COLORADO
Department of Health Care Policy & Financing

Provider Bulletin

Reference: B1500367 **June 2015**

colorado.gov/hcpf

In this issue:

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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

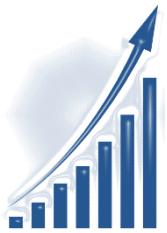
Did you know…?

The Department of Health Care Policy and Financing has received legislative approval for targeted rate increases effective on July 1, 2015 for fiscal year 2016. The fee schedule is being updated to reflect the increase. Please reference the Fact Sheet and FAQs for more information.

All Providers

Medicaid Provider Rate Increases Effective July 1, 2015

Medicaid provider rate increases were approved during the 2015-2016 legislative session and are effective for dates of service on or after July 1, 2015. All rates require approval from the Centers for Medicare and Medicaid Services (CMS). The Department of Health Care Policy and Financing (the Department) is working to attain approval from CMS in order to implement the rates on July 1, 2015. Some providers will be paid retroactively if there is a delay in implementation. Other rate increases will be implemented when approved.



The fee schedule is located within the Medicaid Fee Schedules section of the Provider Rates & Fee Schedule web page and is being updated to reflect the approved 0.5% rate increase:

- Eligible physician and clinic services
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services
- Emergency transportation services (EMT)
- Non-emergent medical transportation services (NEMT)
- Inpatient hospital services
- Outpatient hospital services
- Laboratory & x-ray services
- Durable Medical Equipment (DME), supplies, and prosthetics
- Mental health fee-for-service
- Non-physician practitioner services
- Tobacco cessation counseling for pregnant women
- Ambulatory Surgery Center services (ASC)

- Dialysis center services
- Audiology services
- Physical, occupational, and speech therapy services
- Screening, Brief Intervention, and Referral to Treatment (SBIRT) services
- Dental services
- Freestanding Birth Centers
- Family planning services
- Outpatient substance use disorder services
- Targeted case management for behavioral health
- Targeted case management for substance use disorders
- Vision services
- Mental health and substance abuse disorder rehabilitation services for children in psychiatric residential treatment facilities
- Prosthesis services
- Residential Child Care Facility (RCCF) services
- Extended services for pregnant women
- Drugs administered in the office setting including vaccine administration
- Private duty nursing (PDN)
- Home Health (HH)
- Hospice Fee for Service
- Home and Community Based Services (HCBS) waivers:
    - Home and Community Based Services - Brain Injury (BI)
    - Home and Community Based Services - Community Mental Health Supports (CMHS)
    - Home and Community Based Services - Elderly, Blind, and Disabled (EBD)
    - Home and Community Based Services - Consumer Directed Attendant Support (CDASS)
    - Home and Community Based Services - Children's Waiver
    - Home and Community Based Services - Children with Life Limiting Illnesses (CLLI)
    - Colorado Choice Transition Qualified Services (EBD, CMHS, BI)

The rates for services provided under the HCBS waivers operated by the Division for Intellectual Developmental Disabilities (DIDD) will increase by 1.7% for the services noted below, with dates of service beginning July 1, 2015:

- Home and Community Based Services - Developmental Disabilities (DD)
- Home and Community Based Services - Supported Living Services (SLS)
- Home and Community Based Services - Children Extensive Support (CES)
- Home and Community Based Services - Children Residential Habilitation Program (CHRP)
- Colorado Choice Transition Qualified Services (SLS)

Exclusions for the Legislative Across-the-Board Increases:

Although these rate increases will affect most Medicaid providers, a number of providers are exempted from the across-the-board increases. Additional details regarding these exclusions can be found in the Department's R-12: Community and Targeted Provider Rate Increase submitted to the Legislature on November 1, 2014.

Exclusions Include:

- Skilled nursing facility services
- Public Health Agencies
- Federally Qualified Health Centers (FQHC)
- Home and Community Based Services (HCBS) EBD, CMHS, BI, and Spinal Cord Injury (SCI) Personal Care Services
- Home and Community Based Services EBD, CMHS, BI, and SCI Homemaker Services
- Home and Community Based Services EBD, BI, and SCI In-Home Respite Services
- Home and Community Based Services EBD, CMHS, BI, and SCI Consumer Directed Attendant Support Services (CDASS) Personal Care and Homemaker services
- Home and Community Based Services EBD and SCI IHSS Personal Care and Homemaker services
- Home and Community Based Services Children with Autism (CWA) waiver
- Private duty nursing registered nurse hourly rate
- Early and Periodic Screening, Diagnosis, and Treatment services previously impacted by Section 1202 of the Affordable Care Act
- Contract based administrative payments including Dental Administrative Services Organization (ASO), NEMT ASO, and CDASS FMS and Training vendors
- Pharmacy reimbursement
- Rural health centers
- The Program of All-Inclusive Care for the Elderly (PACE)
- Risk-based physical health managed care programs (Denver Health and Rocky Mountain Health Plans)
- Risk-based mental health managed care programs (Behavioral Health Organizations)
- Hospice rates (room and board component of rates only)

General Information

Mass adjustments made by the Department can only be performed 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 revised 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 forthcoming. Please refer to the Department web page or Billing Manuals section for the appropriate rate and fee schedule.

Please contact Colin Laughlin at Colin.Laughlin@state.co.us for Home and Community Based Service Waivers.

Please contact Tess Ellis at Teressa.Ellis@state.co.us for all other services.

Provider Revalidation and Enrollment Update

What is provider revalidation and enrollment?

The revalidation process is **required** for providers who want to continue (or begin) providing services to Medicaid and CHP+ members after **September 15, 2015**. The revalidation process will include a licensure and federal database check for all providers. For some providers, based on Centers for Medicare and Medicaid Services (CMS) risk designation, the process may also include a criminal background check, fingerprinting, and unannounced site visits (including pre-enrollment site visits). More information on the provider-screening rule is available on the Department's Provider Implementations web page under the Federal Provider Screening Regulations tab.

Application Fee and Exemptions

The Centers for Medicare and Medicaid Services also requires a revalidation and enrollment application fee of approximately $550 from institutional providers. Visit the application fees and exemptions Frequently Asked Questions (FAQ) for the CMS definition of an 'institutional provider'.

Many providers are exempt from the fee. In addition to the exceptions noted in the May 2015 Provider Bulletin (B1500366) and on the Provider Resources web page, providers may request an exemption through a hardship request. For more information please see the Hardship FAQs located on our Provider Resources web page.

What you can do now to prepare?

- Obtain your National Provider Identifier (NPI).
  - If you do not have an NPI, you may acquire one through the National Plan & Provider Enumeration System (NPPES) website.
- Gather documentation needed for enrollment.
  - A general Provider Enrollment checklist is available on our Provider Resources web page.
- Make electronic copies of your certifications and licensures.

Visit the Provider Resources web page frequently for updates and more details.

New Medicaid ID Cards Coming

New Medicaid ID Cards in July

Some changes are being made to Medicaid ID cards issued after July 1, 2015. New cards will look very similar to the current cards, but will be made out of sturdy paper stock and will no longer contain a magnetic strip.

Current Medicaid ID cards are still valid; Medicaid members do not need to request new cards

As a reminder, Medicaid members are only required to furnish their photo ID at appointments. Medicaid ID cards are not required to receive services. Providers should verify member identity and eligibility at each appointment. For additional information on how to verify member eligibility, see pages 22–24 of the General Provider Information Billing Manual.

Anesthesiologist Assistant Participation and Billing in Colorado Medicaid

The Colorado Medical Board recognized Anesthesiologist Assistants as licensed practitioners in 2013. For Colorado Medicaid, services provided by an Anesthesiologist Assistant are reimbursable by using the Medicaid Identification Number of the supervising physician as the rendering provider on the claim, when the supervising physician is immediately available and onsite.

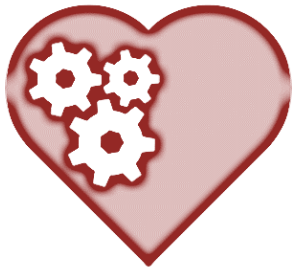
At present time, Anesthesiologist Assistants are not able to enroll in Colorado Medicaid as a provider type, and all services must be submitted under the supervising physician's identification number.

Please contact Richard Delaney at Richard.Delaney@state.co.us or 303-866-3436 with questions regarding services provided by an Anesthesiologist Assistant.

ColoradoPAR Program Retroactive Prior Authorization Request (PAR) Process Per Category

Diagnostic Imaging:

- The PAR date range requested may be up to 90 calendar days
- Retroactive PARs are not accepted*
- If during the course of the exam the Provider needs to update the code(s), they have two (2) business days to submit a PAR Revision
- Current Procedural Terminology (CPT)/Procedure Codes Only



Transplants**:

- The PAR date range requested may be up to one (1) year
- Retroactive PARs are not accepted*
- Prior Authorization type is Inpatient Diagnosis Related Group (DRG)
- ICD-9 Codes Only

Surgical Services:

- The PAR date range requested may be up to 90 calendar days
- Retroactive PARs are not accepted*
- Current Procedural Terminology/Procedure Codes Only

Long-Term Home Health:

- The PAR date range requested may be up to one (1) year
- Retroactive PARs are allowed for up to 10 business days*
- Revenue Codes Only

Out-of-State (OOS) Inpatient Stays:

- The PAR date range is the length of inpatient stay for the member (admission-discharge date)
- Retroactive PARs are not accepted*
- Prior Authorization Type is done as OOS Inpatient/Outpatient
- ICD-9 Codes Only

Durable Medical Equipment (DME):

- The PAR date range requested may be up to one (1) year
- Retroactive PARs are allowed for up to 90 calendar days*
- Current Procedural Terminology/HCPC Codes Only

Physical and Occupational Therapy:

- The PAR date range requested may be up to one (1) year
- Retroactive PARs are allowed for up to two (2) business days*
- Prior Authorizations must include a plan of care and a current prescription
- Modifiers required: GP for PT, GO for OT, and GP/GO+TL for Early Intervention therapies, GP/GO + HB for Habilitative therapy (only available for Expansion members)
- Current Procedural Terminology/Procedure Codes Only

Exceptions:

- * Services delivered without prior authorization shall not be reimbursed except for provisions of services during an emergency pursuant to 10 CCR 2505-10, Section 8.058.4.
- * Provider and/or member eligibility concerns that prevented a timely PAR may also qualify for an exception.
- * Exceptions must be requested by the provider. Utilization Management (UM) vendor must seek State approval for these circumstances. Exceptions will only be granted with Department approval on a case by case basis.
- ** Transplants performed in the state of Colorado that require a PAR include heart, lung, liver, and bone marrow.

ColoradoPAR New Vendor Notification

eQHealth Solutions was selected by the Department of Health Care Policy and Financing to provide utilization management services for the ColoradoPAR Program **beginning September 1, 2015**. Together, eQHealth and HCPF will serve Medicaid members by focusing on and implementing the Department's mission to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.

The current provider portal used to submit online PARs will be modernized to provide additional features and clarity for providers.

In the coming months, please look for additional information regarding this transition in Provider Bulletins, the current provider portal (CareWebQI), on ColoradoPAR.com, and on the Department's ColoradoPAR Program website. Additionally, face-to-face training, webinars, and provider outreach campaigns are planned to assist providers and staff in submitting PARs on the new portal starting September 1, 2015.

PEAK*Health* Mobile App for Medicaid & CHP+ Clients

The Department has launched the new PEAK*Health* mobile app. PEAK*Health* gives Medicaid and Child Health Plan *Plus* (CHP+) members a simple way to keep information up-to-date and access important health information right from their phones.

PEAK*Health* is for **current** Medicaid and CHP+ members who have a Colorado.gov/PEAK account. Medicaid and CHP+ members can create a PEAK Account at any time on Colorado.gov/PEAK. PEAK*Health* is **not** for people who want to **apply** for benefits.

PEAK*Health* will help Medicaid and CHP+ members to search for a provider, view medical cards, update income and contact information, view benefit information, make a payment, and access health and wellness resources.

As a reminder, Medicaid members are only required to furnish their photo ID at appointments. Medicaid ID cards are not required to receive services. Providers should verify member identity and eligibility at each appointment. For additional information on how to verify member eligibility, see pages 22-24 of the General Provider Information Billing Manual.

PEAK*Health* can be downloaded at the Apple iTunes Store or Android/Google Play App Store for free. For more information on the PEAK*Health* mobile app, check out our Partner Resource Page at Colorado.gov/HCPF/PEAKHealth-Stakeholders and view this video tour.

Independence Day Holiday

Due to the Independence Day holiday on Saturday, July 4, 2015, State offices, DentaQuest, the Department's fiscal agent, and the ColoradoPAR Program offices will be closed on Friday, July 3, 2015. The receipt of warrants and Electronic Funds Transfers (EFTs) may potentially be delayed due to processing at the United State Postal Service (USPS) or providers' individual banks.

Dental Providers

Dental Program – 2015 Legislative Session Update

The Protective Restorations by Dental Hygienists bill (HB15-1309), which was sponsored by Rep. Ginal and Sen. Crowder, passed through the Legislature and was sent to the Governor for his signature during the closing days of the 2015 session. The bill allows a dental hygienist to apply to the Colorado Dental Board for a permit to place interim therapeutic restorations (ITRs) on children and protective restorations on adults. A dental hygienist who meets the following requirements is eligible to receive a permit to place ITRs and protective restorations:

- He or she holds a license in good standing to practice dental hygiene.
- He or she carries professional liability insurance.
- He or she completes the required hours of dental hygiene practice.
- He or she completes a board-approved course based on uniform standards developed by an ITR advisory committee.

To the extent that state Medicaid or Children's Basic Health Plan (CHP+) reimbursement is available for the placement of ITRs and protective restorations, the reimbursement will extend

to services provided via telehealth in connection with the placement of an ITR and/or protective restoration. The bill also establishes the interim therapeutic restorations advisory committee to develop uniform standards for training dental hygienists to place ITRs and protective restorations.

Dental Program – Rate Increases Coming July 1, 2015

Effective July 1, 2015, an across-the-board rate increase and targeted rate increases were approved for the Colorado Medicaid dental fee schedule by the Legislature and signed by the Governor as part of the 2015-2016 state budget process. The dental program will publish a ***draft*** Medicaid dental fee schedule in early June 2015 on the DentaQuest Colorado Provider website.

The dental program must get federal approval from CMS before it can implement the dental rate increases on the dental fee schedule. The Department cannot guarantee that it will have the federal approval necessary to begin reimbursing dental providers at the newly increased rates on July 1, 2015; however, if federal approval is not received by the Department by the July 1, 2015 effective date, the dental program will apply the increase retroactively. Therefore, the dental program encourages dental providers to check their billing procedures to ensure they are billing at their Usual and Customary Rates (UCR), or at minimum, using the increased rates on the draft dental fee schedule for all services rendered on or after July 1, 2015. Billing at or above the increased rates will enable DentaQuest to retroactively apply the increases to pay the providers accordingly without any additional action required on the part of the provider.

The 0.5% across-the-board increase will be applied in addition to the targeted rate increases. The targeted rate increases include increases in reimbursement for dental intra-oral complete mouth series radiographs (i.e., full mouth series x-rays), dental sealants for children, certain amalgam and resin-based composite fillings, as well as various extraction and surgical extraction procedures. Specific services included in the targeted rate increases for dental procedures will be outlined in detail and by code in the draft dental fee schedule. The draft dental fee schedule will reflect both the across the board increase and the targeted rate increases effective on July 1, 2015.

Please contact DentaQuest Provider Services at 855-225-1731 for more information.

Durable Medical Equipment (DME), Prosthetics, Orthotics and Supplies (DMEPOS) Providers

Billing Manual Updates

- Complex Rehabilitation Technology (CRT) code section: The Specialty Eval grid was updated to remove the Specialty Eval requirement from codes **E1231** through **E1238**. Additionally, since no CRT repair requires a Specialty Eval, the Repair column was removed.
- Modifiers '22' and '52' have been removed as billable modifiers. Per National Correct Coding Initiative's (NCCI's) correct billing methodologies, numeric modifiers should not be used with alpha-numeric HCPCS. These modifiers were initially introduced to the DME codes as a way to track utilization and did not affect the reimbursement rate.

Reminders:

- Shipping charges are not a covered DME benefit and should not be billed under **A9901**.
- References to proper, correct, or appropriate HCPCS coding is referring to NCCI and/or Pricing, Data Analysis, and Coding (PDAC), Medicare's Pricing, Data Analysis, and Coding contractor. If the product you are providing has been coded by the PDAC, unless specifically noted otherwise in the DME Billing Manual, the PDAC code(s) should be used. For more information on NCCI and PDAC, please visit their websites.

Helpful Hint: Use **A9901** with the 'UB' modifier on claims with codes that are manually priced by invoice (actual acquisition cost). This will allow the line items to be paid at 17.26% above their invoice price.

Example:

Line	Code	Modifier	Charge	Reimbursement
1	K0004		$750.00	$750.00
2	K0108	UB	$100.00	$100.00
3	A9901	UB	$17.26	$17.26

***Actual acquisition cost (Invoice) of K0108 is $100**

Transportation Providers

Non-Emergent Medical Transportation: Hospital to Inpatient Facility Transfers

Non-Emergent Medical Transportation is not procedurally designed to assist hospitals with same day transportation to another inpatient facility where the use of an ambulance is required. However, to address this specific need, the Department is allowing ambulance companies to bill Colorado Medicaid through fee-for-service, and the discharge team should direct the ambulance company to bill Colorado Medicaid directly for the trip. All ambulance companies are set up to bill Medicaid for both emergency and non-emergent transportation codes.

Please contact Doug van Hee at Doug.vanHee@state.co.us or 303-866-4986 with questions.

Transportation Billing Manual Update

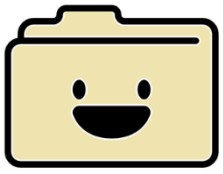
The Transportation Billing Manual has been updated. Significant changes include:

- The elimination of prior authorization requirements (PAR) for Non-Emergent Medical Transportation (NEMT). The one (1) exception is over-the-cap, which should be rarely, if ever, used and will require state approval and additional documentation.
- A new pre-approval process for all Non-Emergent Medical Transportation air transportation.
- Clarification on out-of-state transportation.
- New requirements for child escorts.

Please contact Doug van Hee at Doug.vanHee@state.co.us or 303-866-4986 with questions.

Pharmacy Providers

Pharmacy Audits



Reminder: Pharmacy providers must maintain records that indicate whether drug therapy counseling was not, or could not, be provided to a Medicaid member (10 CCR 2505-10, section 8.800.9B). Pursuant to state and/or federal audits, providers must furnish information about submitted claims, including records on drug therapy counseling, upon request (10 CCR 2505-10, section 8.076.2.D). Any claims where the requested documentation is not received is considered an overpayment subject to recovery, regardless of whether the goods or services have been provided (10 CCR 2505-10, section 8.076.2.G).

Tobacco Cessation

Effective July 1, 2015, the Department has made adjustments to the policy regarding Tobacco Cessation products. The changes are seen below in bold.

"Medicaid will cover only one (1) tobacco cessation product at one (1) time, **except in the case of the Nicotine Replacement Therapy (NRT) Patch and NRT gum/lozenge co-administration.**

Member must receive a prescription (provider must be a Medicaid enrolled provider) and a PAR (the Department), **except for the first fill of NRT gum/lozenge**."

New Global Prior Authorization Form

Effective July 1, 2015, a new Global Prior Authorization Form and criteria will be used. The form and criteria are posted on the Forms section of the Department's website. The form must be fully completed prior to review.

July Preferred Drug List (PDL) Announcement

Effective July 1, 2015, the preferred medications in the following categories are:

Testosterone products will require a PAR; however, the preferred products will be Androgel 1.62%, Androderm, and brand or generic Depo-Testosterone.

Newer generation antihistamines and combination preferred products will be cetirizine and loratadine. All combination products will require a PAR.

Angiotensin Receptor blockers preferred products will be irbesartan, Benicar, Diovan, and losartan. Combination preferred products will be Benicar-HCT, Diovan-HCT, and losartan/HCTZ.

Fibromyalgia agent preferred products will be Lyrica and duloxetine (generic Cymbalta).

Long Acting Oral Opioid preferred products will be methadone, morphine sulfate ER, fentanyl patches, and tramadol ER. If a member has tried and failed ONE (1) of these preferred products, he or she may request a PAR for Butrans patches. To view criteria for all other products, please refer to the PDL in the Pharmacy section of the Department's Forms website.

Inhaled anticholinergics and combinations preferred products will be albuterol/ipratropium, ipratropium, Atrovent HFA, Combivent Respimat, and Spiriva Handihaler.

Inhaled beta 2 agonist preferred products will be albuterol solutions and Proair HFA inhaler.

Long acting inhaled beta 2 agonists will not have a preferred product.

Inhaled corticosteroids preferred products will be budesonide nebules, Asmanex twist, Flovent HFA and diskus, and QVAR. Combination preferred products are Advair HFA and diskus and Dulera.

Skeletal muscle relaxant preferred products will be baclofen, cyclobenzaprine, and tizanidine.

Topical immunomodulators will still require a PAR but the preferred product will be Elidel.

Please refer to the Pharmacy section of the Forms website for additional coverage information for these products.

Pharmacy and Therapeutics (P&T) Meeting

Tuesday, July 7th, 2015

1:00 p.m. - 5:00 p.m.

303 E 17th Street

11th floor conference room

Testosterone Criteria:

This is a new addition to testosterone criteria on the preferred drug list (pdl):

Grandfathering: Members may be grandfathered on preferred agents without requirement of updated low serum testosterone laboratory testing that meet the following criteria:

- Male member at least 18 years of age AND
- Has at least one (1) past documented low serum testosterone levels below the lower limit of normal range for testing laboratory prior to initiation of therapy AND
- Has documented diagnosis of hypogonadotropic or primary hypogonadism AND
- Does not have a diagnosis of breast or prostate cancer AND
- Does not have a palpable prostate nodule or prostate-specific antigen (PSA) > 4ng/mL

June and July 2015 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.

Class descriptions and workshop calendars are also posted in the Provider 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.

June 2015

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
7	8	9 CMS 1500 9:00AM-11:30AM Web Portal 837P 11:45AM-12:30PM ***WebEx*** Vision 1:00PM-3:00PM	10 ***All Classes WebEx*** UB-04 9:00AM-11:30AM Web Portal 837I 11:45AM-12:30PM IP/OP 1:00PM-3:00PM	11 Home Health 9:00AM-11:00AM ***WebEx*** Nursing Facility 1:00PM-3:00PM	12 ***All Classes WebEx*** Dialysis 1:00PM-3:00PM	13

July 2015

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
12	13	14 CMS 1500 9:00AM-11:30AM Web Portal 837P 11:45AM-12:30PM ***WebEx*** Audiology 1:00PM-3:00PM	15 UB-04 9:00AM-11:30AM Web Portal 837I 11:45AM-12:30PM ***WebEx*** FQHC 1:00PM-3:00PM	16 ***All Classes WebEx*** Waiver 9:00AM-11:30AM Billing Portal 837P 11:45AM-12:30PM Billing Portal 837P 3:45PM-4:30PM	17 ***All Classes WebEx*** CMS 1500 9:00AM-11:30AM Billing Portal 837P 11:45AM-12:30PM Transportation 1:00PM-3:00PM	18

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.

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: 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.

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