Provider Bulletin

Reference: B1000278 **February 2010**

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...?

The 2010 HCPCS are published in the Provider Services Bulletins section of the Web site. CDs containing the 2009 bulletins and 2010 HCPCS bulletins will not be mailed to providers. Please contact ACS Provider Services if you would like a CD.
Existing providers, who change their EFT routing and have been waiting more than 30 days, should check with their bank. If the EFT routing change has not taken place, the provider may now contact the Security Section at hcpfsecurity@hcpf.state.co.us or 303-866-6164.

All Providers

Recovery of Payments for Claims with Dates of Service After the Death of a Medicaid Client

The Department of Health Care Policy and Financing (Department) has contracted with Health Management Systems, Inc. (HMS) to assist with Medicaid recovery services. HMS has begun data matches and recoveries for services provided after the client's death.

Durable medical rental equipment and oxygen will be allowed for the month of the client's death, as will bulk supplies that are drop shipped to the client's home. Recoveries will be made for other services following the date of the client's death or for rental and bulk supplies billed after the month of the client's death.

Providers affected by these recoveries will receive a letter from HMS containing a listing that displays detailed information on the claims that appear to have been overpaid by Medicaid. Federal regulations require that Medicaid recover overpayments made to providers. The Department will initiate recoupment procedures for the claims identified in each letter unless acceptable documentation (defined in the instructions in the letter), proving that the claims should not be recouped is received from you or your facility within forty-five (45) days from the date of the letter. Please direct all questions to the HMS Recovery Unit at 1-877-262-7396 (toll free) or by fax at 1-214-905-2064.

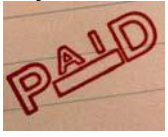
A New Look for Medical Identification Cards

In the spring of 2010, the Department anticipates a new look for the Medical Identification Card. First and foremost, it will be bilingual (English and Spanish). Please watch for further details in the March 2010 Provider Bulletin. If you have questions, you may contact Roberta Lopez at 303-866-6114 or roberta.lopez@state.co.us.

Payment Error Rate Measurement (PERM) Program

What is PERM?

The PERM program was developed and implemented by the Federal Centers for Medicare and Medicaid Services (CMS) to comply with the Improper Payments Information Act (IPIA) of 2002. The purpose of this program is to examine eligibility determinations and to check claims payments made for the Medicaid program and Children's Health Insurance Program (CHIP) for accuracy and to ensure the states only pay for appropriate claims.



Please note that in Colorado, CHIP is called Child Health Plan Plus (CHP+).

Why is PERM required?

- PERM is required by CMS pursuant to the Improper Payments Information Act of 2002 (IPIA; Public Law 107-300).
- Medicaid and CHIP are identified as programs at risk for significant improper payments by the U.S. Office of Management and Budget (OMB).
- CMS has to report the improper payment error rate and estimates of improper amounts to Congress.
- CMS has to submit the report on actions to reduce erroneous expenditures.

PERM Process

- A group of states is selected on a rotational basis once every three years.
- Colorado is one of 17 States, or Cycle 2 states, randomly selected by CMS for Federal Fiscal Year (FFY) 2010 and previously in FFY 2007. FFY runs from October 1 through September 30.

How is PERM implemented?

Claims Review

- A claim is reviewed to determine if it was processed and paid/denied correctly, and that the services were actually provided, medically necessary, and coded correctly.
- For FFY 2010 PERM cycle, CMS uses two contractors to perform claims review:
    1. Statistical Contractor (SC) – Livanta LLC, who collects a universe of claims data quarterly from states and uses a stratified random sampling design to draw the sample for review.
    2. Review Contractor (RC) – Yet to be determined, who uses the sample list to request copies of the medical record from the providers and reviews it for medical necessity, correct coding, correct payment or denial of claims, and services actually provided.

Eligibility Review

- Beneficiary's eligibility determinations are reviewed for accuracy.
- The Department of Health Care Policy and Financing (the Department) has selected the option to contract out the PERM eligibility review and is currently in the process of procurement.

What type of review is conducted on a claim?

There are two types of claims review:

- Medical review – examines the accuracy of the claim information relative to the documentation in the medical record.
- Data processing review – examines the accuracy of the claims processing system.

Why are providers required to participate in PERM?

Providers are required by section 1902(a)(27) of the Social Security Act and 10 C.C.R. 2505-10, Sec. 8.130.2.A to:

- Retain records necessary to disclose the nature and extent of services provided to recipients.
- Maintain records which fully substantiate or verify claims submitted for payment.
- Submit records to federal and state government upon request.

How will providers know if any of their claims have been selected?

- The Review Contractor for CMS will contact providers and request a copy of their medical records to support the medical review.

What do providers need to do?

- Providers need to submit all requested medical records and supporting documents within 60 calendar days of the request date, either electronically or via hard copy.
- Providers are responsible for submitting all requested information in a timely manner.
- Providers need to update the Department with the most current and accurate contact information.

Who will send the medical record request?

- The Review Contractor will send out the request letters, and the Department will send the follow up letters to the providers.
- The Review Contractor is yet to be determined. When its name is released by CMS, it will be posted in a future provider bulletin.
- It is critical for the Department to have current and accurate contact information of providers to prevent any delay.

What happens if the provider does not cooperate?

- Any claims for which documentation is not received upon request shall be considered an overpayment subject to recovery, regardless of whether or not services have been provided.
- Monies for claims for which the requested information was not submitted or submitted late will be recovered by the Department's Program Integrity Unit.

What about maintaining patient privacy?

- The collection and review of protected health information contained in individual-level medical records for payment review purposes is permissible by the Health Insurance Portability and Accountability Act (HIPPA) of 1996 and implementing regulations at 45 Code of Federal Regulations, parts 160 and 164.

What happens if there is an error finding in medical review?

- The Review Contractor will notify the Department about the error and the Department will have the option to agree or disagree with its findings.

What happens if the Department disagrees?

- The Department can file a request for a Difference Resolution, and providers may be contacted to assist in the Difference Resolution Process.

What if an error is confirmed?

- States are required to return the federal share of overpayments to CMS. The Department will pursue recoveries as part of the corrective actions according to applicable law and regulations.

Where can I find out more information?

- Providers can go to the CMS website at http://www.cms.hhs.gov/PERM/

Who do providers contact with PERM questions?

Vivian Tran at 303-866-5780 or Vivian.tran@state.co.us.

2010 Holiday Remaining Claims Processing Schedule

Holiday	Holiday Processing Date
Memorial Day Monday, May 31	Thursday, May 27, 2010
Independence Day (Observed) Monday, July 5	Thursday, July 1, 2010
Labor Day Monday, September 6	Thursday, September 2, 2010
Columbus Day Monday, October 11	Thursday, October 7, 2010
Christmas Day (Observed) Friday, December 24	Thursday, December 23, 2010
New Year's Day (Observed) Friday, December 31	Thursday, December 30, 2010

Receipt of warrants or EFTs will be delayed by one or two days due to the following holidays:

Holiday	Date
Veterans Day	Thursday, November 11, 2010
Thanksgiving Day	Thursday, November 25, 2010

State Furlough Day

All Colorado State offices will be closed on Friday, February 12, 2010 due to a statewide furlough day. ACS Government Solutions and the Provider Services Call Center will be open during regular business hours. Please contact ACS Provider Services at 303-534-0146 or 1-800-237-0757 (toll free) with questions.

Tax Season and 1099s

Please don't forget to update your current provider enrollment information with the fiscal agent. By using the Provider Enrollment Update Form, you can update your address, National Provider Identifier, license, email address, affiliations and receive electronic bulletin notifications. The form is available in Enrollment for Existing Providers in the Provider Services Enrollment section of the Department's Web site. With the exception of provider license information, the above updates may also be made through the Web Portal. Updated provider license information must be made using the Provider Enrollment Update form.

Dental Providers

Dental Services Provided in an Ambulatory Surgery Center or Outpatient Hospital Setting

Effective February 1, 2010, dentists providing services to Medicaid clients in outpatient hospitals may not bill for x-rays performed in this setting. The x-ray component of the procedures may be billed by the facility using *Current Procedural Terminology* (CPT) codes. Appropriate CPT codes for standard dental radiographs are: 70300 - radiologic examination, teeth, single view; 70310 - partial examination, less than full mouth; 70320 - complete, full mouth. Questions may be directed to Marcy Bonnett at 303-866-3604 or Eric Wolf at 303-866-5963.

Orthodontic PAR

The 2009 Handicapping Malocclusion Assessment Form is now available in a MS Word format in the Provider Services Forms section of the Department's Web site at colorado.gov/pacific/hcpf. The form can be found by expanding the, Dental Forms option. You may complete the form online, print it and submit it with all supporting diagnostic and radiographic services used to determine and fully diagnose the client's condition. Submit all documentation and the dental claim to the Colorado Medical Assistance Program. If you have any questions, please contact Marti Holmes at marti.holmes@state.co.us or 303-866-6006.

Family Planning Clinics and Other Providers of Family Planning Services: "Out-of-Network" Providers Serving Managed Care Clients

Federal regulations require that all Medicaid clients, including clients enrolled in a managed care plan, have a free choice of providers for family planning services regardless of whether the provider is "in-network" or "out-of-network" with a managed care plan.

Effective January 1, 2010, all claims for family planning services provided by "out-of-network" providers to clients enrolled in Denver Health Medicaid Choice, Rocky Mountain Health Plans, or Colorado Access must be submitted directly to the health plan for payment. These claims should not be submitted through the Colorado Medical Assistance Program Secure Web Portal (Web Portal) or on paper to the fiscal agent, ACS.

"Out-of-network" providers shall receive reimbursement directly from the managed care plan for family planning services provided to managed care clients. However, only those services directly related to family planning must be reimbursed by the health plan. "Out-of-network" providers should contact the health plan for approval prior to providing non-family planning services to managed care clients. Non-family planning services provided by "out-of-network" providers to managed care clients should not be submitted to the fiscal agent and will not be separately reimbursed by the fiscal agent. Denver Health Medicaid Choice, Rocky Mountain Health Plans, and Colorado Access issue claims payment on a weekly basis. Claims must be submitted to the health plan within 120 days from the date of service.

Below, please find billing addresses for claims submission and contact information for the health plans:

Health Plan	Claims Billing Address	Questions About Claims
Denver Health Medicaid Choice	Denver Health Medicaid Choice PO Box 40606 Denver, CO 80204-0606	720-956-2100
Rocky Mountain Health Plans	Rocky Mountain Health Plans PO Box 10600 Grand Junction, CO 81502-5600	970-243-7050 1-800-346-4643 customer_service@rmhp.org
Colorado Access	Colorado Access Claims PO Box 17470 Denver, CO 80217-0470	303-751-5903 1-888-380-3726 customer.service@coaccess.com

Please contact Christy Hunter at Christy.Hunter@state.co.us with questions.

Provider-Purchased Contraceptives

Effective January 1, 2010, the list of eligible provider types able to receive reimbursement for provider-purchased contraceptives billed with Healthcare Common Procedure Coding System (HCPCS) codes has been expanded. Submitted charges for provider-purchased contraceptives (such as those purchased through the 340B Drug Pricing Program) cannot exceed the usual and customary fee the provider charges non-Medicaid clients.

The following four contraceptive items may now be billed by the following billing and rendering provider types:

Contraceptives
A4267
J7303
J7304
S4993

Provider Types	
Physician	Osteopath
Clinic	Family Planning Clinic
Certified Nurse-Midwife	Physician's Assistant
Non-Physician Practitioner	Nurse Practitioner
Non-Physician Practitioner Group	

Reimbursement rates for these contraceptive items can be found on the Medicaid Fee Schedule located in the Provider Services section of the Department's Web site.

Please contact Christy Hunter at Christy.Hunter@state.co.us with questions.

Financial Assistance Offices within Hospitals and Other Medical Facilities

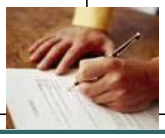
New Medicaid Disability Determination Contractor

The Department awarded the disability determination services contract to Arbor E&T, LLC, Action Review Group (ARG). Effective February 1, 2010, ARG will process all disability determinations for Medicaid. Patients who wish to qualify for Medicaid because of a disability will continue to complete the Application for Assistance, Disability Application, and Release Form(s). Application materials are available on our Web site at colorado.gov/pacific/hcpf, click on 'Medicaid' and scroll to the section that begins with… *If you are 64 years old or younger and have not been determined disabled….* ARG's contact information has been added to the Release Form. Please begin using this new Release Form immediately.

ARG may be contacted by email at actionreviewgroupmrt@arboret.com; by phone at 1-877-265-1864; or by fax at 1- 877-672-2077.

Mail the disability application and medical records to ARG to one of the following:

a. United States Postal Service	b. United Parcel Service or Federal Express
Arbor E&T, Action Review Group P.O. Box 340 Olyphant, PA 18447	Arbor E&T, Action Review Group 410 2nd Avenue Jessup, PA 18434



Pharmacy Providers

Pharmacy and Therapeutics (P&T) Committee News

The Department would like to welcome three new Pharmacy and Therapeutics (P&T) Committee members - Dr. Elizabeth Hogan, Dr. Jennifer Hyer, and Dr. Lynn Parry. The Department would like to thank all of the experts that submitted CV's for consideration. Selecting members for appointment was extremely difficult due to the wealth of talent in the pool. For a complete list of P&T Committee members, please check the Pharmacy and Therapeutics (P&T) Committee Web page.

The next P&T Committee meeting will be held:

Friday, February 5, 2010
3:00 p.m. - 5:00 p.m.
225 E. 16th Ave.
6th Floor Conference Room
Denver, CO 80203

The only drug classes under review will be the atypical antipsychotics. We appreciate that high-quality, effective mental health treatment is important and potentially complex. Thus, we want to allow adequate time for dedicated discussion and set up an additional meeting for the review of this class. A separate P&T meeting will allow adequate opportunity for clients and providers to have their voices heard and should minimize the impact on other classes. We would also like to note that for this therapeutic class, the Department plans to grandfather clients currently taking these medications. Please submit written comments to pdl@state.co.us on or before February 4, 2010 for Committee consideration.

Prescription Drug List (PDL) Update

Effective January 1, 2010, the following medications were added as preferred agents on the Medicaid Preferred Drug List and are now covered without a prior authorization:

Newer Generation Antidepressants:

citalopram, fluoxetine, fluvoxamine, Lexapro (escitalopram), mirtazipine, nefazodone, paroxetine, sertraline, venalfaxine, venlafaxine ER tablets, Wellbutrin and bupropion in IR, SR and XL formulations

Phosphodiesterase Inhibitors:

Revatio (sildenafil)

Prostanoids:

generic IV epoprostenol

Endothelin Antagonists:

Letairis (ambrisentan)

Antiemetics:

Zofran and ondansetron tablets, ondansetron ODT (clients 12 years and under for ODT), ondansetron suspension, and Emend

Proton Pump Inhibitors:

Prilosec OTC, Aciphex, Prevacid 24hr (OTC), and Prevacid Solutabs (clients 12 years and under for solutab)

Triptans and Triptan Combinations:

Maxalt MLT, Imitrex and sumatriptan generic tablets, and Imitrex (brand) nasal spray and Imitrex (brand) subcutaneous injection

The complete PDL and prior authorization criteria for non-preferred drugs are posted on the Preferred Drug List (PDL) Web page.

For questions or comments regarding the PDL, contact Jim Leonard at jim.leonard@state.co.us.

State Maximum Allowable Cost List

The Department is developing a State Maximum Allowable Cost (State MAC) list. The State MAC list will become one of the pricing methodologies referenced when determining the reimbursement rate paid to pharmacies for dispensing prescription drugs to Colorado Medicaid clients.

The State MAC list will be comprised of specific prescription drugs that have a reimbursement rate based on the actual acquisition costs paid by pharmacies plus 18% in accordance with the Department's rules. Although a State MAC list has been a reimbursement methodology option available to the Department for several years, a State MAC list has not been developed up to this point.

Pharmacies will be surveyed on the specific list of drugs and requested to submit acquisition cost data to the Department. The Department will analyze the data received along with other marketplace data in order to determine the reimbursement rates for the State MAC list.

The survey is available by accessing any of the following:

- The Pharmacy section of the Department's Web site
- The Provider Claim Report beginning January 29, 2010
- An email that will be sent in February 2010 from Colorado.MedAssist@acs-inc.com

Please return the completed survey by February 22, 2010. If you have any questions, feel free to contact Kerri Coffey at kerri.coffey@state.co.us or 303-866-4131.

Practitioners

Invega ® Sustenna™ Administered in the Office Setting

Invega ® Sustenna™ (paliperidone palmitate) extended-release injectable suspension is indicated for the acute and maintenance treatment of schizophrenia in adults. When administered in the office setting, Invega ® Sustenna™ should be billed using HCPCS procedure code J3490 (unclassified drugs) on the Colorado 1500 paper claim form. Providers must attach a copy of the acquisition cost invoice for Invega ® Sustenna™ and indicate the National Drug Code (NDC) number and total dosage given in the notes field on the claim form. Reimbursement will be calculated based on the acquisition cost invoice + 10%.

For more information on Invega ® Sustenna™, please visit the Invega ® Sustenna™ homepage at http://www.invegasustenna.com/invegasustenna/index.html.

Please contact Teresa Knaack at Teresa.Knaack@state.co.us or 303-866-3064 if you have any questions.

Enjoy the Benefits of Direct Deposit

Providers who use Electronic Funds Transfer (EFT) can receive payments up to a week sooner than those receiving paper checks (warrants). EFT eliminates payment delays due to inclement weather, holidays, or post office mishaps.

Sign up to receive payments via EFT today! Complete the EFT form located in the Provider Services Forms section under *Other Forms* of the Department's Web site. You may also use this same form to update your bank account information by indicating "Change" in the top-right corner and complete the form as directed. Please allow 30 days to process your EFT request.

You will receive paper warrants until the EFT has been established or your update request has been processed. After 30 days, check with your bank to verify that EFT has been set up. You may contact the Department at 303-866-6164 with any EFT update questions.

Electronic Provider Bulletin Notification

Help save postage costs by receiving an electronic notification containing a link to the most recent publication. Colorado Medical Assistance Program enrolled providers who are not receiving electronic notifications can complete and submit their information through the "(MMIS) Provider Data Maintenance" option via the Web Portal.

Providers may also complete and submit the Publication Preferences form located in the Provider Services Forms section of the Department's Web site. Please fax or mail the completed form to the fiscal agent at the fax number or address on the form.

The Colorado Medical Assistance Program will not be responsible for undeliverable notifications due to incorrect email addresses. Providers may have only one email address on file with the fiscal agent.

February and March 2010 Provider Billing Workshops

Denver 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 February and March 2010 workshop calendars are included in this bulletin and are posted in the Provider Services Training 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 cannot be processed successfully. Your confirmation will be mailed to you within one week of making your reservation.

If you do not receive a confirmation within one 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.

February and March 2010 Specialty Workshop Class Descriptions

Dental

The class is for billers using the 2006 ADA/837D claim format. The class covers billing procedures, claim formats, common billing issues and guidelines specifically for the following provider types: Dentists, Dental Hygienists

Dialysis

This class is for billers who bill for Dialysis services on the UB-04/837I and/or CO1500/837P claim format. 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 Hospital Class)

DME/Supply PAR Workshop

The PAR class focuses on completing the PAR correctly and avoiding common mistakes. This class is for DME/Supply providers who bill procedures requiring prior authorization.
(This class is not for Dental, HCBS, Nursing Facility, Pharmacy or Pediatric Home Health Providers.)

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-DD

This class is for billers who bill on the CO1500 claim format for the following: Comprehensive Services (HCBS-DD), Supported Living Services (SLS), Children's Extensive Support (CES), Children's Residential Habilitation Program (CHRP) and Targeted Case Management (TCM). The class covers billing procedures, common billing issues and guidelines for HCBS-DD providers

Occupational, Physical and Speech Therapy

This class is for billers using the CO1500/837P format for therapies. The class covers billing procedures, common billing issues and guidelines specifically for Occupational, Physical and Speech Therapists providers.

Pharmacy

This class is for billers using the Pharmacy claim format/Point of Sale and/or PCF Format. The class covers billing procedures, common billing issues and guidelines specifically for Pharmacies. *(This is not the class for DME/ Supply Providers – please refer to DME/ Supply Provider Class)*

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

Provider 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.

Supply/DME

This class is for billers using the CO1500/837P claim format. The class covers billing procedures, common billing issues and guidelines specifically for Supply/DME providers.

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).

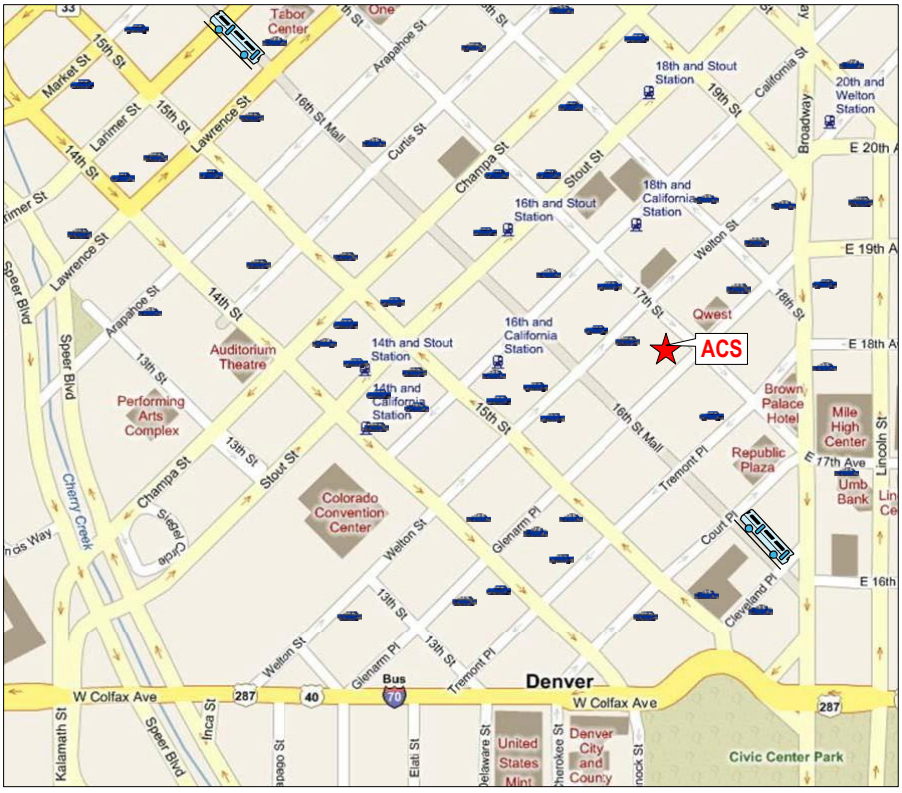
Parking: Parking is not provided by ACS and is limited in the Downtown Denver area.

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_Map.shtml

Free MallRide: MallRide stops are located at every intersection between 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 note: *WebEx trainings are* ***not*** *for providers on the Front Range.*

Email all WebEx training reservations to: workshop.reservations@acs-inc.com

A meeting notification containing the Web site, phone number, meeting number, and password will be emailed to providers who sign up for WebEx.

February 2010 Workshop Calendar

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	1	2	3	4	5	6
7	8	9 Beginning Billing – CO -1500//837P (Web Portal)	10 Beginning Billing – UB-04/837I (Web Portal) Dialysis – 3:00 pm-4:30 pm	11 Supply/DME PAR 101 - 9:00 am -11:00 am Supply/DME Billing - 12:00 pm-1:30 pm Pharmacy - 2:00 pm – 3:00 pm	12 Beginning Billing – CO-1500 **(WebEx)** 9:00am – 12:00pm FQHC/RHC **(WebEx)** - 1:00pm – 4:00 pm *State Furlough Day*	13
14	15 *President's Day State Holiday*	16	17	18	19	20
21	22	23	24	25	26	27
28						

March 2010 Workshop Calendar

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	1	2	3	4	5	6
7	8	9 Beginning Billing – CO -1500//837P 9:00 am-11:30 am Web Portal 1:00 pm-2:00 pm OT/PT/ST 3:00 pm-4:30 pm	10 Beginning Billing – UB-04/837I 9:00 am-11:30 am Web Portal 1:00 pm-2:00 pm	11 Provider Enroll 9:00 am-12:00 pm Practitioner **(WebEx)** 1:00 pm-4:00 pm	12 HCBS-DD **(WebEx)** 9:00 am-12:00 pm Dental **(WebEx)** 1:00 pm-3 pm	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

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 (Colorado toll free).
Please remember to check the Provider Services section of the Department's Web site at colorado.gov/pacific/hcpf