Provider Bulletin

Reference: B1100292 **January 2011**

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...?
The Adjustment Transmittal form has been updated and revised. The new version of the Adjustment Transmittal is available under Claim Forms and Attachments in the Provider Services Forms section of the Department's Web site.

All Providers

Application Assistance – Mapping Tool

The Department of Health Care Policy and Financing (the Department) is excited to share the launch of the new Application Assistance Site- Mapping Tool! The Mapping Tool is a project funded by The Colorado Trust. It has replaced the *List of Locations that can Verify Documents* spreadsheet on the Department's Web site at colorado.gov/pacific/hcpf and can be accessed from any computer.

This mapping tool allows applicants, providers, and community partners to locate an application assistance site closest to them by utilizing various search criteria such as: city, site type, location and more. The tool maps the location entered and identifies sites that can assist with medical assistance applications.

Please contact Tonya Bruno at Tonya.Bruno@state.co.us or 303-866-2362 if you have any questions.

Electronic Only Notifications Coming Soon

Beginning March 2011, copies of provider bulletins will no longer be sent by mail. Bulletins are posted on the Department's Web site by the 2nd of every month. Visit the For Our Providers home page and click on the **What's New?** option. This will allow you to get the information quickly and at a time that is convenient for you.

Urgent messages and time-sensitive notices will be sent electronically by email. This assures that providers will receive messages quickly and at the same time.

It is very important that you make sure that the fiscal agent, ACS, has your current email address. You can submit your email address by accessing the *(MMIS) Provider Data Maintenance* option through the Colorado Medical Assistance Program Web Portal (Web Portal) or by submitting a *Publication Email 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.

If you do not have Internet access and need to receive provider bulletins by mail, please complete the *"Email Op-Out Form"*, Attachment A, at the end of this bulletin. The form is also located under Other Forms in the Provider Services Forms section of the Department's Web site. Please return the completed form to the address on the form.

*Please note that only **one** email address per provider number may be on file.*

Web Portal News

Refreshing the COTP ID Password

The security changes that were implemented on the Web Portal in November 2010 reinforce that providers must use the State-assigned COTP ID as the administrator ID for their Trading Partner.

In order to ensure that the State-assigned COTP ID remains in an active status for the Web Portal, it is important that the user assigned to this ID change their password at least every 180 days.

Normal password settings for the Web Portal require all users to change their passwords every 180 days. For those individuals who use both a regular User Name to complete daily tasks and the administrator COTP ID, when prompted to change your password for the regular User Name, also log in with the COTP ID. If the system settings indicate it is time to change your COTP ID password, you will be prompted to do so after your COTP ID login information has been authenticated by the system.

Self-Password Reset Feature

Users who forget their passwords or who get locked out of the Web Portal should first attempt to reset the password by choosing the *"I forgot my password"* option on the main log in page and answer the challenge questions in the Self-Password Reset feature. If unsuccessful with the Self-Password Reset, users should work with their Trading Partner Administrator (TPA) or the individual with the Restricted Admin role to assist in resetting a password. Utilizing the CGI Help Desk for assistance with password resets should be a last resort option.

If a user is unable to contact his/her TPA or Restricted Admin user to assist with a password reset, the CGI Help Desk can assist with this task. All Web Portal users should have the following information readily available when calling the help desk for a password reset:

- Their **User Name**
- Agency/ Organization Name
- **Provider Number**
- Names of providers for whom the individual bills (if applicable)

At its discretion, the help desk may or may not ask for additional information not listed above to ensure proper identification of an individual for a User Name password reset.

Billing Agencies/Agent Requesting Provider Password Resets

Billing agencies/agents do not have the authority to request password resets for User Names assigned to Providers for accessing the Web Portal. Billing agencies/agents are issued their own Trading Partner ID for purposes of billing on behalf of the provider, and should be prepared to identify themselves as individuals who are submitting claims on behalf of a provider when they call the help desk for a password reset.

If you have any questions, please contact Tanya Ward at Tanya.Ward@state.co.us or 303-866-3579.

Important Changes for Processing Laboratory Services - CLIA Certification Required

As a reminder, processing of all laboratory procedures covered by the Clinical Laboratory Improvement Act (CLIA) will change beginning as early as April 2011. Please refer to the December 2010 Provider Bulletin (B1000291) for more information.

If you have any questions, please contact ACS Provider Services at 1-800-237-0757 or 1-800-237-0044.

2011 HCPCS/Procedure Codes Bulletins

The 2011 HCPCS/Procedure Codes bulletins will be available in the Provider Services Provider Bulletins section of the Department's Web site during January 2011.

Medicaid Post-Payment Review Program

The Medicaid post-payment review program is also called the Recovery Audit Contractor (RAC) program. Providers may be familiar with Medicare's RAC program, which is expanding to Medicaid pursuant to Section 6411 of the Federal Patient Protection and Affordable Care Act (ACA). For those of you who are not familiar with it, the RAC program is a contingency-based post-payment review program operated by the Department, but using contracted vendors to perform audit and review functions. The Department will have two vendors in its RAC program, one to audit hospital providers and the DRG billing system, and another for all other Medicaid-enrolled provider types. The Department's program will have these provider-friendly characteristics:

- To prevent overly aggressive repayment demands that are not supported by sufficient evidence, the Department's contingency contractors will not be paid any fees until all appeal processes are complete and the providers have accepted the audit review results.

- The RAC contractors will not be allowed to employ workers on a bonus or incentive basis.
- The Department will have a systematic process for reviewing and approving, in advance, the types of claims that will be subject to review by the Medicaid RAC. No review will be initiated until the RAC receives the Department's express approval.
- The Department will individually review each and every demand for repayment before it is mailed, to assure that the demand is honest, logical and supported by a case-specific rationale.
- The RAC will be required to offer all providers an exit conference before any initial demand letter issues. Providers will know in advance what the preliminary audit findings are and can offer explanations and have the opportunity to submit additional documentation before the demand letter issues.
- Any RAC determination based upon medical necessity must be signed off by a physician reviewer, of the same or similar specialty, who has been recruited from Colorado. Only when no Colorado physicians are available will the Department permit the RAC contractor to use out-of-state reviewing physicians.
- The Department will ensure that provider claims are only audited once. Where other federal auditors have already demanded records and evaluated services, the Colorado RAC contractor will not be allowed to do so a second time.
- The Department will take measures to ensure that no provider is overwhelmed by too many RAC record requests at one time. Safeguards will be in place to limit both the number of records that can be requested at one time and to limit the number of audits that can occur at the same time.
- The Department will limit the number of look-back years to three, and will only resort to the longer, statutorily-approved six year look-back period when highly irregular billings are encountered, or when fraud, waste or abuse is suspected.
- The Department will require the RAC contractor to minimize problems or issues with provider contact information.

  - The RAC contractors will be required to have customer service staff available to answer provider questions about audits in general and to answer specific questions arising in their particular review cases.
  - Each RAC reviewer will be comprehensively trained on Medicaid payment and coverage policy issues, and will be familiar with State billing and re-billing protocols, and the Medicaid appeals process. All coding determinations will be made only by certified coders.
- The Department will ensure that all reviews are conducted timely, according to Department policy and contractual timelines, and that each provider receives written notification of each audit upon conclusion; even if the audit is entirely favorable to the provider.
- No monies will be collected until the appeals process is complete, and only the Department will initiate and undertake the actual recoveries.
- The appeals process will include two levels of review. The first is a provider requested informal reconsideration where the provider can make its case directly to the RAC contractor. The second is a formal appeal to the State of Colorado Administrative Court. At both levels, the Department's contract manager will be available to facilitate solutions and to ensure that the RAC contractor is not overreaching.
- The RAC will be responsible for providing provider outreach and education; before, during and after audit cycles. The education will include basic information on RAC program operations, how audits are conducted, what errors were being targeted and how the appeals process works. In the individual cases, providers have received education on how to reduce improper payments in the future.

The Department will closely oversee all aspects of the RAC program and the actions of the contingency contractors. The Department project manager will have regular discussions with the RAC contractors and will ensure the RAC contractors are following all program and contractual requirements.

The RAC solicitations will be publicly posted on the State's BIDS portal and will be available for download by any interested party. Until the procurement process is completed, the Department will not be able to discuss specifics about the RAC program with individual providers or vendors.

However, the Department will continue to post information about the status of the program in provider bulletins as milestones are reached.

Please contact Rick Dawson at Rick.Dawson@state.co.us or 303-866-2416.

Oxygen Benefit for Dually Eligible Clients in the Home and Community Setting

When dually eligible clients with both Medicare and Medicaid coverage residing in the home or community setting receive oxygen benefits, Medicaid only covers the co-pay for the Medicare benefit.

In the past, some suppliers have been reimbursed by Colorado Medicaid for oxygen contents provided to dually eligible clients receiving Medicare oxygen benefits using the GY modifier on the claim.

Beginning on February 1, 2011, billing policies for oxygen contents will change. Any oxygen content payment that a supplier receives from Medicaid (that is not a co-pay) for a client that receives Medicare oxygen benefit coverage will be subject to recovery.

Oxygen coverage for dually eligible clients residing in a nursing facility is not affected by this policy clarification.

For any questions or concerns about this policy, please contact Richard Delaney at Richard.Delaney@state.co.us or 303-866-3436.

Updated Colorado Medical Assistance Program Standard Provider Application is Now Available

Effective March 1, 2011, the fiscal agent will only accept the November 2010 version of the Provider Enrollment Application. The revision date is located in the bottom left corner of the application pages. The fiscal agent will not process older versions of the enrollment application and will return them to the providers. To download the application, go to Provider Enrollment, click on your provider type and then select *Go*.

Please direct questions regarding the updated application to ACS Provider Services at 1-800-237-0757 or 1-800-237-0044.

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 notifications.

The form is available in the Provider Services *Forms* 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 found under *Update Forms*.

January and February 2011 Holidays

Martin Luther King Day Holiday

Due to the Martin Luther King Day holiday on Monday, January 17, 2011, claim payments will be processed on Thursday, January 13, 2011. The processing cycle includes claims accepted on Thursday before 6:00 P.M. Mountain Time. The receipt of warrants will be delayed by one or two days.

Presidents' Day Holiday

Due to the Presidents' Day holiday on Monday, February 21, 2011, claim payments will be processed on Thursday, February 17, 2011. The processing cycle includes claims accepted on Thursday before 6:00 P.M. Mountain Time. The receipt of warrants will be delayed by one or two days.

State offices will be closed on both Monday, January 17, 2011 and Monday, February 21, 2011. Fiscal agent offices will be open during regular business hours.

Dental Providers

Diagnostic Casts and Study Models

No dental provider, including orthodontists, should send diagnostic casts or study models to the fiscal agent unless requested to do so by the fiscal agent's dental consultant.

If you have questions, please contact Marcy Bonnett at Marcy.Bonnett@state.co.us or at 303-866-3604.

Expansion of Medicaid Allowable Procedures by Unsupervised Dental Hygienists

Effective January 1, 2011, Medicaid enrolled unsupervised dental hygienists (as defined by the Colorado Department of Regulatory Agencies) may provide and be reimbursed for the following dental procedures for clients ages 20 and under:

D0120 - *periodic oral evaluation-established patient*
D0145 - *oral evaluation for a patient under three years of age and counseling with primary caregiver*
D0180 - *Comprehensive periodontal evaluation– new or established patient*
Limited to ages 15 through 20 for all dental providers
D0210 - *Intraoral - complete film series*
D0220 - *Intraoral - periapical first film*
D0230 - *Intraoral - periapical each additional film*
D0240 - *Intraoral - occlusal film*
D0270 - *Bitewing - single film*
D0272 - *Bitewings - two films*
D0274 - *Bitewings - four films*
D0999 - *unspecified diagnostic procedure-*
For screening and assessment purposes only
D1110 - *prophylaxis – adult* (age 20 and under when appropriate)
D1120 - *prophylaxis – child*
D1203 - *topical application of fluoride-child*, ages 6 and older
D1204 - *topical application of fluoride*-adult, ages 12 and older
D1206 - *topical fluoride varnish; therapeutic application for moderate to high caries risk patients*
Ages 0 through 20. Fluoride varnish is the only acceptable fluoride treatment that will be reimbursed by Medicaid for clients under age 6.
Risk assessments must be included as part of the procedure.
D1330 - *Oral hygiene instructions*, ages 3 through 20
D1351 - *Sealant (per tooth-*
Benefit only for the occlusal surface of permanent molar teeth – tooth numbers 2,3,14,15,18,19,30,31
D4341 - *Periodontal scaling and root planing*
Pre-authorization required.
D4355 - *Full mouth debridement.*
Must be followed by a referral to dentist to perform a comprehensive oral evaluation.

Diagnostically acceptable copies of the films (or originals) must be sent to the referral dentist. Dental Hygiene providers not able to provide duplicate x-rays are subject to a post-payment review. For more information, contact Marcy Bonnett at Marcy.Bonnett@state.co.us or 303-866.3604.

Dental Web Portal Claim Submissions

Effective January 1, 2011, dental providers submitting claims through the Web Portal will have two additional options for place of service: ambulatory surgery centers and schools. Providers should select the appropriate place of the dental service from all the choices in the list. If you have questions, please contact Marcy Bonnett at Marcy.Bonnett@state.co.us or 303-866-3604.

Federally Qualified Health Centers (FQHC) and Rural Health Center (RHC) Providers

Reimbursement for Providers After FQHC or RHC Application

To become a recognized FQHC or RHC, an organization must apply for that status with the Department. After organizations are approved as either a FQHC or a RHC, payment as the new entity will begin for dates of service on or after the application is approved by the Department.

There is a period of time between application and approval as an FQHC or RHC. If the provider is an existing Colorado Medicaid provider, they may continue to submit claims after application as an FQHC or RHC but before approval. Claims made by existing providers for dates of service after the application date will be paid as a fee-for-service provider and adjusted to reimburse at the different rate after approval.

If the organization has a provider identification number at the time they apply for the new status, the existing provider identification number will be deactivated as their new FQHC or RHC identification number is activated.

If the organization applying to be an FQHC or RHC is a new provider to Colorado Medicaid, the organization's claims will not be reimbursed until after the application is approved. No claims with dates of service before the date of the approved application as an FQHC or RHC will be paid for organizations that are a new Colorado Medicaid provider.

For any questions or concerns about this policy, please contact Richard Delaney at Richard.Delaney@state.co.us or 303-866-3436.

Clarification of October 2010 Bulletin Article on Services Incident to Physician's Professional Services

The October 2010 Bulletin article stated the Department's position that FQHCs or RHCs may not bill for encounters for services provided incident to the services of approved providers. This article clarifies the information on billing for encounters.

The federal definition of a visit that is reimbursable as an encounter is found in Medicare Benefit Policy Manual, Chapter 13, §30, A visit is a face-to-face encounter between the patient and a physician, physician assistant, nurse practitioner, certified nurse midwife, visiting nurse, clinical psychologist, or a clinical social worker. The Colorado Medicaid Program has adopted this definition with one difference, which is to allow a visit to a dentist to also be billed as an encounter (10 CCR 2505-10, 8.700.4.A.1.a).

Services of an optometrist are not covered as encounter visits under Colorado rules. Encounters with more than one professional and multiple-encounters with the same health care professional which take place on the same day and at a single location, constitute a single encounter for payment. An exception allowing multiple encounters occurs in cases in which the patient, subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment on the same day.

A medical encounter and a dental encounter on the same day and at the same location shall count as two separate visits.

FQHCs and RHCs may also bill face-to-face visits by physician employees or full-time and part-time nurse practitioners, physician assistants (including nurse midwives), visiting nurse, clinical psychologist, or a clinical social worker who are employees of an FQHC or RHC in other locations such as a patient's home. For any questions or concerns about this policy, please contact Richard Delaney at Richard.Delaney@state.co.us or 303-866-3436.

Hospital Providers

ICD-9-CM Codes Crosswalk

As reported in the October 2010 bulletin, the Department is updating the crosswalk for new ICD-9-CM codes (diagnosis and procedure codes) so that the DRG grouper currently in place is able to recognize new codes and group accordingly.

The following versions of the Centers for Medicare and Medicaid Services (CMS) Grouper are used to process Medicaid inpatient hospital claims:

Discharge Date	Grouper
On or after October 1, 2006	Version 24.0
October 1, 2005 to September 30, 2006	Version 23.0
October 1, 2004 to September 30, 2005	Version 22.0
October 1, 2003 to September 30, 2004	Version 21.0
October 1, 2002 to September 30, 2003	Version 20.0

Until the crosswalk table is implemented, claims that include new ICD-9-CM codes may not group and consequently the system may automatically deny them or price incorrectly. However, hospitals do not need to resubmit claims for this particular reason. The Department will automatically adjust paid and denied claims that denied for any of the edits listed below, or claims that contain a new diagnosis code, after the system's crosswalk has been updated with the new ICD-9-CM codes.

0582	*DRG record not on database*
0583	*DRG return code 1 - Diagnosis not principal diagnosis*
0584	*DRG Return Code 2 - No DRG in major diagnostic category for principal diagnosis*
0585	*DRG pricing span not found*
0592	*DRG return code 6 - Illogical principal diagnosis*
0593	*DRG return code 7 - Invalid principal diagnosis*

The updated crosswalk table and previous versions are published in the Diagnosis Related Group (DRG) Relative Weights section of the Department's Web site.

The Department recognizes this problem and it is working on the necessary updates. We apologize for this inconvenience. Please send an email to Eric Wolf at Eric.Wolf@state.co.us if you have any questions.

Pharmacy Providers

Next P&T Committee Meeting

Tuesday, January 11, 2011
1:00 P.M. - 5:00 P.M.
This meeting will be held at 225 E. 16th Avenue,
1st Floor Conference Room, Denver, CO 80203

Please see the agenda on the Pharmacy and Therapeutics (P&T) Committee page in the Provider Information section of the Department's Web site.

Preferred Drug List (PDL) Update

Effective January 1, 2011, the following medications will be preferred agents on the Medicaid PDL and will be covered without a prior authorization:

Targeted Immune Modulators for RA
Enbrel and Humira

Newer Generation Antidepressants
bupropion, bupropion SR, citalopram, Effexor (brand), Effexor XR (brand), fluoxetine, fluvoxamine, mirtazipine, nefazodone, paroxetine, sertraline, and venlafaxine ER tablets.
Grand fathering will be approved for up to one year for clients stabilized on a non-preferred newer generation antidepressant if medically necessary. Please see PDL for individual drug criteria.

Phosphodiesterase Inhibitors
Adcirca and Revatio are preferred, but an indication of Pulmonary Hypertension must be documented.

Endothelin Antagonists
Letairis

Prostanoids
Veletri and generic epoprostenol

Antiemetics
ondansetron and Zofran (brand) tablets (non-ODT)
ondansetron suspension for children under 6
Please see PDL for criteria specific to Emend.

Proton Pump Inhibitors
Aciphex, lansoprazole 15mg OTC (currently available as Prevacid 24hr), generic omeprazole capsules (RX), Prevacid Solutab (for children under 6) and Prilosec OTC

Triptans and Combinations
Imitrex (brand) injection/nasal spray/tablets, generic sumatriptan tablets and Maxalt MLT

The complete PDL and prior authorization criteria for non-preferred drugs are posted on the Preferred Drug List (PDL) under *Provider Service > Forms under Pharmacy*. For questions or comments regarding the PDL contact Jim Leonard at Jim.Leonard@state.co.us.

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 curriculum vitae (CV) or for additional information, please contact Jim.Leonard@state.co.us or visit the Drug Utilization Review (DUR) Board Web page.
Next DUR Board Meeting will be held on February 22, 2011. Please see the DUR Board Web page for more information.

Updates to Appendix P (Prior Authorization Criteria)

Infused Targeted Immune Modulators for Rheumatoid Arthritis – Remicade, Orencia and Rituxan will be approved for administration in the client's home or in long term care if one of the following conditions is met:

- Client has a diagnosis of rheumatoid arthritis and has tried and failed therapy with Enbrel and Humira; or
- Client has a Food and Drug Administration (FDA) approved diagnosis for Remicade, Orencia or Rituxan other than Rheumatoid Arthritis.

Silenor (doxepin) – Silenor will be approved for clients who meet one of the following criteria:

- Client has a contraindication to preferred oral sedative hypnotics (see PDL)
- There is medical necessity for a doxepin dose < 10 mg
- Clients is over 65 years old or has hepatic impairment (3mg dose will be approved)

Appropriate use of Proton Pump Inhibitors (PPI)
Vimovo will be approved for clients in the treatment of ankylosing spondylitis, osteoarthritis or rheumatoid arthritis who have also failed treatment with two Preferred PPI agents in the last 24 months.
PPI Quantity Limits – Prior authorization will be required for proton pump inhibitor therapy beyond 100 days. Prior authorization will be approved for clients with Barrett's Esophagus, Erosive Esophagitis, GI Bleed, Hypersecretory Conditions (Zollinger Ellison), or Spinal Cord Injury clients with any acid reflux diagnosis. In addition, clients with documented continuation of symptomatic GERD or recurrent peptic ulcer disease who have documented failure on step down therapy to an H2-receptor antagonist (of at least two weeks duration) will be approved for up to one year of daily PPI therapy.

Synagis® Prior Authorization Request Updates

Effective December 13, 2010, the Pharmacy Provider Call Center at 1-800-365-4944 will be accepting prior authorizations via phone for Synagis® if the drug will be administered in the client's home or in long-term care. For administration in the provider's office or other facility, the prior authorization will still require a faxed form. Faxes using the Synagis® Prior Authorization form will continue to be accepted.

January and February 2011 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 January and February 2011 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 completion of the UB-04 and the Colorado 1500 paper claim forms.

*The Beginning Billing 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.

January and February 2011 Specialty Workshop Class Descriptions

Dialysis
This class is for billers who bill for Dialysis services on the UB-04/837I and/or Colorado 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.)*

FQHC/RHC
This class is for billers using the UB-04/837I and Colorado 1500/837P format. The class covers billing procedures, Encounter Payments, common billing issues and guidelines specifically for FQHC/RHC providers.

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.

HCBS-EBD
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-DD
This class is for billers who bill on the Colorado 1500/837P 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.

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

Outpatient Substance Abuse
This class is for billers using the Colorado 1500/837P claim format for outpatient substance abuse treatment services: substance abuse assessment, individual and family therapy, group therapy, alcohol/drug screening, case management and social/ambulatory detoxification. The class covers billing procedures, common billing issues and guidelines specifically for outpatient substance abuse 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 Colorado 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			

Supply/DME
This class is for billers using the Colorado 1500/837P claim format. The class covers billing procedures, common billing issues and guidelines specifically for Supply/DME providers.

Supply/DME PAR
This 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)*

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 miles.
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).

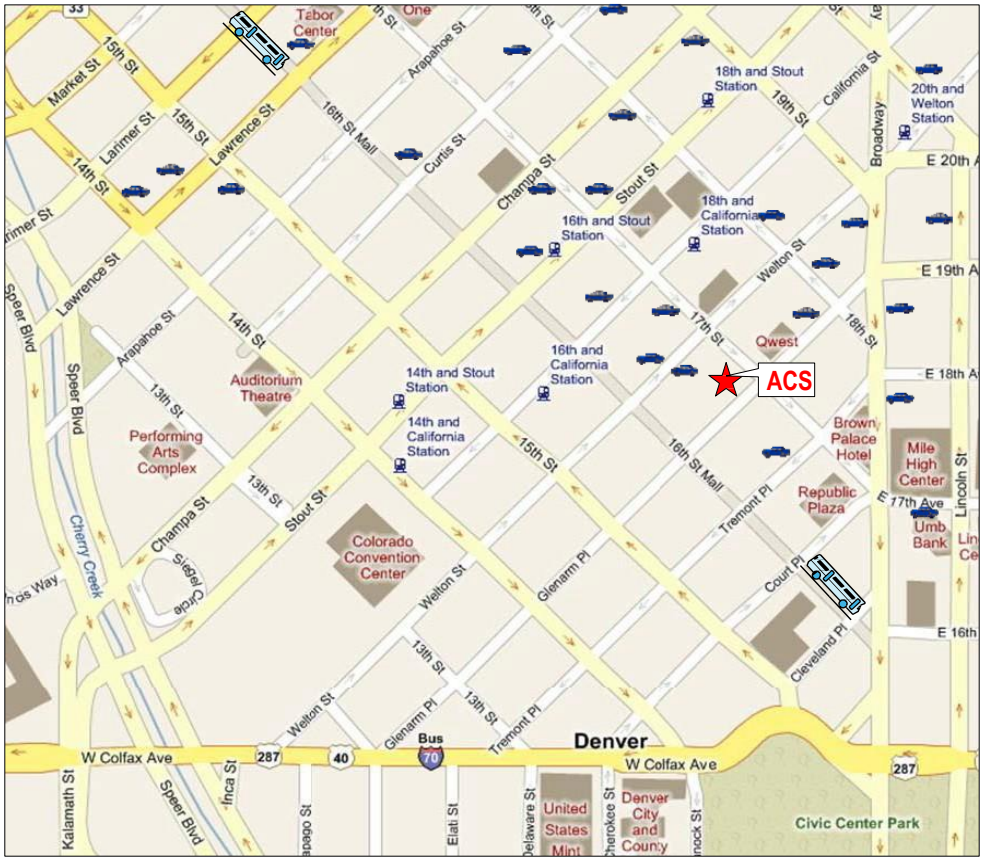
Parking: Parking is not provided by ACS and is limited in the downtown Denver area.

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.

January 2011

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						1
2	3	4	5	6	7	8
9	10	11 Beginning Billing – CO -1500 9:00 am-11:30 am Web Portal 837P 11:45 am-12:30 pm	12 Beginning Billing – UB-04 9:00 am-11:30 am Web Portal 837I 11:45 am-12:30 pm Hospice 1:00 pm-3:00 pm	13 Practitioner **(WebEx)** 9:00 am-12:00 pm	14 Beginning Billing – CO -1500 9:00 am-11:00 am HCBS-EBD 11:00 am-1:00 pm HCBS-BI 1:00pm-2:30 pm HCBS-DD 3:00 pm-4:30 pm	15
16	17 *Martin Luther King Day*	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

February 2011

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		1	2	3	4	5
6	7	8 Beginning Billing – CO -1500 9:00 am-11:30 am Web Portal 837P 11:45 am-12:30 pm Outpatient Substance Abuse 1:00 pm-3:00 pm	9 Beginning Billing – UB-04 9:00 am-11:30 am Web Portal 837I 11:45 am-12:30 pm Dialysis 1:00 pm-3:00 pm	10 Supply/DME Billing 9:00 am-11:00 am Supply/DME PAR 11:30 am-1:30 pm Pharmacy 2:00 pm-3:00 pm	11 Beginning Billing – CO -1500 **(WebEx)** 9:00 am-12:00 pm FQHC/RHC **(WebEx)** 1:00 pm-4:00 pm	12
13	14	15	16	17	18	19
20	21 *Presidents' Day*	22	23	24	25	26
27	28					

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.

FISCAL AGENT FOR THE **COLORADO MEDICAL ASSISTANCE PROGRAM**

Colorado Medical Assistance Program Provider Services
P.O. Box 1100
Denver, CO 80201-1100

ACS A xerox Company

1-800-237-0757
Fax: 303-534-0439

Email Opt-Out

If you are unable to receive emails containing links to monthly provider bulletins, urgent notifications and other significant Colorado Medical Assistance Program information, please complete the information below. Return the completed form to:

Medical Assistance Program Provider Enrollment
P.O. Box 1100
Denver, CO 80201-1100

☐ **I do not have a computer**

☐ **I do not have an email address**

☐ **I do not have internet access**

☐ ***I am unable to receive Colorado Medical Assistance Program emails for the reason checked above. When available, please send a paper copy of the Colorado Medical Assistance Program monthly provider bulletin, urgent notifications and other significant information to me at:***

Name: _____

Address: _____

_____

City: _____ State: _____ Zip Code: _____

Provider #: _____ Phone #: _____

By checking the box and signing and dating below, you acknowledge that you have read and understand the following statement.

☐ **I understand that by choosing to receive hardcopy documents rather than email notifications, there will be a delay in the receipt of all bulletins and notices, including time-sensitive information.**

_____ _____
Signature Date

December 2010