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Did You Know?

All providers are reminded that they must revalidate every five (5) years per federal mandate ([42 CFR § 455.414](#)) from the Centers for Medicare and Medicaid Services (CMS). All provider IDs must be actively enrolled and revalidated with Health First Colorado (Colorado's Medicaid Program) for claims to be paid per rule [42 CFR § 455.410\(b\)](#).

Providers are encouraged to review the [Provider Revalidation Dates Spreadsheet](#) posted on the [Revalidation web page](#) to confirm revalidation dates. This file is updated weekly and can be used to verify active enrollment for any provider.

Claims will deny if providers are past the revalidation date.

New applications, revalidations and enrollment updates are currently being processed by the Department of Health Care Policy & Financing's (the Department's) fiscal agent within eight (8) business days on average.

All Providers

Provider Enrollment, Revalidation and Reenrollment

Providers have three (3) options regarding applications for Health First Colorado (Colorado's Medicaid Program):

1. **Enrollment:** Enrollment is the process by which an individual or entity that has never been enrolled as a provider submits a new provider enrollment application and is approved by the Department for participation in the program. Visit the [Provider Web Portal Enrollment web page](#) to start an application.
2. **Revalidation:** Revalidation is the process by which an individual or entity actively enrolled as a provider submits a revalidation application and receives approval to continue participation in the program. Revalidation is required at least every five (5) years. Providers may begin the revalidation process up to six (6) months prior to the revalidation due date. Providers also have the revalidation link available six (6) months after the revalidation date and should not attempt to reenroll during this period. Log into the [Provider Web Portal](#) and click **Revalidation** to get started.
3. **NEW: Reenrollment:** Providers that were previously enrolled in the program and were later disenrolled may reenroll. Log into the [Provider Web Portal](#) and click **Reenrollment** to get started if it has been more than six (6) months since the revalidation date.

Providers who have forgotten their Provider Web Portal password should refer to either the [Password Reset Process for Administrative Accounts](#) or the [Password Reset Process for Delegates](#) Quick Guides for assistance.

New Reenrollment Link in the Provider Web Portal

Reenrollment is the process of reactivating a provider enrollment number that was previously disenrolled. Reenrolling will reconnect the provider to the previous ID and historical data. Providers who have been previously enrolled as a Health First Colorado provider should **not** start a new application from the Provider Enrollment web page but instead log into the existing Provider Web Portal account.

Disenrolled providers who are eligible for reenrollment will see a new Reenrollment link in the [Provider Web Portal](#) when they log into their existing Provider Web Portal account.



Refer to the [Provider Reenrollment Manual](#) and the [Provider Web Portal Quick Guide: Reenrollment](#) for information.

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.

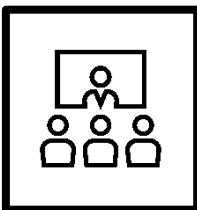
Electronic Data Integration (EDI) functionality, including batch processing and trading partner enrollment, is transitioning to a new platform and vendor: Edifecs, a Cotiviti Business.

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 log-in 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.

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. Trading partners currently using the Provider Web Portal should switch immediately to the Move-It 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 as of 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 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.

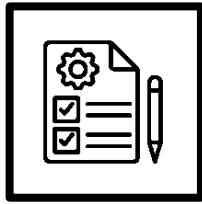


Atrezzo® Users: Login Reminders

Staff members who submit Prior Authorization Requests (PARs) via Atrezzo should be using their own distinct login information, not sharing login information with other staff members. Each provider entity will have a Provider Group Administrator for their facility that can add and edit users for staff turnover.

Refer to the [Atrezzo® Provider Manual](#) available on the [ColoradoPAR Training web page](#).

Acentra Health 2026 Annual Provider Satisfaction Survey



Acentra Health and the Department are announcing the opening of the Colorado Prior Authorization Request (PAR) Provider Survey for all providers that work with Acentra Health and use the Atrezzo® provider portal.

The Colorado PAR Provider Survey opens April 13, 2026, and will remain open through May 22, 2026.

The Colorado PAR Provider Survey is an opportunity to provide feedback regarding Acentra Health services in processing PARs, customer service, provider education and timeliness.

Acentra Health will send email reminders to all providers, including links to complete the survey, once it opens.

Prior Authorization Request (PAR) Submission Training for Acentra Health

Acentra Health will provide benefit-specific Prior Authorization Request (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:

- [Diagnostic Imaging Provider Benefit Specific Training April 8, 2026, at 9:00 a.m.](#)
- [Diagnostic Imaging Provider Benefit Specific Training April 8, 2026, at 12:00 p.m.](#)
- [Portal Registration and PAR Submission Training April 22, 2026, at 9:00 a.m.](#)
- [Portal Registration and PAR Submission Training April 22, 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.

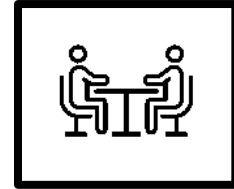
Behavioral Health Providers

Qualified Residential Treatment Program (QRTP), Psychiatric Residential Treatment Facility (PRTF) and Out-of-state High Intensity Residential Treatment (OHIRT) Office Hours

Starting July 1, 2026, medically necessary Qualified Residential Treatment Program (QRTP), Psychiatric Residential Treatment Facility (PRTF) and Out-of-state High Intensity Residential Treatment (OHIRT) services for youth in the custody of county child welfare/departments of human services (CW/DHS) or the Division of Youth Services (DYS) will be covered under the

capitated behavioral health benefit and reimbursed by the Regional Accountable Entities (RAEs).

Historical policy prohibited RAEs from paying for residential behavioral health treatment for youth in the custody of county CW/DHS or DYS. A 2018 statutory change removed authority for this “carve out”. After considering all available options to update this policy in alignment with statute, the Department has elected to carve residential services for the child welfare population into the RAE capitated benefit.



The Department began holding monthly office hours to answer provider questions in preparation for this transition.

QRTP, PRTF and OHIRT office hours:

- April 23, 2026, from 12:00 to 1:00 p.m. MT
- May 28, 2026, from 2:00 to 3:00 p.m. MT

[Register via Zoom](#) and include the question(s) to be addressed during the office hours so staff can prepare accordingly.

Feedback Requested: Behavioral Health (BH) Peer Recovery Groups Draft Policy

A draft policy on Behavioral Health Peer Recovery Groups has been created to provide clarity on the Peer Support services that are covered by Health First Colorado. This draft policy outlines standards for Peer Recovery Group activities and aligns with the Behavioral Health Administration (BHA) definitions outlining disallowed activities for Peers.

The draft policy is available on the [BH Peer Support Policy web page](#). Community partners are encouraged to submit feedback on the policy to hcpf_peerservices@state.co.us before April 15, 2026.

The final policy will be posted on the [BH Peer Support Policy web page](#) when approved.

Dialysis

Mircera® (Epoetin Beta)

Effective May 1, 2026, Mircera®, also known as epoetin beta, will be considered a Routine Drug for Dialysis using codes J0887 and J0888.

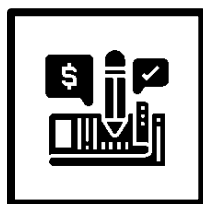
Refer to the [Dialysis Billing Manual](#) on the [Billing Manuals web page](#) for more information regarding Routine and Non-Routine Dialysis.

Durable Medical Equipment

Continuous Glucose Monitor (CGM) Updates

Overview

Effective November 1, 2025, Continuous Glucose Monitors (CGMs) may be 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 dropdown.

A new PAR will be required for CGMs that are billed to the pharmacy benefit.

Managed Care Carveouts

Effective November 1, 2025, all Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) providers who supply CGMs and CGM supplies 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 previous carve-in method of CGMs supplied to children.

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

Durable Medical Equipment, Physician Services

Rate Reductions

On August 28, 2025, pursuant to Article IV, Section 2 of the Colorado Constitution, and [C.R.S. § 24-75-201.5](#), Governor Polis issued [Executive Order D 2025 014](#) declaring that there are insufficient revenues available for expenditures and ordering the suspension, in whole or in part, of certain State programs or services in order to meet a revenue shortfall for Fiscal Year (FY) 2025-2026 and balance the state budget.

Pursuant to the Executive Order and consistent with the Governor's Office presentation to the Joint Budget Committee, the Department has reduced all applicable fee-for-service rates to 85% of their Medicare benchmark as a result of legislative appropriations for FY 2025-2026. This reduction is effective April 1, 2026. Fee schedules are located on the [Provider Rates and](#)

[Fee Schedules web page.](#)

Family Planning

Changes to Review Timing for Doula Training Organization Applications

Overview

The review and approval process for doula training organizations seeking designation as an approved doula training organization for Health First Colorado is being updated by the Department.

These changes are being implemented to:

- Improve consistency and transparency in the review process.
- Ensure timely and accurate updates to the published list of approved training organizations.
- Minimize the risk of certification verification delays during provider application reviews.

What Is Changing

Beginning in Calendar Year **2026**, the Department is moving to a quarterly review schedule for applications submitted by doula training organizations seeking Health First Colorado approval.



Key details include:

- Applications will no longer be reviewed on a rolling basis.
- Applications will be reviewed and approval decisions issued only during the first two (2) weeks of the following quarter, provided the application is complete.
- Applications may continue to be submitted at any time during a calendar quarter.

Quarterly Review Schedule (Effective 2026)

Beginning in Calendar Year 2026, applications will be reviewed on a quarterly **schedule** rather than on a rolling basis.

Applications Submitted	Review Period
January 1 - March 31	First two weeks of April
April 1 - June 30	First two weeks of July

Applications Submitted	Review Period
July 1 - September 30	First two weeks of October
October 1 - December 31	First two weeks of January

What This Means for Applicants

1. Plan for Review Timing

Organizations may submit applications at any time; however, review and approval will occur only during the designated quarterly review window.

2. Complete Applications Are Required

Only **complete applications** will be reviewed during the quarterly review window.

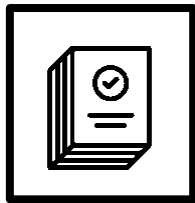
Common reasons for delayed approvals include:

- Required supplemental documentation not submitted
- Supplemental materials not emailed as instructed
- Missing supporting documentation (e.g., curriculum details, or other required materials)

Incomplete applications will not be reviewed and may be deferred to the next quarterly review cycle once all required materials are received.

3. Approval Status Duration

This update affects review timing only. Approved Doula Training Organizations must complete reapproval every five (5) years to maintain their approved status with Health First Colorado.



Organizations are responsible for monitoring their approval period and submitting reapproval materials in accordance with the quarterly review schedule described above.

Failure to complete reapproval may result in removal from the Approved Doula Training Organization list.

Expectations After Approval

Once approved:

- The organization will be added to the official list of Approved Doula Training Organizations listed on the Department's [Doula web page](#).
- Updates to the list will occur in alignment with the quarterly review cycle.
- Providers submitting doula applications must reference the most current approved training list at the time of submission.

- Doulas interested in applying to be an approved provider and not seeing the training organization where their certification is from should take note of the updated timeline.
- Doula providers are encouraged to apply through the experience pathway if their doula training organization is not yet listed.

Complete the [application](#) if interested in applying to be added to the list of approved doula training organizations.

Contact the Health First Colorado Doula program at hcpf_maternalchildhealth@state.co.us with any questions regarding the application process or eligibility requirements.

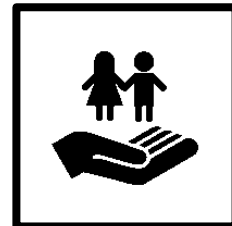
Visit the [Doula web page](#) for more information about the approved list of Health First Colorado doula training organizations.

Home and Community-Based Services Providers

Children's Habilitation Residential Program (CHRP) Group Respite Now Available

Group respite is now available on the Children's Habilitation Residential Program (CHRP) waiver. Group respite is when the member receives respite with other individuals, who may or may not have a disability. It may be provided by unit or day.

There are no additional provider requirements to provide unskilled group respite. Enrolled providers with specialties 676 or 885 who currently provide unskilled respite on the CHRP waiver began providing group respite effective March 23, 2026, upon obtaining a signed Person-Centered Service Plan (PCSP) from the Case Manager.



Electronic Visit Verification (EVV), when applicable, should reflect a group service rather than an individual for group respite. Providers can refer to the [Electronic Visit Verification web page](#) for additional information.

Providers must bill according to prior authorization requests (PAR) provided by the Case Management Agency and [billing manual](#) guidance. The rates for this service can be found on the [Home and Community Based Services \(HCBS\) rate and fee schedule](#).

Refer to [Operational Memo 26-014](#) for more information.

Provider Training Requirements

A memo is being issued to inform providers of Home and Community-Based Services (HCBS) and providers of Community First Choice (CFC) services of a new training curriculum which supplements existing trainings with a new training. Existing trainings in the new curriculum

cover Provider Enrollment and Revalidation, and Person-Centered Thinking (PCT). The new training covers the HCBS Settings Final Rule.

The memo explains how to access the curriculum and the included trainings. The memo includes a table that identifies, for each training, which provider agencies must take the training (based on the specialties in which they are enrolled), what constitutes proof of completion and when the training must be taken or retaken/refreshed.

For new provider enrollments and/or initial revalidation submissions on or after April 1, 2026, HCBS and CFC provider agencies must submit proof of completion of the trainings, if applicable, as part of their provider enrollment/revalidation submissions to the Fiscal Agent.

Refer to [Operational Memo 26-017](#), available on the [Memo Series Page](#). Contact hcpf_hcbs_questions@state.co.us for more information.

Hospital Providers

General Updates

Hospital Stakeholder Engagement Meetings

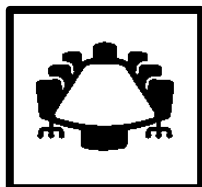
Bi-monthly Hospital Engagement meetings will be hosted by the Department to discuss current topics regarding ongoing rate reform efforts and operational concerns. [Sign up to receive the Hospital Stakeholder Engagement Meeting newsletters.](#)

- The next Hospital Stakeholder Engagement meeting is set for **Friday, May 1, 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 Stakeholder Engagement Meeting



A meeting for Rural Health Clinics (RHCs) has been scheduled for April 30, 2026, from 1:00 p.m. to 2:00 p.m. Mountain Time. 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.

Hospital Specialty Drug Billing Guidance

Certain Hospital Specialty Drugs are reimbursed outside of the All-Patient Refined Diagnosis Related Group (APR-DRG) methodology when administered in the Inpatient (IP) hospital setting and billed on an Outpatient (OP) hospital claim, as of January 1, 2024.

Payments for certain Hospital Specialty Drugs have been carved out of the Enhanced Ambulatory Patient Group (EAPG) methodology for OP hospital claims with the first date of service on or after August 11, 2018.

Hospital Specialty Drug reimbursement for administration in either the IP or OP hospital setting is based on a percentage of invoice cost.

The following is required prior to IP and OP hospital administration of Hospital Specialty Drugs:



- A member-specific prior authorization (PA) must be approved.
 - All Hospital Specialty Drugs requiring a PA are listed on [Appendix Z](#).
 - Retroactive authorization is not usually considered.
 - An approved PA on file does not guarantee payment.
 - Hospital Specialty Drug policy and procedures can be found on the [PAD Provider Resources web page](#).

The following billing requirements must be completed after administration:

- IP hospital administration
 - IP claim is billed
 - The IP claim must be in a paid status before proceeding.
 - OP claim is billed
 - The Hospital Specialty Drug should be the only line billed
 - The OP claim will be denied if the IP claim is not on file and in a paid status.
 - National Drug Code (NDC)
 - The NDC of the Hospital Specialty Drug administered to the member
 - Units billed

- The amount of drug administered to the member must be billed on the claim line in both Healthcare Common Procedure Coding System (HCPCS) and NDC units.
- **Amount billed**
 - **The acquisition cost must be billed on the line.**
 - **The acquisition cost is the cost per NDC unit multiplied by the number of NDC units administered to the member**
 - **The claim line will be denied if the amount billed does not equal the cost per NDC unit multiplied by the number of NDC units administered to the member.**
 - Drug-specific invoice must be attached to the claim.
 - The claim will be denied if no invoice is attached or if the invoice attached is not for the drug being billed.
- 340B exception
 - 340B inventory may not be used when a Hospital Specialty Drug is administered in an IP hospital setting and billed on an OP claim.
 - The claim line should **not** include the “UD” modifier.
 - Modifier “SE” must be billed on the claim line.
 - All other Physician-Administered Drug (PAD) and IP/OP policies apply.
- OP hospital administration
 - All requirements from above apply, with the following exceptions:
 - No IP claim is required.
 - In addition to the Hospital Specialty Drug line, the OP claim may have additional lines billed for the services provided during administration of the Hospital Specialty Drug.
 - 340B inventory may be used when a Hospital Specialty Drug is administered in an OP hospital setting and billed on an OP claim.
 - Modifier “UD” must be billed on the line if the drug used is from 340B inventory.
 - Modifier “SE” should not be billed on the line.
 - The claim will be denied if the “SE” modifier is billed.
 - All PAD, 340B and IP/OP policies apply.

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

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.

The Hospital Specialty Drug Carveout Consideration form has been updated. Providers must use the revised form posted on the [Physician-Administered Drugs web page](#) under Hospital Specialty Drug Policy for all request submissions effective April 1, 2026.

In addition, and in accordance with the U.S. Food and Drug Administration (FDA) labeling changes, Appendix Z criteria updates have been made for Carvykti® (ciltacabtagene autoleucel), HCPCS code Q2056.

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 - Hospital Specialty Drugs, coverage standards, request forms and submission requirements are listed on the [Physician Administered Drug \(PAD\) Provider Resources web page](#) under the Hospital Specialty Drug Policy section.

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.

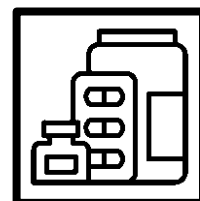
Pharmacy and All Medication Prescribers

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

Effective April 1, 2026, Health First Colorado Fee-for-Service (FFS) pharmacy claims processing and prior authorization review transitioned to MedImpact Healthcare Systems, Inc.

Note: There are no changes to the Bank Identification Number (BIN), Processor Control Number (PCN) or Group. Pharmacies are advised to contact their switch vendor to confirm that claims are being routed correctly to MedImpact if experiencing issues submitting claims. Contact the [MedImpact Pharmacy Help Desk](#) for further assistance, if needed.

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 for any questions related to the PDL.



Prior Authorization (PA) Form: PA forms had no significant changes. The only change to the PA form is the contact information. 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 for any questions related to PA requests or the form.

Electronic Prior Authorization (ePA): MedImpact strongly encourages the use of ePA via Electronic Medical Records (EMR) system or ePA vendor (e.g., CoverMyMeds) 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.

Pharmacy Help Desk 24 hours a day/7 days per week	Phone 888-672-7203
Prior Authorization Requests 24 hours a day/7 days per week	ePA Phone 888-672-7203 Fax 833-465-8957
Claim Reconsideration Form and other NON-PA Related forms	Fax 833-465-8958

Preferred Drug List (PDL) Announcement of Preferred Products

Changes for the following PDL classes, effective April 1, 2026

PDL Drug Class	Moved to Preferred	Moved to non-preferred
Non-opioid Analgesia Agents - Oral and Topical	none	<ul style="list-style-type: none"> Gabapentin Solution <i>-Mylan formulation (NDC 59762505007) will continue to be preferred</i> Tridacaine™ II Patch
Calcitonin Gene-Related Peptide Inhibitors (CGRPIs)	<ul style="list-style-type: none"> Qulipta® 	<ul style="list-style-type: none"> Aimovig® Autoinjector
Stimulants and Related Agents	<ul style="list-style-type: none"> Focalin XR 	none

PDL Drug Class	Moved to Preferred	Moved to non-preferred
	<ul style="list-style-type: none"> Vyvanse Chewable Tablet 	

No changes for the following PDL classes:

PDL Drug Class	PDL Drug Class
Non-Steroidal Anti-Inflammatories (NSAIDs) - Oral and Non-oral	Ophthalmic Immunomodulators
Anticonvulsants - Oral	Anti-Parkinson's Agents
Opioids: Short Acting, Fentanyl Preps (TRIF) and Long Acting	Anxiolytics: Non-benzodiazepine & Benzodiazepine (Non-sedative Hypnotics)
Sedative Hypnotics (Benzo and Non-benzo)	Lithium Agents
New Generation Anti-Depressants	Neurocognitive Disorder Agents
Atypical Anti-Psychotics - Oral and Topical	Ophthalmic Allergy
Multiple Sclerosis Agents - Disease Modifying & Symptom Management	Triptans, Ditans and other Migraine Treatments - Oral and Non-oral
Ophthalmic Anti-Inflammatories (NSAID and Corticosteroids)	Monoamine Oxidase Inhibitors (MAOIs)
Skeletal Muscle Relaxants	Tricyclic Anti-Depressants (TCAs)
Ophthalmic Glaucoma	

Refer to the [Pharmacy Resources web page](#) for more information.

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.

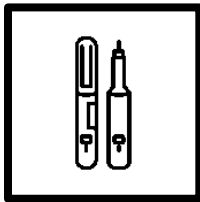
No action is required by providers. Claims will adjudicate using the updated methodology for dates of service on or after the effective date.

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

Physician-Administered Drug (PAD) Providers

Prior Authorization Update

In accordance with the U.S. Food and Drug Administration (FDA) labeling, Appendix Y criteria updates have been made for Xolair® (omalizumab), Healthcare Common Procedural Coding System (HCPCS) code J2357.



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

Providers must ensure that a member-specific PA request 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.

Quarter 2 Rate Update 2026

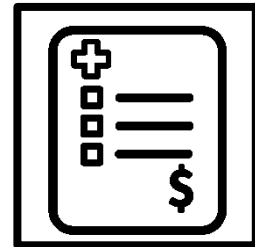
The Physician-Administered Drug (PAD) rates for the second quarter of 2026 have been updated. The new rates are effective April 1st, 2026, and are posted to the [Provider Rates & Fee Schedule](#) web page under the [Physician Administered Drug Fee Schedule section](#).

Physician Services

Current Procedural Terminology (CPT) Codes 99221-99223 (Modifier 77 and Duplicate Edit 5104)

Current Procedural Terminology (CPT) codes 99221-99223 describe initial hospital inpatient or observation care, per day. Per American Medical Association (AMA) CPT Evaluation and Maintenance (E/M) guidance, these services require a medically appropriate history and/or examination and are selected based on the level of medical decision making. Under AMA guidance, a clinician may report 99221-99223 when the patient has not received any professional services during the admission from a clinician of the same specialty and subspecialty in the same group practice.

When a Health First Colorado member has more than one medically necessary initial inpatient/observation E/M (99221-99223) on the same date of service (e.g., services furnished by providers of a different specialty or subspecialty), the repeat 99221-99223 line(s) **must** be billed with modifier 77 (repeat procedure/service by another physician or other qualified health care professional). Claims meeting established criteria (including applicable Place of Service and rendering provider requirements) will bypass duplicate edit 5104 and continue to process when billed with modifier 77.



Modifier 77 must be used **only** when the repeat initial E/M service is distinct and medically necessary and supported by documentation. It may not be used for routine duplicate billing or solely to bypass denials. Providers who received denials due to duplicate edit 5104 on or after January 15, 2025, may resubmit claims with modifier 77, if applicable, consistent with timely filing requirements. Providers with claims outside the 365-day timely filing window can resubmit claims with modifier 77. The Department will identify resubmitted claims that deny for timely filing between January 15, 2025, to present and reprocess those claims manually.

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

Remote Patient Monitoring (RPM) - ICD-10 Diagnosis Allowable List

Effective April 1, 2026, all outpatient remote patient monitoring services will require a qualifying diagnosis code for coverage. A qualifying ICD-10 code must appear within the first four diagnosis code positions on the claim. Coverage will be authorized with clinical history of

the ICD-10 diagnosis codes listed in this bulletin and found in the [Telemedicine and eConsult Billing Manual](#). These qualifying conditions align with [Colorado Senate Bill 24-168](#).

Condition	ICD-10	Pediatric Specific ICD-10
Diabetes mellitus	E08.* E09.* E10.* E11.* E12.* E13.* Z96.41 O24.* Z13.1 Z79.4 Z79.84 Z83.3	P70.2
Chronic Obstructive Pulmonary Disease (COPD)	J44.* J96.0x J96.1x J96.9x Z87.891 J43.* J41.* J42 I27.8 I27.2 J84.8 J31.0 B44.0 J98.0 A48.1 J39.8 I26.0 Q22.3	P27.1
Heart failure	I50.* I42* I48* Z95* I11.0 I13.0 I13.2 I09.81 I97.13x	P29.0 Q24.8 Q20.4 Q20.*- Q28.*
Asthma	J45.* J82.83 J82.89	N/A

Condition	ICD-10	Pediatric Specific ICD-10
Pneumonia (including influenza with pneumonia)	J12.*- J18.* J09.X1 J09.X3 J09.X9 J10.0 J11.0 J69.0 J95.851 J85.1 J15 J15.7 J15.0 J15.9 J15.1 J15.4 J13 J16 J16.0 J82.8	P23.* P24.*
High-risk pregnancy	O09.* O10.*- O16.* O20* O24.* O26.* O30.* O34.* O36.* O41.* O43.* O44.* O60.* O99.* P01.8	N/A

Note: “.” denotes all child ICD-10-CM codes under that category (prefix match). “X” in a code (e.g., J09.X1) is an ICD-10 placeholder character, not a wildcard.

Contact Sahara Karki at Sahara.Karki@state.co.us or Morgan Anderson at Morgan.Anderson@state.co.us with questions.

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

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

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

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

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

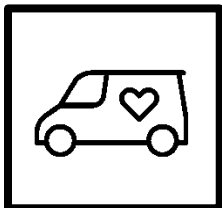
Register for an upcoming SBIRT training at the [PAS training calendar](#). The shared goal is to promote SBIRT as a standard of care throughout Colorado. Refer to the [SBIRT Billing Manual](#) to learn more about best billing practices.

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

Transportation Providers

Non-Emergent Medical Transportation (NEMT) Providers Upcoming Broker Communications

All actively enrolled NEMT providers expect communications from the Department in the coming weeks regarding new broker timelines, key transition information and enrollment details.



An Operational Memo outlining the transition plan will soon be published and be made available on the [Operational Memo web page](#). All TransDev providers will also be directly contacted via email with specific instructions to begin contracting with MediDrive.

Providers are encouraged to verify that their email addresses are current in the [Provider Web Portal](#) to ensure timely receipt of updates.

Information will be shared by the Department through email notifications, newsletters and the monthly provider bulletin as the transition begins and continues.

Action needed - Transdev network providers only: Timely closeout is necessary for Transdev to process claims and issue payments. **Effective immediately**, close out trips as soon as they are completed to support timely payment during the broker transition.

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

Insurance Requirements:

NEMT providers shall maintain commercial automobile liability insurance covering “any auto” (or providing coverage for Owned, Non-Owned and Hired Autos) for all vehicles operated by the provider in performance of NEMT services. Policies limited solely to a Schedule of Covered Vehicles are not acceptable. Provider shall also comply with all applicable insurance and, *if applicable*, Public Utility Commission (PUC) requirements under [10 C.C.R. 2505-10 8.014.3](#).

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

Reminder to NEMT Providers:

Enrolled Non-Emergent Medical Transportation (NEMT) providers are reminded that they must follow these policies:

- Providers must **not** directly solicit individual members known to have already established NEMT service with another provider (10 CCR 2505-10 8.014.3.B.6.c.).
- Providers must only provide NEMT services appropriate to their current licensure(s) and within the geographic limitations applicable to that licensure (10 CCR 2505-10 8.014.3.B.6.d.).
- Providers must ensure that all vehicles and auxiliary equipment used to transport members meet all applicable federal, state and local safety inspection and maintenance requirements (10 C.C.R. 2505-10 8.014.3.B.6.f.).

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

Reminder to NEMT Providers:

Non-Emergent Medical Transportation (NEMT) documents must **not** be faxed, emailed or mailed to the Department. These forms are to be exchanged only between the NEMT provider and the referring or treating provider, as applicable.



Documents sent to the Department which are not part of the claim submission or approval process detailed in the [NEMT billing manual](#) will not be forwarded to the appropriate provider. Submitting forms to the Department may result in delays and administrative burden.

Ensure all NEMT documentation is sent through the correct provider-to-provider process.

Providers are reminded to contact the [Provider Services Call Center](#) for assistance, and not the main phone number for the Department.

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

Vision Providers

Eyeglasses Coverage

Eyeglasses coverage is limited to one (1) or two (2) single or multifocal vision clear plastic or polycarbonate lenses with one (1) frame.

- Eyeglasses for adult members (ages 21 and over) are benefits following eye surgery only.
- Eyeglasses for members under 21 are benefits when medically necessary. Replacement is a covered service when there is a change in prescription, a loss or when repair exceeds the cost of replacement. Second or duplicate pairs of eyeglasses are not a covered benefit.



The Current Procedural Technology (CPT) codes of *either* V2020 or V2025 should be used in eyeglass frame claims.

Rates can be found on the [Provider Rates & Fee Schedule web page](#). Further vision services billing guidance can be found in the [Vision Services Billing Manual](#) on the [Billing Manuals web page](#).

Contact Christina Winship at Christina.Winship@state.co.us with any Vision Policy questions. Contact the [Provider Services Call Center](#) for assistance with claims and billing.

Provider Training Sessions

April 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 April:

- **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) hour 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 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
- **Provider-Specific Billing Training (April Training: Physical, Occupational and Speech Therapy; Hospice; Clinic Practitioner)**

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

- Audience: This training applies to specific provider types.
 - Time: One (1) hour presentation / half (0.5) hour Q&A
 - **Member Eligibility Training**
- This focused micro-training details important aspects of member eligibility from the provider's perspective including eligibility verification, detailed eligibility types, member billing and using the Provider Web Portal to access this critical information.
- 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



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.



April 2026				
Monday	Tuesday	Wednesday	Thursday	Friday
		1	2	3
6	7 Provider-Specific Billing Training: Physical, Occupational and Speech Therapy 1:00 p.m. - 2:30 p.m. MT	8	9 Member Eligibility Training 10:00 a.m. - 11:30 a.m. MT	10
13	14	15 Beginner Billing Training: Professional Claims (CMS 1500) 10:00 a.m. - 12:00 p.m. MT	16	17
20	21 Provider-Specific Billing Training: Hospice 1:00 p.m. - 2:30 p.m. MT	22	23 Provider-Specific Billing Training: Clinic Practitioner 9:00 a.m. - 10:30 a.m. MT	24
27	28	29 Provider Enrollment Training 10:00 a.m. - 12:00 p.m. MT	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 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

