Provider Bulletin

colorado.gov/pacific/hcpf

Xerox State Healthcare
Denver Club Building
518 17th Street, 4th floor
Denver, CO 80202

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

ColoradoPAR Program PARs
www.coloradopar.com

Did you know...?
The 2013-2014 Synagis® and seasonal influenza season will begin November 18, 2013 and end March 31, 2014. More information will be provided in an upcoming special Provider Bulletin.

All Providers

National Corrective Coding Initiative (NCCI) Modifiers 24, 25, and 57 Guidelines

Most medical and surgical procedures include pre-procedure, intra-procedure, and post-procedure components. When multiple procedures are performed during the same surgical session, there is often overlap of the pre-procedure and post-procedure care. Payment methodologies for surgical procedures account for the overlap of the pre-procedure and post-procedure care. Many NCCI procedure-to-procedure (PTP) edits address coding issues related to the medical/surgical package.

The elements of the pre-procedure and post-procedure work-ups for each procedure are included component services of that procedure as a standard of medical/surgical practice.

In some circumstances, an Evaluation and Management (E&M) service is separately reportable on the same date of service as a major or minor surgical procedure.

Modifier 24: For major and minor surgical procedures, postoperative E&M services related to recovery from the surgical procedure during the postoperative period are included in the global surgical package, as are E&M services related to complications of the surgery that do not require additional trips to the operating room. Postoperative visits unrelated to the diagnosis for which the surgical procedure was performed, unless related to a complication of surgery, may be reported separately on the same day as a surgical procedure with *modifier 24* ("Unrelated E&M Service by the same Physician or Other Qualified Health Care Professional During a Postoperative Period").

Modifier 25: Modifier 25 may be used with an E&M Current Procedural Terminology (CPT) code to indicate that the E&M service is significant and separately identifiable from other services reported on the same date of service. The E&M service may be related to the same or different diagnosis as the other procedure(s).

Modifier 57: If an E&M service is performed on the same date of service as a *major* surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier 57. However, other E&M *preoperative* services performed on the same date of service as a major surgical procedure are included in the global surgical package for the procedure and are, therefore, not separately reportable.

Evaluation and Management services performed on the same date of service as a minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the global surgical package for the minor surgical procedure and should not be reported separately as an E&M service.

Important Reminder: Each NCCI PTP edit has an assigned modifier indicator. A modifier indicator of "0" indicates that NCCI PTP-associated modifiers cannot be used to bypass the edit. A modifier indicator of "1" indicates that NCCI PTP-associated modifiers may be used to bypass an edit under appropriate circumstances. A modifier indicator of "9" indicates that the edit has been deleted, and the modifier indicator is not relevant. The Correct Coding Modifier Indicator can be found in the files containing Medicaid NCCI PTP edits on the Centers for Medicare and Medicaid Services' (CMS) website.

Modifiers may be added to Healthcare Common Procedure Coding System (HCPCS)/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier should not be added to a HCPCS/CPT code solely to bypass an NCCI PTP edit if the clinical circumstances do not justify its use.

When the use of a modifier is appropriate, refer to the CMS NCCI Policy Manual, Chapter 1, sections C, D, and E located on the CMS website for specific guidance on proper use of modifiers.

NCCI Quarterly Update

Providers are encouraged to monitor the CMS website for updates to the NCCI rules and guidelines. The updates for PTP and Medically Unlikely Edit (MUE) files are updated quarterly, with the next update available this month (October). A link to the CMS NCCI website is also available on the NCCI web page located on the Department of Health Care Policy and Financing's (the Department's) website (colorado.gov/pacific/hcpf).

ColoradoPAR Program

CareWebQI (CWQI) Upgrade

The ColoradoPAR Program is pleased to announce the release of CWQI Version 5.0. The tentative date for the upgrade is Monday, October 21, 2013. While the basic function of the site will remain the same, the look and process will change to improve efficiency.

Please refer to upcoming Provider Bulletins and continue to reference coloradopar.com as new information will be added regarding the exact upgrade date.

Urgent or Expedited Reviews and Reconsiderations

An urgent review is one that is required to be done on an expedited basis because a delay could: (a) seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function, or (b) in the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment requested. Urgent review requests not meeting the above definition will be processed using the normal Prior Authorization Request (PAR) process.

Expedited Reconsiderations

If a reconsideration is requested and the original authorization request was considered an "expedited" or "urgent" request, then the reconsideration will be considered "expedited" as well, and will be completed quickly. All parties will be notified within 72 hours (excluding non-business days). If a reconsideration is for a request that was not originally marked expedited or urgent, but the provider wishes to have the reconsideration handled as an urgent reconsideration, this should be noted on the fax cover sheet when submitting the request. Expedited reconsideration requests not meeting the above definition of urgent will be processed using the normal reconsideration process.

PAR Revisions

A PAR revision is a request to change something on the current approved PAR. For example, requesting additional days, visits, units, etc., are reasons to request a revision. It is important to note that when entering a PAR revision request, "yes" should be selected in the dropdown on the Episode Edit screen for "revision" ONLY if the request is truly a revision. "No" should be selected only if the request is NOT a revision. Doing so will allow the ColoradoPAR Program to process the requested revision in a correct and timely fashion.

Please contact the ColoradoPAR Program by email at RES_ColoradoPAR@apshealthcare.com or call 1-888-454-7686 with questions.

Updated MED-178

The Department has updated the MED-178 form to include an additional field (Field 24). Field 24 allows an explanation when a different practitioner has to perform the procedure. In addition, the form has been updated with numbers to help determine what information is needed in each field. Instructions have also been updated and can be found with the form. The updated form is effective October 1, 2013 and will be required beginning with dates of service November 1, 2013. Use of the form with the revision date of 10/2004 will not be processed after November 1, 2013.

Please contact the Department's fiscal agent, Xerox State Healthcare, Provider Services at 1-800-237-0757 with questions.

New Affordable Care Act (ACA) Consumer Website

There is a new resource, colorado.gov/health, to which clients can be directed for information regarding ACA and how it may impact them. The site is a collaboration among various organizations including the Department (HCPF), Human Services (DHS), Public Health and Environment (CDPHE), Regulatory Agencies (DORA), the Division of Insurance (DOI), Connect for Health Colorado, and the Program Eligibility and Application Kit (PEAK). Providers are encouraged to inform clients of this valuable resource.

ACA Health Insurance Portability and Accountability Act (HIPAA) Operating Rule Changes Improve Eligibility Response Information

Colorado Medical Assistance Program Web Portal (Web Portal)

In compliance with the Administrative Simplification provision under the ACA of 2010, the Department has implemented several changes that are intended to improve the information that is displayed to users in the eligibility inquiry response (271 transactions) via the Web Portal. These changes are part of the HIPAA Operating Rule.

Beginning October 25, 2013, users will see a new field on the interactive and batch Client Eligibility Inquiry and Verification screens. The new **Service Type Code** drop-down field has been added to allow users to inquire if a client is eligible for a particular type of service. There are 52 valid value options to pick from the **Service Type Code** drop-down. If a user finds that none of those values are applicable to the inquiry, the default value of 30 – Health Benefit Plan Coverage can be selected.

Once an eligibility inquiry has been completed, users will also see new information on the returned eligibility response screen. This information is tied directly to the **Service Type Code** that is entered on the eligibility inquiry.

The new information will include the specific services that the client is eligible for, if there is any co-payment due from the client, and the co-payment dollar amount.

Below is an example of the eligibility response a user might receive on a client, depending on the type of eligibility and enrollment coverage the client might have.

Client Eligibility Details

Eligibility Status: **Eligible**

Eligibility Benefit Date:
    02/06/2013 - 02/06/2013

Guarantee Number: 1234567890

Coverage Name: Medicaid

Health Plan Name: **ILLEGAL ALIEN**

Eligible for Health Benefit Plan Coverage

Eligible for Mental Health, Medical Care, Chiropractic, Dental Care, Hospital Outpatient, Vision (Optometry), Professional (Physician) Visit – Office, Pharmacy, Hospital Inpatient, Hospital.

Co-Payment for Mental Health, Medical Care, Chiropractic, Dental Care, Hospital Outpatient, Vision (Optometry), Professional (Physician) Visit – Office, Pharmacy is **$10**.

Co-Payment for Hospital Inpatient, Hospital is **$20**

PREPAID HEALTH PLAN

Eligibility Benefit Date:
    02/06/2013 - 02/06/2013

Health Plan Name: Prepaid Health Plan

In addition, two new error codes have been added to the eligibility inquiry response. If the client ID or name has been entered incorrectly into the eligibility inquiry or if a match cannot be found in the Medicaid Management Information System (MMIS), the response error code of *72 – Invalid/Missing Subscriber/Insured ID or 73 – Invalid/Missing Subscriber/Insured Name* could be received instead of the eligibility response screen.

The Web Portal web-based training module, User Guide, and in-screen help files for eligibility inquiry will be updated to reflect these new changes. Users are encouraged to review this information which might answer any questions they may have. Please contact the CGI Help Desk by email at HelpDesk.HCG.central.us@cgi.com or 1-888-538-4275, option 1 with additional questions about how to use the new **Service Type Code** field in the Web Portal eligibility screens.

Interactive Voice Response System (IVRS)
Improvements have also been made to the IVRS. The IVRS will now:

- Verbalize eligible service types to the caller (If using Faxback, eligible service types will be displayed).
- Include co-pay amounts and descriptions for applicable service types. (Faxback will also display co-pay amounts and descriptions for applicable service types.)
- Allow callers the ability to skip through the co-pay messages if the client is exempt from co-pay requirements or if the caller doesn't want to hear the information.

Please note that the search criteria will **not** be changing.

Please contact the Department's fiscal agent's Provider Services at 1-800-237-0757 with questions about the client's eligibility/enrollment coverage and co-payment amounts.

October and November 2013 Holidays

Columbus Day
Due to the Columbus Day Holiday on Monday, October 14, 2013, the claims processing cycle will include electronic claims accepted before 6:00 p.m. Mountain Time (MT) on Thursday, October 10, 2013. The receipt of warrants may be delayed by one (1) or two (2) business days. State and the ColoradoPAR Program offices will be closed on Monday, October 14, 2013. The Department's fiscal agent offices will be open during regular business hours.

Veterans Day
Due to the Veterans Day Holiday on Monday, November 11, 2013, the claims processing cycle will include electronic claims accepted before 6:00 p.m. MT on Thursday, November 7, 2013. The receipt of warrants may be delayed by one (1) or two (2) business days. State and ColoradoPAR Program offices will be closed on Monday, November 11, 2013. The Department's fiscal agent offices will be open during regular business hours.

Thanksgiving Day Holiday
The Thanksgiving Day holiday on Thursday, November 28, 2013 will delay the receipt of warrants and Electronic Funds Transfers by one (1) or two (2) business days. State, ColoradoPAR Program and the Department's fiscal agent offices will be closed on Thursday, November 28, 2013

Dental Providers

Dental Benefit Update

In Senate Bill 13-230 (SB13-230), the Department was allocated dollars to acquire an Administrative Service Organization (ASO) to manage the Department's current Children's Dental Benefit. The Department is hosting a series of Dental Benefit Collaborative meetings to discuss services being offered in the current Medicaid Dental policies, which include both the newly created Adult Dental Benefit (SB13-242) and a review of the Children's Dental Benefit. The Department welcomes all stakeholder input. Please visit the Department's website→ Committees, Boards, and Collaboration→ Benefits Collaborative for a meeting schedule and additional information.

Durable Medical Equipment (DME) Providers

NCCI Edits

The Colorado Medical Assistance Program compared a sample of claims to the NCCI edits and found that most claims are compliant with the CMS' expectations. The potential exists that these edits may impact claims payments for DME.

PTP Edits
Please note that some wheelchair code combinations have been identified on the NCCI PTP edit list that may be affecting claims. The Department is working through a resolution with our partners at CMS. Please email DME_HCPF@hcpf.state.co.us with outstanding claims for secondary wheelchairs that are being denied with the PTP edit (edit 2021).

As a reminder, the Department makes every effort to reduce payment issues related to quarterly NCCI edit implementation. However, to ensure potential issues are not overlooked, we also ask that providers stay updated on the quarterly release of codes and notify the Department of any NCCI MUE or PTP edits that are anticipated to result in issues with payment or services provided to clients.

Please review the Medicaid NCCI program information and edit files or contact the Department at DME_HCPF@hcpf.state.co.us with additional questions or concerns.

DME Wheelchair Billing Requirements Reminder

The DME and Supply Billing Manual has been updated to reflect updates regarding wheelchair billing requirements:

- Modifier 76 is not an allowable modifier for DME claims and should not be used. Claims effective for dates of service on or after October 1, 2013 with modifier 76 will be denied.

- Primary equipment and backup equipment are identified by Make/Model/Serial number and the corresponding approved PAR ID. This identifying information must be included on all new claims and on claims for repair. Beginning with dates of service on or after October 1, 2013, claims submitted without this information will be denied.

Augmentative and Alternative Communication Devices (AACD)
Benefit Coverage Standard

The Department received final approval from the Medical Services Board (MSB) on the AACD Benefit Coverage Standard. This coverage standard was effective September 30, 2013, and incorporated by reference to the Durable Medical Equipment and Disposable Medical Supplies Rule 10 CCR 2505-10, §8.590.2.S.

The AACD Benefit Coverage Standard contains two notable updates to coverage of communication devices, effective September 30, 2013:

- *Prior authorization requirements:* Questionnaire #13 is no longer required for prior authorization submission. The ColoradoPAR Program does not require the questionnaire to determine medical necessity for communication devices. However, it will remain on the Department's website for providers who would like to continue using it to capture evaluation information.
- *Tablet computers:* Tablet computers have been approved as an addition to the AACD coverage standards.

Please refer to the updated DME and Supply Billing Manual and the approved AACD Benefit Coverage Standard on the Department's website for details on coverage guidelines, limitations and requirements:

- DME
- colorado.gov/pacific/hcpf >Committees, Boards, and Collaboration > Benefits Collaborative > Approved Benefit Coverage Standards

Hospice Providers

Increase to Hospice Provider Rates

Effective October 1, 2013, the Department is increasing Hospice Routine Home Care, Hospice Continuous Home Care, Hospice Inpatient Respite, and Hospice General Inpatient Care rates. Hospice provider rates are set annually by CMS and are adjusted for regional differences in labor costs using a CMS published wage index. Below are the Hospice provider rates for the different regions within Colorado. Any Hospice provider not located within a listed county will be reimbursed using the Rural Hospice provider rates. Please contact Jeff Wittreich at Jeff.Wittreich@state.co.us or 303-866-2456 with questions.

Region	Hospice Service	FY 13-14 Rate
Boulder County	651 Routine Home Care	$164.52
	652 Continuous Home Care	$39.97
	655 Inpatient Respite	$176.99
	656 Gen Inpatient Care	$728.36
El Paso / Teller County	651 Routine Home Care	$151.29
	652 Continuous Home Care	$36.76
	655 Inpatient Respite	$165.66
	656 Gen Inpatient Care	$673.62
Denver Metro Area	651 Routine Home Care	$163.37
	652 Continuous Home Care	$39.69
	655 Inpatient Respite	$176.01
	656 Gen Inpatient Care	$723.61

Region	Hospice Service	FY 13-14 Rate
Larimer County	651 Routine Home Care	$156.42
	652 Continuous Home Care	$38.00
	655 Inpatient Respite	$170.06
	656 Gen Inpatient Care	$694.86
Mesa County	651 Routine Home Care	$151.85
	652 Continuous Home Care	$36.89
	655 Inpatient Respite	$166.14
	656 Gen Inpatient Care	$675.93
Weld County	651 Routine Home Care	$153.79
	652 Continuous Home Care	$37.36
	655 Inpatient Respite	$167.80
	656 Gen Inpatient Care	$683.97
Pueblo County	651 Routine Home Care	$142.03
	652 Continuous Home Care	$34.51
	655 Inpatient Respite	$157.73
	656 Gen Inpatient Care	$635.31
Rural (All Hospices not found in a listed county)	651 Routine Home Care	$160.51
	652 Continuous Home Care	$39.00
	655 Inpatient Respite	$173.56
	656 Gen Inpatient Care	$711.79

Hospital Providers

Immediate Postpartum Long-Acting Reversible Contraception (LARC)

Effective for dates of service on or after October 1, 2013, the Department is updating Colorado's Medicaid's policy to include reimbursement for long-acting reversible contraception provided in a hospital. This *temporary* process will enable hospital providers to be reimbursed for these devices immediately following delivery. The Department will revert to the normal claims process when All Patient Refined Diagnosis Related Groups (APR-DRG) is implemented in early January 2014.
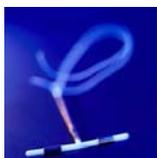
From October 1 through December 31, 2013, hospitals MUST include the National Drug Code (NDC) along with the appropriate CPT codes on inpatient claims for LARC in order to receive reimbursement from the Colorado Medical Assistance Program. Claims that do not include the NDC will not be processed. The Department will issue payment for these claims to hospitals in the spring of 2014. Reimbursement is based upon the fee schedule.

The following table includes the devices, the CPT codes, and the NDCs included in this temporary process:

DEVICE	CPT CODE	NDC
Skyla	Q0090	50419042201
Mirena	J7302	50419042101
Implanon	J7307	00052027201
Nexplanon	J7307	00052027401
ParaGard	J7300	51285020401

Please contact Kirstin Michel at Kirstin.Michel@state.co.us with any questions.

Waiver Providers

Prior Authorization Request (PAR) Over Utilization Review

Effective October 1, 2013, the Department of Human Services, Division for Developmental Disabilities (DDD) is reviewing PARs for the Home and Community Based Service (HCBS) for Persons with Developmental Disabilities (DD), HCBS-Supported Living Services (SLS), and HCBS-Children's Extensive Support (CES) waivers to ensure services are reimbursed only according to the PAR and the Service Plan.

The Department's prior authorization rule 10 CCR 2505-10, Section 8.058 states that certain services are available as a benefit only with prior authorization. This is further clarified in the Department's rules for the HCBS-DD, HCBS-SLS and HCBS-CES Waivers (10 CCR 2505-10, Section 8.500.12.D.4; 10 CCR 2505-10, Section 8.500.101.D.4 and 10 CCR 2505-10, Section 8.500.120.D.4).

A recent review shows some services were billed and paid more than the amount approved on the PAR. Therefore, the DDD will conduct monthly reviews and monitor service utilization on a monthly basis to ensure claims are paid in accordance with the PAR and the Service Plan.

The DDD staff will monitor PARs with an October 1, 2013 end date and later. For active PARs with over utilized services, DDD staff will contact the Case Manager at the Community Centered Board (CCB) to allow time for the PAR or claims to be corrected prior to the end date of the PAR.

Note: For expired PARs with over utilized services, DDD staff will contact the CCB and the service providers by the 15th of the month to notify providers of over utilized waiver services and the DDD will follow up with a formal letter by the end of the month. Service providers will have 30 days from the date of the letter to review and respond to the DDD before funds will be recovered. After the 30 days, the DDD will recover funds in the amount utilized above the approved amount in the PAR. Providers may appeal the DDD decisions regarding the recovery of funds as set forth in 10 C.C.R. 2505-10, Section 8.050.3.

Please contact Angie Sanders at Angeline.Sanders@state.co.us or Nancy Fritchell at Nancy.Fritchell@state.co.us with questions.

Pharmacy Providers

Distribution of Cost of Dispensing and Total Annual Prescription Volume Surveys

The Department has contracted with Mercer Government Human Services Consulting (Mercer) to distribute two (2) surveys to Colorado Medicaid pharmacies.

The first survey is a Cost of Dispensing (COD) survey. Reimbursement for Fee-For-Service (FFS) Medicaid claims consists of two separate parts. The first part is reimbursement for the costs of acquiring a medication from a wholesaler or manufacturer (Acquisition Cost), while the second part is reimbursement for the costs of dispensing the medication to a client who receives Medicaid benefits (Dispensing Fees). The COD survey will allow the Department to examine current dispensing costs to determine if the current Dispensing Fees are appropriate, or if they require updates to better align with costs incurred by Colorado pharmacies.

TAKE THE SURVEY

The second survey is a Total Annual Prescription Volume (TAPV) survey. Reimbursement for dispensing costs is tiered into four (4) separate Dispensing Fees. Each tier represents a range of TAPV with every Colorado Medicaid pharmacy placed into one of the four tiers depending on their TAPV. The current tiers, with their TAPV range and Dispensing Fees are as follows:

Tier	TAPV Range	Dispensing Fee
Tier 1	0 – 59,999 TAPV	$ 13.40
Tier 2	60,000 – 89,999 TAPV	$ 11.49
Tier 3	90,000 – 109,999 TAPV	$ 10.25
Tier 4	110,000+ TAPV	$ 9.31

The TAPV survey will be used to determine what tier each Colorado Medicaid pharmacy will be placed into for calendar year 2014 (January – December). Completion of this survey is vital; a pharmacy not completing this survey will be placed into Tier 4 and reimbursed at the lowest Dispensing Fee.

Mercer will be sending the surveys out to the Colorado Medicaid pharmacy community via mail and/or email, beginning October 1, 2013. Please look for these communications over the next few weeks.

Please contact Mercer by email at CO.Rx_reimbursement@mercer.com with questions.

Preferred Drug List (PDL) Update

Effective October 1, 2013, the following will be preferred agents on the Medicaid PDL and will be covered without a prior authorization:

Oral Anticoagulants: warfarin

Oral Bisphosphonates: Alendronate (generic) 5mg, 10mg, 35mg, and 70mg tablets

Biguanides: Metformin generic 500mg, 850mg, and 1000mg tablets; metformin XR 500mg tablets (this does not include generic equivalents of Fortamet)

Hypoglycemic Combinations: None

Meglitinides: None

TZDs: None

- Patients stabilized on Actos will continue to be able to receive the drug; however, a Prior Authorization (PA) will be required for new starts or interruptions in therapy.

Newer Diabetic Agents: Byetta, Januvia and Tradjenta

Erythropoiesis Stimulating Agents: Procrit and Aranesp

Overactive Bladder Agents: oxybutynin, oxybutynin ER and Toviaz

Protease Inhibitors for Hepatitis C: Victrelis

- Patients taking Victrelis will be subject to meeting clinical requirements

Stimulants and ADHD: mixed amphetamine salts IR, Adderall XR (brand), dexmethylphenidate, Focalin XR (brand), methylphenidate (generic Ritalin), methylphenidate SR (generic Ritalin SR), methylphenidate ER (generic Concerta), Strattera, Vyvanse

The complete PDL and prior authorization criteria for non-preferred drugs are posted on the PDL web page.

Pharmacy &Therapeutics (P&T) Committee Open Positions Beginning 2014

The Department is currently accepting curriculum vitae (CV) for the following P&T Committee positions:

- Four (4) Physicians
- Two (2) Pharmacists
- One (1) Client Representative

These positions will serve a two year term from January 2014 through December 2015. If interested in serving or know someone who would with the required qualifications, please submit a CV along with a completed Conflict of Interest form to:

Colorado Department of Health Care Policy and Financing
Attn: Robert Lodge
1570 Grant Street
Denver, CO 80203-1818

Fax: 303-866-3590

Robert.Lodge@state.co.us

The Conflict of Interest form can be found on the Pharmacy & Therapeutics web page under *Contact Us/Join Us.*

Submission deadline is November 15, 2013. Please contact Robert Lodge by email or 303-866-3105 with questions.

November 2013						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

Next P&T Committee Meeting

Tuesday, October 8, 2013
1:00 p.m. - 5:00 p.m.
University of Colorado School of Pharmacy
Anschutz Medical Campus
Education 2 South Auditorium, Building 28
Room 1102
12631 E. 17th Ave.
Aurora, CO 80045

October and November 2013 Provider Workshops

Provider Billing Workshop Sessions and Descriptions
Provider billing workshops include both Colorado Medical Assistance Program billing instructions and a review of current billing procedures.

The current and following month's workshop calendars are included in this bulletin.

Class descriptions and workshop calendars are also posted in the Provider Services Training section of the Department's website.

Who Should Attend?
Staff who submit claims, are new to billing Colorado Medicaid services, need a billing refresher course, or administer accounts should consider attending one or more of the following Provider Billing Workshops.
Courses are intended to teach, improve, and enhance knowledge of Colorado Medical Assistance Program claim submission.

October 2013

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
6	7	8 Beginning Billing – CO -1500 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM Vision 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 Nursing Facility 1:00 PM-3:00 PM	10 Dental Billing 9:00 AM-11:00 AM Web Portal 837D 11:15 AM-12:00 PM Pharmacy 1:00 PM-3:00 PM ***WebEx –** IP/OP 1:00 PM-3:00 PM	11 Basic Billing Waiver Providers 9-11:30 Web Portal 837P 11:45 AM-12:30 PM Practitioner 1:00 PM-3:00 PM	12

November 2013

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
10	11 Veteran's Day Holiday	12 Beginning Billing – CO -1500 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM	13 Beginning Billing – UB-04 9:00 AM-11:30 AM Web Portal 837I 11:45 AM-12:30 PM FQHC/RHC 1:00 PM-3:00 PM	14 DME Billing 9:00 AM-11:00 AM Home Health 1:00 PM-3:00 PM	15 ***WebEx –** Beginning Billing – UB-04 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM Transportation 1:00 PM-3:00 PM	16

Reservations are required for all workshops

Email reservations to:
workshop.reservations@xerox.com

Or   Call the Reservation hotline to make reservations: 1-800-237-0757, extension 5.

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 the information noted above is necessary to process reservations successfully. Look for a confirmation e-mail within one week of making a reservation.

Reservations will only be accepted until 5:00 p.m. the Friday prior to the training workshop to ensure there is adequate space available.

If a confirmation has not been received at least two business days prior to the workshop, please contact the Department's fiscal agent and talk to a Provider Relations Representative.

All Workshops presented in Denver are held at:

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

*Please note: *For WebEx training, a meeting notification containing the website, phone number, meeting number and password will be emailed or mailed to those who sign up.*

The fiscal agent's office is located in the Denver Club Building on the west side of Glenarm Place at 17th Street (Glenarm is a two-way street).

Free parking is not provided and is limited in the downtown Denver area. Commercial parking lots are available throughout the downtown area. The daily rates range between $5 and $20. Carpooling and arriving early are recommended to secure parking. Whenever possible, public transportation is also recommended.

Some forms of public transportation include the following:

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

Free MallRide – The MallRide stops are located on 16th St. at every intersection between the Civic Center Station and Union Station.

Please direct questions about Colorado Medical Assistance Program billing or the information in this bulletin to
Xerox State Healthcare Provider Services at 1-800-237-0757.

Please remember to check the Provider Services section of the Department's website at colorado.gov/pacific/hcpf for the most recent information.