Provider Bulletin

Reference: B0900266 **May 2009**

colorado.gov/hcpf

In this issue:

Denver Club Building
518 17th Street, 4th floor
Denver, Colorado 80202

ACS Contacts

Billing and Bulletin Questions
303-534-0146
1-800-237-0757

Claims and PARs Submission
P.O. Box 30
Denver, CO 80201

Correspondence, Inquiries, and Adjustments
P.O. Box 90
Denver, CO 80201

Enrollment, Changes, Signature authorization and Claim Requisitions
P.O. Box 1100
Denver, CO 80201

Did you know...?

Billing groups, with less than 400 affiliated providers, can access their affiliation list with the group affiliation effective dates through the Web Portal's MMIS Provider Data Maintenance.

All Providers

Fee for Service Rate Adjustments

CPT and Healthcare Common Procedure Coding System (HCPCS) procedure codes currently reimbursed above 100% of Medicare

Effective June 1, 2009, reimbursement rates for a number of Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) procedure codes currently reimbursed above 100% of the corresponding Medicare allowable will be reduced as mandated by the Colorado Legislature. The reimbursement rates for these codes will be adjusted to 100% of the Medicare allowable rates as listed in the January 2009 Medicare fee schedule. The adjusted rates will be incorporated in the Colorado Medicaid Fee Schedule and will be available in June 2009 on the Department of Health Care Policy and Financing's (the Department's) Web site at colorado.gov/hcpf. You may access the fee schedule by selecting ➡ Providers ➡ Provider Services. A list of the affected codes will also be published in the June 2009 Provider Bulletin. Please contact ACS Provider Services at 1-800-237-0757 or 303-534-0146 if you have any questions.

Old Age Pension (OAP) Health and Medical Care Program

Because the OAP Health and Medical Care Program is a State-funded program and not an entitlement, the authorized spending authority cannot be exceeded. The following provider payment rates are effective for dates of service on or after April 15, 2009 and will remain in effect until further notice:

- Inpatient hospital services reimbursed at 10% of the Medicaid rate
- Outpatient services (including services received in outpatient hospital settings, federal qualified health centers, rural health centers and dialysis centers) reimbursed at 65% of the Medicaid rate
- Practitioner services reimbursed at 65% of the Medicaid rate
- Emergency transportation services reimbursed at 65% of the Medicaid rate
- Home health services (including hospice services) and supplies reimbursed at 65% of the Medicaid rate
- Emergency dental services reimbursed at 65% of the Medicaid rate
- Laboratory and x-ray services reimbursed at 65% of the Medicaid rate
- Medical Supply services reimbursed at 65% of the Medicaid rate
- Pharmacy Services will be reimbursed at 75% of the Medicaid rate (an increase of 5%).

Clients are eligible to apply for the Colorado Indigent Care Program (CICP) for benefits not covered by the OAP Health and Medical Care Program. The Emergency Medical Services to Aliens Program may cover life and death emergency hospital admissions for non-citizen OAP Health and Medical Care Program clients. Please continue to verify client eligibility through CMERS, Fax-Back or the Web Portal. Clients covered by the OAP Health and Medical Care Program are identified by the following eligibility message: "*The client that you have entered is enrolled in the OAP Health and Medical Care Program. NOT Medicaid eligible. Limited benefits. Payment may be reduced. No guarantee of covered services or payment amounts. More information: www.chcpf.state.co.us*".

As a reminder, the current rules for the OAP Health and Medical Care Program include:

- Maximum client co-payment of $300
- Co-payment amounts for services are the same as the co-payment amounts under Medicaid
- There are no retroactive benefits (client can only be eligible from date of application). If claim overpayments are made in error, recoveries will be made retroactively.

More information can be found at colorado.gov/hcpf. For questions regarding these changes, please contact Cindy Arcuri, Safety Net Programs at 303-866-3996.

Billing Clients Covered by the OAP Health and Medical Care Program

Providers may not bill clients for the difference between what Medicaid pays and what OAP State Only pays. Per 10 C.C.R. 2505-10, Section 8.941.5 (CERTIFICATION OF PAYMENT FOR PROVIDERS):

All providers of medical services in their submission of claim to the Old Pension Health Care Program and the Old Age Pension Health Care Supplemental Program certify that, "I will accept as payment in full, payment made under the Old Age Pension Health Care Program, and certify that no supplemental charges have been, or will be, billed to the patient, except for those non-covered items, or services, if any, which are not reimbursable under the Old Age Pension Health Care Program or the Old Age Pension Health Care Supplemental Program."

In addition, as provided by the Colorado Medical Assistance Program General Provider Information manual and Provider Agreement, providers agree to accept the Colorado Medical Assistance Program payment as payment in full for benefit services. Furthermore, Section 26-4-403, Colorado Revised Statute, prohibits providers from billing Colorado Medical Assistance Program clients.

Regional Conferences Coming in May and June 2009

The Department is pleased to announce that we will be hosting regional conferences this May and June. The conferences will provide training for all who administer programs on behalf of the Department. Training will cover an array of topics: eligibility for Family Medicaid, CHP+, and Adult Medicaid; an overview of the communication process between County Eligibility, Case Management Agencies, and Service Providers; best practices that explore the relationship between eligibility, enrollment, and benefits from all perspectives; and much more. For complete session descriptions and conference schedules, please visit colorado.gov/hcpf ➡ Partners and Researchers ➡ County and Medical Assistance Site ➡ Training and Reference Documents.

Conference Dates	Locations
May 4 and 5	Fort Collins
May 7 and 8	Denver
May 19 and 20	Grand Junction
June 2 and 3	Burlington
June 15 and 16	Durango
June 18 and 19	Alamosa
June 22 and 23	Colorado Springs

Please contact Whitney Ice, Client Services, at 303-866-4724 with questions.

Durable Medical Equipment (DME)/Supply Providers

New Procedure Codes for Repair or Non-Routine Service for DME and Oxygen Equipment

The Centers for Medicare and Medicaid Services (CMS) has established two new HCPCS procedure codes for repair or non-routine service for DME and oxygen equipment effective April 1, 2009. The new codes are:

- K0739 - Repair or non-routine service for durable medical equipment other than oxygen requiring the skill of a technician, labor component, per 15 minutes
- K0740 - Repair or non-routine service for oxygen equipment requiring the skill of a technician, labor component, per 15 minutes

These two new codes were established to replace code E1340 - Repair or non-routine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes.

Although CMS will no longer use code E1340 for Medicare services rendered after March 31, 2009, the Colorado Medicaid program will continue to accept code E1340 until July 31, 2009 to accommodate active prior authorization approvals that are currently in use by providers. Beginning August 1, 2009, no claims for code E1340 will be accepted.

Code E1340 should not be used for new prior authorization requests (PARs). Providers should begin using codes K0739 and K0740 when submitting new PARs for non-routine service for DME and oxygen equipment effective April 1, 2009. The reimbursement rate is $35.48 per 15 minutes. The cost of the repair cannot exceed the cost to purchase replacement equipment. The serial number of the equipment being repaired must be identified in field 12 of the PAR. Paper claims must also include the serial number. If procedure codes are available to identify specific components, they must be used (e.g. tires, upholstery, batteries, etc. [1 unit = 15 minutes]). The annual maximum is 480 units or 120 hours of service (average 40 units or 10 hours of service per month). Use K0739 for DME and K0740 for oxygen equipment.

Code E1340-MS should not be used on claims for dates of service on or after April 1, 2009. Providers should also begin using codes K0739-MS and K0740-MS for all quick, minor repairs for DME and oxygen equipment rendered on or after April 1, 2009. No prior authorization is required. The reimbursement rate is limited to a maximum of $156.77 per six (6) months. The MS modifier is required. In addition to labor, the costs of minor parts may be included under this code. Paper claims must include the serial number. Use K0739-MS for DME and K0740-MS for oxygen equipment.

Please contact ACS Provider Services if you have any questions regarding these new procedure codes.

Ocular Prosthetic Benefits and Billing Requirements

The Colorado Medicaid Program provides benefits for ocular prosthetic services when medically necessary. Claims should be submitted on the Colorado 1500 or as an 837 Professional (837P) electronic transaction. For codes that require a prior authorization (PAR), the PAR request form should be faxed to the Colorado Foundation for Medical Care (CFMC) at 303-695-3377.

Providers should submit claims for ocular prosthetic services using the most appropriate ICD-9 diagnosis code(s). Common ICD-9 diagnosis codes related to ocular prosthetic services include but are not limited to 743.00 – Clinical anophthalmos unspecified, 871.3 – Avulsion of eye, and V52.2 - Fitting and adjustment of artificial eye. Providers should use their medical judgment when selecting the most appropriate diagnosis code(s) for each claim.

Effective May 1, 2009, the following benefit guidelines and billing requirements apply to the ocular prosthetic codes listed below:

V2623 – Prosthetic eye, plastic, custom
Prior authorization is required
Reimbursement amount - $2,119.54 per eye
Maximum of 2 units per date of service

- This code includes the evaluation and impression of the socket, development of a fitting model or pattern, painting the iris and sclerotic colorings, finishing and delivery of completed prosthesis.
- The first set of prosthetics should be prior authorized by the ocularist/optician with a written explanation of need by the ophthalmologist or optometrist.
- Medically necessary replacement for clients aged 20 and under is allowed every three years with a PAR and letter of medical necessity by the ocularist. No exam or script from an MD is required.
- Medically necessary replacement for clients aged 21 and older is allowed every five years in adults with a PAR letter of medical necessity from the ocularist.

V2624 – Polishing/resurfacing of ocular prosthesis
No prior authorization is required
Reimbursement amount - $44.21 per eye
Maximum of 2 units per year

- This service item no longer requires an invoice, paper billing or to be prior authorized within the first 12 month period.
- Additional polishing within a one year period must be prior authorized and billed with modifier SC (medically necessary service or supply).

V2625 – Enlargement of ocular prosthesis
Prior authorization is required
Reimbursement amount - $552.30 per eye
Maximum of 2 units per date of service

- Code V2625 should not be billed simultaneously with code V2623.
- Prior authorization by the optician with an explanation of medical necessity is required.

V2626 – Reduction of ocular prosthesis
Prior authorization is required
Reimbursement amount – manually priced based on the provider's invoice
Maximum of 2 units per date of service

- Code V2626 should not be billed simultaneously with code V2623.
- Prior authorization by the optician with an explanation of medical necessity is required.

V2627 – Scleral cover shell
Prior authorization is required

Reimbursement amount - $2,386.00
Maximum of 2 units per date of service

- A scleral shell covers the cornea and the anterior sclera. It may be prescribed as an artificial support to a damaged or shrunken and sightless eye shell with the muscle intact. The scleral shell may also be prescribed as a barrier in the treatment of severe dry eye and serves as a natural surface for normal tear function.
- The first set of scleral cover shells should be prior authorized by the ocularist/optician with a written explanation of need by the ophthalmologist or optometrist.
- Medically necessary replacement for clients aged 20 and under is allowed every three years with a PAR and letter of medical necessity by the ocularist. No exam or script from an MD is required.
- Medically necessary replacement for clients aged 21 and older is allowed every five years in adults with a PAR and letter of medical necessity from the ocularist.
- Codes V2627 and V2623 are mutually exclusive.

V2628 – Fabrication and fitting of ocular conformer

No prior authorization is required
Reimbursement amount - $375.00 per eye
Maximum of 2 units per date of service, 4 units over the patient's lifetime

- This service is performed prior to a permanent prosthetic and is not part of the permanent prosthetic.
- This code may not be billed following V2623 or V2627.
- The maximum allowed units are 4 over the patient's lifetime and would typically be billed once every six weeks to three months until the 4 unit maximum is reached.

V2629 – Prosthetic eye, other type
Prior authorization is required
Reimbursement amount - manually priced based on the provider's invoice
Maximum of 2 units per date of service

- Prior authorization with justification for re-fitting is required

Please contact ACS Provider Services if you have any questions.

2009 Supply HCPCS Code Bulletin Update

The 2009 Supply HCPCS Code Bulletin (B0900261- 01/09) has been updated to include seven approved Supply, DME, Orthotics and Prosthetics HCPCS Codes. These codes are: A4351, Intermittent Catheters; A4352, Intermittent Catheters; A4352-22, Intermittent Catheters; A4388, Ostomy Pouch; A4390, Ostomy Pouch; A4391, Urinary Pouch; and A5061, Ostomy Pouch.

All codes and changes were effective January 1, 2009. Please refer to the 2009 Supply HCPCS Codes (B0900269 - Revised 04/09) by visiting colorado.gov/hcpf➡ Providers ➡ Provider Services ➡ Bulletins.

Hospital Providers

Inpatient Hospitals and Mental Health Services

Clarification for Billing Mental Health or Physical Health Services When the Services Overlap During a Single Inpatient Stay

Inpatient hospital claims billed to fee-for-service Medicaid are paid based upon a Diagnosis Related Group (DRG) system for an entire episode of care from admission to discharge. The Department does not recognize the transfer of a client to a different wing or ward during a single inpatient stay. The hospital is required to submit one claim for the entire hospitalization.

The ICD-9-CM Official Guidelines for Coding and Reporting defines the principal diagnosis as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care". The ICD-9-CM Official Guidelines for Coding and Reporting can be found at http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide08.pdf.

The following billing process should be applied if a Medicaid client's mental health and physical health services overlap during a single inpatient stay:

- If the principal diagnosis is physical health related but the client also received mental health services, one bill should be issued for the entire hospitalization and paid through the fee-for-service program. Additional billing by the hospital to the Behavioral Health Organization (BHO) seeking reimbursement regarding the mental health portion of the claim is considered to be double billing.
- If the principal diagnosis is mental health related and covered under the BHO contract (see Exhibit F of the BHO contract for BHO-covered diagnoses by visiting colorado.gov/hcpf ➡ Clients & Applicants ➡ Medicaid Managed Care ➡ Behavioral Health Program Information) but the client also received physical health services, one bill should be issued for the entire hospitalization and paid through the BHO, as the BHO is obligated to pay for all services provided in the hospital between admission and discharge, provided that the client is an enrolled member in the BHO.
- If the principal diagnosis is mental health related, the hospital will need to follow all BHO billing processes, including prior authorization, to ensure payment.

At the point when mental health is determined to be the primary reason for hospitalization, the prior authorization process must be followed at once. Please note that fee-for-service Medicaid will not pay for a service that is a benefit of the BHO program, even if the BHO issues an administrative denial for that service. The hospital is at risk of not being reimbursed for the services provided if BHO covered services are not billed in accordance with BHO policies and procedures.

- The determination of the principal diagnosis is made by an attending physician, but is subject to review by the Department, the Department's agents, federal auditors, and the BHO.

If the BHO-contracted provider has a billing question, please contact the associated BHO. If the BHO has questions or comments, please contact Marceil Case at marceil.case@state.co.us.

DRG Review and Education Program - Update

Health Management Systems, Inc. (HMS) and the Department have spent the last several months developing a new framework for the DRG Review and Education Program. HMS will be reviewing medical records retrospectively for identification of utilization, billing, DRG assignments, and readmission concerns. The review activity is expected to begin June 1, 2009, and will include review activity directed at claims with discharge dates beginning June 1, 2006.

HMS will be conducting this review through its wholly owned subsidiary, Permedion. Permedion is URAC accredited with full accreditation for compliance with Health Utilization Management Standards and Independent Review Organization Standards. URAC standards ensure that only appropriately trained, qualified clinical personnel conduct and oversee the utilization review process.

Among the features that will be available within the new framework, is the ability for the providers to rebill for utilization denials, and the use of The Milliman Care Guidelines as the criteria source for clinical review. These nationally accepted guidelines are founded on the use of evidence-based research methodology to support the development and understanding of medical care processes. The clinical criteria were developed and are updated on a yearly basis with input from health care providers in active clinical practice.

Many providers may already be using The Milliman Care Guidelines within their facilities and have access to these criteria. Widespread distribution of the Care Guidelines to all providers, however, will not be possible because of a copyright restriction by Milliman. Additional information and contact information for purchasing the Milliman Care Guidelines are available on their Web site at www.careguidelines.com.

A registered nurse will review all records to determine if Milliman Care Guidelines have been met or not. If Milliman Care Guidelines were met, the nurse considers the claim to be appropriate and no overpayment is identified. Any case where the nurse has questions will be referred to a physician for further review.

Another feature of the new review framework will be the use of Colorado licensed physicians in active practice to make decisions of appropriate setting. Peer matching by board specialty will be used for the physician review component for this project for both the initial review, and the reconsideration review.

In order to help hospital providers understand the review process, prior to the release of medical record requests, HMS will be holding webinars to educate providers on the review process, and to allow an opportunity for questions. Watch for mailings with webinar dates and times. The webinar login instructions will be mailed to the current contact on file for this project. If you did not receive this information and would like to attend, please email CODRGProject@hms.com.

HMS has a database with contact information for the CEO/CFO to receive correspondence and demand letters, and a designated medical records contact person that will receive the medical record requests. If you wish to verify or change your contact information, you may e-mail CODRGProject@hms.com or call Kelly Dickson, the Project Manager at 1-800-473-0802.

Pharmacy

Prior Authorization Approval and Denial Letters

The Department would like to remind providers that Approval and Denial Letters for prior authorization requests will only be sent when the initial decision is made or when the approval or denial status changes (e.g., from denied to approved). If additional requests for the same prior authorization are made, a letter will only be sent when and if the original status of the request is changed.

Practitioners

Billing Requirements for Physician-Administered Drugs

Updated List of Medicaid Top 20 Multiple Source Drugs

The Deficit Reduction Act (DRA) of 2005 includes provisions regarding State collection and submission of data for the purpose of collecting Medicaid drug rebates from manufacturers for physician-administered drugs.

Physician-administered drugs are usually billed by providers to Medicaid using HCPCS codes beginning with the letters “J”, “Q”, and “S” (ex: J9265 - paclitaxel, 30 mg). Single-source drugs are those that are still on patent and for which no generic competition exists. Multiple-source drugs are those whose patent has expired and for which generic competition now exists.

Providers are required to submit claims for physician-administered single-source drugs and the 20 multiple-source drugs identified by the Centers for Medicare and Medicaid Services (CMS) as having the highest dollar value under the Medicaid program using both HCPCS procedure codes and National Drug Code (NDC) numbers.

CMS recently published an updated list of the Medicaid top 20 physician-administered multiple-source drugs on their Web site at http://www.cms.hhs.gov/Reimbursement/15_PhysicianAdministeredDrugs.asp#TopOfPage. You may also refer to Appendix X by visiting colorado.gov/hcpf ➡ Providers ➡ Provider Services ➡ Billing Manuals.

The 20 multiple-source drugs identified by CMS as having the highest dollar value under the Medicaid program are as follows:

J0640 Leucovorin calcium, 50 mg
J0696 Ceftriaxone sodium, 250 mg
J1100 Dexamethasone sodium phosphate, 1 mg
J1170 Hydromorphone, up to 4 mg
J1626 Granisetron HCl, 100 mcg
J2430 Pamidronate disodium, 30 mg
J2405 Ondansetron HCl, per 1 mg
J3010 Fentanyl citrate, 0.1 mg
J3370 Vancomycin HCl, 500 mg
J7050 Infusion, normal saline solution, 250 cc
J9000 Doxorubicin HCl, 10 mg
J9045 Carboplatin, 50 mg
J9060 Cisplatin, powder or solution, 10 mg
J9062 Cisplatin, 50 mg
J9178 Epirubicin HCl, 2 mg
J9190 Fluorouracil, 500 mg
J9206 Irinotecan, 20 mg
J9265 Paclitaxel, 30 mg
J9293 Mitoxantrone HCl, per 5 mg
J9390 Vinorelbine tartrate, 10 mg

Effective June 1, 2009, all physician, EPSDT, and Medicare Part B crossover claims for physician-administered single-source and the 20 multiple-source drugs on the updated list above must be submitted using both HCPCS procedure codes and NDC numbers when submitted electronically as an 837P transaction. Claims submitted for these drugs using only HCPCS codes or only NDC numbers will be denied.

Please check the drug packaging to ensure that correct NDC numbers are submitted with the HCPCS procedure codes. Claims submitted with NDC numbers that do not correspond to the HCPCS codes will be denied.

Please refer to the CMS and the Department's Web sites noted above for a list of the top 20 physician-administered multiple source drugs and corresponding NDC numbers. Since the CMS list of the top 20 multiple-source drugs may be modified occasionally to reflect changes in cost and volume, it is recommended that providers routinely submit both HCPCS and NDC numbers on all claims for physician-administered drugs, regardless of whether the drug is a single-source drug or is included on the list of top 20 multiple-source drugs above. Please contact ACS Provider Services if you have any questions.

Botulinum Toxins Administered in the Office Setting

Two botulinum neurotoxins are available currently for therapeutic use in the United States – BOTOX® ([Botulinum Toxin Type A] Purified Neurotoxin Complex), procedure code J0585 and Myobloc® (Botulinum Toxin Type B Injectable Solution), procedure code J0587. An application for approval of a new serotype A botulinum neurotoxin, Dysport®, has been filed with the Food and Drug Administration (FDA), and the FDA may approve this application in 2009. Procedure codes J0585 and J0587 are covered benefits only for on-label, non-cosmetic use.

Botulinum neurotoxins are used to treat various disorders of focal muscle spasm and excessive muscle contractions, such as focal dystonias.[1] When injected intramuscularly, botulinum neurotoxins produce a presynaptic neuromuscular blockade by preventing the release of acetylcholine from the nerve endings.

As a consequence of the chemistry and clinical pharmacology of each botulinum neurotoxin product, botulinum neurotoxins are not interchangeable, even among same serotype products. Units of biological activity are unique to each preparation and cannot be compared or converted into units of another.

It is important that providers recognize there is no safe dose conversion ratio—i.e., one unit of BOTOX® does not equal one unit of Dysport® or Myobloc®. Failure to understand the unique characteristics of each formulation of botulinum neurotoxin can result in under or over dosage. It is expected that provider use of these products will be based on each product's individual dosing, efficacy and safety profiles.

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[1] BOTOX® is indicated for the treatment of cervical dystonia in adults to decrease the severity of abnormal head position and neck pain associated with cervical dystonia.

BOTOX® is indicated for the treatment of severe primary axilary hyperhidrosis that is inadequately managed with topical agents.

BOTOX® is indicated for the treatment of strabismus and blepharospasm associated with dystonia, including benign essential blepharospasm or VII nerve disorders in patients 12 years of age and above.

The efficacy of BOTOX® treatment in deviations over 50 prism diopters, in restrictive strabismus, in Duane's syndrome with lateral rectus weakness, and in secondary strabismus caused by prior surgical over-recession of the antagonist has not been established.

BOTOX® is ineffective in chronic paralytic strabismus except when used in conjunction with surgical repair to reduce antagonist contracture.

Myobloc® is indicated for the treatment of patients with cervical dystonia to reduce the severity of abnormal head position and neck pain associated with cervical dystonia.

Indications for use of Dysport® will be determined upon FDA approval of the product.

May and June 2009 Denver and Statewide Provider Billing Workshops

Provider billing workshops include both Colorado Medical Assistance Program billing instructions and a review of Colorado Medical Assistance Program billing procedures.

The May and June 2009 workshop calendars are included in this bulletin and are posted in the Provider Services Training & Workshops section of the Department's Web site.

Who Should Attend?

New and experienced receptionists, front desk personnel, admission personnel, office managers, billing services, and other billers should consider attending the appropriate workshops.

Reservations are required

Reservations are necessary for ***all workshops***.

Email reservations to: workshop.reservations@acs-inc.com **Or** Call Provider Services to make reservations: 1-800-237-0757 or 303-534-0146

Press "**5**" to make your workshop reservation. You must leave the following information:

- Colorado Medical Assistance Program provider billing number
- The date and time of the workshop
- The number of people attending and their names
- Contact name, address and phone number

Without all of the requested information, your reservation will not be processed successfully. Your confirmation will be mailed to you within one (1) week of making your reservation.

If you do not receive a confirmation within one (1) week, please contact Provider Services and talk to a Provider Relations Representative.

All Workshops held in Denver are located at:
ACS
Denver Club Building
518 17th Street, 4th floor
Denver, Colorado 80202

Beginning Billing Class Description

These classes are for new billers, billers who would like a refresher, and billers who would like to network with other billers about the Colorado Medical Assistance Program. Currently, the class covers in-depth information on resources, eligibility, timely filing, reconciling remittance statements, and paper claim completion for the UB-04 and the Colorado 1500. *These classes do **not** cover any specialty billing information.* The fiscal agent provides specialty training throughout the year in their Denver office.

The classes do <u>not</u> include any hands-on computer training.

Enrollment Application Workshop Description

This workshop focuses on the importance of correctly completing the Colorado Medical Assistance Program Provider Enrollment Application.

Newly enrolling providers, persons with the responsibility for enrolling providers within their groups, association representatives, and anyone who wants to better understand the Colorado Medical Assistance Program enrollment requirements should attend.

Specialty Classes Descriptions

Dialysis

This class is for billers who bill for Dialysis services on the UB-04/837I and/or the Colorado 1500/837P claim format(s). The class covers billing procedures, common billing issues, and guidelines specifically for dialysis providers. *(This is not the class for Hospitals – please refer to the Training & Workshop web page)*

FQHC/RHC

This class is for billers using the UB-04/837I and CO1500/837P format. The class covers billing procedures, Encounter Payments, common billing issues and guidelines specifically for FQHC/RHC providers.

HCBS-EBD/PLWA/MI
This class is for billers using the Colorado 1500/837P claim format for the following services: adult day care, non-medical transportation, home electronics, home modifications and personal care. The class covers billing procedures, common billing issues, and guidelines specifically for the following provider types:
HCBS-EBD HCBS-PLWA HCBS-MI

HCBS-BI
This class is for billers using the Colorado 1500/837P claim format for the following services: adult day care, non-medical transportation, home electronics, home modifications, and personal care. The class covers billing procedures, common billing issues, and guidelines specifically for HCBS-BI providers.

Hospital
This class is for billers using the UB-04/837I claim format. The class covers billing procedures, common billing issues and guidelines specifically for: In-patient Hospital, Out-patient Hospital *(This is **not** the class for FQHC/RHC – please refer to the FQHC/RHC Class)*

Nursing Facility
This class is for billers using the UB-04/837I claim format. The class covers billing procedures, common billing issues, PETI, Medicare Crossovers, and guidelines specifically for Nursing Facility providers.

Practitioner
This class is for providers using the CO1500/837P format. The class covers billing procedures, common billing issues and guidelines specifically for the following provider types:

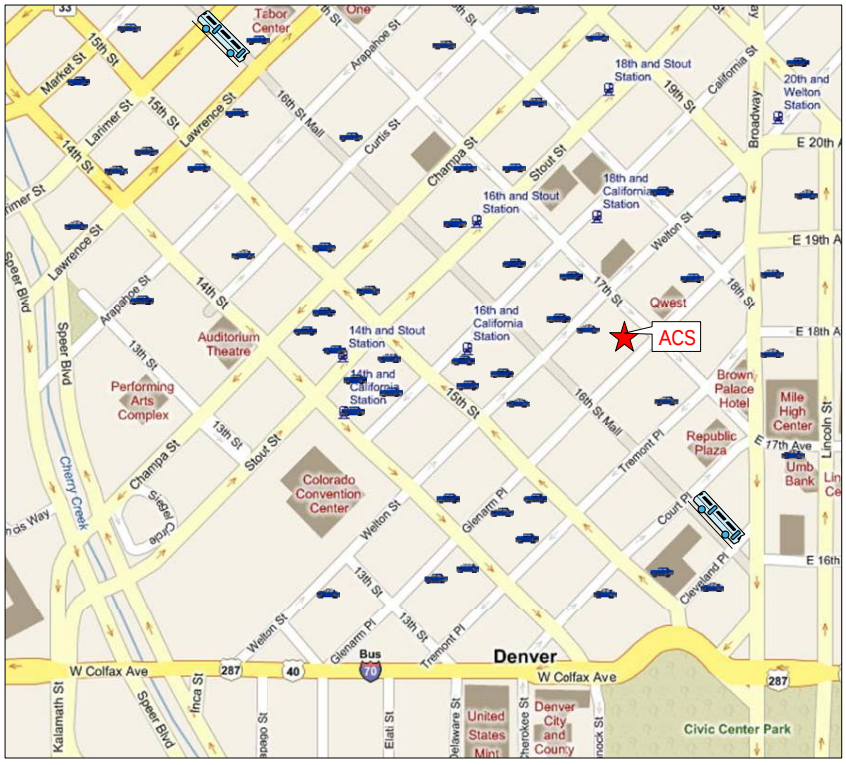
- Ambulance
- Anesthesiologists
- ASC
- Family Planning
- Independent Labs
- Independent Radiologists
- Nurse Practitioner
- Physician Assistant
- Physicians, Surgeons

Driving directions to ACS, Denver Club Building, 518 17th Street, 4th floor, Denver, CO:

Take I-25 toward **Denver**
Take exit **210A** to merge onto **W Colfax Ave (40 E),** 1.1 miles
Turn **left** at **Kalamath St,** 456 ft.
Continue on **Stout St,** 0.6 miles
Turn **right** at **17th St,** 0.2 miles

ACS is located in the Denver Club Building on the west side of Glenarm Place at 17th Street (Glenarm is a two-way street).

Parking: Parking is not provided by ACS and is limited in the Downtown Denver area.
Providers attending workshops are urged to carpool and arrive early to secure parking or use public transportation.
= Light Rail Station: A Light Rail map is available at:
http://www.rtd-denver.com/LightRail/lrmap.htm
= **Free** MallRide: MallRide stops are located at every intersection between RTD's Civic Center Station and Union Station.
= Commercial parking lots: Lots are available throughout the downtown area. The daily rates are between $5 and $20.



Please direct questions about Colorado Medical Assistance Program billing or the information in this bulletin to
ACS Provider Services at 303-534-0146 or 1-800-237-0757 (toll free).
Please remember to check the Provider Services section of the Department's Web site at colorado.gov/hcpf.

Statewide Locations

Durango
Double Tree Hotel
501 Camino del Rio
Durango, CO 81301
970-382-3913

Pueblo
Holiday Inn
4530 Dillon Drive
Pueblo Colorado, 81008
719-542-8888

Colorado Springs
Embassy Suites
7290 Commerce Center Dr.
Colo. Springs, CO 80919
719-599-9100

Ft Collins
Hilton Hotel
425 W. Prospect Rd.
Fort Collins, CO 80526
970-494-2945

Greeley
Greeley Guest House
5401 W. 9th St
Greeley, CO 80634
970-353-9373

Grand Junction
Double Tree Hotel
743 Horizon Drive
Grand Junction, CO 81506
970-241-8888

May 2009 - Statewide

Sun	Monday	Tuesday	Wednesday	Thursday	Friday	Sat
					1	2
3	4	5	6	7	8	9
10	**11 Durango** Beginning Billing – 8:30-10:00 AM Colorado 1500/837P – 10:30-12:00 PM UB-04/837I – 10:30-12:00 PM Practitioner – 1:00-3:00 PM IP/OP-IHS – 1:00-3:00 PM	12	**13 Pueblo** Beginning Billing – 10:30-12:00 PM Colorado 1500/837P – 12:00-12:30 PM UB-04/837I – 12:00-12:30 PM Practitioner – 1:30-3:30 PM FQHC/RHC – 1:30-3:30 PM	**14 Colorado Springs** Beginning Billing – 8:30-10:00 AM Colorado 1500/837P – 10:30-12:00 PM UB-04/837I – 10:30-12:00 PM Practitioner – 1:00-3:00 PM IP/OP – 1:00-3:00 PM	**15 Ft Collins** Beginning Billing – 9:00-10:30 AM Colorado 1500/837P – 11:00-12:00 PM UB-04/837I – 11:00-12:00 PM Practitioner – 1:00-3:00 PM IP/OP – 1:00-3:00 PM	16
17	18	**19 Greeley** Beginning Billing – 9:00-10:30 AM Colorado 1500/837P – 11:00-12:00 PM UB-04/837I – 11:00-12:00 PM Practitioner – 1:00-3:00 PM IP/OP – 1:00-3:00 PM	20	**21 Grand Junction** Beginning Billing – 8:30-10:00 AM Colorado 1500/837P – 10:30-12:00 PM UB-04/837I – 10:30-12:00 PM Practitioner – 1:00-3:00 PM IP/OP – 1:00-3:00 PM	22	23
24 31	25	26	27	28	29	30

June 2009 – Denver

Sun	Monday	Tuesday	Wednesday	Thursday	Friday	Sat
	1	2	3	4	5	6
7	8	**9** Beginning Billing – Colorado 1500/837P 9:00AM-2:00PM	**10** HCBS-EBD 9:00AM-11:30AM HCBS-BI 1:00PM-3:30PM	**11** Beginning Billing – UB-04/837I 9:00AM-2:00PM	**12** DME/Supply PAR 9:00AM-11:00AM DME/Supply 11:30AM-1:30 PM Pharmacy 2:30 PM-4:00PM	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				