Provider Bulletin

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colorado.gov/hcpf

In this issue:

All Providers....1
Possible Payment Delay....1
Reimbursement Rate Reductions....1
CRICC Update....1
Benefits Collaborative Update – Reproductive Health Services....2
Health Care Policy and Financing Disease Management Program Changes....2
Audiology Providers....2
Cochlear implants Reminder....2
FQHC Providers....3
CPT and CDT Codes....3
HCBS and CMAS Providers....3
Critical Incident Reporting System Changes....3
Adult HCBS PAR Changes....5
Supply/DME Providers....5
DMEPOS Supplier Accreditation....5
Correction to Ocular Prosthetic Benefits and Billing Requirements Article....6
Correction to 2009 Supply HCPCS Codes Bulletin....6
Pharmacy Providers....6
Reimbursement Rate Change....6
PDL Update....6
Global Prior Authorization....6
Rx Review Program....7
Independence Day Holiday....7
Electronic Provider Bulletin Notification....7
Enjoy the Benefits of Direct Deposit....7
June and July 2009 Denver Provider Billing Workshops....7

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

ACS Contacts

Billing and Bulletin Questions
303-534-0146
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

All Providers

Possible Payment Delay

Due to the current economic conditions, the possibility exists that we will be required to delay payments scheduled to be made June 30, 2009 until July 7, 2009. According to 25.5-4-401(1)(c), C.R.S. (2008), we will not take this step unless we are notified jointly by the director of the Office of State Planning and Budgeting and the State Controller that there is the possibility that adequate funds will not be available to make payments to providers and for other state expenses. As of the time of this bulletin, we have not yet been informed that adequate funds are not available.

If we have to delay this payment, notifications will be posted on Provider Claim Reports (PCRs), in a future bulletin, and on the Provider Services Home Page at colorado.gov/hcpf ➡ Providers ➡ Provider Services. An email notification will also be sent to those who have a valid email address on file with the fiscal agent, ACS.

If you have questions about claims processing or the payment cycle, please contact ACS Provider Services at 303-534-0146 or 1-800-237-0757. If you have questions about our policy, please contact Joanne Lindsay at 303-866-3144.

Reimbursement Rate Reductions

In order to balance the budget, the Long Bill for Fiscal Year 2009-2010, signed by the governor includes a two percent rate reduction for Medicaid providers. The Department of Health Care Policy and Financing (the Department) was given the flexibility to try and achieve the reduction in expenditures through targeted utilization and volume reductions. Efforts targeted at eliminating waste, duplication and unnecessary services which can be quantified, tracked, and reported can be used to off-set the across-the-board rate reductions.

The Department is reaching out to all stakeholders to request that you partner with us in exploring opportunities to achieve reductions in Medicaid expenditures through focused and thoughtful initiatives. All of the recommendations received by Department staff will be evaluated for feasibility. If no viable ideas are instituted, the two percent reduction will be implemented on July 1, 2009.

After three to six months of tracking expenditure and utilization patterns for changes that were implemented, the Department will measure the efforts in order to determine if budget targets are being met. If expenditures exceed targets, the Department will be forced to implement larger rate reductions. Please assist us in reaching our targets by sending your ideas to ProviderSuggestions@hcpf.state.co.us by **June 11, 2009**. Ideas submitted after this date will be evaluated for implementation at a later time.

Colorado Regional Integrated Care Collaborative (CRICC) Update

The Department partnered with Colorado Access and Kaiser Permanente to implement the Colorado Regional Integrated Care Collaborative (CRICC).

The goal of the CRICC program is to improve the quality of care received by Colorado Medicaid's highest-need, highest-cost fee-for-service clients by better coordinating health services.

Beginning in June 2008, CRICC was implemented and available to eligible Medicaid clients in Adams, Arapahoe, Boulder, and Broomfield counties through Colorado Access. **Beginning August 2009, the program will expand into Weld County.** The CRICC program will be available to Medicaid clients living in Weld County who are in the following eligibility categories: Aid to the Needy Disabled/Aid to the Blind (AND/AB-SSI) and Old Age Pension – Under Age 65 (OAP-B).

The program will exclude: clients 20 and under, dual eligibles, clients receiving Home and Community Based Services (HCBS) waivers with the exceptions of the Persons with Major Mental Illness (MI) and Elderly, Blind and Disabled (EBD) waivers.

The Department is also partnering with Kaiser Permanente to implement an additional CRICC program **effective August 1, 2009 in Jefferson County.**

The Kaiser Permanente CRICC program will be available to Medicaid clients living in Jefferson County who are in the following eligibility categories: AND/AB-SSI and OAP-B. The program will exclude: clients 20 and under, dual eligibles, clients receiving HCBS waivers with the exceptions of the MI and EBD waivers.

For more information about this program, please contact Cindi Terra at the Department (Cindi.Terra@state.co.us), Stephanie Denning at Kaiser Permanente (Stephanie.P.Denning@kp.org), or April Abrahamson at Colorado Access (April.Abrahamson@coaccess.com).

Benefits Collaborative Update- Reproductive Health Services

Maternity Services, Family Planning Services, Women's Health and Abortion Services policy statements have been drafted by the Reproductive Health Services Benefits Collaborative. These draft policies will be posted for a 30-day public comment period in the first week of June. Drafts can be found on the Department's Web site at colorado.gov/hcpf ➡ Boards & Committees ➡ Benefits Collaborative.

The Department encourages all interested stakeholders to review the policies and offer feedback to Jagruti Shah at jagruti.shah@state.co.us or 303-866-2245.

Health Care Policy and Financing Disease Management Program Changes

We are changing the Disease Management program funding to work towards an integrated care model.

The following information highlights important changes in the Department's Disease Management Programs. As such, the current Disease Management Programs listed below will no longer be in effect as of July 1, 2009:

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Colorado Maternity Care Program
- Fitlogix Weight Management Program

We are working closely with each vendor to ensure a smooth transition and disenrollment from the program for each client. All clients will be given the nurse advice line and other resource lists related to their specific disease condition. Please keep in mind that the Department will continue to look towards an integrated care model for the disease management programs.

If you are currently treating a Medicaid client enrolled in one of the above programs and you have questions, please contact Bernadette Marra at 303-866-6076.

Audiology Providers

As a reminder, cochlear implants are not a covered benefit for Medicaid clients over age 20, and providers must pre-authorize cochlear implants for clients under age 21.

If you have any questions, please contact Marcy Bonnett (Policy Specialist-Adult Audiology) at 303-866-3604 or Gina Robinson (Early Periodic Screening, Diagnosis, and Treatment [EPSDT] Supervisor) at 303-866-6167.

Federally Qualified Health Center (FQHC) Providers

Effective July 1, 2009, Federally Qualified Health Centers (FQHCs) are required to include Current Procedural Terminology (CPT) codes or Current Dental Terminology (CDT) codes on all claims.

The purpose of this change is to provide the Medicaid program with basic clinical information for use in evaluating services requested and received by Medicaid clients.

The CPT codes and Healthcare Common Procedure Coding System (HCPCS) codes for laboratory, X-ray, supplies, and other services must all be used with revenue code 529. Payment for an encounter will be based on the first line of the claim. No subsequent line will generate a payment and will be treated as duplicates by the Medicaid Management Information System (MMIS).

The FQHC/RHC Billing Manual has been updated and is available at colorado.gov/hcpf ➡ Providers ➡ Provider Services ➡ Billing Manuals.

If you have any questions or concerns, please contact Eric Wolf at eric.wolf@state.co.us or 303-866-5963.

HCBS Providers and Case Management Agencies (CMA) for HCBS-EBD, HCBS-MI, HCBS-BI, HCBS-PLWA, Children's HCBS, HCBS-PHW, HCBS-CWA and LTHH

Critical Incident Reporting System Changes

The Department has made improvements to the Critical Incident Reporting System (CIRS) in the Business Utilization System (BUS), which will be implemented on **June 1, 2009**. The BUS CIRS was originally implemented by the Department in December 2007. Since implementation, the Department has been reviewing the data collected in an effort to provide appropriate monitoring and oversight of the health and welfare of HCBS waiver clients. As a result of this ongoing review, the Department has made changes to the CIRS to improve the value and utility of the CIRS process.

The Department has made the following improvements:

- Modified the types of incidents captured in the CIRS
- Addition of incident type specific descriptors to provide more incident detail
- Limiting entry to one (1) type of incident per report to focus reporting process
- Addition of identification of provider reporting the incident to Single Entry Point (SEP)/CMA
- Addition of internal procedures to improve incident follow-up information

What types of incidents need to be reported?

- Death
- Suspected Abuse, Neglect or Exploitation
- Serious Injury to or Illness of Client
- Damage to Client's Property/Theft
- Medication Management Issues
- Other High Risk Issues

Which waiver programs need to report incidents in the BUS?

The Department's BUS CIRS has been established to report incident information involving clients enrolled under Long-Term Home Heath (LTHH) and the following waiver programs:

- Children's HCBS
- Persons with Major Mental Illness (MI)
- Elderly, Blind and Disabled (EBD)
- Children with Autism (CWA)
- Persons Living with HIV/AIDS (PLWA)
- Persons with Traumatic Brain Injury (BI)
- Pediatric Hospice Waiver (PHW)

Incident Definitions:

Death

Any death of an accidental, intentional or suspicious nature or any death, including incidents involving law enforcement (law enforcement investigation) or a coroner must be reported. If there is any reason to believe the death may be accidental, of a suspicious nature, or NOT due to natural causes, a critical incident should be recorded in the BUS.

Occurrences of death should be reported when it is unexpected or the cause of death is unknown.

If the person has been in ailing health, do not make the assumption that the ailment was the cause of death unless there is reasonable certainty the cause of death was an expected outcome of the client's ongoing illness.

Suspected Abuse, Neglect or Exploitation

- **Abuse** includes actions which result in bodily harm, pain or mental distress.
- **Neglect** is a failure to provide care and service when an adult is unable to care for him or herself.
- **Exploitation** is the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a client's belongings or money without the client's consent.

Serious Injury to or Illness of Client

Injury or illness requiring treatment beyond first aid includes: lacerations requiring stitches or staples, fractures, dislocations, loss of limb, serious burns, skin wounds, etc. Illness or injury requiring immediate emergency medical treatment to preserve life and/or limb; or resulting in emergency admission to the hospital.

Damage to Client's Property/Theft

Deliberate damage, destruction, theft, misplacement or use of a client's belongings or money without the client's consent. Also, includes the deliberate diversion of medications.

Medication Management:

Problems with medication dosage, scheduling, timing, set-up, compliance, administration or monitoring which result in documented harm or an adverse effect which necessitates medical care.

Other High Risk Issues:

Serious issues that do not yet rise to the level of a critical incident, but have the potential to do so in the future. This could include events such as environmental hazards, suicide threats, self-injurious behaviors, arrest or detention, etc.

HCBS waiver provider requirements

- All HCBS waiver service providers, regardless of the nature of services provided, are required to report incidents to their area SEP agency or CMA within one (1) business day of learning of an incident.
- SEP/CMAs are required to report all critical incidents they learn of, directly or indirectly, to the Department within one (1) business day of learning of an incident in the BUS.
- Reporting critical incidents in the BUS does not relieve the provider, provider agency or SEP/CMA of other forms of mandated reporting, including reports to law enforcement, Child or Adult Protective Services, or Occurrence Reports to the Colorado Department of Public Health and Environment.

Reminders

- If an incident occurs, the crucial first step is to ensure the safety of the persons involved, providing needed first aid, or obtaining medical care.
- Incident reports should clearly identify what specific efforts have been made to secure client safety and stability and whether client care needs have changed as a result of the incident.
- A "Critical Incident" is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the health or welfare of a client. A critical incident could have, or has had, a negative impact on the mental and/or physical well being of a consumer in the short or long term.

Adult HCBS PAR Changes

The *Request for Adult HCBS Prior Approval and Cost Containment* (PAR) forms and PAR approval process for HCBS-EBD, HCBS-MI, HCBS-PLWA, and HCBS-BI clients will change effective July 1, 2009.

Changes to the PAR include:

The revised PAR form for HCBS-EBD, HCBS-MI and HCBS-PLWA includes the addition of a Consumer-Directed Attendant Support Services (CDASS) section for documenting the Effective Date of CDASS, the CDASS Monthly Allocation Amount, and the CDASS Monthly Administrative Fee.

Other revisions to this form and the HCBS-BI form include the addition of a Case Manager's Supervisor Signature line with Agency and Date fields and a field title change from "Authorizing Agent Signature" to "Department Approval Signature."

Changes to the PAR Approval process include:

All HCBS PARs require the authorizing case manager's signature in order to be approved by ACS. In addition, per the Dear Administrator Letter (DAL) 07-03-CB, *Request for Adult HCBS Prior Approval and Cost Containment,* all PAR requests that exceed the Daily Cost Containment Ceiling *are required to* include the following two signatures: 1. SEP case manager, and 2. SEP case management supervisor. Furthermore, when the Daily Cost Containment Ceiling is exceeded by $250.00 or more, the PAR is required to contain the following three signatures: 1. SEP case manager, 2. SEP case management supervisor signature, and 3. Department approved signature. Absent the required signatures, ACS and/or the Department will deny the PAR and return the form for correction.

The PAR approval notification process is also changing to the following: Upon PAR approval by authorized Department staff, an email and a copy of the Department approved PAR will be sent to the SEP agency case manager informing him/her of the Department's approval or denial. Upon receipt of the approval, the SEP case manager shall forward a copy of the approved PAR to the applicable provider agency. The Department will send the original approved PAR directly to ACS.

The revised PAR forms can be found at colorado.gov/hcpf ➡ Providers ➡ Provider Services ➡ Forms.

A diagram depicting the Cost Containment/Authorization process is located at colorado.gov/hcpf ➡ Providers ➡ Provider Services ➡ Forms.

Send any questions about these revisions to the Community Based Long Term Care (CBLTC) Section's FAQ email address CBLTC.FAQ@state.co.us.

Supply/DME Providers

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier Accreditation

Effective October 1, 2009, suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) who bill Medicare under Part B must be accredited in order to retain or obtain a Medicare Part B billing number. As Colorado Medicaid pays Part B coinsurance, accreditation must also be obtained in order to bill Medicaid.

Accreditation means that Colorado Medicaid DMEPOS suppliers must comply with the Medicare program's supplier standards and quality standards. Requirements apply to supplier of durable medical equipment, medical supplies, home dialysis supplies and equipment, therapeutic shoes, parental/enteral nutrition, transfusion medicine and prosthetic devices, and prosthetics and orthotics.

Further information on the DMEPOS accreditation requirements along with a list of the accreditation organizations and those professionals and other persons exempted from accreditation may be found at the Centers for Medicare & Medicaid Services (CMS) Web site at http://www.cms.hhs.gov/MedicareProviderSupEnroll/03_DeemedAccreditationOrganizations.asp.

Correction to Ocular Prosthetic Benefits and Billing Requirements Article (B0900266 – May 2009)

The correct fax number for codes that require a pre-authorization by CFMC is **303-790-4643**. The PAR request form should be faxed to the CFMC at this number**.** The fax number published in the May 2009 bulletin (B0900266) was incorrect.

The correct contact phone number for questions is the CFMC PAR-line at **1-800-333-2362**.

Correction to 2009 Supply HCPCS Codes Bulletin (B0900261)

On page 73 of the DME/Supply bulletin, code E0625 is incorrect. The correct code is E0235. The corrected bulletin, 2009 Supply HCPCS Codes (B0900261 - Revised 05/09) has been posted at colorado.gov/hcpf ➡Providers ➡Provider Services ➡Bulletins.

Pharmacy Providers

Reimbursement Rate Change

Effective July 1, 2009, the Average Wholesale Price (AWP) reimbursement methodology will change to AWP minus 14% for brand name medications and AWP minus 40% for generic medications. Currently, the Department reimburses pharmacy claims using the lesser of four pricing methodologies including: Federal Upper Limit, Average Wholesale Price (AWP) minus 13.5% for brand name medications and AWP minus 35% for generic medications; Direct Price plus 18%; and Submitted Charge.

Preferred Drug List (PDL) Update

Effective July 1, 2009, the following medications will be preferred agents on the Medicaid PDL and will be covered without a prior authorization:

Antihistamines (newer generation):
cetirizine and loratadine in all dosage forms

Angiotensin Receptor Blockers:
Atacand, Avapro, Benicar, Cozaar, Diovan and Micardis

Angiotensin Receptor Blocker Combinations:
Atacand-HCT, Avalide, Benicar-HCT, Hyzaar, Diovan-HCT, and Micardis-HCT

Anticholinergic Inhalants:
ipratropium nebulizer solution, Atrovent HFA and Spiriva

Anticholinergic and Short Acting Beta-2 Agonist Combinations:
albuterol/ipratropium nebulizer solution and Combivent inhaler

Corticosteroid Inhalants:
Pulmicort in nebulizer solution and Flexhaler, Flovent HFA and diskus and Qvar inhalers

Corticosteroid and Long-Acting Beta-2 Agonist Combinations:
Advair diskus products only

Short-acting Beta-2 Agonists:
albuterol nebulizer solution, Ventolin HFA, ProAir HFA and Proventil HFA

Long-acting Oral Opiates:
Kadian (morphine ER), methadone and morphine ER

Skeletal Muscle Relaxants:
baclofen, dantrolene, tizanidine, methocarbamol and cyclobenzaprine

The complete PDL and prior authorization criteria for non-preferred drugs are posted on the PDL Web site at colorado.gov/hcpf ➡Providers ➡Pharmacy ➡Preferred Drug List.

Global Prior Authorization

In order to protect the health of our most vulnerable Medicaid clients, qualified individuals will be exempt for one year from prior authorization requirements for non-preferred drugs (also known as a global prior authorization). They will also be exempt from prior authorization requirements for non-PDL drugs currently requiring prior authorization.

The Department will implement this policy on June 1, 2009. In order to qualify for the global prior authorization, an individual must have a "focal point of care", must be taking four or more medications and/or taking high risk medications and must have a qualifying diagnosis.

For more information or to download the Global Prior Authorization form, visit the Prior Authorization (PA) Web site at colorado.gov/hcpf ➡Providers ➡Pharmacy ➡Prior Authorization Policies.

Rx Review Program

As a result of legislation passed in the 2007 legislative session, the Department created a medication management therapy program known as the Rx Review Program for Medicaid clients who are high drug utilizers (five or more drugs each month for three months in a row).

The Department is looking to contract with pharmacists within the client's community to provide a comprehensive medication evaluation, which includes a review of all prescription medications as well as over-the-counter and nutritional supplements, to identify drug-drug interactions, drug-over the counter/supplement interactions, drug duplication, or use of multiple providers, if any. If you are a pharmacist who is interested in participating in this program, please contact Megan Wood at megan.wood@state.co.us.

Independence Day Holiday

Due to the observance of Independence Day on Friday, July 3, 2009, claim payments will be processed on Thursday, July 2, 2009. The processing cycle includes electronic claims accepted before 6:00 P.M. MST on Thursday.

Electronic Provider Bulletin Notification!

Help save postage costs by receiving an electronic notification containing a link to the most recent publication. Colorado Medical Assistance Program enrolled providers who are not receiving electronic notifications can complete and submit their information through the "(MMIS) Provider Data Maintenance" option via the Web Portal.

Providers may also complete and submit the Publication Preferences form located at colorado.gov/hcpf ➡Providers ➡Provider Services ➡Forms. Please fax or mail the completed form to the fiscal agent at the fax number or address on the form.

The Colorado Medical Assistance Program will not be responsible for undeliverable notifications due to incorrect email addresses. Providers may have only one email address on file with the fiscal agent.

Enjoy the Benefits of Direct Deposit

Providers who use Electronic Funds Transfer (EFT) can receive payments up to a week sooner than those receiving paper checks (warrants). EFT eliminates payment delays due to inclement weather, holidays, or post office mishaps.

Sign-up to receive payments via EFT today! Complete the EFT form located at colorado.gov/hcpf ➡Providers➡ Provider Services ➡Forms.

You may also use the same form noted above to update your bank account information by indicating "Change" in the top-right corner and complete the form as directed. Please allow 30 days to process your EFT request.

You will receive paper warrants until EFT has been established or your update request has been processed. After 30 days, check with your bank to verify that EFT has been setup. You may contact the Department at 303-866-4372 with any EFT questions.

June and July 2009 Denver Provider Billing Workshops

Provider billing workshops include both Colorado Medical Assistance Program billing instructions and a review of Colorado Medical Assistance Program billing procedures.

The June and July 2009 workshop calendars are included in this bulletin and are posted at colorado.gov/hcpf ➡Providers➡ Provider Services ➡Training & Workshops.

Who Should Attend?

New and experienced receptionists, front desk personnel, admission personnel, office managers, billing services, and other billers should consider attending the appropriate workshops.

Reservations are required

Reservations are necessary for ***all workshops***.

Email reservations to:
workshop.reservations@acs-inc.com

Or

Call Provider Services to make reservations:
1-800-237-0757 or 303-534-0146

Press "**5**" to make your workshop reservation. You must leave the following information:

- Colorado Medical Assistance Program provider billing number
- The date and time of the workshop
- The number of people attending and their names
- Contact name, address and phone number

Without all of the requested information, your reservation will not be processed successfully. Your confirmation will be mailed to you within one (1) week of making your reservation.
If you do not receive a confirmation within one (1) week, please contact Provider Services and talk to a Provider Relations Representative.

All Workshops held in Denver are located at:
ACS
Denver Club Building
518 17th Street, 4th floor
Denver, Colorado 80202

Beginning Billing Class Description

These classes are for new billers, billers who would like a refresher, and billers who would like to network with other billers about the Colorado Medical Assistance Program. Currently, the class covers in-depth information on resources, eligibility, timely filing, reconciling remittance statements, and paper claim completion for the UB-04 and the Colorado 1500. *These classes do **not** cover any specialty billing information.* The fiscal agent provides specialty training throughout the year in their Denver office.

The classes do <u>not</u> include any hands-on computer training.

Enrollment Application Workshop Description

This workshop focuses on the importance of correctly completing the Colorado Medical Assistance Program Provider Enrollment Application.
Newly enrolling providers, persons with the responsibility for enrolling providers within their groups, association representatives, and anyone who wants to better understand the Colorado Medical Assistance Program enrollment requirements should attend.

Specialty Classes Descriptions

DME/Supply

This class is for billers using the CO1500/837P claim format. The class covers billing procedures, common billing issues and guidelines specifically for Supply/DME providers.

DME/Supply PAR

The PAR class focuses on completing the PAR correctly and avoiding common mistakes. This class is for DME/Supply providers who bill procedures requiring prior authorization.
(This class is not for Dental, HCBS, Nursing Facility, Pharmacy or Pediatric Home Health Providers.)

HCBS-EBD/PLWA/MI

This class is for billers using the Colorado 1500/837P claim format for the following services: adult day care, non-medical transportation, home electronics, home modifications and personal care. The class covers billing procedures, common billing issues, and guidelines specifically for the following provider types:

HCBS-EBD HCBS-PLWA HCBS-MI

HCBS-BI

This class is for billers using the Colorado 1500/837P claim format for the following services: adult day care, non-medical transportation, home electronics, home modifications, and personal care. The class covers billing procedures, common billing issues, and guidelines specifically for HCBS-BI providers.

Hospital (IP/OP)

This class is for billers using the UB-04/837I claim format. The class covers billing procedures, common billing issues and guidelines specifically for: In-patient Hospital, Out-patient Hospital *(This is **not** the class for FQHC/RHC providers)*

Pharmacy
This class is for billers using the Pharmacy claim format/Point of Sale and/or PCF Format. The class covers billing procedures, common billing issues and guidelines specifically for Pharmacies.

Practitioner
This class is for providers using the CO1500/837P format. The class covers billing procedures, common billing issues and guidelines specifically for the following provider types:

- Ambulance
- Anesthesiologists
- ASC
- Family Planning
- Independent Labs
- Independent Radiologists
- Nurse Practitioner
- Physician Assistant
- Physicians, Surgeons

Driving directions to ACS, Denver Club Building, 518 17th Street, 4th floor, Denver, CO:

Take I-25 toward **Denver**
Take exit **210A** to merge onto **W Colfax Ave (40 E),** 1.1 miles
Turn **left** at **Kalamath St,** 456 ft.
Continue on **Stout St,** 0.6 miles
Turn **right** at **17th St,** 0.2 miles

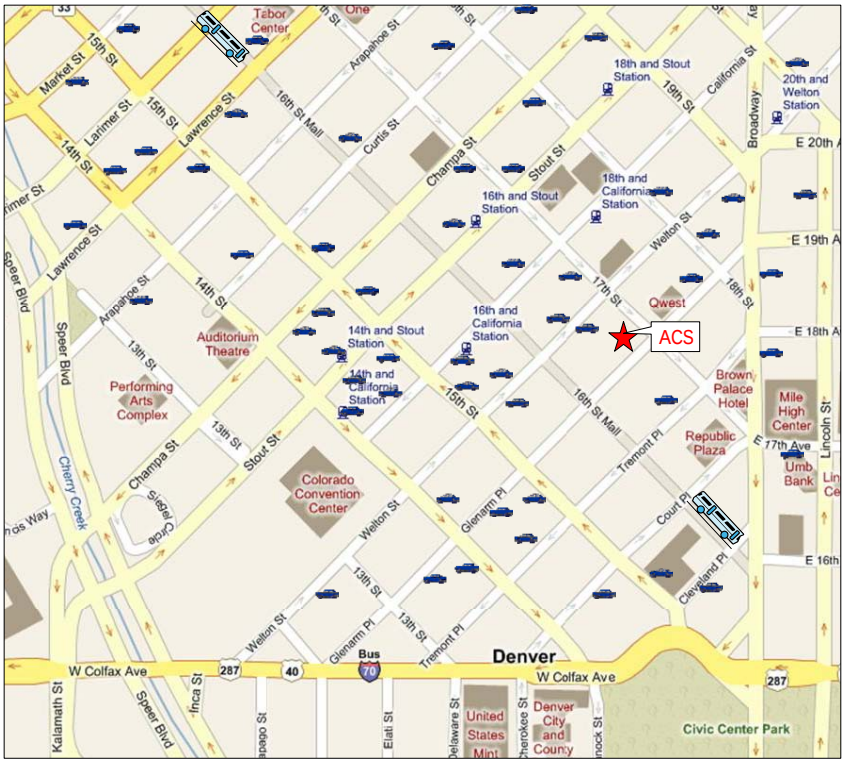
ACS is located in the Denver Club Building on the west side of Glenarm Place at 17th Street (Glenarm is a two-way street).

Parking: Parking is not provided by ACS and is limited in the Downtown Denver area. Providers attending workshops are urged to carpool and arrive early to secure parking or use public transportation.

= Light Rail Station: A Light Rail map is available at:
http://www.rtd-denver.com/LightRail/lrmap.htm

= **Free** MallRide: MallRide stops are located at every intersection between RTD's Civic Center Station and Union Station.

= Commercial parking lots: Lots are available throughout the downtown area. The daily rates are between $5 and $20.



Please direct questions about Colorado Medical Assistance Program billing or the information in this bulletin to
ACS Provider Services at 303-534-0146 or 1-800-237-0757 (toll free).
Please remember to check the Provider Services section of the Department's Web site at colorado.gov/hcpf.

June 2009

Sun	Monday	Tuesday	Wednesday	Thursday	Friday	Sat
	1	2	3	4	5	6
7	8	**9** Beginning Billing – Colorado 1500/837P 9:00AM-2:00PM	**10** HCBS-EBD 9:00AM-11:30AM HCBS-BI 1:00PM-3:30PM	**11** Beginning Billing – UB-04/837I 9:00AM-2:00PM	**12** DME/Supply PAR 9:00AM-11:00AM DME/Supply 11:30AM-1:30 PM Pharmacy 2:30 PM-4:00PM	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

July 2009

Sun	Monday	Tuesday	Wednesday	Thursday	Friday	Sat
			1	2	3	4
5	6	7	8	9	10	11
12	13	14 Beginning Billing – Colorado 1500/837P 9:00AM-2:00PM IP/OP – 3:00PM-4:30 PM	15 Provider Enrollment 9:00AM – 12:00PM	16 Beginning Billing – UB-04/837I 9:00AM-2:00PM Practitioner – 1:00-3:00 PM	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	