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Did You Know?

Providers can view members' Prior Authorization Request (PAR) statuses in the [Provider Web Portal](#) by choosing the Care Management option on the home page and clicking View Authorization Services. Users should enter the member's ID.

Home and Community-Based Services (HCBS) providers must also enter the PAR number to search for the PAR status. HCBS providers should still be receiving PAR letters from case managers.

Only finalized PARs are visible in the Provider Web Portal. PARs that are still in progress with Acentra or a case manager cannot be viewed through the Provider Web Portal. Refer to the [Viewing Prior Authorizations in the Portal Quick Guide](#), available on the [Quick Guides web page](#), for more information on viewing PARs in the Provider Web Portal.



All Providers

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 April 2026. For more information, visit the [National Correct Coding Initiative \(NCCI\) Edits web page](#).

All Providers Who Use a Trading Partner

Electronic Data Integration (EDI) Vendor Transition

Providers that use a clearinghouse or billing agent to submit X12 batch transactions on their behalf will need to ensure that the vendor is aware of the changes below.

Electronic Data Integration (EDI) functionality, including batch processing and trading partner enrollment, is transitioning to a new platform and vendor: Edifecs, a Cotiviti Business.

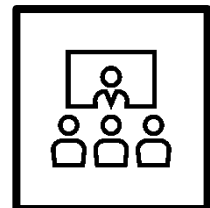
These changes are being implemented in three (3) phases.

The initial phase, [X12 File Naming Standards Changes](#), went live on January 7, 2026.

The next phase is targeted for implementation in the summer of 2026 and includes the following changes:

- New agreement to be signed by trading partners
- New platform for trading partners to exchange files
- New login credentials for the platform (to be issued once the agreement has been acknowledged)
- New Trading Partner Enrollment and Testing Site

Trading partners will be invited by email to participate in one (1) of multiple training groups. Group training sessions will start later this spring and continue until implementation. Ensure [contact information is current](#) to receive the training invitation. More detailed information will be shared in future Provider Bulletins.



The final phase is expected to be implemented in the fall of 2026.

What is staying the same?

- Providers may still use the [Provider Web Portal](#) to submit individual claims, maintain enrollment, verify individual eligibility and more.

- Providers and trading partners will contact the [Provider Services Call Center](#) with any questions about claims, the Provider Web Portal or EDI.
- Active trading partners will retain the same trading partner IDs.

Note: Trading partners will **not** be able to utilize the Provider Web Portal going forward to submit any files or update contact information. Trading partners currently using the Provider Web Portal should switch immediately to the MOVEit FTP server for X12 file exchanges. Providers may not assign a trading partner role in the Provider Web Portal.

Refer to the [Electronic Data Interchange \(EDI\) Support web page](#) and [Colorado Medicaid Enterprise Solutions \(CMES\) Transition web page](#) for more information.

All Providers Who Utilize the ColoradoPAR Program

What is the ColoradoPAR Program?

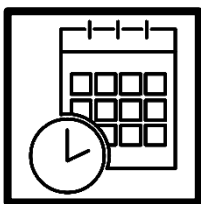
The ColoradoPAR Program is a third-party, fee-for-service Utilization Management (UM) program administered by Acentra Health, Inc. Visit the [Colorado Prior Authorization Request Program \(ColoradoPAR\) web page](#) for more information about the ColoradoPAR Program.

Interoperability Changes Beginning 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 Final Rule have been implemented as required. The most notable changes impacting providers are highlighted here:

- Pends for additional information are **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.
- Expedited PARs: **pends or requests for information** will not be allowed in order to comply with CMS three (3) calendar day Turn Around Time (TAT) requirement. 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 Final Rule. This will facilitate a faster standard turnaround time for PARs, reducing it to seven (7) calendar days. All PARs, including pends, should be processed within 21 calendar days of initial submission. Visit the [CMS Interoperability and Prior Authorization Final Rule web page](#) for more information on the rule.

Acentra Provider Satisfaction Survey

The ColoradoPAR Provider Survey for Durable Medical Equipment (DME) providers will remain open through March 13, 2026. The [DME Provider Survey](#) is an opportunity to provide feedback regarding Acentra Health services in processing PARs, customer service, provider education and use of their provider portal, Atrezzo®.

PAR Submission Training for Acentra

Acentra Health will provide benefit-specific PAR submission training for all providers and benefit-specific training for Molecular and Genetic Testing. The training dates and times are listed below in Mountain Time:

- [Molecular and Genetic Testing Provider Benefit Training March 11th, 2026, at 9:00 a.m.](#)
- [Molecular and Genetic Testing Provider Benefit Training March 11th, 2026, at 12:00 p.m.](#)
- [Portal Registration and PAR Submission Training March 25th, 2026, at 9:00 a.m.](#)
- [Portal Registration and PAR Submission Training March 25, 2026, at 12:00 p.m.](#)

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

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

Behavioral Health Providers

Billing Guidance for Neurological/Psychological Testing

This article is to provide clarification on billing requirements for psychological evaluation and testing services. Effective immediately, psychological evaluation and testing services must be billed fee-for-service (FFS) and not to the Regional Account Entities (RAEs).

The following Current Procedural Terminology (CPT) codes are applicable to psychological testing:

- 96130
- 96131
- 96136
- 96137

To ensure correct payment under fee-for-service, Rocky Mountain Prime (Rocky) or Denver Health Medical plan (Denver Health), providers **must use the SC modifier** when billing these codes:

- Claims billed **with the SC modifier** will process under FFS, Rocky or Denver Health
- Claims billed **without the SC modifier** will deny and direct the provider to bill the RAE

Claims that were billed under the previous process will need to be **resubmitted**.

Previously, as of January 1, 2022, a Neurological/Psychological Testing Policy allowing certain psychological testing services to be billed FFS regardless of diagnosis was published by the Department of Health Care Policy & Financing (the Department). This policy recognized that the referring diagnosis may differ from the established diagnosis.

Due to unanticipated system configuration delays, the Department temporarily allowed the impacted CPT codes to be reimbursed in FFS **without** an SC modifier. However, in mid-January 2026, the Medicaid Management Information System (MMIS) started enforcing the use of the SC modifier, **regardless of diagnosis**. This was a departure from the originally published policy.



The Department sincerely apologizes for any confusion or issues that this created. The Department thanks the providers who reported this issue and recognizes that the proper amount of communication on this policy was not provided. The Department is committed to improving the provider experience.

The published policy is in the process of being updated to reflect the need for an SC modifier for claims to pay in FFS. At this time, the MMIS will reimburse FFS claims for the impacted code when billed with the SC modifier.

[Office hours](#) are held regularly for providers to come with billing questions or to receive additional clarification. Providers may also contact hcpf_bhbenefits@state.co.us.

Colorado Certified Community Behavioral Health Center (CCBHC) Updates

The State of Colorado intends to apply for participation in the four (4)-year [Section 223 Medicaid Certified Community Behavioral Health Center \(CCBHC\) Demonstration program](#) authorized by the Protecting Access to Medicare Act (PAMA) of 2014. This initiative aligns with Colorado's broader goal to expand access to high-quality, comprehensive behavioral health services statewide.

The federal CCBHC Demonstration requires that at least two (2) participating provider organizations be provisionally certified as CCBHCs under federal and state-specific standards with at least one (1) organization serving rural communities. To meet federal requirements, the Behavioral Health Administration (BHA) and the Department required interested organizations to:

- Attest that all BHA CCBHC Certification Checklist requirements would be met

- Be currently approved as a Comprehensive Safety Net Provider (CSNP)
- Be current or former recipients of a CCBHC Expansion grant

In addition to federal requirements, Colorado established the following criteria for provider organizations to be considered for participation in the Demonstration:

- Submission of a fully auditable CCBHC cost report by November 2025 to support the state's cyclical Prospective Payment System (PPS) rate setting timeline
- Contracting with Carina Health Systems to support required data collection and quality measurement activities
- Attestation of the organization's ability to submit quality measure reporting in accordance with Substance Abuse and Mental Health Services Administration (SAMHSA) requirements
- Completion of a Community Needs Assessment in compliance with parameters established by the Behavioral Health Administration

Colorado has selected four (4) organizations as participants in the initial provisional certification cohort under the state's proposed Section 223 CCBHC Demonstration. These organizations are:

- Jefferson Center for Mental Health
- North Range Behavioral Health
- Aurora Mental Health and Recovery
- Solvista Health

Additional provider organizations will have the opportunity to pursue CCBHC certification in each subsequent year of the Demonstration, subject to federal approval and state capacity.

Final state participants in the 2026 Section 223 CCBHC Demonstration program will be formally announced by SAMHSA in June 2026. Full CCBHC certification of any Colorado behavioral health provider is contingent upon the state's acceptance into the Demonstration program.



BHA and the Department appreciate the continued engagement of providers, partners and stakeholders as the state advances this important initiative to strengthen the behavioral health system.

Visit the [CCBHC Planning Grant webpage to learn more about Colorado's participation in the CCBHC Planning Grant and opportunities to share your perspective.](#)



Child Health Plan *Plus* (CHP+) Providers

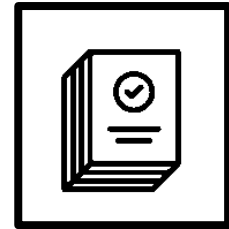
Child Health Plan *Plus* (CHP+) Fee Schedule Correction Requests

Providers are reminded to use the [Child Health Plan *Plus* \(CHP+\) Fee Schedule Correction Form](#) when there are issues identified with the CHP+ fee schedule, found on the [Provider Rates and Fee Schedule](#) web page under [Child Health Plan *Plus* \(CHP+\) Fee-for Service \(FFS\) Rates](#).

Submit this form if:

- A procedure code or modifier does not appear on the CHP+ fee schedule, and the provider believes it should be on the CHP+ fee schedule
- A rate is missing
- A listed rate appears incorrect

The alignment between the CHP+ and Health First Colorado (Colorado's Medicaid program) fee schedules is actively being improved upon by the Department. However, discrepancies, missing codes or incorrect rates may occasionally occur. This form allows providers to report issues to be reviewed and corrected when appropriate. Include the procedure code or modifier, a brief description of the issue and any relevant supporting information when completing the form.



Hospital Providers

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, March 6, 2026, from 9:00 a.m. to 11:00 a.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.

Rural Health Clinic (RHC) Stakeholder Engagement Meeting

A meeting for Rural Health Clinics (RHCs) has been scheduled for March 5, 2026, from 1:00 p.m. to 2:00 p.m. Mountain Time. Topics of discussion will include an overview of the RHC

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

Outpatient Hospital Enhanced Ambulatory Patient Group (EAPG) Update:

Changes to the Medicaid Management Information System (MMIS) affecting outpatient hospital payments were recently completed, which include:

- EAPG 3.18 Version Update, effective July 1, 2025
- 1.6% rate increase, effective July 1, 2025
- Executive Order reversing the 1.6% rate increase, effective October 1, 2025
- 340B drug rate reduction. The reprocessing of the affected claims were completed as of the January 23, 2026, financial cycle.

Contact Sean Paschke at Sean.Paschke@state.co.us, or Andrew Abalos at Andrew.Abalos@state.co.us with any questions.

Pharmacy and All Medication Prescribers

Pharmacy Reimbursement Methodology Update

Effective April 1, 2026, the outpatient pharmacy reimbursement methodology for covered outpatient drugs will be updated.

What is changing:

- Reimbursement Methodology:
 - Claims will be reimbursed at the lesser of:
 - Usual & Customary (no dispensing fee) or
 - Average Acquisition Cost (AAC), National Average Drug Acquisition Cost (NADAC), Maximum Allowable Cost (MAC) or Submitted Ingredient Cost (SIC), plus the pharmacy's assigned professional dispensing fee. Previously, MAC applied only when AAC or NADAC were unavailable.
 - Clotting Factor reimbursement methodology is not changing.
- MAC Rate:
 - Generic drugs: Wholesale Acquisition Cost (WAC) minus 20% is changing to WAC minus 22%
 - Brand-name drugs: WAC minus 3.5% is changing to WAC minus 4%
- Dispensing Fees:
 - The two (2) lowest dispensing fee tiers will be reduced from \$10.25 to the new rate of \$9.93, and \$9.31 to the new rate of \$8.72.

No action is required by providers. Claims will adjudicate using the updated methodology for dates of service on or after the effective date.

Contact Korri Conilogue at Korri.Conilogue@state.co.us with questions regarding this update.

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) pharmacy 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) or Group, which will result in a seamless transition at the pharmacy. Pharmacies are advised to contact their switch vendor to confirm that claims are being routed correctly to MedImpact if experiencing issues submitting claims on or after April 1, 2026. Contact MedImpact at COFFSTeams@medimpact.com for further assistance if needed.

Upcoming Informational Session: MedImpact will hold an informational session via Teams video conferencing on March 2, 2026, from 9:00 a.m. to 10:00 a.m. MT 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

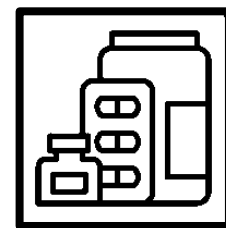
+1 858-252-2734, 594960382# United States

[Find a local number](#)

Phone conference ID: 594 960 382#

Provider Network: Enrollment with Health First Colorado will not change. Providers do not need to reenroll with MedImpact.

Preferred Drug List (PDL): All existing PDL limits and requirements remain in effect. A copy of the PDL is available on the [Pharmacy Resources web page](#). Pharmacists and prescribing practitioners may contact MedImpact's Pharmacy Help Desk on or after April 1, 2026, for any questions related to the PDL.



Prior Authorization (PA) Form: PA forms have no significant changes. The only change to the PA form is the contact information. The new form with changes will be posted on March 1, 2026. The [PA form](#) is available on the [Pharmacy Resources web page](#) under Pharmacy Prior Authorization Request. Pharmacists and prescribing practitioners may contact MedImpact's Prior Authorization Request Desk on or after April 1, 2026, for any questions related to PA requests or the form.

Electronic Prior Authorization (ePA): MedImpact strongly encourages the use of ePA for submitting prior authorization requests as it is the preferred and most efficient method for processing requests. Prior authorizations are also accepted via fax and phone.

Prior Authorizations (PAs): There is no need to submit a new PA if an active PA already exists for the member with Prime Therapeutics, as current active PAs will be transferred to MedImpact.

Reversals: B3 Claim Rebill is not supported. Claims requiring adjustment must first be reversed and then resubmitted as a new claim.

The procedures for submitting paid pharmacy claims adjustments remain unchanged with this transition and continue to follow the guidelines outlined in the [Reversals section](#) of the [Pharmacy Billing Manual](#).



If a claim that is older than 120 days is reversed, it will not be able to be resubmitted. If a claim older than 120 days needs to be reversed and resubmitted, a Request for Reconsideration Pharmacy Form must be completed and submitted to MedImpact. The Request for Reconsideration Pharmacy Form can be found on the [Provider Forms](#) page under the **Claim Forms and Attachments** drop-down section.

Incremental Fills: If greater than 60 days from date written for Schedule II (CII) drugs, claims will deny with Reject Code 650 - Fill Date Greater Than 60 Days from CII Date Prescription Written. Please see the Pharmacy Billing Manual for additional information regarding incremental and subsequent fills.

Usual and Customary (U&C): When claims are paid based on the submitted U&C, the U&C value will be represented in the Ingredient Cost Paid (506-F6) field and the Dispensing Fee Paid (507-F7) will be zero (0).

Prescriber Drug Enforcement Administration (DEA) Enforcement: A DEA license, or registration, is a federal license required for healthcare providers to legally prescribe, administer or dispense controlled substances. Prescriber DEA licenses will be edited as follows:

- If the prescriber does not have a valid DEA license on file, claims will deny with Reject Code 44 - Plan's Prescriber Database Indicates the Associated DEA To Submitted Prescriber ID Is Not Found.
- If the pharmacy can verify the DEA license is valid, the pharmacy can utilize one (1) of the following Submission Clarification Codes to override Reject Code 44:
 - 43 = For the prescriber ID submitted, the associated DEA number has been renewed, or the renewal is in progress
 - 45 = For the prescriber ID submitted, the associated DEA number is a valid hospital DEA number with suffix
- If the prescriber does not have a valid DEA license to prescribe controlled substances, claims will be denied with Reject Code 46 - Plan's Prescriber Database Indicates Associated DEA To Submitted Prescriber ID Does Not Allow This Drug DEA Schedule.

Payer Sheet: All electronic pharmacy claims should continue to be submitted in accordance with the National Council for Prescription Drug Programs (NCPDP) version D.0 standard format. MedImpact enforces NCPDP standards according to the *Telecommunication Standard Implementation Guide Version D.0*. Fields submitted, even if not required, will be edited according to NCPDP standards and denied with the appropriate NCPDP Reject Codes. Providers can download a complete version of the Health First Colorado D.0 payer sheet from the [Pharmacy Resources web page](#). The payer sheet will be updated to reflect several changes as part of the PBM transition. These changes are noted below and will be effective April 1, 2026. Contact MedImpact at COFFSTeam@MedImpact.com with any questions or clarification.

Note: Pharmacies should consult with their software vendor as soon as possible to determine if, and when, changes need to be made to a pharmacy's billing software or procedures so that no disruption occurs during this transition. Failure by the pharmacy to effect all such changes could lead to Point of Sale (POS) claims rejections.

Additional note: Prime Therapeutics, the current PBMS vendor, will begin enforcing certain NCPDP D.0 standards effective March 1, 2026. These include: M/I Patient ZIP/postal code (special characters (e.g., dashes) are not permitted), M/I Patient Street Address (must be entered in all capital letters) and M/I Cardholder Name (first and last name must be all capital letters).

The tables below summarize the key changes pharmacies need to work on to be ready at the implementation date.

Changes to Claim Billing Request Transaction

Segment	NCPDP Field	NCPDP Field Name	MedImpact Value/Situation Defined
Header	103-A3	TRANSACTION CODE	B3 (Rebill) Not supported
Insurance (111 AM) = "04"	303-C3	PERSON CODE	Required When (RW) - Use value printed on card to identify specific person when cardholder ID is for family. A valid value must be submitted. Adding a space or submitting blank will result in the claim being denied with Reject Code 08 - M/I Person Code.
Insurance (111 AM) = "04"	309-C9	ELIGIBILITY CLARIFICATION CODE	RW - needed to clarify member eligibility If submitted, only valid numeric values will be accepted. Other values will result in the claim being denied for Reject Code 14, M/I Eligibility Clarification Code.

Segment	NCPDP Field	NCPDP Field Name	MedImpact Value/Situation Defined
Insurance (111 AM) = "04"	360-2B	MEDICAID INDICATOR	RW - This field will not accept space or values other than a valid two (2)-character state code. If a space or value other than a valid two (2)-character state code the claim will deny for Reject Code 2B, M/I Medicaid Indicator.
Patient (111 AM) = "01"	322-CM	PATIENT STREET ADDRESS	RW- for state/federal/regulatory agency programs. This field does not accept lower case letters. If submitted, it will result in the claim being denied for Reject Code CM, M/I Patient Street Address.
Patient (111 AM) = "01"	323-CN	PATIENT CITY ADDRESS	
Patient (111 AM) = "01"	324-CO	PATIENT STATE/PROVINCE ADDRESS	
Patient (111 AM) = "01"	325-CP	PATIENT ZIP/POSTAL ZONE	RW - Submitted value should only contain numeric characters. A dash is not allowed and claim will be denied for Reject Code CP, M/I Patient Zip/Postal Zone.
Claim (111 AM) = "07"	429-DT	SPECIAL PACKAGING INDICATOR	RW - Required for Long Term Care (LTC) claims for brand oral solid drugs.
Claim (111 AM) = "07"	461-EU	PRIOR AUTHORIZATION TYPE CODE	RW - Required to indicate the need for special handling to override a normal processing rejection.
Claim (111 AM) = "07"	462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED	RW - Required to indicate the need for special handling to override a normal processing rejection.
Claim (111 AM) = "07"	996-G1	COMPOUND TYPE	RW - Required when billing for compound.
Claim (111 AM) = "07"	147-U7	PHARMACY SERVICE TYPE	RW- Required for Mail Order, LTC and Specialty Pharmacies for proper reimbursement.

Segment	NCPDP Field	NCPDP Field Name	MedImpact Value/Situation Defined
Claim (111 AM) = "07"	408-D	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	Required (R) - Dispense as Written (DAW) 0,1,8 and 9 are allowed. All others will deny. DAW 0 cannot be submitted on a multi-source drug with available generics. DAW 1 cannot be submitted on generics or Single Source Brands.
Pricing (111-AM) = "11"	433-DX	PATIENT PAID AMOUNT SUBMITTED	NOT USED: This field is not used for COB billing. Claim will deny if value is other than \$0.
Pricing (111-AM) = "11"	438-E3	INCENTIVE AMOUNT SUBMITTED	RW - Required when pharmacy is entitled to a Vaccine Administration fee.
Pricing (111-AM) = "11"	478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	
Pricing (111-AM) = "11"	479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER	
Pricing (111-AM) = "11"	480-H9	OTHER AMOUNT CLAIMED SUBMITTED	
Pricing (111-AM) = "11"	481-HA	FLAT SALES TAX AMOUNT SUBMITTED	RW - Flat Sales Tax Amount should be submitted when a governing jurisdiction requires the collection of a fixed amount for all applicable prescriptions. Pharmacy is responsible for submission of accurate flat tax values for use in payment calculation. Required when flat sales tax is applicable to product dispensed.

Segment	NCPDP Field	NCPDP Field Name	MedImpact Value/Situation Defined
Pricing (111-AM) = "11"	482-GE	PERCENTAGE SALES TAX AMOUNT SUBMITTED	RW percentage sales tax is applicable to product dispensed. NCPDP standard field required if its value has an effect on Gross Amount Due Calculation Pharmacy is responsible for submission of accurate percentage tax values for use in payment calculation. NOTE: For payment of Percentage Tax, all three (3) Percentage Tax fields must be submitted: -Percentage Sales Tax Amount Submitted -Percentage Sales Tax Rate Submitted -Percentage Sales Tax Basis Submitted
Pricing (111-AM) = "11"	483-HE	PERCENTAGE SALES TAX RATE SUBMITTED	RW sales tax is applicable to product dispensed to provide the rate for use in payment calculation.
Pricing (111-AM) = "11"	484-JE	PERCENTAGE SALES TAX BASIS SUBMITTED	RW sales tax is applicable to product dispensed to provide the basis for use in payment calculation.
Pricing (111-AM) = "11"	430-DU	GROSS AMOUNT DUE	Must summarize according to NCPDP criteria. Ingredient Cost Submitted (409-D9) + Dispensing Fee Submitted (412-DC) + Flat Sales Tax Amt Submitted (481-HA) + Percentage Sales Tax Amt Submitted (482-GE) + Incentive Amount Submitted (438-E3) + Other Amount Claimed (480-H9) If not equal to gross amount due, then claim will deny for Reject Code R9 - Value in Gross Amount Due Does Not Follow Pricing Formula.

Segment	NCPDP Field	NCPDP Field Name	MedImpact Value/Situation Defined
Prescriber (111-AM) = "03"	427-DR	PRESCRIBER LAST NAME	RW - Required to identify the prescriber of the product dispensed.
Prescriber (111-AM) = "03"	368-2P	PRESCRIBER/ZIP POSTAL ZONE	If submitted, it must contain valid value. This field is numeric. A dash or space is not allowed and claim will deny for Reject Code 2P, M/I Prescriber Zip/Postal Zone.
Coordination of Benefits/Other Payments (111-AM) = "05"	337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Mandatory (M)
Coordination of Benefits/Other Payments (111-AM) = "05"	338-5C	OTHER PAYER COVERAGE TYPE	M
Coordination of Benefits/Other Payments (111-AM) = "05"	339-6C	OTHER PAYER ID QUALIFIER	Required (R) - 03 = BIN Number
Coordination of Benefits/Other Payments (111-AM) = "05"	340-7C	OTHER PAYER ID	R - If no BIN exists due to billing of a non-online payer, please use value 999999 as the BIN of the Other Payer.
Coordination of Benefits/Other Payments (111-AM) = "05"	443-E8	OTHER PAYER DATE	R
DUR/PPS (111-AM) = "08"	473-7E	DUR/PPS CODE COUNTER	R
DUR/PPS (111-AM) = "08"	439-E4	REASON FOR SERVICE CODE	<p>RW - needed to communicate Drug Utilization Review (DUR) information.</p> <p>Allowed Values:</p> <ul style="list-style-type: none"> • DD = Drug-Drug Interaction • ER = Early Refill • HD = High Dose • PG = Pregnancy <p>If not included, will receive a soft reject that can be overridden in the pharmacy.</p>

Segment	NCPDP Field	NCPDP Field Name	MedImpact Value/Situation Defined
DUR/PPS (111-AM) = "08"	474-8E	DUR/PPS LEVEL OF EFFORT	RW - Payer requirement. Required when needed by plan for proper adjudication.
DUR/PPS (111-AM) = "08"	475-J9	DUR CO-AGENT ID QUALIFIER	Sometimes (S)
DUR/PPS (111-AM) = "08"	476-H6	DUR CO-AGENT ID	S
Compound (111-AM) = "10"	449-EE	COMPOUND INGREDIENT DRUG COST	R
Compound (111-AM) = "10"	490-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	R
Clinical (111-AM) = "13"	491-VE	DIAGNOSIS CODE COUNT	
Clinical (111-AM) = "13"	492-WE	DIAGNOSIS CODE QUALIFIER	
Clinical (111-AM) = "13"	424-DO	DIAGNOSIS CODE	RW - Decimal point should not be included in the International Classification of Diseases (ICD)-10 value. If submitted, only valid numeric values will be accepted. Other values will result in the claim being denied for Reject Code 30, M/I Diagnosis Code.

Change to Claim Response Transaction Accepted/Paid or Duplicate Paid

Segment	NCPDP Field	NCPDP Field Name	MedImpact Value/Situation Defined
Insurance (111-AM) = "25"	524-FO	PLAN ID	
Insurance (111-AM) = "25"	545-2F	NETWORK REIMBURSEMENT ID	
Insurance (111-AM) = "25"	568-J7	PAYER ID QUALIFIER	
Insurance (111-AM) = "25"	569-J8	PAYER ID	
Status (111-AM) = "21"	987-MA	URL	RW - FUTURE USE
Pricing (111-AM) = "23"	558-AW	FLAT SALES TAX AMOUNT PAID	
Pricing (111-AM) = "23"	559-AX	PERCENTAGE SALES TAX AMOUNT PAID	
Pricing (111-AM) = "23"	560-AY	PERCENTAGE SALES TAX RATE PAID	

Segment	NCPDP Field	NCPDP Field Name	MedImpact Value/Situation Defined
Pricing (111-AM) = "23"	561-AZ	PERCENTAGE SALES TAX BASIS PAID	
Pricing (111-AM) = "23"	523-FN	AMOUNT ATTRIBUTED TO SALES TAX	
Pricing (111-AM) = "23"	571-NZ	AMOUNT ATTRIBUTED TO PROCESSOR FEE	
Pricing (111-AM) = "23"	133-UJ	AMOUNT ATTRIBUTED TO PROVIDER NETWORK SELECTION	
Pricing (111-AM) = "23"	134-UK	AMOUNT ATTRIBUTED TO PRODUCT SELECTION / BRAND DRUG	
Pricing (111-AM) = "23"	135-UM	AMOUNT ATTRIBUTED TO PRODUCT SELECTION / NON-PREFERRED FORMULARY SELECTION	
Pricing (111-AM) = "23"	136-UN	AMOUNT ATTRIBUTED TO PRODUCT SELECTION / BRAND NON-PREFERRED FORMULARY SELECTION	
Pricing (111-AM) = "23"	137-UP	AMOUNT ATTRIBUTED TO COVERAGE GAP	
Pricing (111-AM) = "23"	575-EQ	PATIENT SALES TAX AMOUNT	
Pricing (111-AM) = "23"	574-2Y	PLAN SALES TAX AMOUNT	
Pricing (111-AM) = "23"	148-U8	INGREDIENT COST CONTRACTED / REIMBURSABLE AMOUNT	RW - Returned when payment is based on Patient Responsibility Coordination of Benefits (COB) or Patient Pay Amount.
Pricing (111-AM) = "23"	149-U9	DISPENSING FEE CONTRACTED / REIMBUSABLE AMOUNT	RW - Returned when payment is based on Patient Responsibility COB or Patient Pay Amount.
Pricing (111-AM) = "23"	577-G3	ESTIMATED GENERIC SAVINGS	
Coordination of Benefits/Other Payers (111-AM) = "28"	355-NT	OTHER PAYER ID COUNT	M- Maximum count of three (3)
Coordination of Benefits/Other Payers	338-5C	OTHER PAYER COVERAGE TYPE	M

Segment	NCPDP Field	NCPDP Field Name	MedImpact Value/Situation Defined
Coordination of Benefits/Other Payers (111-AM) = "28"	144-UX	OTHER PAYER BENEFIT EFFECTIVE DATE	
Coordination of Benefits/Other Payers (111-AM) = "28"	145-UY	OTHER PAYER BENEFIT TERMINATION DATE	

Changes to Claim Response Transaction Accepted/Rejected

Segment	NCPDP Field	NCPDP Field Name	MedImpact Value/Situation Defined
Insurance (111-AM) = "25"	301-C1	GROUP ID	
Insurance (111-AM) = "25"	302-C2	CARDHOLDER ID	REMOVED
Insurance (111-AM) = "25"	524-FO	PLAN ID	
Insurance (111-AM) = "25"	545-2F	NETWORK REIMBURSEMENT ID	
Status (111-AM) = "21"	987-MA	URL	RW - Future use
Prior Authorization (111-AM) = "26"	498-PY	PRIOR AUTHORIZATIO NUMBER-ASSIGNED	REMOVED
Coordination of Benefits/Other Payer (111-AM) = "28"	355-NT	OTHER PAYER ID COUNT	M- Maximum count of three (3)
Coordination of Benefits/Other Payer (111-AM) = "28"	338-5C	OTHER PAYER COVERAGE TYPE	M
Coordination of Benefits/Other Payer (111-AM) = "28"	144-UX	OTHER PAYER BENEFIT EFFECTIVE DATE	
Coordination of Benefits/Other Payer (111-AM) = "28"	145-UY	OTHER PAYER BENEFIT TERMINATION DATE	

Changes to Claim Reversal Request Transaction

Segment	NCPDP Field	NCPDP Field Name	MedImpact Value/Situation Defined
Insurance (111-AM) = "04"	301-C1	GROUP ID	R - Value submitted on claim should be included on reversal.
Insurance (111-AM) = "04"	306-C6	PATIENT RELATIONSHIP CODE	REMOVED
Claim (111-AM) = "07"	147-U7	PHARMACY SERVICE TYPE	

Changes to Claim Reversal Response Transaction Accepted/Rejected

Segment	NCPDP Field	NCPDP Field Name	MedImpact Value/Situation Defined
Status (111-AM) = "21"	503-F3	AUTHORIZATION NUMBER	RW - When calling Help Desk, this ID is the fastest means to identify the claim.

Claim Reversal Response Transaction Rejected/Rejected

Segment	NCPDP Field	NCPDP Field Name	MedImpact Value/Situation Defined
Status (111-AM) = "21"	503-F3	AUTHORIZATION NUMBER	RW - When calling Help Desk, this ID is the fastest means to identify the claim.

Physician-Administered Drug (PAD) Providers

Prior Authorization Update

Effective April 1, 2026, following clinical and utilization review, Appendix Y will be updated for Asceniv (human immune globulin), Healthcare Common Procedural Coding System (HCPCS) code J1554, to require trial and failure of two (2) prior immune globulin therapies.

The full list of physician-administered drugs (PADs) that require prior authorization can be found in [Appendix Y: Physician Administered Drug Medical Benefit Prior Authorization Procedures and Criteria](#).

Providers must ensure that a member-specific prior authorization request (PAR) is 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 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

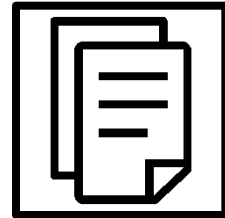
Billing Requirements for Medication Abortion Claims

Health First Colorado covers medication abortions, typically billed with Healthcare Common Procedural Coding System (HCPCS) codes S0190, S0191 and S0199. Providers must submit complete and accurate information when billing for abortion medications, including the drug invoice.

Why Additional Documentation is Required

Mifepristone and Misoprostol are treated as physician-administered drugs (PADs) under Health First Colorado policy. PADs are reimbursed based on the amount of drug administered and acquired by the provider via standard buy-and-bill processes, not a flat or bundled rate.

This requirement applies to all providers billing for PADs and is not unique to abortion services.



Rates for PADs are updated on a quarterly basis and published on the [PAD Fee Schedule](#). PADs listed as manually priced (MP) on the PAD Fee Schedule require the drug invoice to be attached to the claim. MP PADs are reviewed and priced by the fiscal agent.

What Must be Submitted with the Claim

Providers must ensure the following information is available when billing S0190 and/or S0191 and submitted as required:

1. National Drug Code (NDC)
 - a. Report the 11-digit NDC for the actual drug administered
 - b. The NDC must correspond to the mifepristone or misoprostol product used
 - c. The NDC submitted must align with the billed HCPCS code.
 - i. [Appendix X](#) provides additional guidance regarding reimbursable HCPCS/NDC combinations. Claims submitted without a valid or matching NDC may be denied.
2. Drug Purchase Invoice

- a. A copy of the drug purchase invoice must be available and submitted for physician-administered drugs that are manually priced (S0190 and S0191).
- b. The invoice must show:
 - i. Drug name
 - ii. NDC
 - iii. Quantity purchased
 - iv. Cost paid by the provider



This documentation is used to validate reimbursement and is required for physician-administered drug claims.

Medication abortion drug claims may be subject to post-payment review; failure to provide required documentation when requested may result in claim denial or recoupment. These requirements are part of the existing physician-administered drug billing policy and apply regardless of provider type or setting.

More extensive PAD billing guidance may be found in the [Physician Administered Drug Billing Manual](#), and questions can be directed to hcpf_pad@state.co.us.

Ancillary Services Billing Guidance

Ancillary services directly related to an abortion (elective or non-viable) delivered on the same date of service must be billed on the same claim as the abortion procedure.

Ancillary services may be submitted on a separate claim if necessary; however, a corresponding abortion claim must have already been submitted to and paid by Gainwell Technologies for the member.

It is acknowledged that not all ancillary services have been fully identified. The list of ancillary services covered may be expanded as additional appropriate services are identified, and related claims will be reprocessed as needed.

Providers who believe an ancillary service code is appropriate for inclusion and is not currently identified should contact Devinne Parsons at Devinne.Parsons@state.co.us for internal review and consideration. Providers should include relevant coding and clinical rationale to facilitate the evaluation.

Some claims have recently been denied in error. A system fix is being implemented and affected claims will be reprocessed as soon as possible.

Eligibility Clarification

Members in the Alternative Benefit Plan (ABP) eligibility category are eligible for abortion services. Any claims denials providers may have received for ABP members will be

reprocessed once the system fix is complete. Providers may reference the [Known Issues web page](#) under the Women’s Health drop-down section for additional information regarding the denial issues identified.

Contact Alex Weichselbaum at Alex.Weichselbaum@state.co.us for any policy questions regarding the Alternative Benefit Plan.

Family Planning Reminder

The Family Planning Income Expansion (FAMPL) population receives a 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+).

Once a member becomes pregnant, they are no longer eligible for the FAMPL program.

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

- The member must report the pregnancy.
- The member will be evaluated for another eligibility benefit category, which covers elective abortions billed with Z33.2 using state-only funds.
- The member will then be eligible for 12 months of coverage beginning at the end of the pregnancy.

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

Contact hcpf_maternalchildhealth@state.co.us for policy questions regarding FAMPL.

Managed Care Organization (MCO) Billing Clarification

Denver Health MCO or Prime MCO’s must bill Fee for Service (FFS); elective abortions and associated medications are carved out and paid via FFS.

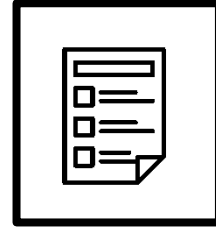
CHP+ providers must submit their claims to their CHP+ Managed Care Organization (MCO) for manual reconciliation reimbursement.

Transportation

Survey on Proposed Treatment in Place (TIP) Policy

Emergency Medical Transportation (EMT) providers are invited to provide feedback on the new Medicaid Treatment in Place (TIP) benefit.

TIP supports EMT providers in delivering appropriate care on scene when transport to an emergency department may not be medically necessary. Feedback will inform implementation, training and operations. [Complete the survey.](#)



The survey takes about 10 minutes to complete. Responses will be accepted through March 31, 2026.

Contact Courtney Sedon, Transportation Policy Specialist, at Courtney.Sedon@state.co.us with questions regarding the survey or the TIP policy.

Women’s Health, Family Planning (including Maternal, Child and Reproductive Health)

Health First Colorado Doula Program Update

Several forms required for individuals applying to become Health First Colorado doula providers have been updated.

Updated Forms for Doula Provider Applications

The following forms have been revised:

- Health First Colorado Doula Attestation
- Letter of Recommendation for the Experience Pathway
- Health First Colorado Doula Code of Conduct

Applicants are encouraged to ensure they are using the most current forms before submission. These forms are located on the [Provider Forms web page](#) under the “Provider Enrollment & Update Forms” drop-down menu and are available in both English and Spanish.

Important:

Changes have been made to the review and approval process for organizations seeking to be listed as an Approved Doula Training Organization. Beginning March 1, 2026, the updated versions of these forms must be used for:

- All new doula provider applications
- Revalidation submissions

Applications submitted on or after **March 1, 2026**, that use prior versions of these forms may be delayed or returned.

Provider Training Sessions

March 2026 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 March:

- **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 of the beginner billing training sessions.
- Time: One and a half (1.5) hour 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 (1) hour presentation / half (0.5) hour Q&A

- **Provider-Specific Billing Training: Audiology**

Provider-specific training delivers an overview of benefits, covered services and provider eligibility unique to each provider type.

- Audience: This training applies to audiology providers.
- 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.

March 2026				
Monday	Tuesday	Wednesday	Thursday	Friday
2	3	4	5	6
9	10	11 Beginner Billing Training: Professional Claims (CMS 1500) 1:00 p.m. - 3:00 p.m. MT	12	13
16	17	18 Beginner Billing Training: Institutional Claims (UB-04) 10:00 a.m. - 12:00 p.m. MT	19	20
23 Provider-Specific Billing Training: Audiology 1:00 p.m. - 2:30 p.m. MT	24	25 Intermediate Billing Training 9:00 a.m. - 11:00 a.m. MT	26	27
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.

[Provider Services Call Center](#)

1-833-468-0362