Provider Bulletin

Reference: B1000288 **September 2010**

colorado.gov/pacific/hcpf

In this issue:

ACS A xerox Company

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

ACS Contacts

Billing and Bulletin Questions
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...?

Providers may inactivate their provider numbers with the Colorado Medical Assistance Program by submitting a letter on their letterhead, or the Provider Enrollment Update Form, to ACS Provider Enrollment at P.O. Box 1100, Denver, CO 80201. The letter should state the reason, effective date, and contact information. Provider Enrollment forwards the letter to the Department for review and providers may be contacted for further information. Once the Department notifies ACS to inactivate the provider's enrollment, a letter of confirmation is sent to the provider.

All Providers

Working with a Non-Medicaid Prescriber

Effective immediately, the following process for Prior Authorization Requests (PARs) should be used when a Medicaid client has a primary insurance other than Medicaid, and a non-Medicaid provider prescribes a Medicaid covered supply or equipment that requires prior authorization:

- The service provider must be a Colorado Medical Assistance Program provider;
- The non-Medicaid prescriber information must be entered in boxes 24, 26 and 27; and
- Box 28 should be left blank, and a notation made under Comments that the client has TPL (Third Party Liability) and a non-Medicaid prescriber.

24. NAME AND ADDRESS OF PHYSICIAN REQUESTING PRIOR AUTHORIZATION		25. NAME AND ADDRESS OF PROVIDER WHO WILL RENDER SERVICE	
26. REQUESTING PHYSICIAN SIGNATURE	27. DATE SIGNED		
TELEPHONE NUMBER ( )	28. REQUESTING PHYSICIAN PROVIDER NUMBER	TELEPHONE NUMBER ( )	29. SERVICE PROVIDER NUMBER

If services are provided according to the manner prescribed by State of Colorado Laws and Regulations, reimbursement will be provided for authorized services following submission of an appropriately completed Medicaid claim.

30. COMMENTS **

Please contact ACS Provider Services at 1-800-237-0757 if you have any questions.

CMS National Correct Coding Initiative (NCCI)

To comply with federal legislation, Colorado Medicaid will, over the coming months, adopt the Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) standard payment methodologies.

Why are we making this change?

President Obama signed the federal Patient Protection and Affordable Care Act (PPACA) into law in March 2010. The bill contains provisions that impact health care policy nationwide across the public and private sectors. A provision of this law requires that state Medicaid agencies integrate the NCCI payment methodologies into their claims payment systems by October 1, 2010.

What do the NCCI payment methodologies do?
These methodologies prevent reimbursement for services that should not be billed together as well as preventing the reimbursement for units of service in excess of the number that a provider would report under most circumstances for a single client on a single date of service.

The methodologies apply to both Current Procedural Terminology (CPT) Level I codes and Healthcare Common Procedure Coding System (HCPCS) Level II codes.

When will the change take place?
For all claims submitted on or after October 1, 2010, the following NCCI methodologies will be applied to the claims adjudication of a select number of codes and code pairs for all practitioner and Ambulatory Surgery Centers:

- NCCI Edits – Physicians
- Medically Unlikely Edits

Over the following months, Colorado Medicaid will be implementing the remainder of the CMS-required NCCI edits for practitioners and ASCs, as well as the following additional NCCI methodologies:

- Medically Unlikely Edits (those not implemented 10/1/2010)
- NCCI Edits – Physicians (those not implemented 10/1/2010)
- NCCI Therapy Edits
- Hospital Outpatient Prospective Payment System

How big an impact will this have on providers?
The NCCI edits were originally implemented by Medicare carriers on January 1, 1996, and many private payers also use them for their claims processing. Most likely, you have already encountered the application of these methodologies to claims submitted for adjudication and payment by Medicare and private payers. These methodologies will now also apply to Medicaid claims.

We will keep you informed of the implementation progress, as well as providing guidance on how Colorado Medicaid will be implementing these national edits based on direction provided by CMS. If you have any questions about the Department's implementation of the NCCI, please contact Teresa Knaack at 303- 866-2573 or Teresa.Knaack@state.co.us. For more information on the NCCI, please visit the CMS Web site at http://www.cms.gov/NationalCorrectCodInitEd/01_overview.asp#TopOfPage.

Medicaid 1931 Program Policy Update

During the implementation of the Medicaid Parent Expansion to 100% of the Federal Poverty Level, the Department confirmed that we are not mandated to require that all household members request Medical Assistance in order to receive 1931 eligibility.

What is changing?

Parents were not showing as eligible in the Medicaid Management Information System (MMIS), and therefore were not showing as eligible in the Provider Web Portal. This issue has been resolved. CBMS changes were implemented on August 14, 2010.

All affected parents are reenrolled in CBMS and bills may now be submitted electronically for their services.

What do clients and providers need to do?

- Clients and providers do not need to take any action. Providers can now bill for services electronically. If providers have any outstanding charges for this time period, please submit bills electronically.
- It is no longer necessary for clients to use a Notice of Action letter.

If you have questions, please send an email to Medicaid.Eligibility@hcpf.state.co.us.

New Automatic Voice Response System (AVRS)

The new AVRS was implemented on August 5, 2010. The new system still allows providers to retrieve client eligibility, claim status, and warrant information. However, there is no longer a limit of three eligibility inquiries per call. Providers are also able to check claim status by Provider ID/National Provider Identifier (NPI) with Client ID and Date of Service, or by Transaction Control Number (TCN).

Please remember that the local "303" number will be **disconnected** on September 1, 2010 and all providers will be required to use 1-800-237-0757 or 1-800-237-0044. Both are toll free numbers.

New Benefit for Screening, Brief Intervention and Referral to Treatment (SBIRT)

On October 1, 2010, the Department of Health Care Policy and Financing (the Department) will begin the Screening, Brief Intervention and Referral to Treatment (SBIRT) benefit. The new benefit will be available to a wide variety of providers in order to assess and intervene in risky substance use behaviors for clients aged 12 and up. More information regarding this benefit will be available soon in the Provider Services section of our Web site. If you have any questions, please contact Anna Davis at 303-866-2113 or Anna.Davis@state.co.us.

Rx Review Program Update

The Rx Review Program provides medication reviews for Medicaid clients who are high-drug utilizers (five or more drugs each month for three months in a row). Statewide consultations will be performed between contracted pharmacists and participating clients, beginning in September 2010. Upon completion of the review, providers and clients will receive a recommendation letter from the pharmacist. The consultations are intended to educate the clients concerning their medications (including OTCs and nutritional supplements), identify drug-drug interactions and drug duplication, review utilization of multiple providers, and evaluate adherence to the Medicaid Preferred Drug List.

Provider support of the program should help ease a client's apprehension to participate once they are contacted by the Department and contracted pharmacist. Client participation is voluntary and will not affect his or her pharmacy benefits in any way.

If you are a pharmacist interested in participating in the program, please contact Jessie Fox-Hernandez at jessie.fox-hernandez@state.co.us or go to the Pharmacist Resources section of the Department's Web site to see the qualifications and to submit an application.

September and October 2010 Holidays

Labor Day Holiday

Due to the Labor Day Holiday on Monday, September 6, 2010, the claims processing cycle will include electronic claims accepted before 6:00 P.M. Mountain Time on Thursday, September 2, 2010. The receipt of warrants and EFTs may also be delayed by one or two days. Both State and ACS offices will be closed on Monday, September 6, 2010.

Columbus Day

Due to Columbus Day Holiday on Monday, October 11, 2010, the claims processing cycle will include electronic claims accepted before 6:00 P.M. Mountain Time on Thursday, October 7, 2010. The receipt of warrants and EFTs may also be delayed by one or two days. State offices will be closed on Monday, October 11, 2010. ACS offices will be open during regular business hours.

We Need Your Email Address

You can receive urgent notifications immediately if the fiscal agent (ACS) has your correct email address on file. When the Provider Payment Delay message was sent out, providers with valid email addresses on file with ACS received the news days before those who either had a wrong email address or no email address on file.

If ACS has your correct/valid email address:

- You will receive urgent notifications immediately;
- You will not need to be concerned about news getting lost in the mail;
- You will not have more paper to deal with at your office;
- We will help the environment; and
- We will save approximately $50,000 per year.

You can submit your email address by accessing the (MMIS) Provider Data Maintenance option through the Web Portal or by submitting a Publications Preference Form located under Other Forms in the Provider Services Forms section of the Department's Web site. You can correct or change an existing email address by using the same methods noted above.

Billing the Client for Colorado Medical Assistance Program Services (Originally published in May 2004, Bulletin B0400175)

The Colorado Medical Assistance Program and fiscal agent representatives frequently address questions as to what can be billed to Colorado Medical Assistance Program clients. Please share this information with your billing offices and use the following questions (Q) and answers (A) as a guide for determining whether clients can be billed for services rendered.

Q: Can Colorado Medical Assistance Program clients be charged for services covered by the Colorado Medical Assistance Program?

A: No. Participating providers agree to accept the Colorado Medical Assistance Program payment as payment in full for benefit services rendered.

Required deductibles, co-insurance or copayments and those specific to specialty areas of practice are described in the billing manuals located in the Provider Services Billing Manuals section of the Department's Web site.

Q: What if the Colorado Medical Assistance Program payment does not cover all of my costs? Can I charge the difference to the client?

A: No. All providers submitting medical services claims to the Colorado Medical Assistance Program certify that, "I accept as payment in full, payment made under the Colorado Medical Assistance 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 Medical Assistance Act."

Q: What if I no longer want to be a Colorado Medical Assistance Program provider? Can I bill the Colorado Medical Assistance Program clients for my services?

A: No. Clients may not be billed if the failure to obtain Colorado Medical Assistance Program payment is caused by the provider's failure to comply with Colorado Medical Assistance Program billing procedures. Constraints against billing Colorado Medical Assistance Program clients for benefit services apply whether or not Colorado Medical Assistance Program makes or has made payment and whether or not the provider participates in the Colorado Medical Assistance Program.

Q: Can I use a collection agency or execute a lien against assets to get payment from Colorado Medical Assistance Program clients?

A: No. Collection agencies cannot submit Colorado Medical Assistance Program claims for payment and cannot collect payment from Colorado Medical Assistance Program-eligible clients. Providers may not assert a lien – including a hospital lien – on any money, settlement, recovery, or judgment paid to the client or to the client's estate as the result of a personal injury lawsuit.

Colorado law prohibits providers from billing Colorado Medical Assistance Program clients or the estates of deceased Colorado Medical Assistance Program clients for Colorado Medical Assistance Program benefit services.

Q: Can I bill Colorado Medical Assistance Program clients for missed appointments?

A: No. Providers may not bill the Colorado Medical Assistance Program clients for missed appointments, telephone calls, completion of claim submission forms, or medication refill approvals. Primary care physicians participating in a managed care program may dismiss an enrolled client from their practice for cause at any time. The primary care physician shall give no less than 45 days notice to both the Department and the client.

Cause shall be defined as any of the following:

- The client misses multiple scheduled appointments.
- The client fails to follow the recommended treatment plan or medical instructions.
- The primary care physician cannot provide the level of care necessary to meet the client's needs.
- The client and /or client's family is abusive to the provider and/or staff in compliance with 42 CFR 438.56(a)(2).
- The physician moves out of the service area.
- Other reasons satisfactory to the Department.

Q: Can I bill Colorado Medical Assistance Program clients for services not covered by the Colorado Medical Assistance Program?

A: Yes. Before providing services that will not be covered by the Colorado Medical Assistance Program, providers shall have the client sign an acknowledgment of financial responsibility. Only if a written agreement is developed do clients have the following responsibilities:

• If the service is not a covered benefit of the Colorado Medical Assistance Program, clients may be billed for the service.

• Clients are responsible for Colorado Medical Assistance Program co-payment. By federal law, providers may not refuse services if the client cannot pay co-payment when services are rendered. Clients may be billed for unpaid co-payment. Providers may apply standard collection policies if the client fails to satisfy co-payment obligations.

• Clients in nursing facilities are responsible for patient payment when under Medicare A (skilled nursing) coverage. If the patient payment amount exceeds the Medicare A co-insurance due, the difference is refunded to the client.

• Colorado Medical Assistance Program clients enrolled in a Colorado Medical Assistance Managed Care Program must follow the rules of the Prepaid Health Plan (PHP). Clients who insist upon obtaining care outside of the PHP network may be charged for non-covered services.

• Colorado Medical Assistance Program clients enrolled in the Primary Care Physician (PCP) Program are required to follow PCP Program rules. Non-emergency care in a setting that is not authorized by the primary care physician is not a benefit of the Colorado Medical Assistance Program. Clients who insist upon obtaining non-emergency care in an emergency or urgent care setting without PCP authorization may be charged for the cost of those services.

• Colorado Medical Assistance Program clients who have commercial insurance coverage that requires them to obtain services through a provider network must obtain all available services through the network.

• Clients who insist upon obtaining non-managed-care covered services outside the network may be charged for such services.

Refer to the following sites for questions concerning charging Medical Assistance Program clients for services rendered:

• Code of Federal Regulations: Title 42 Section 447.15 - Acceptance of State payment as payment in full. http://www.gpoaccess.gov/cfr/index.html

• Colorado Revised Statutes: 26-4-403 - Recoveries–overpayments–penalties–interest–adjustments–liens. http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1223548942896

• Code of Colorado Regulation for Medicaid (10 CCR 2505-10, Volume 8) (State Rules Concerning the Medical Assistance Program): 10 CCR 2505-10, 8.000 et seq. 10 CCR 2505-10, section 8.012 10 CCR 2505-10, section 8.205.4.I in the Medicaid Rules and State Plan section of the Department's Web site.

• Colorado Medical Assistance Program Provider Participation Agreement, Page 2 Item G in the Provider Enrollment Application located under each provider type in the Provider Services Enrollment for New Providers section of the Department's Web site.

• Colorado Medical Assistance Program General Provider Information manual in the Provider Services Billing Manuals section of the Department's Web site.

Dual Eligibles

Providers are reminded that Medicaid is always the payer of last resort, therefore, services for dual-eligible clients - those with coverage from Medicare and Medicaid - must be billed first to Medicare.

Please refer to the December, 2008 Provider Bulletin (B0800255) for an example of exceptions for Home Health services. Providers must be able to show evidence that claims for dual eligible clients, where appropriate, have been denied by Medicare prior to submission to the Colorado Medical Assistance Program. Per the Provider Participation Agreement, this evidence must be retained for six years following the Medicare denial.

The Colorado Medical Assistance Program requires that the Medicare Standard Paper Remit (SPR) accompany any paper claims for dual-eligible clients which are submitted for reimbursement.

Please contact ACS Provider Services at 1-800-237-0757 (toll free) Monday through Friday, 8:00 a.m. to 5:00 p.m. Mountain Time with questions.

Record Retention

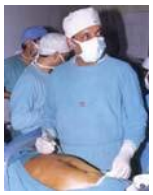
Providers must maintain records that fully disclose the nature and extent of services provided. Upon request, providers must furnish information about payments claimed for Colorado Medical Assistance Program services. Records must substantiate submitted claim information. Such records include but are not limited to:

- Treatment plans
- Prior authorization requests
- Medical records and service reports
- Records and original invoices for items, including drugs that are prescribed, ordered, or furnished
- Claims, billings, and records of Colorado Medical Assistance Program payments and amounts received from other payers

Each medical record entry must be signed and dated by the person ordering and providing the service. Computerized signatures and dates may be applied if the electronic record keeping system meets Colorado Medical Assistance Program security requirements.

Records must be retained for at least six years or longer if required by regulation or a specific contract between the provider and the Colorado Medical Assistance Program.

Bariatric Surgeons



Procedure Code 43775

Effective September 1, 2010, procedure code 43775 for bariatric surgery will require prior authorization.

Please contact Eric Wolf at Eric.Wolf@state.co.us or 303-866-5963 with questions.

Non Emergent Medical Transportation (NEMT)

Elimination of "County" PAR Requirement

Effective September 1, 2010, clients residing in counties designated as "rural" by the State Office of Rural Health may use NEMT to pick up prescriptions at a pharmacy when in conjunction with a medical appointment and for transportation to Durable Medical Equipment (DME) providers for repair appointments.

NEMT codes previously requiring "county" approved Prior Authorization Requests (PARs) will no longer require a PAR. The elimination of the PAR requirement for "county" PARs is due to the fact that each county must authorize all NEMT services and the PAR requirement for those particular codes was redundant.

The following counties are designated as rural:

Alamosa, Archuleta, Baca, Bent, Chaffee, Cheyenne, Conejos, Costilla, Crowley, Custer, Delta, Dolores, Eagle, Fremont, Garfield, Grand, Gunnison, Hinsdale, Huerfano, Jackson, Kiowa, Kit Carson, La Plata, Lake, Las Animas, Lincoln, Logan, Mineral, Moffat, Montezuma, Montrose, Morgan, Otero, Ouray, Phillips, Pitkin, Prowers, Rio Blanco, Rio Grande, Routt, Saguache, San Juan, San Miguel, Sedgwick, Summit, Washington, Yuma.

Feel free to contact Renee Robinson at 303-866-5622 or Renee.Robinson@state.co.us with questions.

Pharmacy Providers

Pharmacy & Therapeutics (P&T) Committee News

The Department would like to welcome our new P&T Committee member, Dr. Kimberly Nordstrom. Dr. Nordstrom is a practicing psychiatrist and will be replacing Dr. Pastor, who resigned earlier this year. The Department would like to thank all of the experts that submitted Curriculum Vitaes (CVs) for consideration. Selecting members for appointment was extremely difficult due to the wealth of talent in the pool.

Next P&T Committee Meeting:

Tuesday, October 5, 2010
1:00 P.M.-5:00 P.M.
This meeting will be held on the Anschutz Medical Campus in Aurora, please see the Pharmacy and Therapeutics (P&T) Committee Web page for full location details.

Preferred Drug List (PDL) Update

Effective October 1, 2010, the following medications will be preferred agents on the Medicaid PDL and will be covered without a prior authorization:

Erythropoiesis Stimulating Agents
Procrit – Clients must meet eligibility criteria

Oral Bisphosphonates
Alendronate tabs in 5mg, 10mg, 35mg and 70mg

Meglitinides
None preferred

Biguanides
Generic metformin in 500mg, 850mg and 1000mg immediate release tablets preferred; generic metformin extended-release 500mg tablets preferred

Hypoglycemic Combinations
None Preferred

Thiazolidinediones
Actos

Newer Generation Diabetes Agents
Byetta, Januvia, Onglyza – Please see PDL for additional information

ADHD and Stimulants
Generic methylphenidate IR and SR, generic mixed amphetamine salts products in IR and XR, CONCERTA, generic dexmethylphenidate, and FOCALIN XR

Overactive Bladder Agents
oxybutynin and oxybutynin ER

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, please contact Jim Leonard at Jim.Leonard@state.co.us.

Drug Utilization Review (DUR) Board Updates

We are currently looking for qualified applicants to serve in a physician position on our DUR Board. The members of the DUR Board shall have recognized knowledge and expertise in one or more of the following:

1. The clinically appropriate prescribing of covered outpatient drugs;
2. The clinically appropriate dispensing of covered outpatient drugs;
3. Drug use review, evaluation, and intervention;
4. Medical quality assurance.

To submit a CV or for additional information, please contact Jim.Leonard@state.co.us or visit the DUR Board Web page.

Change to Dispensing Requirements

Pursuant to review and approval by the Drug Utilization Review Board in May 2010, the Dispensing Requirements for DEA Schedule 2 through 5 drugs have been revised. Effective September 2, 2010, 85% of the days supply will have to lapse before Schedule 2 through 5 drugs can be filled again. The Dispensing Requirements for non-scheduled drugs will not change, 75% of the days supply must lapse before a drug can be filled again.
Effective June 1, 2010, the inclusion of a Prior Authorization Code Type 2 on a pharmacy claim no longer overrides the refill-too-soon edit (NCPDP edit 79). The Medicaid pharmacy claims system received an enhancement so the refill-too-soon edit will not set for changes in dosing. However, if a Medicaid client enters or leaves a nursing facility and requires a refill-too-soon override, a prior authorization request must be submitted by contacting the PA Helpdesk at 800-365-4944.

For more information, please contact Tom Leahey at Thomas.Leahey@state.co.us.

September and October 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 September and October 2010 workshop calendars are included in this bulletin and are also 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

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

All this information is necessary to process your reservation successfully. Look for your confirmation by mail within one week of making your reservation.

If you have not received a confirmation within at least two business days prior to the workshop, 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.

September and October 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 CO-1500/837P 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.)*

HCBS-BI

This class is for billers using the CO1500/837P 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.

HCBS-EBD

This class is for billers using the CO1500/837P 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-DD

This class is for billers who bill on the CO1500/837P 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.

Home Health
This class is for billers using the UB-04/837I format. The class covers billing procedures, common billing issues, and guidelines specifically for Home Health providers.

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.

Pediatric HH PAR Workshop
The Pediatric Home Health PAR workshop focuses on the PAR completion instructions for Pediatric Home Health procedures. This class is specifically for Pediatric Home Health providers.

Practitioner
This class is for providers using the CO-1500/837P 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
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.

Transportation
This class is for emergency transportation providers billing on the CO-1500/837P and/or UB-04/837I format. The class covers billing procedures, common billing issues and guidelines specifically for Transportation provider.

Vision
This class is for ophthalmologists, optometrists, and opticians billing on the CO-1500/837P format. The class covers billing procedures, common billing issues and guidelines specifically for practitioners providing vision services.

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 **Welton St, 0**.5 mi
Turn **right** at **17th St,** 0.2 miles
The Denver Club Building will be on the right.

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**

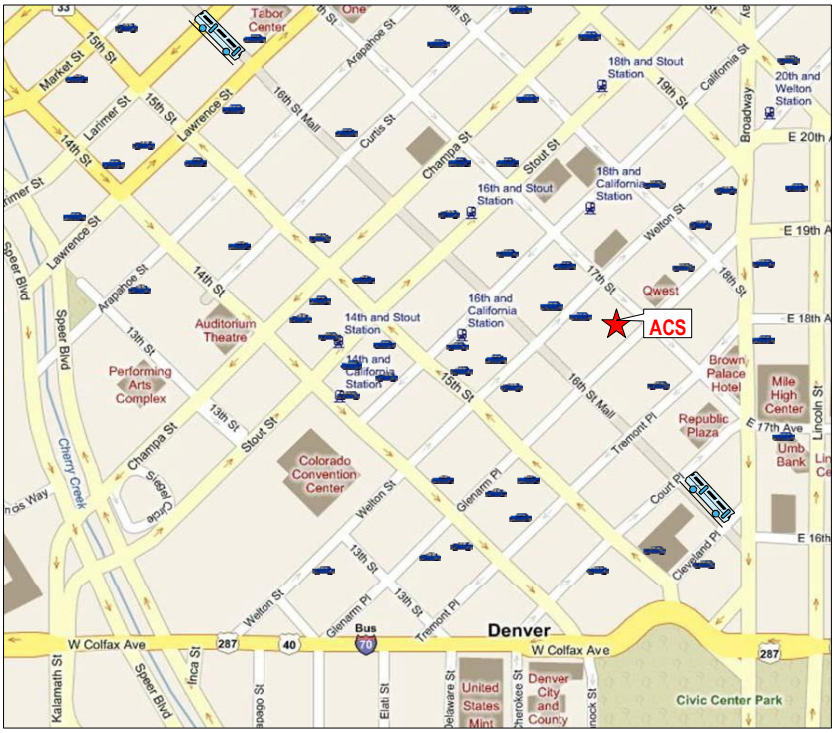
A Light Rail map is available at: http://www.rtd-denver.com/LightRail_Map.shtml

= **Free MallRide**

The 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 or mailed to providers who sign up for WebEx.

September 2010 Workshop Calendar

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			1	2	3	4
5	6 ***Labor Day Holiday***	7	8	9	10	11
12	13	14 Beginning Billing – CO -1500 9:00 am-11:30 am Web Portal 837P 1:00 pm-2:00 pm Transportation 3:00 pm-4:30 pm	15 Beginning Billing – UB-04 9:00 am-11:30 am Web Portal 837I 1:00 pm-2:00 pm Dialysis 3:00 pm-4:30 pm	16 Provider Enrollment 9:00 am-12:00 pm Practitioner **(WebEx)** 1:00 pm-4:00 pm	17 Pediatric Home Health PAR 1:00 pm-3:00 pm Home Health 3:00 pm-4:30 pm	18
19	20	21	22	23	24	25
26	27	28	29	30		

October 2010 Workshop Calendar

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
					1	2
3	4	5	6	7	8	9
10	11 ***Columbus Day Holiday***	12 Beginning Billing – CO -1500 9:00 am-11:30 am Web Portal 837P 1:00 pm-2:00 pm Vision 3:00 pm-4:30 pm	13 Beginning Billing – UB-04 9:00 am-11:30 am Web Portal 837I 1:00 pm-2:00 pm Nursing Facility 3:00 pm-4:30 pm	14 Dental 9:00 am-12:00 pm	15 Beginning Billing – CO -1500 9:00 am-11:00 am HCBS-EBD 11:00 am-1:00 pm HCBS-BI 1:00 pm-2:30 pm HCBS-DD 3:00 pm-4:30 pm	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 1-800-237-0757 (toll free).
Please remember to check the Provider Services section of the Department's Web site at colorado.gov/pacific/hcpf