COLORADO
Department of Health Care Policy & Financing

Provider Bulletin

Reference: B1500371 **September 2015**

colorado.gov/hcpf

In this issue:

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

Contacts

Billing and Bulletin Questions
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...?
A Medicaid member has multiple ways to access their Medicaid ID card and/or request a replacement. For more information, please reference the article below.

All Providers

ColoradoPAR New Vendor Notification

On September 1, 2015, eQHealth Solutions began work as the Department of Health Care Policy and Financing's (the Department) third party utilization management vendor. eQHealth Solutions will review and authorize prior authorization requests (PARs) for the ColoradoPAR Program.

The ColoradoPAR Program reviews PARs for the following categories of services and supplies:

- Audiology
- Diagnostic imaging
- Durable Medical Equipment (DME)
- Inpatient out-of-state admissions
- Medical services, including transplant and bariatric surgery
- Physical & Occupational Therapy
- Pediatric Long Term Home Health (LTHH)
- Private Duty Nursing
- Synagis®
- Vision

Please note: For the above categories, all PARs for members age 20 and under are reviewed according to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) guidelines.

ColoradoPAR's New Provider Portal: eQSuite®

eQSuite® is eQHealth Solutions' proprietary, web-based, HIPAA-compliant PAR system, which offers providers 24/7 access to information and functions providers need.

eQSuite® Webinars

eQHealth Solutions is currently offering general and customized webinar trainings. Providers must register for the trainings at eQSuite® trainings or ColoradoPAR.com. Webinars for each PAR type have been recorded for providers who are unable to attend a live webinar and are available for review at any time at ColoradoPAR.com.

Providers must **complete** and **submit** a request for eQSuite® Access form prior to utilizing eQSuite®. A logon must be assigned and a system administrator designated for each individual provider Medicaid number. The system administrator assigns and maintains logons for all eQSuite® users assigned to enter PARs under a specific Medicaid number. The access form can be found at the eQHealth Solution ColoradoPAR Program provider website, under the Provider Resources menu, and by clicking on Forms and Instructions.

Important Prior Authorization Request Dates

Providers should follow the PAR submission guidelines below:

- All new PAR requests must be submitted to eQSuite® as of September 1, 2015. **CareWebQI is no longer available for PAR entry**.
- All requests for PAR Revisions for PARs approved prior to September 1, 2015 must be resubmitted as a new PAR in eQSuite®.
- Ordering providers who disagree with an adverse PAR determination made prior to September 1, 2015 may submit a new PAR request into eQSuite®.
- In order to better facilitate the transition between PAR vendors, the Department's Retroactive PAR Policy will be waived from September 1, 2015 to October 31, 2015. Providers must again adhere to the Retroactive PAR Policy beginning November 1, 2015. A copy of the policy can be found at ColoradoPAR.com.

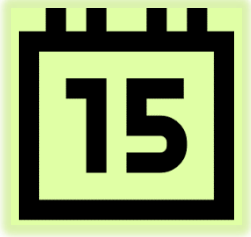
Please take note of the **NEW** contact information for the ColoradoPAR program:

ColoradoPAR Provider Line
eQHealth Solutions Customer Service
888-801-9355 (toll free phone)

ColoradoPAR Provider Fax
eQHealth Solutions Fax Line
866-940-4288 (toll free fax)

Additional information and ongoing updates can be found on ColoradoPAR.com, the Department's website, or the eQHealth Solution ColoradoPAR Program provider website.

Colorado Medicaid and CHP+ Provider Revalidation & Enrollment Begins September 15, 2015



New **federal regulations** established by the Centers for Medicare and Medicaid Services (CMS) require enhanced screening and revalidation for all Medicare, Medicaid, and CHP+ providers.

Beginning September 15, 2015, all Colorado providers who want to continue, or begin, providing services to Medicaid and CHP+ members after March 31, 2016, will be required to be validated and enrolled under new

federal enrollment screening criteria. To meet these new requirements, as well as to ensure enrollment in the new claims processing system, Colorado providers must revalidate using the new Online Provider Enrollment (OPE) tool. Although the new OPE tool will launch in September 2015, Colorado Medicaid asks that providers complete your revalidation during your assigned revalidation and enrollment wave.

Based on the CMS provider type and risk designation, the revalidation process may include a criminal background check, fingerprinting, and unannounced site visits – including pre-enrollment site visits for some providers. Visit our provider resources page for information specific to your provider type and information specific to the Home and Community Based Services (HCBS) provided (if applicable). **Providers who fail to revalidate and enroll by March 31, 2016 may have their claims suspended or denied.**

Revalidation & Enrollment Training Announcement

Enrollment Application Training Available

Online self-paced training for the new Colorado Online Provider Enrollment (OPE) tool is now available.

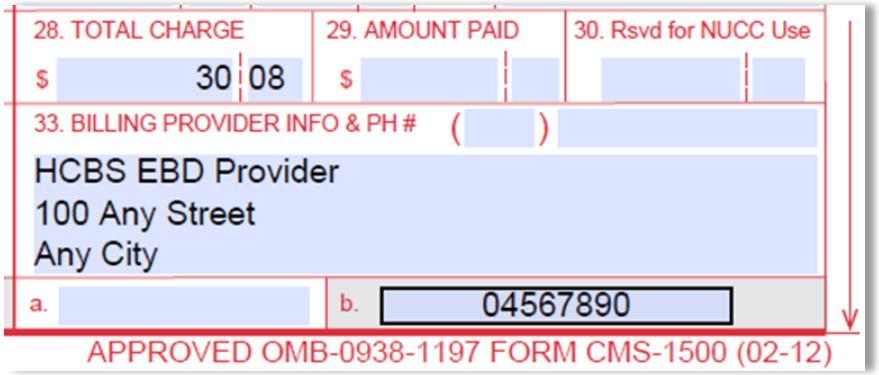
Who: All interested providers
When: Modules available online anytime beginning September 4, 2015
Where: Online via eLearning modules
Please visit the Provider Resources page to register!

Reminder: Medicaid Billing Provider ID on CMS 1500 Paper Claim Forms

When submitting CMS 1500 paper claims, it is required for providers to use their eight (8)-digit Colorado Medical Assistance Program provider number. The Medicaid provider number is different from a national provider identification (NPI) number.

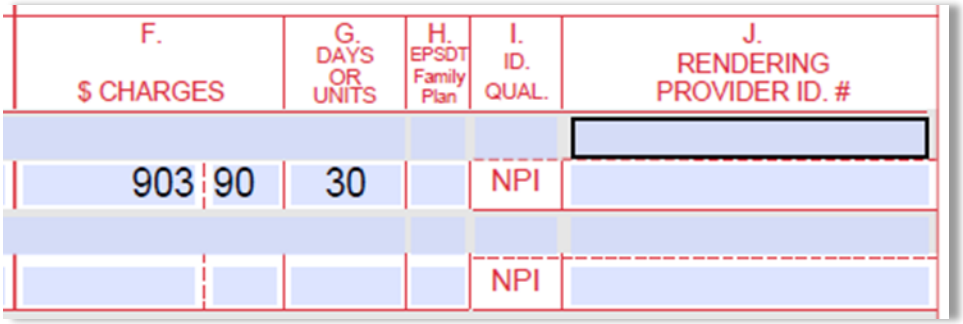
The Medicaid billing ID is required in order to process submitted claims in the current Medicaid Management Information System (MMIS). This includes claims submitted by a third party (e.g. clearinghouse).

- Field 33B – Billing Provider Number



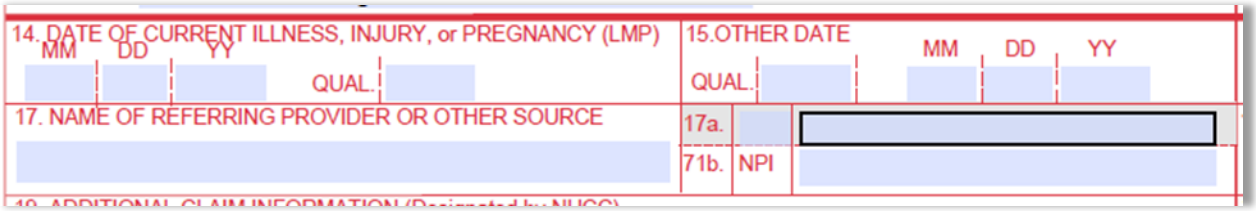
When using the rendering provider, please use the eight (8)-digit Medicaid ID in the following field:

- Field 24J – Rendering Provider Number



When using the referring provider, please use the eight (8)-digit Medicaid ID in the following field:

- Field 17A – Referring Provider Number



Note: If the NPI is the only provider ID used, the paper claim will not be processed and will be returned to the provider.

International Classification of Diseases, 10th Revision (ICD-10) Update

Final Rule: October 1, 2015 - Transition Date to ICD-10

On June 6, 2014, U.S. Department of Health and Human Services (HHS) issued a rule finalizing October 1, 2015 as the new compliance deadline for health care providers, health plans, and health care clearinghouses to transition to ICD-10.

Current Activities: Update Billing Manuals, CMS Compliance

The Department is in the process of updating billing manuals that contain ICD-9 diagnosis codes and replacing that information with corresponding ICD-10 codes. The updated billing manuals will be available by September 8, 2015. The Department completed user acceptance testing (UAT) on June 17, 2015 and would like to thank all providers, state medical agencies, and clearinghouses that participated with the Department in ICD-10 testing.

End-to-End Testing: Critical Success Factors

As of September 2014, the Department is required to meet five (5) critical success factors outlined by CMS in order to complete end-to-end testing as part of meeting the October 1, 2015 deadline.

Any further information can be found in the ICD-10 section of the Provider Implementations website or the external provider websites listed in the "Resources, Guidance and Tools" section below.

Listed below are the critical success factors outlined by CMS:

- Acceptance of ICD-10 electronic claims
- Accurate adjudication of claims and payments
- Payment (processing of 835's) and reimbursements
- Coordination of Benefits (COB)
- Submission of enhanced beneficiary, provider, claims, and encounter data via Transformed Medicaid Statistical Information System (T-MSIS)

External end-to-end testing has confirmed that the Department's systems are integrated, operable, and ready to accept the new ICD-10 codes and formats on October 1, 2015.

Appendix R – Provider Claim Report Messages Update

There are a few Denial/Error code descriptions relating to ICD-9 that will change due to the implementation of ICD-10 on October 1, 2015. These new code descriptions will be captured in an updated version of Appendix R.

Verify the correct Date of Service or Date of Discharge to determine which code is in error.

Resources, Guidance and Tools

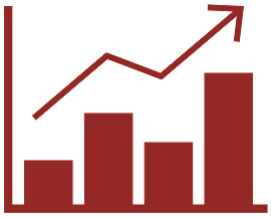
CMS ICD-10 Provider Readiness Letter
CMS ICD-10 Email Updates
Countdown to ICD-10 National Implementation Update

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

Please contact Sean Gagnon at Sean.Gagnon@state.co.us or 303-866-3467, or Shawna Tye at Shawna.Tye@state.co.us or 303-866-2347 with questions regarding the ICD-10 implementation project.

Medicaid Provider Rate Increase Update

Medicaid provider rate increases were approved during the 2015-2016 legislative session and are effective for dates of service beginning July 1, 2015. All rates require approval from CMS. The Department has worked to obtain approval from CMS to implement the rates with an effective date of July 1, 2015. Some providers will be paid retroactively if there has been a delay in implementation, and other rate increases will be implemented when approved and loaded into the Department's Medicaid Management Information System (MMIS). Please see the FY 15-16 Rate Increase Fact Sheet and Frequently Asked Questions on the Department's Provider Implementations website for monthly updates within the Targeted Rate Increases section.



The fee schedule is located on the Provider Rates & Fee Schedule website in the Medicaid Fee Schedules section and is being updated to reflect the approved 0.5% rate increase.

Approved increases:

- 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 and 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
- Physical, occupational, and speech therapy services
- Audiology 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 RN services
- Home Health
- Hospice fee-for-service
- Home and Community Based Services waivers:
    - HCBS - Brain Injury (BI)
    - HCBS - Community Mental Health Supports (CMHS)
    - HCBS - Elderly, Blind, and Disabled (EBD)
    - HCBS - Consumer Directed Attendant Support (CDASS)
    - HCBS - Children's Waiver
    - HCBS - Children with Life Limiting Illnesses (CLLI)
    - Colorado Choice Transition (CCT) Qualified Services (EBD, CMHS, BI)

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

- HCBS - Developmental Disabilities (DD)

- HCBS - Supported Living Services (SLS)
- HCBS - Children Extensive Support (CES)
- HCBS - Children Habilitation Residential 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" request submitted to the Legislature on November 1, 2014.

Exclusions Include:

- Skilled Nursing Facility Services
- Public Health Agencies
- Federally Qualified Health Centers
- Home and Community Based Services 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 and SCI In-Home Support Services (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 Financial Management Services Organization (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 will be forthcoming. Please refer to the Department's website on the Provider Services page or the Billing Manuals section for the appropriate rate and fee schedule.

Obtaining or Replacing Medicaid ID Cards

Once an application is approved, Medicaid members are automatically sent a hard copy of their Medicaid ID card via the US Postal Service. This initial Medicaid ID card can take up to two (2) weeks and is sent to the member's address on file with the Colorado Benefits Management System (CBMS), the state's eligibility system. Members can also get an electronic version of their card **immediately** after being approved by:

- Downloading the **PEAK*Health*** mobile app and getting an electronic version of the card. The card in PEAK*Health* is a real-time feed from CBMS, so members will know by looking at their card if they are "Active" or "Inactive." Members can then use the electronic ID card at a provider's office. The card can be accessed at any time which means there is no need for members to wait for their card to come in the mail.
- Going online to **Colorado.gov/PEAK**, and viewing and/or printing a PDF version of the card. This can be done at any time which means there is no need for members to wait for their card to come in the mail.

It is a best practice to always verify the member's mailing address before requesting a new card be mailed. If members need to order a **replacement card**, they can get it in any of the ways below:

- Members can request a replacement card be mailed to them through **Colorado.gov/PEAK.** This will take up to two (2) weeks to arrive and be sent to the member's address on file with CBMS.
- Call or go in-person to their **local County Department of Human/Social Services** to request a replacement card be mailed. The card will take up to two (2) weeks to arrive and be sent to the member's address on file with CBMS.
- Call the **Medicaid Customer Contact Center** to request a replacement card be mailed. The card will take up to two (2) weeks to arrive and be sent to the member's address on file with CBMS.

Although there are many ways for members to get a copy of their Medicaid ID card, an **ID card does not guarantee eligibility for Medicaid**. Providers should verify member identity and eligibility at each appointment. For additional information on how to verify a member's eligibility see pages 22-24 of the General Provider Information Billing Manual.

Special cases: Though accessing a medical ID card through PEAK*Health* and Colorado.gov/PEAK works for most members, there is a small population of members who may not be able to access their card online. In this situation, the members must be referred to their local County Department of Human/Social Services to obtain a letter of eligibility.

Building Better Health Conference

Registration is now open for the Building Better Health Conference! This comprehensive event will include:

- Training on the health coverage application process and marketplace plan selection
- Access to the latest uninsured data and coverage resources
- Networking time with other health coverage guides, assistance site navigators, certified application assistants, brokers, community-based organizations and advocates

Keynote Speaker: Hear a powerful story from this year's keynote speaker, Regina Holliday, about helping people connect to the care they need through coverage. Regina is a patient advocate and artist known for painting murals depicting the need for transparency in medical records.

For more event details, click here.

This statewide health coverage open enrollment kick-off event is hosted by the Colorado Health Foundation in partnership with Connect for Health Colorado, the Colorado Department of Health Care Policy and Financing, the Colorado Consumer Health Initiative, the Colorado Division of Insurance, PEAK Outreach, and Colorado Covering Kids and Families. Register today to join your colleagues and prepare for the 2016 open enrollment period.

Building Better Health Conference

Sept. 28-29, 2015
Crowne Plaza DIA
15500 E 40th Ave.
Denver, CO 80239

Providing resources, facilitating connections and inspiring enthusiasm for health coverage.

Record Retention

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

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

Each medical record entry must be signed and dated by the person ordering and providing the service. Computerized signatures and dates may be applied if the electronic record keeping system meets Colorado Medical Assistance Program security requirements. Records must be retained for at least six (6) years, or longer if required by regulation or a specific contract between the provider and the Colorado Medical Assistance Program.

Labor Day Holiday

Due to the Labor Day holiday on Monday, September 7, 2015, State offices, DentaQuest, the Department's fiscal agent, and the ColoradoPAR Program offices will be closed. The receipt of warrants and Electronic Funds Transfers (EFTs) may potentially be delayed due to the processing at the United States Postal Service (USPS) or providers' individual banks.

Dental Providers

"Take 5" Pay for Performance Program – New Details

The Department is pleased to announce it has finalized program details for the "Take 5" Pay for Performance program now that required federal approval from CMS has been received. The Centers for Medicare and Medicaid Services approved the "Take 5" program for dental providers who have increased their participation in the Colorado Medicaid Dental Program by providing a "dental home" for new members. The approved qualifying time frame for providers to see new members twice is from October 1, 2014 to December 31, 2015. This increased the qualifying evaluation period from 12 to 15 months. There is still time to reach the highest tier and receive the maximum payment!

The "Take 5" Program payments will be made by DentaQuest via **paper checks that will be mailed to the billing entities** on behalf of the rendering providers. The Department expects the first round of payments for "Take 5" program participation to be sent by DentaQuest shortly after mid-September and on a monthly basis moving forward. Please review the Take 5 Frequently Asked Questions (FAQ) flyer or contact DentaQuest Provider Services at 855-225-1731 for more information.

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

Billing Manual Updates

- Wheelchairs: As of September 1, 2015, the PAR requirements for power wheelchair group 34 batteries changed from PAR always required to PAR required for purchase but not for repair.
- Continuous and Bi-Level Positive Airway Pressure (CPAP/BiPAP) Devices: For the under 21 population, providers may request rental PARs for greater than three (3) months to reach the compliance level necessary for a purchase to be approved.

Questionnaire #10 – Oral & Enteral Nutrition Formula

As posted in the August 2015 provider bulletin, DME Questionnaire #10 was updated on July 31, 2015. As the change to the form was minor and focused toward a specific demographic, both versions of the form will be accepted until further notice. Please note that the DME Questionnaires are only required when stated as a requirement in the DME and Supplies Billing Manual, found on the Departments' website, Billing Manuals page.

Obstetrical Care

Newborn Hearing Screening: Provision and Reimbursements

Provider Eligibility

Newborn hearing screens are provided to infants prior to discharge from a hospital or birthing center. Eligible providers must be appropriately trained to operate any automated hearing screening equipment for testing newborns. If the newborn does not pass the first screening test or a second follow-up hearing test (only billable if the second screening occurs on dates of service outside of the date span for the delivery admission), the newborn should be referred to a specialist for further testing.

Appropriately trained certified nurse midwives (CNMs) will be eligible to provide and bill for these newborn hearing tests as of October 1, 2015 as follows:

- Use the procedure code: **92585**, and
- Include modifier **'33'** (for prevention and wellness services) on the service claim.

Reimbursement for newborn hearing screens will also be available to licensed Freestanding Birth Centers (FSBCs) enrolled with the Colorado Medical Assistance Program as a provider and to Medicaid enrolled physicians and CNMs performing home births when these screening services are rendered to Medicaid members and when:

- Practitioners, such as CNMs, provide hearing screens at birth centers and are enrolled as Medicaid providers and affiliated with the birth center under which claims are submitted.
- The FSBC has received licensure through the Colorado Department of Public Health and Environment (CDPHE), is designated as an FSBC and a non-physician practitioner group in Colorado Medicaid, and
- The affiliated CNMs are enrolled as CNMs, and
- The physicians or CNMs who perform home births are enrolled Medicaid providers and carry malpractice insurance that covers home births.

Newborn Hearing Screens, when done in a hospital setting, are included in the hospital Diagnosis Related Group (DRG) services for delivery and cannot be billed separately by providers during the date span of the hospital delivery stay. For additional information related to hospital deliveries, please see the July 2015 provider bulletin.

Billing Requirements

Claims should be submitted via the web portal using the 837 Professional (837P) electronic transaction, through a clearinghouse, or on a CMS 1500 claim form and utilize the following:

Description	Procedure Code	Modifier – Preventive Service
Newborn Hearing Screens	92585	33

Please contact Melanie Reece at Melanie.Reece@state.co.us or 303-866-3693 with questions or for additional information.

Pharmacy Providers

Morphine Equivalent Limitations Update

Implementation of the morphine equivalent limitations policy has been **delayed**. The Department is continuing to develop a policy for opioid-containing products and methadone that will apply a limit on the total daily milligrams of opioids and methadone that can be dispensed using morphine equivalents conversion calculations. Under this new policy, the daily milligrams of morphine equivalents for each opioid containing agent (including both long-acting and short-acting) and methadone that a member is currently taking will be added together. Prescriptions that exceed the maximum daily limit will be denied. In addition, the current policy that limits short-acting opioids to four (4) per day, except for acute pain situations, will continue to be in effect. The Department anticipates implementing this policy in the next few months. Further details will be provided in future announcements.

Preferred Drug List (PDL) Update

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

- All Hepatitis C agents will require prior authorization. The preferred product will be Viekira Pak.
- Oral anticoagulants preferred products will continue to be warfarin however, if a member fails warfarin, the preferred step-through oral anticoagulant will continue to be Xarelto.
- Bisphosphonate preferred products will continue to be alendronate tablets.
- Biguanide preferred products will continue to be metformin and metformin extended release.
- Hypoglycemic combinations will continue to be non-preferred.
- Meglitinide products will continue to be non-preferred.
- Newer diabetic agents will 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.
    - The Amylin category will remain non-preferred.
- Thiazolidinedione preferred product will continue to be pioglitazone.
- Erythropoiesis stimulating agents preferred product will change to Epogen.
- Overactive bladder agent preferred products will continue to be Oxybutynin tablets, Oxybutynin ER tablets, and Toviaz.
- Stimulants and ADHD preferred products will be brand name only Adderall XR, brand or generic Adderall immediate release, brand only Focalin immediate release, brand only Focalin XR, brand and generic Ritalin immediate release, brand and generic Ritalin SR and LA, Strattera, Vyvanse, brand only Intuniv ER, and generic Concerta.

The current PDL can be found in the Forms section of the Department's website under the Pharmacy subgroup.

September and October 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.

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

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.

September 2015

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
13	14	15 CMS 1500 9:00AM-11:30AM Web Portal 837P 11:45AM-12:30PM ***WebEx*** NHVP 1:00PM-3:00PM Personal Care 1:00PM-3:00PM Web Portal 837P 3:45PM-4:30PM	16 UB-04 9:00AM-11:30AM Web Portal 837I 11:45AM-12:30PM ***WebEx*** IP/OP 1:00PM-3:00PM	17 Waiver 9:00AM-11:30AM Web Portal 837P 11:45AM-12:30PM Personal Care 1:00PM-3:30PM Web Portal 837P 3:45PM-4:30PM	18 ***WebEx*** CMS 1500 9:00AM-11:30AM ***WebEx*** Web Portal 837P 11:45AM-12:30PM Dialysis 1:00PM-3:00PM	19

October 2015

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
11	12	13 CMS 1500 9:00AM-11:30AM Web Portal 837P 11:45AM-12:30PM Vision 1:00PM-3:00PM	14 ***WebEx*** UB-04 9:00AM-11:30AM ***WebEx*** Web Portal 837I 11:45AM-12:30PM Nursing Facility 1:00PM-3:00PM	15 Pharmacy 9:00AM-11:00AM ***WebEx*** Home Health 1:00PM-3:00PM	16 Practitioner 9:00AM-11:00AM Transportation 1:00PM-3:00PM	17

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: 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: 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 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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Elephant by Ealancheliyan S.
Medicine by Yefei
Check-list by Sherrinfo