In accordance with the U.S. Food and Drug Administration (FDA) labeling changes, Appendix Z criteria updates have been made for Elevidys (delandistrogene moxeparvovec-rokl), HCPCS code J1413 and Kymriah (tisagenlecleucel), HCPCS code Q2042.

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

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

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

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

Prior Authorization Update

On November 14, 2025, the Food and Drug Administration (FDA) approved substantial labeling revisions for Elevidys (delandistrogene moxeparvovec-rokl), including:

- Addition of a Boxed Warning describing the risk of serious liver injury and acute liver failure, including fatal outcomes.
- Limiting the indication to ambulatory patients with Duchenne Muscular Dystrophy (DMD).
- Removal of the indication for non-ambulatory patients with DMD.
- Addition of a Limitations of Use statement to guide clinical decision-making.
- Updates to the Warnings and Precautions, Dosage and Administration, Adverse Reactions, Use in Specific Populations, Clinical Studies and Patient Counseling Information sections; and
- Inclusion of a new Medication Guide for patients and caregivers.

The full announcement describing the changes can be found on the FDA Press Announcements web page.

In accordance with the U.S. Food and Drug Administration (FDA) labeling changes, Appendix Y criteria updates have been made for Elevidys (delandistrogene moxeparvovec-rokl), Healthcare Common Procedure Coding System (HCPCS) code J1413.

In addition, effective January 1, 2026, the HCPCS codes listed in the table below will be added to Appendix Y and will be subject to Prior Authorization (PA).

J1442	Q5125	J2506	Q5111	Q5127
Q5101	J9312	Q5108	Q5122	Q5130

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

All PAD PA procedures, clinical criteria and PADs subject to PA requirements can be found 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 on the ColoradoPAR: Health First Colorado Prior Authorization Request Program web page and the Physician Administered Drug Provider Resources web page.

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

Quarter 1 Rate Update 2026

The Physician Administered Drug (PAD) rates for the first quarter of 2026 have been updated. The new rates are effective January 1, 2026, and are posted to the Provider Rates & Fee Schedule web page under the Physician Administered Drug Fee Schedule section.

Pharmacy

Enhanced Dispensing Fee for Parenteral Nutrition Products

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

Billing Instructions:

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

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

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 claims for abortion medication for members enrolled in a physical health managed care plan (Denver Health and Rocky Mountain Health Plans).

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

Physician Services

Co-Surgery Policy Reminder

Providers are reminded that co-surgery services which are reported using modifier 62 are only reimbursable for procedures listed on the Medicare Physician Fee Schedule Database with a co-surgery indicator of two (2). Other procedures billed with this modifier will be denied.

Refer to the Medical-Surgical Billing Manual for additional information.

Contact Chris Lane at Chris.Lane@state.co.us with any questions.

Colorado Medicaid eConsult Update

Health First Colorado providers can access a free, secure statewide electronic consultation platform via the Colorado Medicaid eConsult web page. 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 was expanded to support specialty-to-specialty consultations. This enhancement will broaden 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.

Refer to the Telemedicine Billing Manual for full details on updated criteria and eConsult reimbursement policies.

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

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

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

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

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

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

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

Immunizations Updates and Reminders

All medically necessary immunizations are a benefit for all Health First Colorado members without cost sharing.

A birth dose of Hepatitis B vaccine is a covered benefit for all members.

The Measles, Mumps, Rubella and Varicella (MMRV) combination vaccine is a benefit for all children aged one (1) through 12.

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

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

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

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

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

Telehealth

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

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

Primary Care Medical Providers

New Transitions of Care Codes

The traditional Transitional Care Management codes 99495 and 99496, referred to collectively as Transitions of Care (TOC) codes, are effective January 1, 2026. Outpatient providers will be able to bill the TOC codes for follow-up visits within 14 days of discharge from inpatient or observation-level care. TOC services play a critical role in reducing preventable readmissions and improving continuity of care for members following hospital or facility discharge.

Refer to the Accountable Care Collaborative (ACC) Transitions of Care Billing Guidance Fact Sheet for information about which provider types in addition to Primary Care Medical Providers (PCMPs) are able to use the TOC codes.

What This Means

Effective January 1, 2026, providers can begin billing codes 99495 and 99496 in place of the E/M codes 99214 and 99215 for eligible TOC visits. The TOC codes will be reimbursed at an equivalent rate to the E/M codes (e.g., 99495 will be reimbursed at the same rate as 99214 and 99496 will be reimbursed at the same rate as 99215).

Providers must complete the following activities to successfully bill the TOC codes:

1. **Initial Contact:** Within two (2) business days of the discharge date, the billing provider or qualified auxiliary personnel (under the supervision of the billing provider) makes two (2) attempts to initiate direct and interactive communication with the patient or caregiver (phone, in-person, electronic) addressing: type of services the patient had during admission, discharge diagnosis, patient status and follow-up services that may be needed, medication reconciliation (not required to be part of the interactive contact, but must occur no later than the date of the face-to-face visit/virtual visit) and scheduling a face-to-face visit or virtual visit with the provider based on the required timeframes for each code, as outlined in the billing guidance.
2. **Follow-Up Appointment (Face-to-Face or Virtual Visit):** Following discharge, and after the interactive contact, a face-to-face or virtual visit allows the billing provider to assess the patient and develop a plan to aid the patient's return to the community setting. Medication reconciliation must occur no later than the date of the face-to-face or virtual visit, with the billing provider reviewing and signing off on any medication reconciliation performed by auxiliary personnel. The required time frame for this visit is based upon the complexity of the medical decision making (either moderate or high) for the patient's condition, as outlined in the billing guidance.
3. **Non-Face-to-Face Services:** Additional care coordination services may be performed, as needed, by the patient or caregiver, throughout the 30-day post-discharge time period. Non-face-to-face services may be performed by the billing provider and/or auxiliary personnel. Although auxiliary personnel may not perform provider-only services, the provider may choose to personally perform any care coordination services.

Providers cannot bill the following E/M codes on the same date of service for members:

- Office or other outpatient E/M visits: 99202–99205 (new patient) and 99211–99215 (established patient)
- Home visit E/M codes: 99341–99345 (new patient home visits) and 99347–99350 (established patient home visits)
- Domiciliary / rest home / custodial care E/M codes: 99324–99328 (new patient) and 99334–99337 (established patient)

More information about how and when providers can bill these codes is available in the Accountable Care Collaborative (ACC) Transitions of Care Billing Guidance Fact Sheet.

Benefits for Members

- Reduced readmission risk: TOC visits address clinical needs early, such as medication reconciliation, and close gaps in care by providing structured follow-up within seven (7) to 14 days after discharge.
- Improved overall outcomes: Early post-discharge engagement supports member stability, adherence and long-term health.

Benefits for Providers

- Standardized workflows across payers: Many payers, including commercial and Medicare, already reimburse TOC services. Aligning with these existing practices

allows providers to use the same standardized workflow and documentation processes for all patients, without having to implement a different process for Health First Colorado members.
- Shared savings opportunity: Lower readmission rates and improved medication adherence that result from consistent TOC engagement contribute to improved member outcomes and can enhance providers' ability to earn shared savings. More information is available on the Alternative Payment Model web page.
- Strengthened care coordination: TOC services formalize timely post-discharge follow-up workflows that benefit both providers and members.

Next Steps

Starting January 1, 2026, all primary care providers are encouraged to review Accountable Care Collaborative (ACC) Transitions of Care Billing Guidance Fact Sheet and incorporate TOC visits for eligible members discharged from inpatient or observation-level care.

Contact Morgan Anderson at Morgan.Anderson@state.co.us with questions about billing or reimbursement for these codes. Contact HCPF_ACC@state.co.us with general questions.

Transportation Providers

Credentialing and Revalidation Update

Non-Emergent Medical Transportation (NEMT) providers are advised to no longer initiate or continue provider credentialing or revalidation processes until the current moratorium is lifted. Most providers have had more than a year to complete these requirements, and no further credentialing or revalidation actions can be processed at this time.

This moratorium does ***not*** impact the obligation to maintain current driver and vehicle rosters, which must continue to be updated as changes occur. Additional guidance will be shared as soon as the moratorium is no longer in effect and normal processing can resume.

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

Non-Emergent Medical Transportation Services In Metro County Areas

Reminder: Non-Emergent Medical Transportation (NEMT) services in the nine (9) metro county area (Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson, Larimer and Weld counties) may only be billed through the Department's NEMT Broker, TransDev Health Solutions.

Emergency Medical Transportation (EMT) providers should **not** bill for NEMT services using their EMT Provider Type 13 enrollment. EMT providers who also offer NEMT services must use

their NEMT Provider Type 73 enrollment for billing. **All NEMT services must be scheduled and billed through TransDev Health Solutions for members in the nine (9) metro county brokered area.**

EMT providers in the nine (9) county area who are not enrolled and revalidated to provide NEMT should contact Mattew.Paswaters@state.co.us to express interest.

Women's Health, Family Planning

Abortion Coverage

Effective January 1, 2026, coverage of abortion services is in compliance with SB25-183 for the following eligibility categories:

- Medicaid (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+)

Services related to abortion care will be fully covered via state 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 will not be billed for them (CO Rev. Stat. §25.5-4-301).

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

Family Planning Expanded Income Population (FAMPL) and Abortion Access

The FAMPL population receives federal match, under Senate Bill 21-025, an "eligible member" for FAMPL is defined as one who:

- Is not pregnant and whose income does not exceed the state's current effective income level for pregnant people under Child Health Plan *Plus* (CHP+)

Considering federal matching funds cannot be used for abortion procedures, FAMPL members cannot receive abortion coverage while remaining in the federally matched eligibility category.

The solution for abortion coverage for FAMPL members to ensure access to care:

- The member must report the pregnancy.
- The member will then be automatically moved into CHP+, which covers elective abortions billed with Z33.2 using state-only funds.
- The member will receive 12 months of continuous CHP+ coverage, during which abortion services are payable.

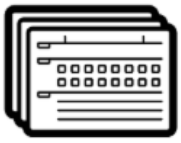
Providers should assist members, when appropriate, in understanding the need to report pregnancy to ensure correct benefit enrollment.

Treatment for Non-Viable Pregnancy

The Department will continue to seek federal matching regarding treatment related to non-viable pregnancies and miscarriage management. No documentation is required for reimbursement on non-viable pregnancy and miscarriage management treatment. Listed below are the appropriate diagnosis codes required to use when a member receives treatment for a non-viable pregnancy condition:

- 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

Claim Submission Requirements



Separation of State-Funded and Federally Matched Services

All abortion and abortion-related services must be billed together on a single claim funded by state-only dollars. If other services provided on the same date of service qualify for a federal match, they must be billed on a separate claim.

Example:

- A member receives an abortion and an IUD insertion on the same date of service:
    - Claim 1 (state-funded):
        - Abortion procedure and all abortion-related services
        - No FP or FP+32 modifiers
    - Claim 2 (federally matched):
        - IUD device and insertion
        - FP or FP+32 modifiers, as appropriate

This ensures accurate federal vs. state fund allocation and prevents claim denials, reprocessing or recoupment.

Modifier and Telemedicine Guidance

Family Planning(FP) Modifiers: FP and FP+32

Although abortion is classified as a family planning service under state law, abortion claims **must not** include the FP or FP+32 modifiers. FP modifiers indicate federally matched services, and abortion services are reimbursed with state-only funds. Using the FP modifiers on abortion claims will cause claims reprocessing or denials.

The Department requests that providers do not append FP to FP+32 modifiers to abortion procedures, abortion-related E/M services, telemedicine components of abortion care, and S0199 abortion service bundles.

Telemedicine and S0199

Effective January 1, 2026, providers are no longer required to append Modifier 52 to S0199 when telemedicine is used for any portion of the service. Telemedicine may be used for components such as counseling, follow-up consultation or confirmation of pregnancy. The Department will issue further guidance regarding any informational telemedicine modifiers to be used with abortion claims.

Procedure Codes

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

Abortion and Pregnancy-Related Procedure Codes

The following CPT codes are appropriate 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 new Reproductive Health Care Billing Manual will reflect these changes on January 1, 2026.

Contact Devinne.Parsons@state.co.us with any questions regarding abortion policy.

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

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

Contact the Provider Services Call Center with any questions regarding provider enrollment.

Provider Training Sessions

January 2026 Schedule

Providers are invited to sign up for provider training sessions. All sessions are held via a Zoom webinar 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 January:

Provider Enrollment Training

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

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

Beginning Billing Training

Beginner billing training provides a high-level overview of member eligibility, claim submission, prior authorizations, Department website navigation, Provider Web Portal use and more. The Department offers two (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) hours presentation / Half (0.5) hour Q&A

Intermediate Billing Training

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.

- Audience: This training applies to all provider types and is recommended after attending beginner billing training.
- Time: One and a half (1.5) hours 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.

January 2026				
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
			1	2
5	6	7 Provider Enrollment Training: 10:00 a.m. - 12:00 p.m. MT	8	9
12	13 Beginner Billing Training: Professional Claims (CMS 1500): 11:00 a.m. - 1:30 p.m. MT	14	15	16
19	20	21 Beginner Billing Training: Institutional Claims (UB-04): 10:00 a.m. - 12:30 a.m. MT	22	23 Intermediate Billing Training 10:00 a.m. - 12:00 p.m. MT
26	27	28 Beginner Billing Training: Professional Claims (CMS 1500): 9:00 a.m. - 11:30 a.m. MT	29	30

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 for more training materials on navigating the Provider Web Portal.

Upcoming Holidays

Holiday	Closures
News Years Day **Thursday, January 1, 2026**	State Offices, Acentra, AssureCare, DentaQuest, Gainwell Technologies and the Provider Services Call Center will be closed. Prime Therapeutics will be open. Capitation cycles may potentially be delayed. The receipt of warrants and EFTs may potentially be delayed due to the processing at the United State Postal Service or providers' individual banks.
Martin Luther King Jr. Day **Monday, January 19, 2026**	State Offices, Gainwell Technologies, DentaQuest, AssureCare and the ColoradoPAR Program will be closed. Capitation cycles may potentially be delayed. The receipt of warrants and EFTs may potentially be delayed due to the processing at the United State Postal Service or providers' individual banks.

[Provider Services Call Center]

1-833-468-0362