ProviderInsight®

Colorado Edition
February 2026

Welcome!

Find medical, dental, and pharmacy information as well as program and plan updates for:

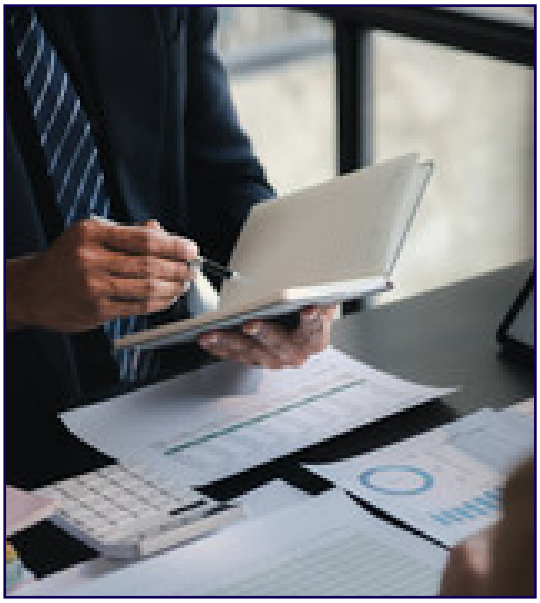
- **Commercial**
- **Select Health Medicare**

Select Health

In this Issue

Select Health News and Networks

Get Started with Zelis = Get Paid Faster



In the coming months, Select Health will manage all provider and pharmacy payments via the Zelis Payment Network. This change will improve the speed, accuracy, and security of Select Health payments. If you have not done so already, your office needs to enroll in Zelis to enjoy maximum payment convenience.

HOW TO ENROLL IN THE ZELIS EPAYMENT CENTER

You will need:

- Federal tax identification number (TIN) or employer identification number (EIN)
- Your practice's corporate name and principal information
- Bank account routing transit number (RTN) or ABA routing number
- Bank account number

Steps to enroll:

1. Visit the Select Health ePayment Center.
2. Choose "No" when asked if you have a registration code. Complete the online form with information about your practice, and "Submit Request."
3. You will receive an email with a link; follow that link to complete your registration and set up your account.
4. Log in to the ePayment Center portal, and enter your bank account information.
5. Review and accept the ACH agreement (if applicable to the payment type you choose; see below). Then, click "Submit."
6. Zelis will validate your bank account prior to beginning electronic funds transfer.

ZELIS PAYMENT TYPES

After enrolling, you can use any of the Zelis payment options. Contact Zelis using the information in **Figure 1** below to set up or change your payment type.

Figure 1. Zelis Payment Types

Payment Type	Basic Function	Provider Cost	Get Started or Change Type
ePayment Center	Direct settlement into provider bank account	None	• Register online. • Contact Zelis at: **(855) 774-4392**; or via email at help@epayment.center.
Paper Check	Cost-efficient paper check delivery		
Virtual Card	Virtual card processed via card terminal	Fee Required	Call: **(877) 828-8770**
ACH+	Direct settlement into provider bank account*		

* ACH+ Solution offers providers a unique payment experience over a traditional electronic funds transfer (EFT). With ACH+, provider payments, 835s delivery, and customer service are all managed under one seamless connection.

Select Health News and Networks, Continued

Compliance Matters: Survey Reminders

Figure 2. Select Health Colorado Provider Survey Overview

Colorado Provider Survey Name (Cadence)	Required by:	Survey Timing
Quarterly Attestations for Provider Directory Info (Quarterly)	Various CMS, NCQA, and state mandates	Quarterly
Provider End-of-Year Experience Survey (Annual)	Select Health Business Practice for Improving Provider Experience	Q1
Clinic Manager End-of-Year Experience Survey (Annual)		
Appointment Wait Times Survey (Annual)	NCQA NET 2: Element A	Q2
QPP Experience Survey (participating clinics only) (Annual)	Select Health Business Practice for Improving Provider Experience	Q2
Appointment Wait Times Secret Shopper Survey[1] (Annual)	CMS 2023 Letters to Issuers Ch. 2, Sect. 3.ii.b	Q1-Q2
After-Hours Audit (Annual)	NCQA NET 2: Element A	Q4

[1] This survey is used to evaluate quality health plan issuers' compliance with appointment wait time standards through simulated patient calls performed by a third-party vendor.

2026 Nutritional Formula Coverage Update

Some commercial plan certificates of coverage (COC) contain language that states nutritional formula can be covered if Select Health medical policy criteria are met.

Effective this year, Select Health will use **InterQual© criteria** to assess the medical necessity of nutritional formula care for these specific plans.

For all other plans, please refer to member materials. You can verify coverage for nutritional formula via the Provider Benefit Tool or by calling Member Services at **800-538-5038**.

Questions about nutritional formula coverage? Contact Catherine Burton at Catherine.Burton@imail.org.

WHAT IS INTERQUAL?

This evidence-based, clinical decision support tool helps payers, providers, and government agencies ensure clinically appropriate medical utilization decisions.

Interqual helps determine the medical necessity and appropriate level of care (LOC) for medical, behavioral health, and rehab services.

Questions?

Contact your Provider Relations representative at provider.development@selecthealth.org.

Select Health News and Networks, Continued

Blood Pressure Basics Course for Patients

Select Health is excited to offer **Blood Pressure Basics**, a monthly virtual course designed to help patients take charge of their health and better understand the fundamentals of blood pressure.

In this course, patients will receive helpful resources and support while exploring key questions like:

- What is blood pressure?
- What is hypertension?
- What's your risk of developing high blood pressure?
- How can you prevent or manage high blood pressure?
- What next steps are you ready to take?

Please share this information with any patients who may be struggling with high blood pressure or are interested in learning more. Patients can find class dates/times and register by visiting selecthealth.org/wellness/wellness-events/blood-pressure-basics.

Download a printable flyer (see image below) to post in your waiting and/or exam rooms.

Share these additional resources with your patients:

- Healthy Habit Builder
- 1-Week Habit Tracker
- Select Health Blog Articles:
  - — *Managing Hypertension*
  - — *What Is High Blood Pressure and What Causes It?*

Guideline for Medication Preauthorization Denials (Commercial Plans Only)

Submitting correct diagnosis and CPT codes when a prescribed medication requires preauthorization reduces denials and delays for your patients.

If a medication preauthorization request is denied due to incorrect diagnosis or documentation, Select Health will immediately dismiss any appeal that has a different diagnosis than the original preauthorization request.

Please share with your clinic staff that they should submit a NEW preauthorization with the correct diagnosis and documentation, rather than appealing the denial.

Thank you for helping us avoid delays and appeal time for your practice and our members.

Questions? Contact Provider.Development@selecthealth.org.

Quality Improvement Programs

Updates to the Quality Plus Provider Program (QPP+)

Effective **January 1, 2026**, Select Health rolled out important enhancements to the Quality Plus Provider Program (QPP+), supporting our transition to proactive care and a more robust alternative payment model. Here's what you need to know:

WHAT'S CHANGING?

- **Measure Updates:** Some measures have been removed. Each provider type will receive a specific schedule of measures in the updated agreement.
- **Entry & Target Goal Thresholds:** Clinics can earn additional compensation for meeting and exceeding gap closure goals, on top of per-gap closure rewards.
- **Line-of-Business Separations:** Measures are now separated into tables for each line of business (Medicare, Medicaid, Marketplace, and Commercial), ensuring alignment with member needs.
- **Payment Schedule Frequency:** Both measurement periods and payout dates will be slightly adjusted in 2026.
- **Refocus on CMS Star Ratings:** Updates emphasize CMS Star Ratings, central to driving value for Medicare Advantage members.

WHY THESE CHANGES MATTER

- **Better Alignment:** Programs now more closely match quality and proactive care goals.
- **Recognition:** High-performing clinics are rewarded for excellence.
- **Tailored Measures:** Program measures reflect the diverse needs of our member populations.
- **Support for Star Ratings:** Providers are empowered to achieve top CMS Star Ratings.

Questions about these changes?
Please contact the Quality Provider team at qualityprovider@selecthealth.org.

Changes Coming to QPP Online Resources

Stay tuned! The QPP online program pages and resources page will soon have links to **measure-specific guides** that include 2026 updated information on:

- Measure Description
- Allowable Corrections
- Frequently Asked Questions
- Working Your Open Gaps
- Best Practices

These guides will give you all the information you need to track and report on any of the current program measures in a single resource!

Pharmacy

Updated Pharmacy Provider Manual

The 2026 updated Pharmacy Provider Manual is now available online.

SUMMARY OF CHANGES AND REMINDERS

The 2026 Pharmacy Provider Manual was last updated on December 20, 2025. **Figure 3** gives an at-a-glance view of the changes to specific sections.

Figure 3. Manual Sections Updated or Added in 2026 Pharmacy Provider Manual

SECTION #	SECTION UPDATE OR ADDITION	UPDATE SUMMARY
3.1	Update	Added new BIN/PCN Combinations
4.4	Update	Clarification on non-covered ingredients
5.3	Update	New MAC List accessibility process
8.0	Update	New payment and reconciliation vendor and processes
9.11	Update	Medicare Service Areas for 2026
9.12	Addition	Medicare Drug Price Negotiation
9.13	Addition	Medicare Transaction Facilitator
5.5, 10.5, 10.6, 10.7	Additions	Utah Medicaid Reimbursement Methodology
Appendix A	Update	Added additional state resources
Appendix B	Update	Full replacement for 2026
Appendix C	Update	Full replacement for 2026

IMPORTANT MEDICARE BILLING INFORMATION

For claims with a date of service:

Before January 1, 2026

Please use
BIN 015938 PCN 7463 / BIN 027357 PCN MPPP.

On or After January 1, 2026

Please use
BIN 028645 PCN 7463 / BIN 028645 PCN MPPP.

Reference the payer sheet in the Pharmacy Provider Manual (Appendix B) for full details on billing Medicare claims.

Pharmacy, Continued

Select Health and Biosimilars

Select Health's proactive biosimilar strategy lowers the total cost of care by prioritizing clinically equivalent, lowest-net-cost therapies and standardizing use across the organization (see **Figure 4** below).

This approach delivers significant system-wide savings, driven by lower acquisition costs, stronger reimbursement margins, and reduced administrative waste, while preserving high-quality outcomes and easing operational burden for clinicians and pharmacy teams.

Figure 4. 2026 Select Health Preferred Biosimilar Product Coverage

DRUG NAME	REFERENCE BRAND	COMMERCIAL	MEDICARE	MEDICAID
adalimumab	Humira	Amjevita, Hadlima		Cyltezo 40mg/0.8ml Hadlima 40mg/0.8ml Simlandi
aflibercept	Eylea	Pavblu		
bevacizumab	Avastin	Mvasi, Zirabev		
denosumab 120 mg/1.7mL	Xgeva	Bilprevda, Wyost		
denosumab 60 mg/mL	Prolia	Bildyos, Jubbonti		
eculizumab	Soliris	Epysqli		
epoetin alfa	Procrit, Epogen	Retacrit		
filgrastim	Neupogen	Nivestym, Granix		
infliximab	Remicade	Renflexis		
natalizumab	Tysabri	Tyruko		
pegfilgrastim	Neulasta	Fulphila, Udenyca		
ranibizumab	Lucentis	Cimerli		
rituximab	Rituxan	Ruxience, Truxima		
tocilizumab	Actemra	Tyenne		
trastuzumab	Herceptin	Ogivri, Trazimera		
ustekinumab	Stelara	Pyzchiva, Steqeymai		

Practice Management Resources

Immunization Updates and ACIP Highlights

The Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC) met on **December 4–5, 2025,** to discuss hepatitis B vaccine birth dose, and other potential issues impacting the Child/Adolescent Vaccine Schedule.

Figure 5 below summarizes the votes and recommendations from these meetings related to hepatitis B vaccines, antibody tests, and alignment with the Vaccines for Children (VFC) program.

Additional presentations included:

- A review of the evolution of the child/adolescent vaccine schedule by Andrew Siri, a lawyer specializing in vaccine injury lawsuits
- A presentation on Denmark's vaccine schedule that recommends fewer vaccines than the U.S.
- An overview of adjuvants
- ACIP committee restructure updates

Learn more by accessing:

- Related details: Review the full report (vaccine evidence presented, committee discussion, and votes) for each recommendation summarized in **Figure 5** (and for other recent updates).
- **Archived meeting minutes and slides:** Access on the ACIP meeting website (click on "Meeting Materials").

At this time, there are NO changes recommended to vaccine protocols at Intermountain Health. Intermountain Health facilities will continue to offer hepatitis B vaccine to all newborns, regardless of maternal antibody status.

Parent/guardians should be informed that, if they request antibody testing between doses of the primary 3-dose series, those tests may not be covered by insurance.

The information provided concerning the ACIP recommended changes to the vaccine schedule is for informational purposes only.

Questions regarding immunization? Contact Tamara Sheffield, MD, MPA, MPH, Medical Director, Immunization Programs, Intermountain Health Canyons Region, at **801-442-3946**.

Figure 5. Vaccines Guidance Summary

VOTES TO RECOMMEND, SUGGEST, OR SUPPORT	
HEPATITIS B VACCINE	**Voted to recommend:** • Changing the hepatitis B (Hep B) vaccine birth dose from routine to **individual-based decision making** for infants born to mothers known to be hepatitis B surface antigen (HBsAg) negative. • **Not administering** the first dose of the series prior to age 2 months for those infants. • **Not changing** recommendations for infants born to HBsAg-positive mothers or where mother's HBsAg is unknown (ratified by acting CDC director).
HEPATITIS B ANTIBODY TEST	**Voted to suggest that** parents consult with their providers about drawing blood from their infants to test for hepatitis B antibody levels **prior to** administering subsequent doses of the 3-dose series. **NOTE:** The CDC has **not** yet accepted this testing recommendation, which remains under review.
HEPATITIS B VACCINE VFC RESOLUTION	**Voted to support** a revised Vaccines for Children (VFC) Resolution to align the wording with the hepatitis B vaccine birth-dose recommendation. VFC coverage of the hepatitis B vaccine will not change due to these votes.

Practice Management Resources, Continued

Get Started with the Preauth & Care Plan Tool

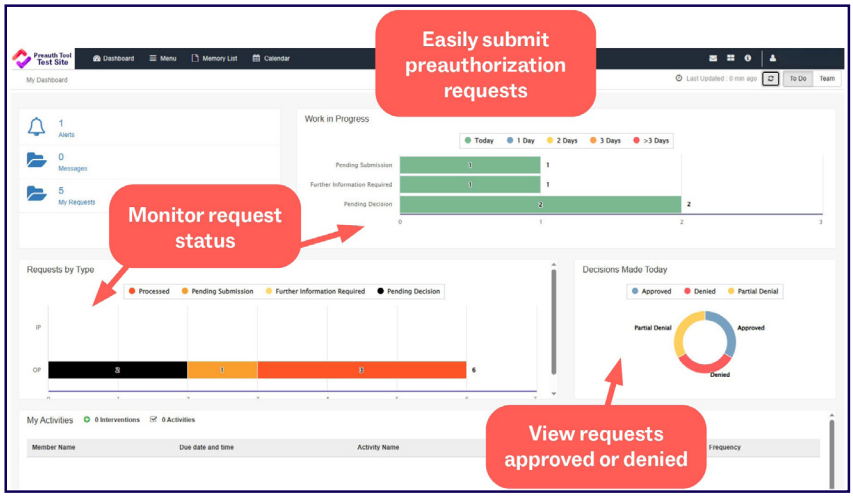
Still faxing your preauthorization requests? Let your practice staff know that they can sign up for the Preauth & Care Plan Tool for submitting and monitoring **Commercial preauthorization requests** online. **Figure 6** below gives a quick tour of the dashboard.

Compared to faxed or emailed requests, this tool makes the Commercial preauthorization process easier. Enjoy the benefits of:

- **Reduced response time**
- **24/7 preauthorization status information**
- **No risk of faxed information being lost,** sent to the wrong number, or other errors
- **Reduced follow-up calls and decision delays** due to missing information
- **Automatic review and preauthorization decisions for many procedures** (including CPAP/BIPAP, eye procedures, hysterectomy, spinal pain interventions, tonsillectomy/adenoidectomy, total joint replacement [hip and knee], and varicose vein procedures)

Learn more.

Figure 6. Dashboard Overview



NEW USERS

New to the Preauth & Care Plan Tool? Get started by:

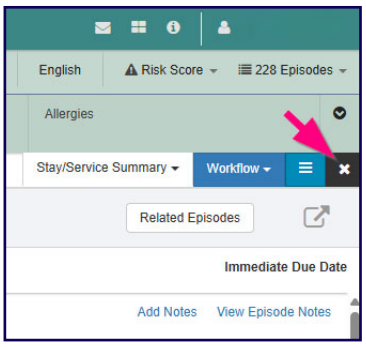
1. Registering to use the Preauth & Care Plan Tool
2. Visiting the Preauth and Care Plan Tool website for training videos, quick guides, and FAQs.

CURRENT USERS

Some users have encountered common issues when logging in or creating authorization requests. These are the steps you should take to resolve these problems:

- **Login Errors:** If you are getting a TaxID XML error when trying to login, please call the help desk at **801-442-7979**, **option 2** to submit a ticket. Be sure to include the error message in your ticket.
- **Member Eligibility Issues:** If a member does not show as eligible in the Preauth & Care Plan Tool but eligibility has been verified, please call the help desk at **801-442-7979, option 2**, to submit a ticket.
- **Editing Authorizations:** Click the black box with the "X" (as indicated in **Figure 7** at right) after adding attachments or a note to an authorization. Not exiting the authorization correctly may block others from working on the request.

Figure 7. Exiting Authorization



- **Facility Role**: When submitting a request using a facility, the facility should always use the role of **Servicing**. "Additional Servicing" is only for providers.

Practice Management Resources, Continued

Colorectal Cancer Screening: What Providers Need to Know

WHO SHOULD GET COLORECTAL CANCER SCREENING?

All adults, ages 45 to 75, should be screened for colorectal cancer. For those **ages 76 to 85**, screening should be discussed with their provider based on preferences, overall health, and past screening history.

Those **younger than 45** who have risk factors (e.g., family history, hereditary diseases) should discuss the need for screening with their providers.

Members can download a colon screening guide (English, Spanish) to understand their risk and the type of screening best for them.

WHAT SCREENING DOES SELECT HEALTH COVER?

Select Health covers testing as follows:

- **Colonoscopy**: Members should have a colonoscopy every 10 years or every 3 to 5 years if there are risk factors (e.g., a history of polyps, family history, or other factors; see information at right).
- **Stool-based Testing:** These at-home tests of stool samples can be mailed into the lab for analysis (see instructions on page 11). Select Health promotes fecal immunochemical testing (FIT) because of its accuracy, cost, and frequency. FIT testing should be done every calendar year for eligible Select Health Advantage (Medicare) members and every 365 days for commercial members. See page 11 for exclusions.

WHAT RISK FACTORS ARE ASSOCIATED WITH COLON CANCER?

Risk factors include:

- **Age.** About 90% of colorectal cancer occurs in adults older than 45.
- **Family History.** Risk may increase if a close relative has had colon cancer or a colon polyp.
- **Ethnicity.** Colorectal cancer rates are higher among African Americans compared with other races.
- **Medical Conditions.** Inflammatory bowel disease may increase risk of developing colon cancer.
- **Lifestyle**. Members can mitigate some risk factors (e.g., by stopping smoking, improving diet, being active, and keeping a healthy weight).

Quick Links for Screening

Members who have an average risk can access **at-home colon cancer screening kits**.

Those at higher risk can **schedule a colonoscopy**.

WHAT IS THE PROCESS FLOW FOR SCREENING?

The algorithm and associated notes in **Figure 8** on page 11 highlight the care process associated with colorectal cancer screening. Be sure to contact Select Health Member Services (**800-538-5038**) to verify plan-specific coverage for preventive screening tests.

Continued on page 11...

Latest Screening Guidelines

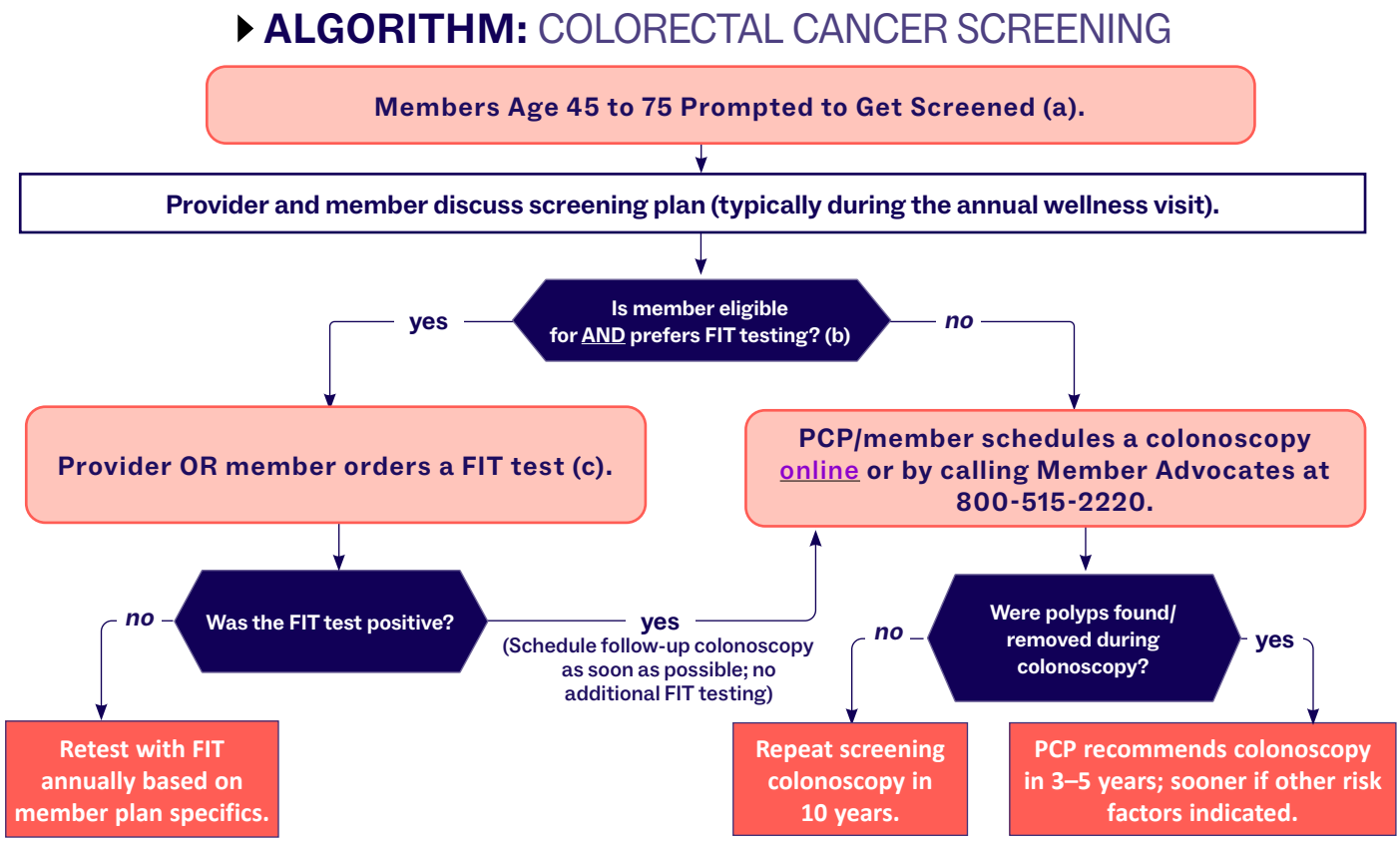
The U.S. Preventive Services Task Force (USPSTF) recently expanded recommended adult colorectal cancer screening to those aged 45 to 49 years.[1] These guideline changes reflect that:

- **There has been a dramatic increase in colorectal cancer among those aged 40 to 49 years.** By expanding the recommendations and offering more screening options, we can help members live the healthiest lives possible.
- **Screening detects colon cancer at an early stage (localized) when it is curable.** The five-year survival rate for localized colorectal cancer (cancer that is confined to the colon or rectum) is **90.6%** as compared to **14.7%** for those whose cancer is detected in later stages.[2]

Thanks to the new guidelines, many insurance plans cover colorectal cancer screenings with no copays (according to the United States Preventive Services Taskforce) as mandated by the Affordable Care Act.

Practice Management Resources, Continued

Figure 8. Colorectal Cancer Screening Algorithm



ALGORITHM NOTES

(a) Member Screening Prompt

Members are prompted to get screened when:

- Primary care providers review prevention screening status with members at annual wellness visits and develop a member-specific screening plan based on criteria.
- Select Health sends reminder letters to members when records indicate that they are due for colorectal cancer screening.

(b) FIT Test Exclusions

- History of polyps or colon cancer
- Hemorrhoids
- Ulcerative colitis or Crohn's disease
- Visible blood in the stool or on toilet paper
- A previously positive FIT test
- Normal colonoscopy within 10 years

(c) How to Order FIT Tests

1. Make sure that your clinic is set up to use Intermountain lab services. Sign up via the lab outreach services team.
2. Providers can order FIT test kits at the Intermountain Central Lab website or download an order form to complete and send to client services).
3. FIT samples not labeled with patient information cannot be processed.

NOTE: Members in Colorado, Utah, Idaho, Nevada, Wyoming, and Montana can order an at-home kit online through Intermountain Health.

REFERENCES

1. U.S. Preventive Services Task Force. *Final Recommendation Statement - Colorectal Cancer: Screening*. May 18, 2021. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening. Accessed January 20, 2026.
2. Moffitt Cancer Center. *Colon Cancer Survival Rate*. moffitt.org website. https://www.moffitt.org/cancers/colorectal-cancer/survival-rates/. Accessed January 20, 2026.

Practice Management Resources, Continued

Navigate! How can we help you today?

Start with Select Health online self-service solutions. Access our provider website (selecthealth.org/providers) for the quickest way to get your questions answered. Direct links are in purple type.

Do you need to:	Go to:
Find member ID card information?	https://selecthealth.org/providers/claims/id-guides
Access non-covered codes/ preauthorization requirements?	https://selecthealth.org/providers/preauthorization/forms-lists
Request preauthorization?	https://selecthealth.org/providers/preauthorization
Appeal a claim?	https://selecthealth.org/content/dam/selecthealth/Provider/PDFs/forms/Provider-Appeal-Form.pdf
Find pharmacy resources?	https://selecthealth.org/providers/programs/pharmacy
Access dental provider resources?	https://selecthealth.org/providers/programs/dental
Access Select Health policies (medical, dental, coding/reimbursement)?	https://selecthealth.org/providers/policies
Learn about our secure provider tools (Provider Benefit Tool, Preauth Tool)?	https://selecthealth.org/providers/provider-access-point

Contact us when you can't find answers online. We're here to help, Monday through Friday, 8:00 a.m. to 5:00 p.m. unless otherwise indicated below. Phone and email requests are answered in the order they are received.

When you need to:	Access:
Verify member benefits or get help with claims payment issues and information	Use the Provider Benefit Tool (see above) or call Member Services: 800-538-5038 (available 7:00 a.m. to 8:00 p.m. on weekdays, 9:00 a.m. to 2:00 p.m. on Saturdays.) For Federal Employee Health Benefit members, contact 844-345-FEHB (3342).
Resolve issues with provider setup or directory listing	Provider Development: COProviderRelations@selecthealth.org
Get help with access to tools on our secure Provider Portal and online tools (Provider Benefit Tool, Preauth Tool)	Provider Web Services: providerwebservices@selecthealth.org
Resolve claims appeals/preauth issues	Compliance and Appeals: **844-208-9012**
Manage Electronic Funds Transfer (EFT)	EDI Department: **800-538-5099** (fax: **801-442-0372**); edi@selecthealth.org
Change passwords, reactivate accounts, resolve issues with 2-Step Authentication (PingID)	Account Help Desk: **801-442-7979, Option 2**
Request fee schedules (contracted providers only)	Provider Development: SHFeeScheduleRequests@selecthealth.org

Select Health