Provider Bulletin

In this issue:

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 Department recently upgraded its website (Colorado.gov/hcpf) and it is now live. The look and feel of the website has been redesigned to align with the new brandCOLORADO standards. For questions or to report any issues with the website, please contact hcpfwebmaster@state.co.us.

All Providers

Billing Information for Clients with Reinstated Benefits

Termination of benefits letters may have been sent to some Medicaid and Child Health Plan *Plus* (CHP+) clients that did not contain complete information. This means that clients may have received a letter that did not provide the reason explaining why their benefits were ending.

Although client benefits were terminated for the appropriate reason, because the clients may not have received the reason in their discontinuation letter, the following action is being taken by the Department:

- Cases for impacted clients will be re-opened, and benefits will be reinstated from the first of the month following the date of initial discontinuance to September 30, 2014.
- Impacted clients will be sent a new letter that includes the reason for the discontinuation, the proper rule reference and the dates their benefits were reinstated.
- Benefits will be discontinued for the impacted clients on September 30, 2014. The only exception to this would be if the client provided recent information that makes them eligible past September 30, 2014

Information Contained in the New Notice
The new complete letters were sent to impacted clients during the first week of September 2014. The letter lists the client's county case worker and the Medicaid Customer Contact Center as a resource for their questions. As always, clients have the right to appeal the discontinuation of their benefits. For these clients, the provider must bill Medicaid and must also reimburse the client for any amounts they paid for services during the covered timeframe. The appeal process is explained in detailed in the letter they received.

The letter tells the client that if they have incurred medical or pharmacy bills during the time their benefits were reinstated, they should present the letter to their Medical Provider of Pharmacy. The following instructions explain how to bill for any Medicaid or CHP+ covered services rendered during the time the client's benefits were reinstated.

Medicaid Billing Instructions for a Doctor or Pharmacy

In accordance with Colorado state law C.R.S. §25.5-4-301(1), doctors and pharmacies may not bill a client eligible for Medicaid or Old Age Pension Health Care Program for services Medicaid covers. Doctors and pharmacies must bill Medicaid for these services and reimburse clients for any incurred costs covered by Medicaid. If the individual has Medicaid or Old Age Pension Health Care Program follow the steps below.

Step 1: Follow standard office procedure for verifying client eligibility through:
- The Colorado Medical Assistance Web Portal (Web Portal),
- Fax Back 1-800-493-0920,
- CMERS/AVRS 1-800-237-0757, or
- Medicaid ID Card through a Switch Vendor.

Step 2: Always print a copy of the eligibility verification received and save it in the client's file for auditing purposes. As a reminder, contacting the Department's fiscal agent (Xerox State Healthcare) directly does not provide an eligibility guarantee number.

Step 3: Contact the Department's fiscal agent Provider Services at 1-800-237-0757, Monday-Friday 8:00 am - 5:00 pm if:
- Providers encounter issues verifying clients' eligibility,
- A providers is not participating in Medicaid
- A claim was previously denied for this client,
- If the services occurred 120 days before the date of this letter, or
- Have questions about this letter.

Child Health Plan Plus (CHP+) Billing Instructions for a Doctor or Pharmacy

Doctors and pharmacies may not bill a client eligible for CHP+ for services CHP+ covers. Doctors and pharmacies must bill CHP+ for these services. If the individual has CHP+ follow the steps below.

Step 1: Follow standard office procedure for verifying client eligibility through:
- Colorado Medical Assistance Web Portal (Web Portal)
- Fax Back 1-800-493-0920; or
- CMERS/AVRS 1-800-237-0757

Step 2: Always print a copy of the eligibility verification received and save it in the client's file for auditing purposes. As a reminder, contacting the Department's fiscal agent directly does not provide an eligibility guarantee number.

Step 3: Depending on the client's enrollment, additional billing questions should be directed to the CHP+ State Managed Care Network or the CHP+ Health Maintenance Organization (HMO). If the client is enrolled in:
- Colorado Access HMO/State Managed Care Network, contact 1-888-214-1101,
- Kaiser Permanente, contact 303-338-3800,
- Denver Health Medical Plan, Inc., contact 303-602-2100,
- Rocky Mountain Health Plans, contact 1-800-346-4643, or
- Colorado Choice Health Plans, contact 1-800-475-8466.

A sample of the letter sent to impacted members can be viewed on the Forms & Rules web page of the Department's website.

Please contact the Department's fiscal agent Provider Services at 1-800-237-0757 with questions on how to bill for services rendered during the time a client's benefits were reinstated.

General Information – July 1, 2014 Rate Increases

In previous Provider Bulletins, the Department announced provider rate increases were effective July 1, 2014; however, the Department is still awaiting final approvals from the Centers for Medicare & Medicaid Services (CMS). Once permitted, the Department will retroactively adjust claims with dates of service on or after July 1, 2014 to reflect the rate increase. Adjustments will be reflected on future Provider Claim Reports (PCRs).

Note: Mass adjustments made by the Department can only be done if the original submitted charge on a claim is greater than the newly revised rate. Any claim on or after the date that new rates become effective, with a submitted charge lower than the corrected rate, must be adjusted by the provider. It is recommended that providers submit charges based on Usual & Customary rates, when applicable. Updated fee schedules are also forthcoming.

Providers may contact the Department's fiscal agent at 1-800- 237-0757 with questions.

National Correct Coding Initiative (NCCI) Notification of Quarterly Updates

Providers are encouraged to monitor the CMS website for updates to the NCCI rules and guidelines. The updates are completed quarterly with the next update available October 2014. A link to the CMS NCCI website is also available on the NCCI web page on the Department's website at Colorado.gov/hcpf/provider-information →NCCI.

The Accountable Care Collaborative (ACC) Medicare-Medicaid Program Automatic Enrollment Process and Member Eligibility Responses

The ACC Medicare-Medicaid Program began enrollment September 1, 2014. The Department will use a phased approach, enrolling about 50,000 members over a period of seven (7) months beginning September 1, 2014 and ending in March 2015. Ultimately, members will appear on eligibility verification responses as "enrolled in the ACC Medicare-Medicaid Program." Until the new eligibility response is available, providers must check two (2) areas of the eligibility response to determine if the member is enrolled in the ACC Medicare-Medicaid Program. Providers should look for ACC enrollment via Client Eligibility Details section as well as Medicare eligibility via the Third Party Liability section of the eligibility response. Providers should expect updates via future Provider Bulletins regarding this eligibility response information.

If a provider encounters any issues or has questions concerning member eligibility, contact Colorado Medical Assistance Program Customer Service at 1-800-221-3943.

Child Welfare Eligibility Verification Reminder

As a reminder for any provider who renders services to children in the child welfare system, when verifying Medicaid Eligibility, it is important to note that these members do not have Social Security Numbers (SSN) attached to their records. Providers will not receive valid eligibility information when using the member name and SSN. Providers should instead verify eligibility for child welfare recipients using the member's name and date of birth before denying services for lack of eligibility.

Providers may contact Ethel Smith at Ethel.Smith@state.co.us or Gina Robinson at Gina.Robinson@state.co.us with questions.

Labor Day Holiday

Due to the Labor Day holiday on Monday, September 1, 2014, the claims processing cycle included electronic claims that were accepted before 6:00 p.m. Mountain Time (MT) on Thursday, August 28, 2014. The receipt of warrants will be delayed by one (1) or two (2) days. State, the Department's fiscal agent, DentaQuest, and the ColoradoPAR Program offices will be closed on Monday, September 1, 2014. Offices will reopen during regular business hours on Tuesday, September 2, 2014.

Affordable Care Act (ACA) - Provider Screenings

New federal regulations require enhanced screening and re-validation of providers enrolling with Colorado Medicaid. These regulations are designed to reduce the potential for Medicaid fraud, waste, and abuse. The Department is seeking stakeholder feedback on how to implement these federal regulations.

Most providers will see very little change in the enrollment process, but some may be required to undergo additional screening before they can be enrolled or re-enrolled in Medicaid. The Centers for Medicare and Medicaid Services has developed three (3) levels of provider screening based on the potential risk of waste, fraud and abuse. The Centers for Medicare and Medicaid Services has previously determined the particular risk level of most major provider types (e.g., physicians, clinics, hospitals, community mental health centers, etc.).

The Department has been granted some flexibility in a few, specific areas and is interested in stakeholder input on these areas. The Department seeks to implement the federal rules in a way that will minimize the administrative burden on providers.
In October 2014, the Department will present the new federal regulations and begin to collect feedback about how best to implement the federal regulations. A web-based forum will be hosted at several locations across the state for providers and stakeholders. Additionally, stakeholders will be provided the opportunity to submit feedback via email. Providers may review the Provider Screening information further on the Provider Implementations web page located on the Department's website (colorado.gov/pacific/hcpf/provider-implementations)

Coverage to Care Resources

From Coverage to Care is an initiative being spearheaded by CMS to help people with new health care coverage understand their benefits and connect to primary care and the preventive services that are right for them. The Centers for Medicare and Medicaid Services has created a series of short videos that describe how members use their coverage, pick a provider, prepare for appointments, and other helpful tips. Providers are encouraged to share these resources with their patients or show them in their waiting rooms. The videos can be found on Colorado.gov/Health → Menu → Health Resources → Videos.

Protect Yourself by Understanding Healthcare Fraud

The Centers for Medicare & Medicaid Services, in collaboration with the Colorado Medical Society, will host the Protect Yourself by Understanding Healthcare Fraud Symposium on September 11, 2014. The purpose of this event is to educate physicians, other healthcare providers, and administrators on how to safeguard and protect their professional identity, and their most valuable assets, their medical practice, and their patients from fraud. The Symposium will be held:

September 11, 2014
8:15a.m. - 4:45p.m.
Colorado Medical Society
7351 E. Lowry Boulevard
Denver, CO 80230

For additional information and/or to register for attendance, please visit the Protect Yourself Event page.

ColoradoPAR Program

Prior Authorization (PAR) Revisions:

A PAR Revision request should be made when requesting a change to an approved PAR. Prior Authorization Requests and revisions should be completed to request additional days, visits, units, and/or a change in provider.

Providers complete a PAR Revision by:
- Selecting "yes" in the dropdown menu on the Episode Edit screen of an existing PAR.
  Note: Revisions cannot be made to an expired PAR.
- Adding a comment stating exactly what is to be included in the PAR Revision. When PAR Revision information is not given, the episode will be denied for lack of information.

Private Duty Nursing (PDN) Hours

Members who receive PDN services must meet the following eligibility requirements and be:
- Technology-dependent
- Medically stable
- Able to be safely managed in the home
- Not residing in a nursing home
- Eligible for Medicaid
- Able to meet one of the following medical criteria:
  - Need PDN while on a mechanical ventilator
  - Need PDN for ventilator weaning
  - Pediatric member need PDN after tracheostomy de-cannulation to stabilize patient
  - Pediatric member need PDN while on C-PAP
  - Pediatric member need PDN for oxygen administration only if there is documentation of rapid desaturation (below 85% within 15-20 minutes) without oxygen
  - Pediatric member with prolonged intravenous infusions including TPN, fluids, and medications

For more information, Providers may refer to the regulations concerning PDN services in the Department Program Rules and Regulations (10 CCR 2505-10 8.540) web page on the Department's website.

Colorado Medicaid Nurse Advice Line:

The Colorado Medicaid Nurse Advice Line offers Colorado Medicaid members free, 24-hour access to medical information and advice by calling 1-800-283-3221 any day of the week.
The Nurse Advice Line provides:
- Registered Nurses who will answer medical questions, provide care advice, and help members determine if they should be seen by a doctor right away.
- Advice and treatment referrals for chronic conditions, such as diabetes or asthma. Advice on the appropriate doctor and setting to treat a member's medical condition.

Please contact the ColoradoPAR Program at 1-888-454-7686 with questions.

<u>Dental Providers</u>

DentaQuest Office Reference Manual (ORM) Status Update

DentaQuest and the Department apologize for the challenges Colorado Medicaid providers have experienced with the transition to DentaQuest as of July 1, 2014. It is known that dental providers are anxiously awaiting the newly updated ORM and DentaQuest is working diligently to audit, revise, and ensure its accuracy. DentaQuest will communicate with dental providers regularly on current progress and highlight changes that are made in order to provide clarity.

A detailed audit of the Diagnostic, Preventive, Restorative and Periodontics sections of the manual have been completed. Highlights of those changes include:
- Corrected ages and PAR requirements to remain consistent with those of the Colorado Medicaid Dental Program prior to July 1, 2014.
- Eliminated frequency limitations for certain diagnostic services when performed by orthodontists.
- Added procedure codes that were previously covered benefits of the Colorado Medicaid Dental Program prior to July 1, 2014.

In addition, DentaQuest has reprocessed claims that were incorrectly denied. Future updates will include counts of claims that were reprocessed and corresponding dollar amounts. We recommend that dental providers regularly check the DentaQuest Colorado Providers website for news and updates. Additionally, Colorado Medicaid dental providers can always contact DentaQuest Provider Services at 1-855-225-1731 for further assistance.

2% Across-the-Board Rate Increase for Colorado Medicaid Providers
Update for Dental Providers

The July 1, 2014 Colorado Medicaid dental fee schedule does not yet reflect the 2% increases as the Department is awaiting final approvals from CMS. Once permitted, claims with dates of service on or after July 1, 2014 will be retroactively adjusted to reflect the rate increase. The Department will communicate the status of rate increases via future provider communications.

Qualified and Service-Limited Medicare Beneficiaries and the Adult Dental Benefit

Certain Medicaid programs pay Medicare premiums, deductibles, and co-insurances for Medicare beneficiaries with limited income and resources. Members eligible for these programs are referred to as Qualified Medicare Beneficiaries (QMB) and Service Limited Medicare Beneficiaries (SLMB). Such premium assistance is meant to ensure individuals have access to the Medicare benefit.

Though QMB and SLMB members have Medicaid ID numbers, only **some** of these individuals, due to income-eligibility guidelines, qualify for adult dental benefits. When verifying a member's Medicaid eligibility, if the provider receives a response that includes "Client has Regular Medicaid PLUS QMB" *or* "Client has Medicare & Medicaid Benefits," the member does qualify for the adult dental benefit. However, if the provider does not receive either of these messages, the member does not qualify.

A provider who checks a member's eligibility on the day of service and finds the member eligible receives an eligibility guarantee number. If eligibility has changed when the claim is submitted, the guarantee number exempts those claims from eligibility edits for that date of service. Providers are reminded to review the entire eligibility response.

Children's Dental Benefit – Rules and Regulations

As a follow up to the previous month's Provider Bulletin (B1400355) concerning the revised Children's Dental Benefit Rule, the revision passed its first reading through the Medical Services Board (MSB) hearing on August 8, 2014. Input for the revised rule has been received throughout the process and has led to many changes in collaboration with dental providers, community members, and advocates. The Department is working on final recommendations. The second reading of the Children's Dental Rule, and permanent adoption, will be presented at the next scheduled MSB meeting on Friday, October 10, 2014. If accepted, the earliest possible effective date for the rule would be November 30, 2014.

The Department would like to thank everyone who has contributed time and expertise in assisting with the revisions to the children's dental rule and the improvements it will bring to the administration of the children's dental benefit.

Physical, Occupational, and Speech Therapy Providers

Assistive Technology Assessments (Current Procedure Code 97755)

Effective October 1, 2014, the following billing policy changes will be made to CPT procedure code 97755 to accommodate House Bill (HB) 14-1211. HB14-1211 requires that all Medicaid members seeking complex rehabilitation technology have an initial Assistive Technology Assessment (complex rehabilitative technology evaluation/assessment) prior to receiving complex rehabilitation technology and any follow-up assessments as needed. Only qualified health care professionals, including but not limited to licensed Physical, Occupational, and Speech Therapists (PT/OT/ST), may provide these types of specialty evaluations.

All providers billing procedure code 97755 must follow these guidelines. The Department recognizes that only a portion of Assistive Technology Assessments will be used for complex rehabilitation technology evaluation/assessment.

Policy Change	Notes
Complex rehabilitation technology evaluations / assessments are billed using only procedure code 97755.	Combinations of procedure codes, including procedure code 97542, for the purposes of complex rehabilitation technology evaluation / assessment are not allowed.
Procedure code 97755 always requires a Prior Authorization Request (PAR).	PARs must be submitted electronically using ColoradoPAR via CareWebQI (CWQI). Details are found on the ColoradoPAR Program's website.
Member daily limit for procedure code 97755 is 20 units.	Up to five (5) hours of assessment is allowed per date of service.
Member yearly limit for procedure code 97755 is 60 units.	Members may have up to 60 units of procedure code 97755 per State fiscal year (July 1 – June 30). This limit will reset with the start of each new State Fiscal Year.

Prior Authorization Requests for Current Procedural Terminology (CPT) 97755 must comply with the following policies:
- Must have a current prescription/referral for an Assistive Technology Assessment from the member's primary care physician.
- May indicate up to a one (1) year duration.
- May indicate initial/new assessments or follow-up assessment visits.
- Only one active PAR for CPT 97755 is allowed per member, per span of time. Overlapping PARs will be denied.

- Initial PT/OT evaluation services, such as CPT 97001, are not required prior to requesting a PAR for procedure code 97755.
- Procedure code 97755 is separate from PT/OT PARs and is not part of a member's PT/OT benefit limitation.
- PARs for CPT 97755 should be submitted independently from other services. The Medical PAR type should be selected for CPT 97755 in CWQI.

Contact Alex Weichselbaum at Alex.Weichselbaum@state.co.us with questions.

Pharmacy Providers

Short-Acting Opioids (dosing limits) – Effective August 1, 2014

The Department would like to provide clarification on the new short-acting oral opioid policy that was published in the August 2014 Provider Bulletin (B1403355).

The new policy, which became effective August 1, 2014, allows for four (4) tablets per day, which equals 120 tablets in 30 days.
- If a member has a history of opioid use and is currently receiving more than 4 tablets per day, the prescriber may call the Help Desk at 1-800-365-4944 to obtain a six-month prior authorization to allow time to taper down to the maximum quantity allowed of 4 tablets per day.
- If a member has a terminal illness or sickle cell anemia, the prescriber may contact the Help Desk and obtain a lifetime prior authorization.
- If the prescriber believes that the member has a pain diagnosis requiring dosing that exceeds the new limit and cannot be addressed using long-acting opioids, or will not complete a taper within six (6) months, the provider may request to have the PAR escalated to a Department pharmacist for review. The Help Desk will provide a six (6) month prior authorization to allow the member to obtain their medication immediately while the Department is reviewing the request for an extended prior authorization. The prescriber will be notified of the Department's decision.
- Acute Pain: As of August 25, 2014: If a member has an acute pain situation, the pharmacy provider may enter diagnosis code 338.1 on the claim to receive an immediate override. The Department will monitor the utilization of the diagnosis code to assure it is being used appropriately. The pharmacy or prescriber may also still call the Help Desk at 1-800-365-4944 and request a prior authorization for acute pain. Examples of acute pain situations are post-operative surgery (including dental), fractures, shingles, or a car accident; however, this is not an all-inclusive list.

Providers may refer to the "oral opioids- short-acting" section of Appendix P for more information. Appendix P can be found on the Forms web page of the Department's website under Pharmacy.

Pain management resources are also available on the Department website (colorado.gov/hcpf/pain-management-resources)

Frequently Asked Questions	
What is a short-acting opioid?	A short-acting opioid is a type of pain medication that provides pain relief for a few hours per dose. Examples of an opioid are Oxycodone immediate release, Percocet (oxycodone/acetaminophen), Vicodin or Norco (hydrocodone/acetaminophen), Dilaudid (hydromorphone), Demerol (meperidine), morphine immediate release, and Nucynta immediate release.
What is the definition of terminal illness?	Terminal illness is defined as a patient in hospice or palliative care.
What if the client is on a pain contract?	If a member is on a pain contract, they can still fill prescriptions at varying intervals such as weekly, bi-weekly, or even every 28 days. A member may refill an opioid prescription after 85% of the previous prescription has been completed. After the six-month prior authorization expires, the 4 tablets per day limit will apply to members who are on a pain contract.
Is Tramadol included?	Tramadol is not included at this time.
Do long acting opioids count against this limit?	Long acting opioids are not included.
Are buprenorphine products included in this limit?	Buprenorphine products currently have other limits. Details can be found on Appendix P.
Do butalbital-containing products have limits?	Yes, the limits on these products are 6 tablets per day which equate to 180 tablets per month. The limit of 6 tablets per day is different from the opioids because this is the recommended dosing limits for these products. These products were included in the policy because some of the butalbital products contain opioids.

Providers may contact the Department's Pharmacy Benefits Section at 1-303-866-3614 with questions.

New Butalbital-Containing Product Policy

As a reminder, effective August 1, 2014, products containing Butalbital were limited to 180 units per 30 days. For members receiving more than 180 tablets in 30 days, claims will be escalated to the Department for individual review. Please note that if more than one agent is used, the combined total utilization may not exceed 180 units in 30 days.

National Take Back Initiative

On Saturday, September 27, 2014, from 10:00 a.m. to 2:00 p.m., the Drug Enforcement Agency (DEA) will coordinate its 9th National Take Back Initiative. This program is focused on providing convenient locations across the nation for the public to drop off excess, unused, and expired controlled-substance and other medication from our nation's medicine cabinets. The State is collaborating with state and local law enforcement agencies to host the sites.

Drug Enforcement Agency staff will provide collection bags and posters, help coordinate the pick-up of drugs obtained on the collection day, and adequately dispose of all medication.

This event occurs twice per year in April and September. For locations, future events, and additional information, providers and members may visit the DEA's webpage concerning the National Take-Back Initiative.

Preferred Drug List (PDL) Update

Effective October 1, 2014, the preferred medications in the following categories are:

- All Hepatitis C agents will require prior authorization. There will not be a preferred product in this category.
- The Oral Anticoagulants: Warfarin. If a member fails Warfarin, the new preferred step-through oral anticoagulant will be Xarelto.
- Bisphosphonate: alendronate tablets.
- Biguanide: Metformin and Metformin extended release.
- The Hypoglycemic combinations will continue to be non-preferred.
- The Meglitinide products will continue to be non-preferred.
- For the newer diabetic agents the classes will be differentiated but still require the trial of Metformin prior to approval. The dipeptidyl peptidase-4 (DPP-4) enzyme inhibitor preferred product will be Tradjenta, the sodium-glucose cotransporter 2 (SGLT2) inhibitors will not have a preferred product, the glucagon-like peptide-1 (GLP-1) receptor agonist preferred product will be Byetta, and the Amylin category will remain non-preferred.
- Thiazolidinedione: Pioglitazone.
- Erythropoiesis stimulating agents: Procrit.
- Overactive bladder: Oxybutynin tablets, Oxybutynin ER tablets, and Toviaz.
- Stimulants and ADHD: brand name products: Adderall XR, Adderall immediate release, Focalin immediate release, Focalin XR, Ritalin immediate release, Ritalin SR, Strattera, Vyvanse and Intuniv. Generic Concerta will also be preferred.
- The current PDL can found on the Department's website (colorado.gov/hcpf/provider-forms) under Pharmacy.

Pharmacy and Therapeutics (P&T) meeting

Tuesday, October 7, 2014
1:00 p.m. – 5:00 p.m.
Anschutz Medical Campus
12850 East Montview Boulevard
Aurora, CO 80045
The meeting will be held in the Education Building #2 South, Room 1102.

September and October 2014 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 & Workshops 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.

September 2014

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
7	8	9 Beginning Billing – CO -1500 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM	10 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	11 ***WebEx –** Provider Enrollment 9:00 AM-11:00 AM Pharmacy 1:00 PM-2:00 PM ***WebEx –** IP/OP 1:00 PM-3:00 PM	12 **All *WebEx –** Beginning Billing – CO -1500 9:00 AM-11:30 AM Web Portal 837P 11:45 AM-12:30 PM	13
14	15	16 **All *WebEx –** Beginning Billing – CMS -1500- Waiver 9:00 AM-11:00 AM Beginning Billing – CMS -1500 1:00 PM-3:00 PM	17 Beginning Billing – CMS -1500- Waiver 9:00 AM-11:00 AM	18 Beginning Billing – CMS -1500 9:00 AM-11:00 AM	19	20

October 2014

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
5	6	7 Beginning Billing – CO -1500 9:00 AM-11:30 AM Web Portal 11:45 AM-12:30 PM Vision 1:00 PM-3:00 PM	8 Beginning Billing – UB-04 9:00 AM-11:30 AM Web Portal 11:45 AM-12:30 PM Nursing Facility 1:00 PM-3:00 PM	9 Web Portal 11:45 AM-12:30 PM	10 Beginning Billing – Waiver 9:00 AM-11:30 AM Web Portal 11:45 AM-12:30 PM Practitioner 1:00 PM-3:00 PM	11
12	13	14 Beginning Billing – CMS 1500 9:00 AM-11:30 AM Beginning Billing – CO -1500 1:00 PM-3:00 PM	15 Beginning Billing – CMS 1500 9:00 AM-11:30 AM	16 Beginning Billing – CMS 1500 9:00 AM-11:30 AM	17	18

Reservations are required for all workshops

Email reservations to:
workshop.reservations@xerox.com
Leave the following information:

- Colorado Medical Assistance Program provider billing number
- The date and time of the workshop

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

- 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.

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/hcpf for the most recent information.